RAE Name: Health Colorado, Inc. (Health Colorado) **Region:** Region 4 **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	Annual Well Child Visit	Reduce ED Visits for Ambulatory Sensitive Conditions	Reduce risk of injury							
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. 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 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 comprises 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 4 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 4 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.

☐ 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.

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 which focused on pediatric health care to effectively communicate with and educate parents, grandparents, and caregivers.

- Cellular phone adoption and the use of texting is 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.

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 Clinical Director and the 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: 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: Health Colorado 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) 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 Health Colorado 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 Clinical Director 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 determine the effectiveness and cultural sensitivity of our messages. 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: Reduce Emergency Department Visits for Ambulatory Sensitive Conditions.

Description: We will actively promote The Department of Health Care Policy and Financing's (HCPF) Nurseline 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 4 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:

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 Health Colorado website that focus on how to access Nurseline 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 Clinical Director 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 Nurseline 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 PIAC, Health Colorado 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: Reduce the risk of injury among children and adolescents.

Description: Population Served: Infants, children and adolescents through 18 by communicating through multiple channels with their parents, caregivers and grandparents. This intervention leverages technology through Text4kids in which parents of children ages 1 to 18 receive health information based on their child's age.

We will coordinate with all local partners with whom we have strong and ongoing relationships to provide local opportunities for improving the health of children and adolescents—Departments of Public Health, WIC, schools, churches, EMTs, etc. to name a few.

Our local provider partners are piloting an anti-bullying program to address violence and bullying by young adolescents. Their programs interface with school anti-bullying efforts. The intent of these programs is to improve child safety, and to reduce risk of injury and anxiety among middle school children.

Please check one of the following three options:

☒ Evidence-Based: (1) https://www.cdc.gov/traumaticbraininjury/prevention.html. (2) https://www.cdc.gov/violenceprevention/pdf/yv-technicalpackage.pdf. (3) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2598379/.
☐ Promising Practices:
☐ Other:

How the frequency of intervention will be determined: Multiple campaigns will focus on timely topics, e.g. bike helmets during the summer, appropriate buckling of children in car seats. These will occur weekly or more frequently.

Programs within the Health Neighborhood occur routinely throughout the year.

How the method of delivering the intervention will be determined:

- Focus on use of helmets, appropriate buckling of infants and seat belts
- Supports the CO Opportunity project—addressing needs of children and adolescents through young adult
- Significant issue especially in rural areas
- Coordinate with Departments of Public Health
- Leverage and expand programs in place
- Can use texting and social media as solution in addition to adding information on CONNECTS

Potential outcomes: Reduced injury and death in children. Measured through CDPHE data.