nebraska total care™

Care Management Program

Paula Stapleton, Director of Clinical Operations
Kristi Goldenstein, Manager Community Health Services
Sally Urbanec, Manager Clinical
Ted White, Senior Behavioral Health Service Manager
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Why we're in business

OUR PURPOSE

Transforming the health of the community, one person at a time

What we do

OUR MISSION

Better health outcomes at lower costs

What we represent

OUR PILLARS

Focus on the Individual

+

Whole Health

+

Active Local Involvement

What drives our activity

OUR BELIEFS

We believe healthier individuals create more vibrant families and communities.

We believe treating people with kindness, respect and dignity empowers healthy decisions.

We believe we have a responsibility to remove barriers and make it simple to get well, stay well, and be well.

We believe in treating the whole person, not just the physical body.

We believe local partnerships enable meaningful, accessible healthcare.

Benefits

Medical benefits are established by Nebraska Medicaid and consistent across the MCOs.

Physical Health

Behavioral Health

Dental

Pharmacy

Vision

Population Heath

Our Care Management team includes:

Nurses
Pharmacists
Medical Doctors
Community Health Workers
Psychiatrists
Licensed Mental Health Practitioners
Alcohol and Drug Counselors
Social Workers

POPULATION HEALTH INCLUDES BOTH CLINICAL AND NON-CLINICAL POSITIONS, TO INTEGRATE ALL OF THE ELEMENTS NECESSARY FOR IMPROVED HEALTH OUTCOMES.

Why Care Management?

- Improves equity with health care services by addressing social determinants of health
- Improves care coordination for members
- Improves medical adherence and self-management skills
- Interventions are effective & measurable
- Reduces non urgent emergency department utilization
- Removes barriers for member accessing health care

Provider Support

- Provide education and support to members to follow their provider's prescribed treatment plan
- Assist members with obtaining services not available through Medicaid
- Coordinate care amongst the various providers serving the member (Physicians, Therapists, Home Health Agencies & Service Coordinators)
- Assist members with obtaining assistive technology to increase independence
- Create an overarching plan of care that incorporates the members holistic needs to share with providers.

Levels of Support

- **Program Coordinators** – Staff trained to complete screening assessments for members to identify what level of care management may be best for our members, assist with transportation needs and answer any basic benefit questions.
- **Community Health Service Representatives –** Nonclinical staff specially trained to provide in person Diabetic Health Coaching, ED Diversion, Perinatal Health Coaching, connection to community resources, and facilitation of community Baby Showers.
- **Program Specialists** - Address members social determinant issues, engage in social services/resources and support members with coordinating their healthcare. Support for CM.
- **Complex Care Managers** - Licensed clinicians with diverse backgrounds, (RN's/LIMHP's/LADC's) support members and the providers care plan by coordinating treatment interventions, promoting self-management and addressing barriers.

Programs

- Social Determinants of Health
- Housing First
- Sickle Cell
- Transplant
- Foster Care
- AUD/SUD & HALO (substance use)
- Choose Tomorrow/Neuroflow (suicide prevention)
- Digital Care Management (DCM)
- Start Smart for Your Baby
- NICU

Community Health Service Workers, Housing, SDoH (Social Determinants of Health) & Transition of Care Programs

Kristi Goldenstein, Manager Community Health Services

Community Health Service Representatives

Diabetic Health Coaching

- Target: Adult, Type 2 Diabetes
- Goal: improve diabetes self-management skills and life-style change through education and linkage to community resources for social determinants of health
- Members receive Living Well with Diabetes book from Krames
- Face to face or telephonic

Perinatal Health Coaching

- Target: Low risk pregnant members with social needs
- Goal: Extend gestational period and reduce risk of complications, premature delivery, and low birth weight
- Members receive educational books: A Mother's Guide to Pregnancy and Life After Delivery

Community Baby Showers

ED Diversion

- Target: members access the ED for non-emergent reasons
- Goal: Link with providers, urgent cares, nurse advice line, address social barriers

