



# MOM Model Quarter 2 Design Collaborative

Medicaid Office of Innovation, Research and Development  
Chesapeake Regional Information System for our Patients

May 12, 2020



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# Agenda and Housekeeping

# Agenda

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- Welcome
- MOM Implementation Update
- Participant Engagement Strategies
- Participant Consent and Data Privacy
- Wrap-up and Next Steps

# Housekeeping

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- We will keep lines muted during the meeting.
- Please send any questions you have through the webinar's question function.
- If we do not directly answer your question during the meeting, we will be keeping a list of 'parking lot' items for follow-up.
- Please be sure to enter your audio PIN in case timing does allow for discussion.

*Sandy Kick*

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**Welcome**

*Laura Goodman*

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# **MOM Model Implementation Update**

# Section Overview

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- MOM model six-month extension
- Coverage and payment strategy
- Q1 Design Collaborative results
  - Social determinants of health screening tool
  - Care plan elements
  - Future design collaborative topics

# MOM Model Extension

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- Six-month delay to ‘start of services,’ meaning participant enrollment will begin on July 1, 2020
- Transition funding will still be available for 12 months
- Model end date still remains December 31, 2024, with the option for a no-cost extension through CY 2025
- See separate FAQ document from CMMI; more information forthcoming

# Coverage and Payment Strategy

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- Conversations with CMCS on hold due to COVID-19
- Current vision
  - MOM model services to be included in MCO contracts
  - MOM PMPMs to be included in capitation rates, similar to approach taken for adult hearing benefit
- Coming soon: CY 2021 contract language

# Q1 Design Collaborative Results

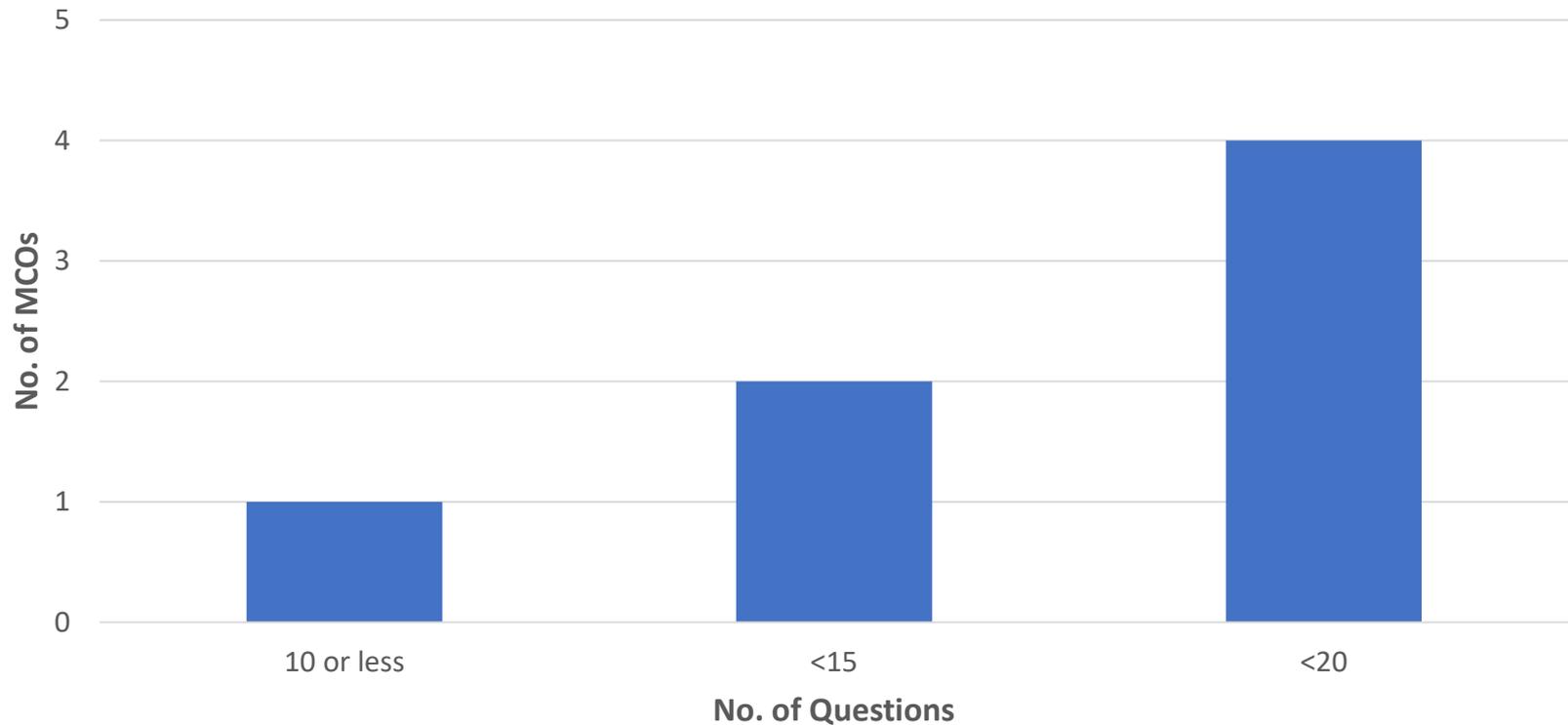
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## MCO homework responses:

- Social Determinants of Health (SDOH) Screening Tool
- Care Plan Core Elements

# SDOH Tool: Ideal Length

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# SDOH Tool: Frequency of Screening

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- Three MCOs suggested at enrollment, then every three months; others varied.
- Others factors to consider—reassessing upon:
  - Participant ‘triggers’
  - When participant-identified goals are met
  - Prior to MOM model ‘graduation’ (or other closure of case)

# SDOH Tool: Suggested Additions

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- Several MCOs had no changes to the tool
- Recommendations:
  - Behavioral health: SBIRT, maternal depression
  - Family and community: Support during delivery, need for infant supplies, other children living in the home
  - Safety: Feeling safe leaving the home for food, medication, medical appointments
  - Transportation: Primary mode to go medical appointments, work, etc.

# SDOH Tool: Incorporated Feedback— Additions

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- **Transportation:** Add example of specific appointment types (prenatal and OUD)
- **Safety:** New questions on intimate partner violence and community safety
- **Financial Strain:** Add example of baby supplies and child care
- **Family and Community Support:** New questions on support during pregnancy and delivery, caregiver burden, need for baby-specific supplies and caring for baby, substance use by household members

# SDOH Tool: Suggested Deletions

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- A few MCOs suggested all questions were relevant, with one saying perhaps some could be combined to make the screening shorter.
- Five MCOs suggested questions related to physical activity could be removed or modified.
- Other MCOs suggested deleting:
  - Utilities;
  - Employment, as it is hard to obtain or keep a job during pregnancy; and
  - Help with activities of daily living.

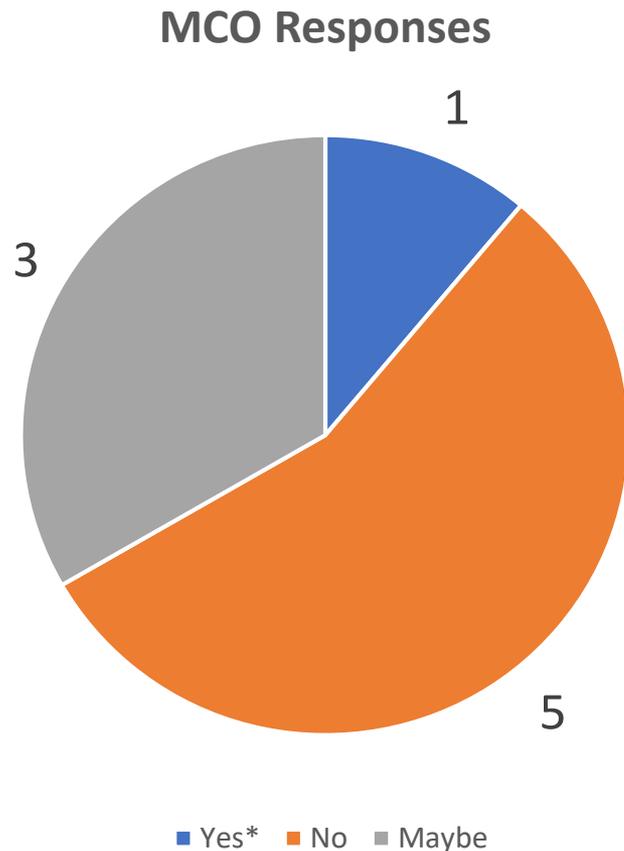
# SDOH Tool: Incorporated Feedback— Deletions

