Monitoring the Involvement of Insurance Carrier Case Management Services with Plans of Care
Implementation of HB230

Report of the J Paul Taylor Task Force to the Interim Health and Human Services Committee

14 November 2019

Implementation of the Plan of Care Act: Two generation care for mothers and infants affected by substance use disorders

INVOLVING INSURANCE CARRIERS AND MCOS TO MONITOR Plans Of Care For Substance-Exposed Newborns and their Families

Presenters: Andy Hsi, MD, MPH and Susan Merrill, LCSW

Date: **14 November 2019**

Agenda

- Background – where we've been
- Best Practices – where we want to go
- Implementation and Planning - how are we going to get there
- Roles of Insurance Care Coordinators and other professionals.
- Plan of Care Portal and Forms
- More Best Practices
- Resources

A Collaboration of Stakeholders

- Medicaid managed care organizations
- Advocacy Groups
- NM CYFD
- NM Department of Health
- NM Human Services Department
- Hospitals
- Other Medical Providers
- Indian Health Services
- The Brindle Foundation
- Families

CARA Work Group

The CARA Work Group is co-chaired by Cynthia Chavers (CYFD) and Dr. Andy Hsi (UNM). The group, consisting of approximately 160 public- and private-sector stakeholders, has been working since 2017 to bring the State of New Mexico into compliance with federal law regarding substance-exposed newborns and their families.

Federal Law

The 2016 Comprehensive Addiction and Recovery Act (CARA) amended the Child Abuse Prevention and Treatment Act (CAPTA) to require that states identify and report annually on the following:

- Number of substance-exposed infants born;
- Number of substance-exposed infants for whom a **Plan of Care** has been created; and
- Number of infants with a **Plan of Care** for whom referrals were made to appropriate services, including services for affected family members or caregivers.

State Law

New Mexico has passed a law supporting CARA amendments to CAPTA.

The new law…

- Gives CYFD until January 1, 2020 to develop rules that guide stakeholders in the care of newborns who exhibit physical, neurological, or behavioral symptoms consistent with prenatal drug exposure or fetal alcohol spectrum disorder.
- Specifies that the rules are to include guidance on the creation of a **Plan of Care** for any substance-exposed newborn.
- Provides that pregnant women who communicate use of drugs or alcohol will be offered supports through a **Plan of Care**.
- Provides that CYFD will receive notification if a baby is born substance-exposed, in addition to receiving referrals for suspected abuse or neglect if such referrals are warranted.

Continuum of Care: Opportunities to Improve Outcomes

- **Pre-pregnancy**: Education promoting awareness among women of child-bearing age and their family members of the effects that prenatal substance use can have on infants.
- **Prenatal:** Health care providers have the opportunity to screen pregnant women for substance use as part of routine prenatal care and to make referrals that facilitate access to treatment and related services for the women who need these services.
- **Birth**: Health care providers may identify newborns for prenatal substance exposure at the time of delivery by detailed history or biological specimen testing.
- **Neonatal**: Health care providers can conduct a developmental assessment of the newborn, review the Plan of Care, and ensure access to services for the newborn as well as the family.
- **Throughout childhood and adolescence**: Interventions include the ongoing provision of coordinated services including treatment and behavioral care for both child and family.

Evidence Based Practice: EARLY START

Early Start

A Cost–Beneficial Perinatal Substance Abuse Program

Nancy C. Goler, MD, Mary Anne Armstrong, MA, Veronica M. Osejo, BS, Yun-Yi Hung, PhD, Monica Haimowitz, LCSW, and Aaron B. Caughey, MD, PhD

OBJECTIVE: To conduct a cost–benefit analysis of Early Start, an integrated prenatal intervention program for stopping substance use in pregnancy.

METHODS: A retrospective cohort study was conducted of 49,261 women who had completed prenatal substance abuse screening questionnaires at obstetric clinics and who had undergone urine toxicology screening tests. Four study groups were compared: women screened and assessed positive and followed by Early Start (screened-assessed-followed, n=2,032), women screened and assessed positive without follow-up (screened-assessed, n=1,181), women screened positive only (screened-positive-only, n=149), women in the control group who screened negative (control, n=45,899). Costs associated with maternal health care (prenatal through 1 year postpartum), neonatal birth hospitalization care, and pediatric health care (through 1 year) were adjusted to 2009 dollars. Mean costs were calculated and adjusted for age, race, education, income, marital status, and amount of prenatal care.