Housing First Care Management

Meet members where they are

Address urgent needs

Link to community resources

Enroll in Housing Aftercare Program

Prevent homelessness from reoccurring

Resolve care gaps

Education on maintaining housing

Social Determinants of Health

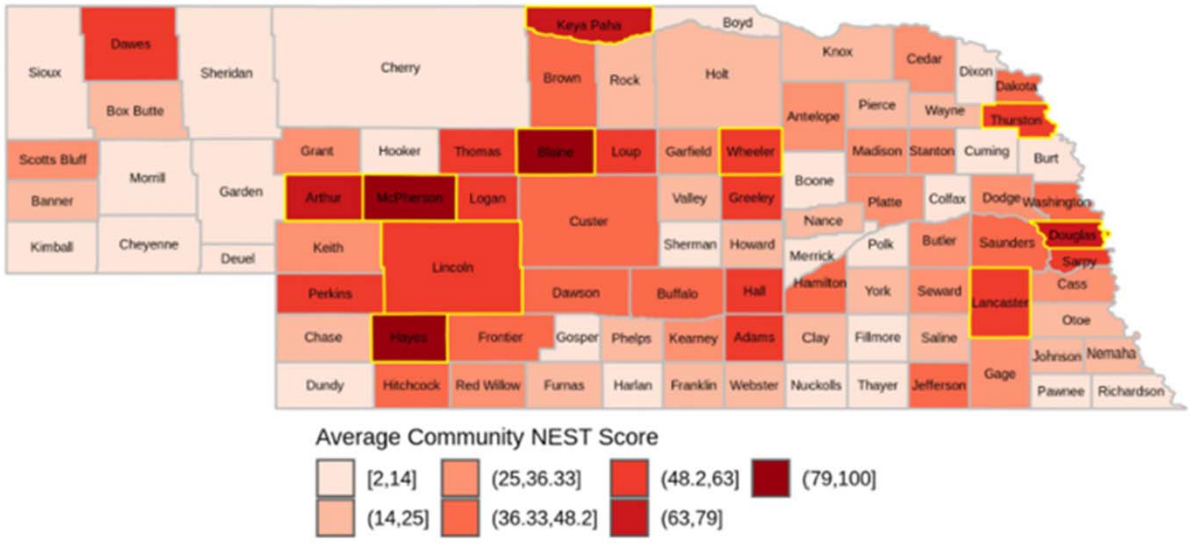
- **Findhelp platform**
  - Free tool for members and providers
- **Top 5 social needs in Nebraska:**
  - Food
  - Rental assistance
  - Utility assistance
  - Financial assistance
  - Transportation

- **Program information can be emailed or texted, and some community-based organizations accept referrals from the platform.**
- **Care Managers follow up on resources offered to ensure needs are met and provide more as needed.**

Social Determinants of Health Risk Score- NEST

NEST- Neighborhood, Economic, and Social Traits Model

- Predictive modeling used to capture the disease burden that can be associated with neighborhood conditions in which our members live
- Community Score
- Individual Score



Value-Added Benefits

Value-Added Benefits are specific to MCOs.

Healthy Rewards Program
Earn dollar rewards by completing healthy behaviors.

YMCA
Get moving with a YMCA membership.

Boys and Girls Clubs
Help kids learn powerful life skills and stay active.

Community Gardens
Engage the community through growing healthy food.

WW (Weight Watchers)
Establish a healthy lifestyle to feel better and reach goals.

Transition of Care Programs

Face to Face Hospital and Home Program

Purpose: engage members and providers to assist with discharge planning and successful post hospital transition to achieve a reduction in preventable readmission and decrease overall length of stay

Members receive:

- A visit in the hospital prior to discharge
- A home visit within 48 hours of discharge from a nurse
- A home second home visit 30 days later from a Community Health Worker

Post Hosptial Outreach

Purpose: assist members transitioning home from the hospital to ensure they have timely follow up appointments with providers, have assistance at home, have obtained new medications/DME, and support meeting other identified needs

- Outreach to all behavioral health discharges
- Outreach to all physical health discharges that have a high readmission risk

Transplant & Foster Care

Sally Urbanec, Manager Clinical

Transplant Case Management Program

The Purpose of the **Transplant Case Management** program is to provide assistance to members and providers with health care navigation, education, support and address barriers to treatment.

Transplant Case Manager:

Registered Nurse

Collaborating with transplant coordinators, providers, members and utilization management.

Interventions:

Receive a transplant list monthly when authorizations identified, referral initiated for Case Management.

All referrals result in outreach.

Outreach initiated prior to transplant and continues through post transplant for support.

Even if member is unengaged, CM will continue to work with transplant coordinators to address any needs or concerns.

Foster Care Case Management Program

The Purpose of the **Foster Care Case Management** program is to empower those who impact the health and wellness of Foster Care children. Our staff are dedicated to helping caregivers navigate the complicated health care and child welfare systems. A member centric care plan is created around each child enrolled in Case Management and partners with agencies throughout the state to coordinate services.