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- Physical Activity domain
- Substance Use domain
- Undetermined: Question 13 (Help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc.)—what would be the follow-up or referral activity?

# SDOH Tool: Use Beyond MOM

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- The one MCO responding 'yes' was referring to the unaltered AHC tool.
- The 'maybe' responses ranged from 'we should meet to discuss' to 'perhaps with time.'

# Care Plan: Incorporated Feedback

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- Majority of MCOs agreed the Care Plan framework captured the essential elements
- Several MCOs made recommendations regarding the order, structure and content of the framework
- Incorporated feedback:
  - Added clinical conditions
  - Added identification of barriers
  - Added area to include care team goals and progress to goal completion (participants & care team)
  - Rearranged order of the Care Plan elements

# Workflow and Barriers

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- Workflow—need to determine:
  - Costs for configuring new screening tool
  - Appropriate locations for enrollment and screenings
  - Staffing models, including incorporation of non-traditional health care workers
- Identified barriers
  - Programming new screening tools
  - Language and reading proficiency levels
  - Confidentiality

# Technology and Integration

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- Electronic input vs. paper-based
  - Tablets or laptops: Seven MCOs
  - Paper with electronic input later: One MCO
- Integration vs. separate system
  - Several MCOs vocalized interest in integrating the CRISP-based MOM Care Coordination Module and SDOH screening tool with their native systems.
  - Others suggested a phased approach, with screenings inputted directly into CRISP initially while potentially working toward integration.
  - A few prefer to input directly into CRISP.

# Implementation: Next Steps

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- SDOH
  - MCO feedback on changes to the tool and integration vs. a stand-alone tool
  - CRISP development
- Care Plan: CRISP build-out underway
- Future Design Collaborative Topics
- MCO contracts
- Maryland Addiction Consultation Service kick-off

*Amy Woodrum and Marcia Crandall*

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# **Participant Engagement Strategies**

# Participant Engagement Background

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- The Department conducted a literature review on best practices for engaging pregnant and postpartum individuals with OUD throughout services.
- These practices are meant to serve as a resource to consider while MCOs develop their participant engagement strategies.
- These slides and a separate write-up will be published to our website.
- The following outlines evidence-based engagement strategies found to be effective throughout the continuum of care.

# Engagement at Enrollment

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- Enrollment in the MOM model will be the responsibility of the case managers within the participants' MCO.
- The Patient Activation Measure (PAM) is a requirement of the CMMI grant and must be used as a tool by case managers to understand participants readiness to change and assist with determining appropriate engagement techniques based off a participant's PAM score.
- The initial SDOH screening will also guide the case managers approach to linking participants with various resources.

# Participant Engagement

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## *Addressing Barriers*

- There are recognized barriers that impede participant engagement and retention that MCOs may encounter:
  - Examples include frequent address changes, outdated contact information, lack of culturally responsive care, the absence of childcare, transportation issues, and other competing demands.
- MCOs will need to design initial participant engagement strategies that acknowledge unmet social needs and anticipate other known barriers to MOM model enrollment.

# Participant Engagement

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## *Addressing Stigma*

- Stigma can instigate feelings of diminished self-worth, increase isolation, and decrease retention in treatment.
- Case managers can combat stigma by using a strengths-based approach, trauma-informed care, and person-first language (i.e. saying person with an opioid use disorder rather than using the more stigmatizing term ‘addict’).