RESULTS: Screened-positive-only group adjusted mean maternal total costs ($10,869) were significantly higher than screened-assessed-followed, screened-assessed, and control groups ($9,430; $9,230; $8,282; all *P*<.001). Screened-positive-only group adjusted mean infant total costs ($16,943) were significantly higher than screened-assessed-followed, screened-assessed, and control groups ($11,214; $11,304; $10,416; all *P*<.001). Screened-positive-only group adjusted mean overall total costs ($27,812) were significantly higher than screened-assessed-followed, screened-assessed, and control groups ($20,644; $20,534; $18,698; all *P*<.001). Early Start implementation costs were $670,600 annually. Cost–benefit analysis showed that the net cost benefit averaged $5,946,741 per year.

CONCLUSION: Early Start is a cost-beneficial intervention for substance use in pregnancy that improves maternal–infant outcomes and leads to lower overall costs by an amount significantly greater than the costs of the program.

(Obstet Gynecol 2012;119:102–10)
DOI: 10.1097/AOG.0b013e31823d427d

LEVEL OF EVIDENCE: II

Alcohol, tobacco, and other drug use remains a paramount problem in pregnancy leading to preventable morbidity and mortality in more than 400,000 pregnancies annually.[1–3] Exposure to alcohol, tobacco, and other drugs in pregnancy leads to increased rates of placental abruption, intrauterine fetal demise, low-birth-weight neonates, neonatal abstinence syndrome, and preterm labor and birth.[1,2,4] In turn, preterm birth, associated with short-term and long-term morbidity, adds significant costs.[5] Despite multiple educational advertising campaigns, substance use during pregnancy continues to be significant. Data from the Substance Abuse and Mental Health Services Administration in 2008 revealed no significant decrease in pregnancy usage (5.1% up from 4% in 2005–2006).[6]

In 1990, Kaiser Permanente Northern California developed Early Start, an integrated prenatal intervention program for stopping alcohol, tobacco, and other drug use.[7] The program created the Early Start specialist position, a licensed clinical social worker or marriage and family therapist with expertise in substance use and pregnancy who is located within the obstetrics and gynecology department. Appointments for substance use are linked to routine prenatal care

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Award for Quality Second-Place Selection

: An Integrated Model of Substance ervention for Pregnant Women

By Cosette Taillac, LCSW, BCD
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Mary Anne Armstrong, MA
Kathleen Haley, MS
Veronica Osejo

stance abuse is associated hal and neonatal outcomes. s have prevented pregnant nent. Early Start (ES) breaks g these barriers with a fully model.
ed prenatal substance-abuse ates targeting all pregnant anente Northern California rrently screening more than The program is based on the se is a treatable disease and ental, accepting manner. A is located in each obstetrics one-to-one counseling to at risk for alcohol, tobacco, utine prenatal care package

ed by the Kaiser Foundation ed program effectiveness in tal and maternal outcomes. uded 49,986 KPNC patients th pregnant women whose stance use were positive but ted women had significantly outcome measures. rability of ES has led to both ion. Universal screening of cess to an integrated model nt should be the standard of nt because of the significant ir babies.

Introduction

In the early 1990s, two prevalence studies confirmed that prenatal substance abuse was a significant problem among Kaiser Permanente Northern California (KPNC) patients. An internal prevalence study conducted by neonatologist Marc Usatin, MD (Walnut Creek), from 1989 to 1990 tested newborn meconium for prenatal exposure to street drugs but not alcohol. An overall exposure rate of 3.2% was found for all KPNC birthing facilities. Shortly thereafter, the California Department of Alcohol and Drug Programs conducted a study that included five KPNC hospitals and found rates of perinatal alcohol and drug exposure ranging from 10% to 18% of all births (two KPNC sites had rates higher than the statewide average of 11.35%).[1] This information, coupled with a body of literature documenting adverse neonatal outcomes such as placental abruption, fetal death, premature delivery, and babies born small for gestational age,[2–7] prompted the development of a new approach to treating this population.