Foster Care Case Management Team:

LIMHP's, Social Worker, and Registered Nurse

Collaborate with providers, DHHS partners and utilization management.

Interventions:

Initial and ongoing assessment based upon age specific needs

Education on community-based resources, provide resources needed to achieve health goals, advocacy to caregivers

Transition of Care/Discharge planning & Care Gap Closure

a2A Program for those aging out of Foster Care, building success through independence

Referrals can be submitted directly to the Foster Care Team at NTC_Foster_Care@NebraskaTotalCare.com

Substance Use Disorder & Suicide Risk

Ted White, Senior Behavioral Health Service Manager

SUD/AUD Program

Identify members that have Emergency Room visits, short detox stays or inpatient with diagnosis related to substance use and/or alcohol use disorder

Outreach to members through phone calls and letter correspondence

Refer to CHSR (Community Health Service Representative) for in person contact and engagement

If unable to engage initially, member is placed on monitoring status

Track member engagement, visits to providers and interventions

Collaborate with inpatient and outpatient providers

Face to face engagement in homeless shelters

HALO

(Health Assistance, Linkage and Outreach)

Goals:

- Prevent and/or address substance misuse
- Identify early treatment or preventative measures
- Address healthy behaviors and barriers
- Impact ER use

Interventions/Resources:

- Consistent outreach to member and collaboration with providers
- Provide education through Krames on Demand (health education) and Teladoc (self-paced program management tool) related to substance used and pain management, and resources as needed
- Review prescription medications
- Case manager talking points related to treatment and substance abuse

Choose Tomorrow

Outreach to identified members for case management support based on a suicide risk score of 95 percent through corporate reporting

Provide Safe Plan of Care

-Stanley Brown Safety Plan (warning signs, coping, supports)

How Choose Tomorrow works:

Early Identification: prediction and stratification of those at risk to prevent suicide attempts and behaviors.

Evidence-Based Intervention: develop member driven safety planning, training for administering assessments

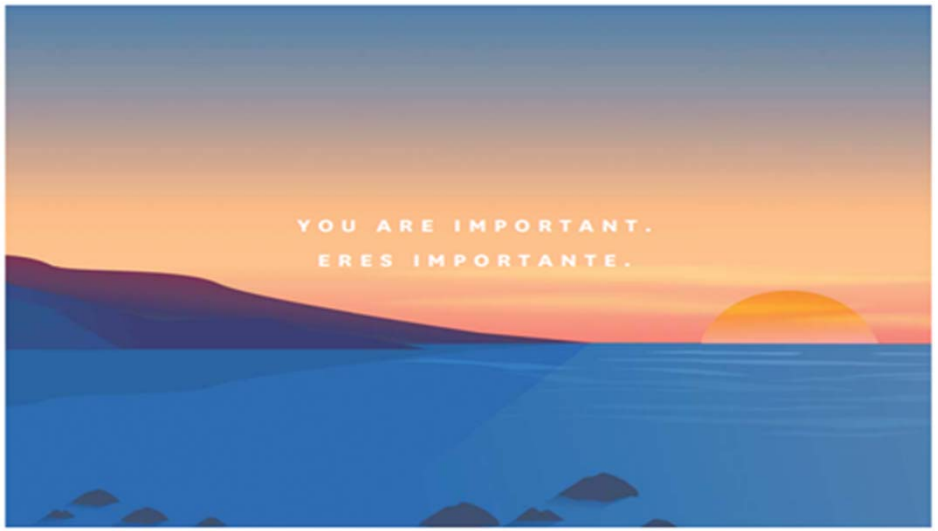
Population support: positive connections with members and enables appropriate screening and safety planning to help prevent suicide

Connectedness and Post-Vention: establish trusting relationships through frequent contact (weekly outreach), reassessing risk, review of safety plans, caring contact letter sent, identify resources needed

Choose Tomorrow

Provide Caring Contact cards

- Example: We're thinking of you because you matter. We're a phone call away if you need someone to listen, offer support, or connect you with resources. Please feel free to reach us at 1-844-385-2192 (TTY 711) also sent in Spanish



NeuroFlow

NeuroFlow is an interactive platform available via mobile app and website that provides personalized and preventative resources to improve overall health. There is 24/7 access to tools to help you take control of your health