# Participant Engagement

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Positive, Person-First Language	Stigmatizing Language
<ul style="list-style-type: none"><li>• Person with a substance use disorder (SUD)</li><li>• Person who uses drugs (PWUD)</li><li>• Substance use / substance misuse</li><li>• Person in recovery</li></ul>	<ul style="list-style-type: none"><li>• Substance Abuse / Substance Abuser</li><li>• Addict, alcoholic, junkie</li><li>• Recovering “addict, alcoholic, substance abuser, junkie, etc.”</li></ul>
<ul style="list-style-type: none"><li>• Neonatal abstinence syndrome / Substance-exposed newborns</li></ul>	<ul style="list-style-type: none"><li>• Addicted baby</li></ul>
<ul style="list-style-type: none"><li>• Recurrence of use / recurrence of symptoms</li></ul>	<ul style="list-style-type: none"><li>• Relapse</li></ul>

# Participant Retention Strategies

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## *Motivational Interviewing*

- Motivational Interviewing (MI) is an evidenced-based technique in which individuals are asked open-ended questions in a non-judgmental manner and assesses readiness for change.
- MI is a strategy that can be used throughout the continuum of a participant's enrollment in the model.
- MI can be used to help individuals struggling with OUD make meaningful behavioral changes to support their overall health, such as remaining consistent with Medication-Assisted Treatment (MAT) throughout the pregnant and postpartum periods.

# Participant Retention Strategies

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## *Shared Decision Making*

- Shared decision-making (SDM) is an approach where participants and clinicians collaboratively work towards making informed clinical treatment decisions based on evidence and the participant's preferences.
- This approach is considered integral to achieving person-centered care and has demonstrated positive outcomes:
  - Increased participant satisfaction, treatment adherence and engagement.
- Evidenced-based approach to use with patients who have chronic conditions and documented success with pregnant individuals with OUD.

# Participant Retention Strategies

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## *MCO Incentives*

- Providing incentives to plan participants has been shown to enhance health outcomes, reduce health care costs, and influence healthy behavior.
- Examples of incentives include offering free parenting classes, bus passes to help with transportation to appointments, or pre-loaded debit cards to use for supplies or food.
- MCOs have the flexibility to provide appropriate incentives for participants.

# Participant Retention Strategies

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## *Lay Health Workers*

- For the MOM model, MCOs may choose to include lay health workers such as certified community health workers (CHWs) or certified peer recovery specialists (CPRS) in outreach and engagement strategies.
- Evidence demonstrates that engagement of peer recovery specialists and other paraprofessionals is a promising practice for continued engagement among individuals with OUD.
- MCOs could consider using PMPM payments towards supporting CHWs or CPRS in their staffing model.

# Substantial Outreach Strategies

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## *Potential substantial outreach strategies to consider:*

- Sending mail correspondence to the participant's home or listed addresses
- Contacting participants' family members, friends, partners and emergency contacts via phone multiple times at different times of day
- Deploying assigned MOM model case manager or other assigned care plan team members to the participant's home and/or community, including on evenings or weekends
- Contacting participant's PCP and other providers to assist with re-engagement
- Connecting with local ACCUs or other connected departments and community programs participant is involved with
- Monitoring CRISP hospital utilization alerts to check inpatient admissions and emergency encounters

# Warm Handoffs

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- A warm handoff are transitions in care between two members of the participant's healthcare team and can be done at any point during treatment.
- This strategy can be deployed to enhance collaboration between the MOM model participant's various care team members and reduce unintended consequences
  - i.e. fragmentation in care and service duplication.
- MCOs are encouraged to examine their current workflows and adopt warm handoffs, where possible.

# Warm Handoffs

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Steps for implementing warm handoff practices:

- Identify all patient transition points within the practice
- Understand the current handoff process
- Set warm handoff priorities
- Understand the current workflow
- Analyze the current workflow to design new workflows
- Seek input from everyone affected by the proposed new workflow
- Establish new workflows
- Identify solutions to any barriers
- Phase in the use of warm handoffs
- Evaluate implementation progress