Historically, pregnant women at KPNC who were identified as having substance abuse problems were referred by their prenatal clinician to existing internal or community-based treatment programs. These efforts were largely unsuccessful; only a fraction of the women referred to these programs attended them. Several clinicians, concerned about the poor outcomes and poor intervention record with this approach, explored other successful prenatal substance abuse intervention models, all of which were in the public sector at that time. To capitalize on KPNC's strength and history as a vertically integrated program, the clinicians identified models that would further integrate services. Experts from Born Free, a program in Contra Costa County that routinely screened

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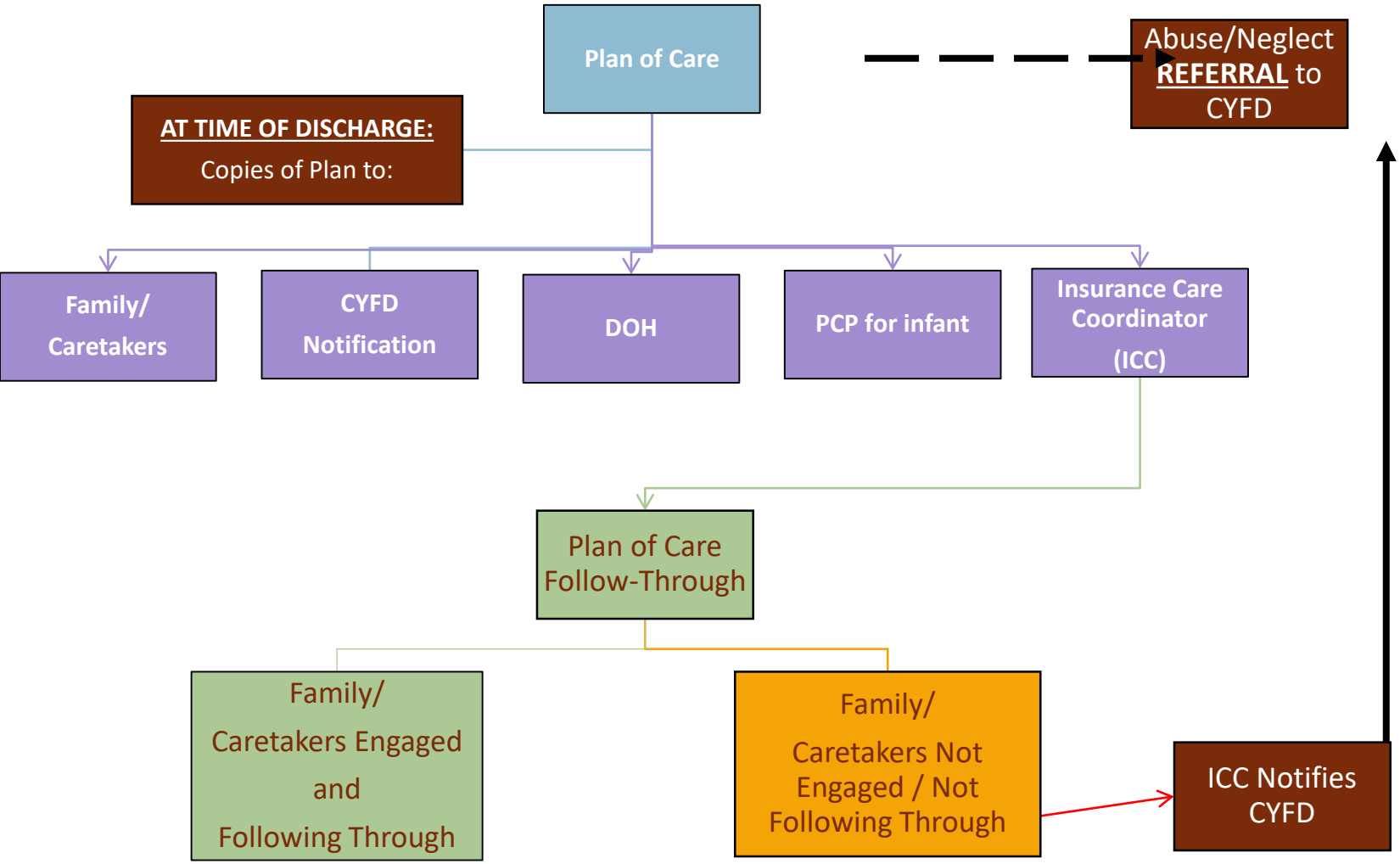
Mary Anne Armstrong, MA, is a biostatistician and investigator at the Division of Research in Oakland, CA. E-mail: maryann.armstrong@kp.org.
Kathleen Haley, MS, is a Project Manager for the Early Start Program for the Patient Care Services Department

What is a Plan of Care?

A Plan of Care is a document created by a healthcare professional and involved family members or caretakers to ensure the safety and well-being of an infant born substance exposed.