NeuroFlow offers support to help manage stress, anxiety, depression, loneliness, sleep, pain, thoughts of suicide and more

Access is available through an app or on the website

Content based upon what member accesses/suggestions are provided on a home page

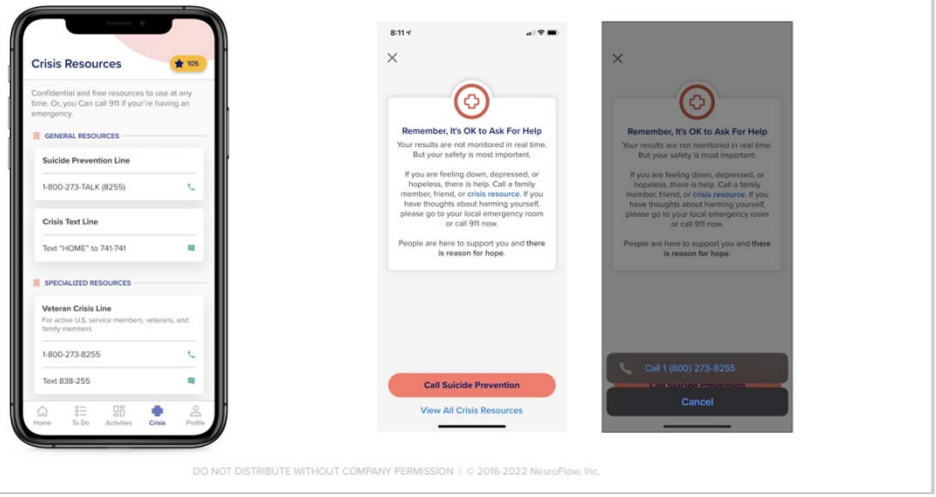
Content can be self-assigned or suggested by case manager

Crisis resource tab that connects to 24/7 resources to include 988, crisis texting and local resources

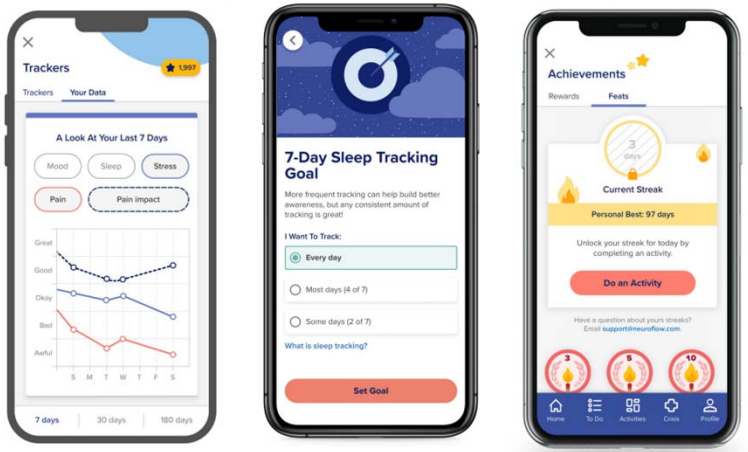
Urgent at-risk alerts through platform monitored by case management

NeuroFlow Screen Shots

24/7 Access to Crisis Resources and Proactive Pop Up Messages Encourage Members to Seek Help When Needed



Members View and Maintain Their Progress with Tracker Trends, Goal Setting, and Daily Streaks



Sickle Cell & Start Smart for Baby (SSFB)

Erica Anderson, Manager Clinical

Sickle Cell Case Management Program

The mission of the **Sickle Cell program** is to improve the health and quality of life of our members with sickle cell disease by removing barriers to care and engaging with members to develop and improve disease self-management strategies.

Program Goals:

Decrease Utilization: Work with member and provider to develop a plan of care to manage illness as able.

Increase Engagement: Work with members to enroll in case management to provide education and additional supports.

Increase Adherence: Work with members and providers to assist member in compliance on ordered medications.

Sickle Cell Case Manager

Registered Nurse

Specific Sickle Cell Training

Start Smart for Your Baby®

SSFB program incorporates care management, care coordination, disease management, and health education in an effort to improve the health of mothers and newborns.

Goals of the program are to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, low birth weight and infant disease.

Our SSFB Program includes a NICU program for parents/ infants that are in the NICU.

We outreach to all NICU parents to offer case management and additional support.

We assist with transition of care, wrap services and any DME/ pharmacy needs.