# Additional Resources

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- Best Practices and Barriers to Engaging People with Substance Use Disorder in Treatment:  
<https://aspe.hhs.gov/system/files/pdf/260791/BestSUD.pdf>
- Partnering with Patients and Families to Strengthen Approaches to the Opioid Epidemic: [https://www.ipfcc.org/bestpractices/opioid-epidemic/IPFCC\\_Opioid\\_White\\_Paper.pdf](https://www.ipfcc.org/bestpractices/opioid-epidemic/IPFCC_Opioid_White_Paper.pdf)
- The guide to Medicaid Member Engagement: <https://www.ahip.org/wp-content/uploads/2018/08/AHIP-Value-Campaign-Digital-Media-Plan-5.2.2018.pdf>
- AHRQ's Design Guide for Implementing Warm Handoffs: <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfprimarycare/warmhandoff-designguide.pdf>
- HRSA's Home Visiting Program: Supporting Families Impacted by Opioid Use and Neonatal Abstinence Syndrome: <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/MIECHV-Opioid-NAS-Resource.pdf>

# Guided Discussion Questions

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- How do the engagement strategies presented compare to strategies that are currently in place?
- What are some retention and outreach strategies your MCO have found to be particularly successful?
- What experience has your MCO had with using paraprofessionals such as CHWs or CPRS with populations similar to the MOM model target population?
- Are there any strategies presented that do not appear to be feasible? If so, why?

*Laura Goodman and Adrienne Ellis*

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# **Participant Consent and Data-Sharing Elements**

# Section Overview

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MOM model requirements: Data-sharing and informed consent

Informed consent process

Timeline

Data Privacy

# CMMI Requirements: Monitoring

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- Pre-implementation
- Implementation
  - Enrolled participants (disaggregated by new vs. previously-enrolled, active recipients vs. substantive outreach); average duration of engagement
  - Additional data to be determined
- Milestones
  - Gains in Patient Activation Measure scores
  - Health-related social needs screenings
  - Postpartum follow-up
  - Maternal OUD treatment
  - Use of pharmacotherapy at delivery

# CMMI Requirements: Evaluation

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- Objectives
  - MOM model operations, barriers and successes
  - Beneficiary experience, engagement and service use
  - Effectiveness of payment strategies
  - Effect on quality of care and expenditures
- Methods
  - Qualitative: Interviews, focus groups, individual conversations
  - Model process data
  - Regression analysis using T-MSIS data and other quantitative data sources

# MOM Model Evaluator

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- Third-party evaluator: Insight Policy Research, Urban Institute, Abt Associates
- Maryland's MOM model informed consent to cover data-sharing for quantitative evaluation activities
- Evaluators to have separate informed consent and IRB process for qualitative data-collection activities with MOM participants

# CMMI Requirements: Consent

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A condition of CMS funding is to obtain “authorization from beneficiaries for themselves and for their infants to access/transmit individual level, identified vital records data. Awardees are required to develop beneficiary consent forms that comply with all federal, state and local laws governing the access and transmission of patient data, including (but not limited to) substance use treatment claims, laboratory test results and other treatment data.”

*(NOFO pg. 56)*

## Data-Sharing:

### Consent for data-sharing for MOM model implementation

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**MOM participants MUST agree to share data between these entities in order to enroll in the program.**

- There are options about which data elements will be shared between the different entities.
- CRISP can make all data available to MCOs and providers and share only reportable elements with the Department and CMMI.

#### • **Operations**

- MCOs
- Members of the care team
- Social services providers and community-based organizations (non-PHI)

#### • **Monitoring and Evaluation**

- The Department
- CRISP
- Hilltop
- CMMI, including additional partners such as evaluation and reporting contractors

# Informed Consent Process

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- Consent will be captured in care coordination module
  - Either in the CRISP ULP tool or in the MCO system and transmitted to CRISP with other required elements
- Consent forms themselves will be stored with the MCO
  - Could be paper/scan or electronic
  - Not collected but must be on record
- Each step in enrollment process provides an opportunity to educate MOM model participants about the program and data sharing
  - Explain how data will be shared and with whom
  - Explain any mandatory reporting requirements as they pertain to the information provided to case managers
  - Sample educational materials will be provided

# Consent and Data-Sharing Timeline

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- May-June 2020: Data dictionary due from CMMI
- July-July 2020: Informed consent and MDH IRB protocol development
- August 2020: MDH IRB protocol submission