The Plan of Care:

- Identifies the newborn and his/her primary caretakers
- Details prenatal substance exposures
- Indicates the post-discharge housing plan
- Details support services engaged prenatally or referred to since delivery for infant and affected family/caregivers
- Notes referral to CYFD Child Protective Services, if applicable


Plan of Care
Abuse/Neglect REFERRAL to CYFD
AT TIME OF DISCHARGE:
Copies of Plan to:
Family/ Caretakers
CYFD Notification
DOH
PCP for infant
Insurance Care Coordinator (ICC)
Plan of Care Follow-Through
Family/ Caretakers Engaged and Following Through
Family/ Caretakers Not Engaged / Not Following Through
ICC Notifies CYFD

Role of the Insurance Care Coordinator

- The goal with this model is that every baby's care giver will be offered a Care Coordinator through their MCO. If a biological parent is the primary care giver, such as the mom, both mom and baby will have the same Care Coordinator.
- For those without insurance, or Medicaid Fee For Service CMS will provide the Care Coordination.
- The Care Coordinator is then responsible for communication with the Primary Care Provider, and assuring that all services/referrals for the baby and family are followed through.

Best Practices: Warm Hand-off

A warm hand-off is any effort you make to assure a follow-through connection between two parties. We have developed a process so that families will have an Insurance Care Coordinator assigned within 24 to 48 hrs prior to discharge.

MCOs report that as many as 50% of referrals fail when the referring entity goes no further than supplying a name and contact information.

If you are a discharge planner, be sure that your patient knows or is introduced to her Insurance Care Coordinator (ICC) - ideally before discharge - because that is the person who will assist the family in implementing the Plan of Care.

If you are an ICC, be sure that your client knows or is introduced to support service providers identified in the Plan of Care.

Who gets copies of the Plan of Care, and why

Infant's Family or Caregivers	Infant's Primary Care Provider (PCP)	Insurance Care Coordinator (ICC)	NM DOH	NM CYFD
Parents/Caregivers are expected to participate in Plan of Care development and implementation.	PCP must be aware of contents of Plan of Care to support implementation	ICC assists family/ caregivers in accessing support services identified in the Plan of Care and other supports the family may need.	NM DOH matches Plan copies to newborn data supplied by hospitals and other birthing facilities.	Plan copies go to NM CYFD per state law. NM CYFD reports de-identified data to the federal government.
			NM DOH assists families/caregivers in accessing services if infant is uninsured or insured without care coordination.	If there is a report to NM CYFD Protective Services, the caseworker will need a copy of the Plan to monitor implementation.

Anticipate Notify *and* Refer

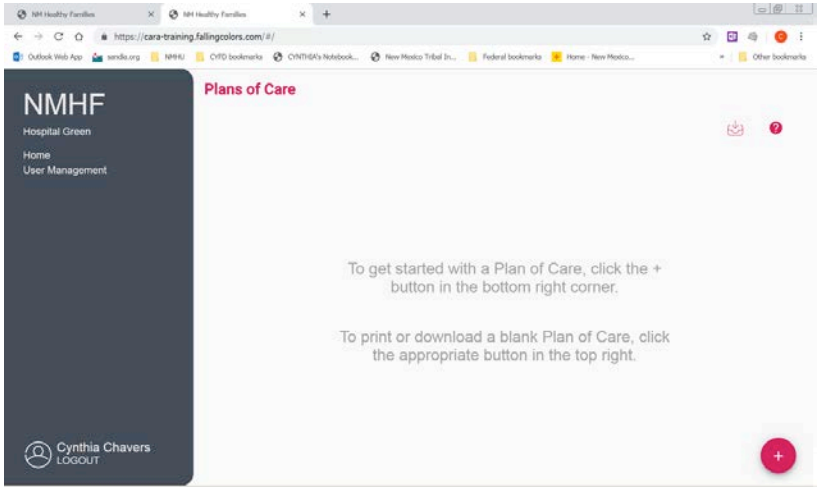
CYFD Notification

To comply with federal reporting requirements under CARA, CYFD must be notified of any infant born substance-exposed. The notification is accomplished by providing a copy of the Plan of Care to CYFD through a portal being designed for this purpose.

CYFD Referral or Report

As in the past, you are expected to report a family to CYFD Child Protective Services if you reasonably suspect that abuse or neglect (either or both) are occurring or are likely to occur in the postpartum phase.