Factors Considered in SSFB

In addition to physical health factors that contribute to a high-risk pregnancy, additional factors considered:

- Past or current substance misuse
- Active and unstable mental health issues
- Social determinates of health
- Teen pregnancies
- History of postpartum depression
- Nicotine use

Notice of Pregnancy Value Add for 2024 Member Incentive

Member completed Notice of Pregnancy at least 60 days before baby is due.

- Car Seat
  OR
- Stroller
  OR
- Pack and Play
  OR
- Meal delivery of 10 frozen meals

Provider Notice of Pregnancy Incentives for 2024

Notice of Pregnancy:

Incentive limited to Providers within the Nebraska Total Care Network.

Incentives are based on timely submission of the Nebraska Total Care

Notification of Pregnancy Form (NOP) as outlined below:

- **1ST Trimester** (0-14 weeks gestation): **$100 incentive**
- **2ND Trimester** (15-28 weeks gestation): **$40 incentive**
- **3RD Trimester** (29+ weeks gestation): **$20 incentive**

The NOP forms are located on the Nebraska Total Care Provider Portal and Nebraska Total Care Provider Website.

Duplicate ONAF and NOP forms will not qualify for multiple incentives.

Submitted forms must be accurate and complete, i.e., member name, date of birth, member ID, full name of provider, gestation, initial OB visit date and Provider's Tax ID Number (TIN).

Provider Obstetric Needs Assessment Form (ONAF) 2024

ONAF:

Incentive limited to Providers within the Nebraska Total Care Network.

Incentives are based on timely submission of the Heritage Health Obstetric

Needs Assessment Form (ONAF) as outlined below:

- **1ST Trimester** (0-14 weeks gestation): **$50 incentive**
- **2ND Trimester** (15-28 weeks gestation): **$30 incentive**

ONAF form is located on the Nebraska DHHS MLTC website.

Duplicate ONAF and NOP forms will not qualify for multiple incentives.

Submitted forms must be accurate and complete, i.e., member name, date of birth, member ID, full name of provider, gestation, initial OB visit date and Provider's Tax ID Number (TIN).

EPSDT

- Education on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) at all points of member outreach/contact.
- All departments at Nebraska Total Care focus on EPSDT
    - Member Services – complete HRS- discuss care gaps
    - Member Connect Stations- options to complete HRS and other assessments, also access to the member portal
    - Welcome Packet/Member Handbook/Website
    - Member incentives
    - VBC (Value Based Contracting) Pay for Performance
    - Member and Provider Alerts
    - Community events
- Programs within Care Management Department with special focus on EPSDT opportunities.
    - Start Smart For Baby
    - Community Health Workers – face to face and coaching programs
    - Housing First Team
    - Quality Workstreams
    - NICU visits
    - Face to Face hospital and home visits

Online resources

NebraskaTotalCare.com

Find a Provider

Secure member portal

MyNTC mobile app

Krames Health Library and Assessments

Teladoc

Social Needs Assessment

FindHelp

Frequently Asked Questions

Can the Care Management staff meet with members in person?

Yes

What is the frequency of communication between the Case Manager and the member?

Based on member needs and preference

Will Providers get a copy of the care plan?

Yes. CM will notify the PCP if the member is in the CM program and provide a copy of the care plan. The PCP can review and collaborate.

Is Care Management voluntary?

Yes, members participate in their care. Motivational interviewing techniques are utilized to promote the benefits of participating in the program.

Referrals

Let's make a difference together!

- Members, Providers, and Guardians can call Nebraska Total Care Member Services and ask to be enrolled in the Care Management program.
- Providers and members may complete a referral in the secure online portal.
- Providers can refer through our Utilization Management team.
- Nebraska Total Care uses data and predictive models to initiate outreach.
- Providers can share member information with their Provider Relations Representative.
- Contact Care Management directly any time. We appreciate your partnership!

Contacts

Member and Provider Services: 1-844-385-2192, TTY 711

NebraskaTotalCare.com for Provider Resources and map for delegated representative

Care Management:

- Kristi Goldenstein MSW Manager for Community Health (402-970-0743)
  Kristi.Goldenstein@NebraskaTotalCare.com
- Erica Anderson LMHP, MS Manager of Care Management (402-970-0792)
  Erica.M.Anderson@NebraskaTotalCare.com
- Sally Urbanec RN, BSN Manager of Care Management (402-970-0793)
  Sally.J.Urbanec@NebraskaTotalCare.com
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  Paula.Stapleton@NebraskaTotalCare.com

Questions?