Reserved for introducing CYFD Notification Portal



If substance use disorder or other factors are interfering with the parents' ability to care for the infant, or if there are concerns that the family does not have adequate supports, a referral shall be made to CYFD Child Protective Services for potential child abuse/neglect. Creating a Plan of Care does not exempt the family from potential investigation by CYFD. Dial #SAFE.

Plan of Care

This 3-page document must be completed before discharge.

Infant Name:	Admission Date:
D.O.B.:	Discharge Date:
Discharge Address (Street, City, Zip Code):	Discharge Phone:

Infant's Discharge Housing Status (Circle one):

Parental Home Designated Caregiver Home Facility/Shelter Precariously Housed

Plan of Care

Identify ICC and PCP as well as key household members.

Infant's Insurance Care Coordinator (ICC):	Infant's Primary Care Provider (PCP):
ICC Phone:	PCP Phone:
ICC Fax:	PCP Fax:
Health Insurance Company: _____ Health Insurance Plan: _____	First Appointment Following Discharge: ____/___/___ ____:____ AM/PM

Key Household Members: Birth parent(s), adoptive or foster parent(s), or designated caregiver(s).

Name	Age	Relationship to Infant	Contact Information
1.			
2.			
3.			

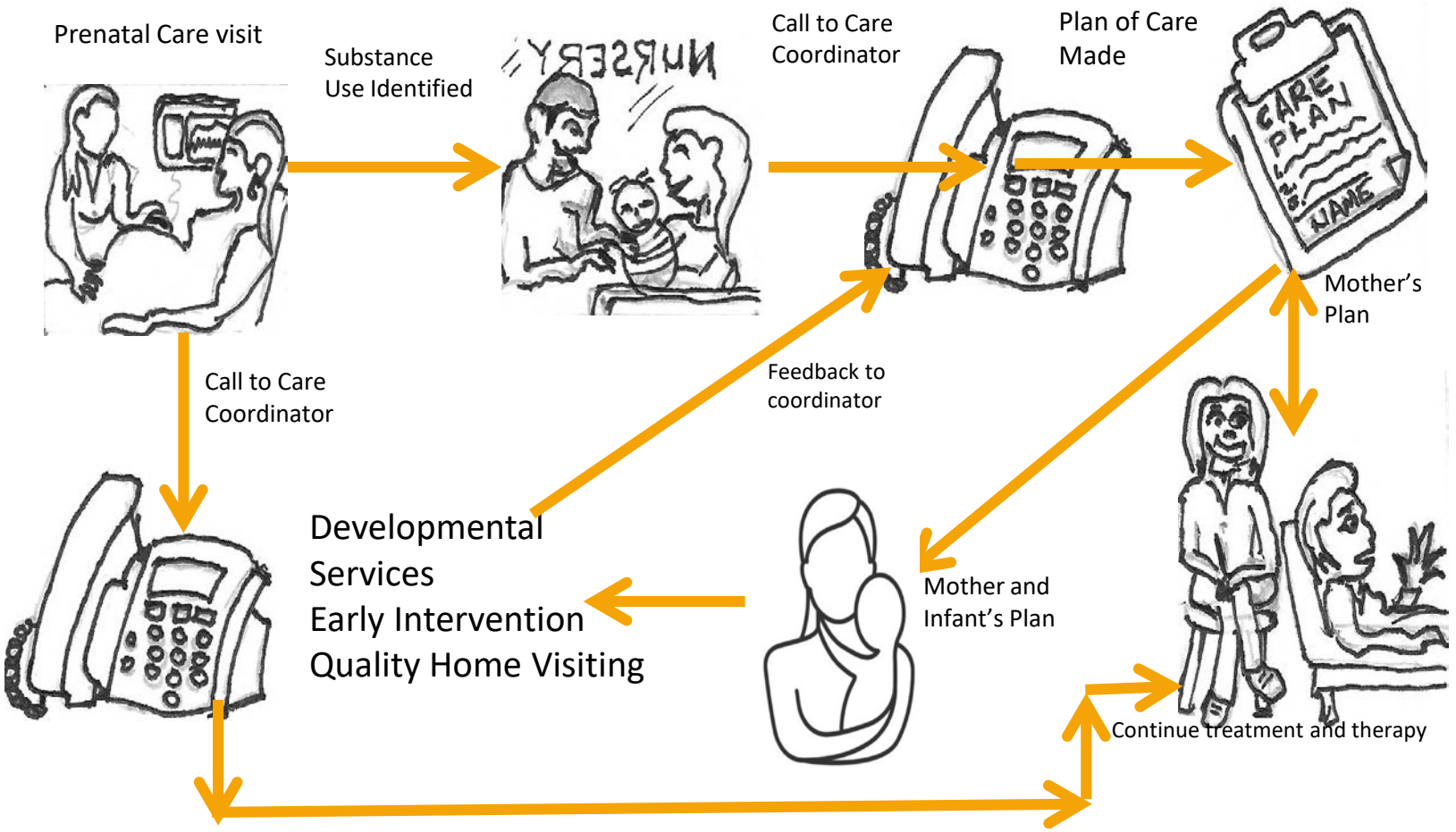
Safety Plan/Plan of Care Dovetail

A well-developed and effectively implemented Plan of Care may prevent removal of an infant from his/her family or provide an opportunity for quick reunification if initial placement is away from the birth mother or father.

A strong Plan of Care benefits an infant and his/her caregivers by addressing their treatment needs, regardless of immediate child placement decisions.*

National Center on Substance Abuse and Child Welfare (2018). A planning guide: Steps to support a comprehensive approach to Plans of Safe Care; March 2018 Draft.*

The Processes Developed for HB230 Plan of Care Bill



Best Practices: A vision for the future

- Access to prenatal care for all pregnant women in New Mexico.
- Universal screening at first visit for substance use, ACES, domestic violence, and other needs or risk factors with a validated tool.
- Expand or replicate wrap-around service programs for families that integrate SUD treatment with prenatal and early intervention services.

BCBS of New Mexico

- All Referrals for Care Coordination after baby is born (if mom does not have a CC) should be emailed to **CARA_Care_coordination@bcbsnm.com**

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- Director, Behavioral Health Clinical Operations **|** Government Programs
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  (505-816-2938 **|* Sabrina_Romero@bcbsnm.com**

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- **Dodie_Grovet@bcbsnm.com**

Blue Cross Blue Shield of Texas (MCO)

Lauretta Dozier, RN and Eric Cibak, RN

Special Beginnings TX
Unit Manager, Clinical Operations
Lauretta_F_Dozier@bcbsnm.com
Office: 505-816-5515
Eric_S_Cibak@bcbsnm.com

505-816-5725
Blue Cross Blue Shield of Texas
4411 The 25 Way NE, Suite 300
Albuquerque NM 87109

Please send all referrals to:

NMCNTLSpecialBeginnings@bcbsnm.com

Presbyterian Health Plan (MCO and Commercial)

Lane Evans, RN, BBA, CCM

Director, Health Services

Clinical Operations

505-923-5463

CARA@phs.org.

- Can also call: 505-923-8858 option 2
- Intake Toll Free: 806-672-1242
-

Notes: Response typically occurs within 48 hours, but callers may request an urgent referral to Care Coordination. This will result in same-day member contact.

Our Transition Care Team and Inpatient Utilization Management Team also interact with facilities to identify members who are appropriate for care coordination.

Western Sky Community Care (MCO)

Manager, Program Coordination, MED-Case Management

Charlene.A.Tafoya@westernskycommunitycare.com

Direct: 505-886-6290, ext. 8095090

Western Sky Community Care

5300 Homestead Road NE

Albuquerque NM 87110

1-844-543-8996, #4 for Care Coordination

CARACareCoordination@westernskycommunitycare.com

For Care Coordination during pregnancy:

Jennifer M. Montoya, RN

Direct: 1-505-886-6389 (extension 8095189)

505-331-9225

Jennifer.m.Montoya@westernskycommunitycare.com

Blue Cross Blue Shield of Texas (Commercial)

Pre-Natal up to 34 Weeks

- Special Beginnings Program
- Email **all three**:

Julie Milam

Julie_s_milam@bcbstx.com

Beth Boulanger

Beth_boulanger@bcbstx.com

Toni Allen

Toni_allen@bcbstx.com

34 Weeks or more / Delivery

- Contact Customer Service at phone number on back of insurance card.
- Ask for referral to case manager

NM DOH: Children's Medical Services

Susan Merrill, LCSW

Community and Social Services Coordinator for Birth Defects

Direct: 505-476-8918

FAX: 505-476-8996 or 505-827-5995

Susan.Merrill@state.nm.us

Children's Medical Services

Family Health Bureau

Public Health Division

New Mexico Department of Health