# Data Privacy Assessment

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*Follow-up on Department's research about MOM participant protections*



**CRISP**

# Legal Requirements and CRISP Policies

May 12, 2020

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[www.crisphealth.org](http://www.crisphealth.org)



## Disclaimer

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***The information provided does not, and is not intended to, constitute legal advice; instead, all information, content, and materials available are for general informational purposes only.***



## Consent Requirement Background - HIPAA

- Data shared among covered entities (health care providers and payers) and their business associates is protected by HIPAA
  - HIPAA allows protected health information to be shared for purposes of treatment, payment, and health care operations without patient consent/authorization
    - Example: provider sharing data with MCO for a shared patient/member- no consent needed
  - With a few exceptions, any PHI shared outside the HIPAA permitted purposes or shared beyond covered entities and business associates requires patient consent/authorization
    - Example- provider or payer sharing information with social service agency
  - All information shared via CRISP portal is covered by HIPAA and can only be used for HIPAA permitted purposes.



## Consent Requirement Background – Part 2

- Substance Use Disorder (SUD) Treatment Data is also protected by 42 CFR Part 2
  - Part 2 requires specific written patient consent to share SUD treatment (Part 2-covered data).
  - Current regulation requires that consent be obtained for every disclosure and redisclosure of SUD treatment data held or disclosed by a Part 2 provider
    - Every time SUD treatment data is shared with a few exceptions a consent must be obtained
  - Consents are specific and granular and must include 9 elements, including allowing patients to limit type and amount of data to be shared and with whom
  - SAMHSA guidance clarifies that patient reported information is not protected by 42 CFR Part 2.
    - If the patient tells the MCO that they receive MAT, that is not protected by 42 CFR Part 2.
    - But If an MCO then gets patient consent to talk to their SUD provider and the SUD provider shares information with the MCO. Any of the information shared by the SUD provider is protected by Part 2.



## Consent Requirement Background- Part 2 cont.

- 42 CFR Part 2 will be updated by CARES Act of 2020
  - Congressional intent is that Part 2 better align with HIPAA
  - Regulations must be updated by March 2021
  - One written consent required
  - All additional disclosures align with HIPAA
- Questions remain about the specificity and granularity of written consent under new regulations
- CRISP is working in collaboration with other HIEs to develop a patient consent tool to comply with Part 2 requirements
  - Once consent is obtained, any available SUD treatment data will be available to all members of the care team.



## Consent Requirements Background – CRISP Policies

- Care coordination module will be available on CRISP Patient Care Snapshot
  - Module will include the care plan, care alerts, and SDOH screening
- Access to CRISP tools and services are available to CRISP participants only
  - Health care providers, payers, public health officials, and their care coordination partners
  - Some CRISP access, such as care coordination not on behalf of payer or provider requires patient consent
    - For example, local health department or HCAM performing navigation or care coordination as part of federal or state grant program



# CRISP Authorized User Access and Audit

- CRISP authorized users agree to adhere to CRISP policies and procedures which require among other things:
  - They view only information for whom patients they have an active relationship.
  - They adhere to the permitted purposes and approved use cases for query (posted on CRISP website).
  - They will notify CRISP of an inappropriate use or breach immediately.
- CRISP requires participants to keep updated a panel/list of active patients. Any queries for patients not on the list will require the user to “break the glass” or attest to a relationship
  - These events trigger audits by privacy and security staff which can then be raised to participant privacy and security officer
- CRISP works with Protenu, analytic software, that alerts CRISP when user queries might be suspect and occurred outside of a permitted use case.

# MCO “Homework” Questions

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- What strategies or tools has your organization found to be successful when walking individuals through the consent process?
- Could your MCO leverage its consumer/member advisory groups or special needs coordinators to provide feedback on understandability/comprehensibility of the informed consent document?

# Wrap Up and Next Steps

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- Presentation slides and participant engagement write-up will be posted to MDH's [MOM Model Website](#) (link on following slide)
- 'Homework' questions due back on May 26, 2020.
- Look for additional correspondence regarding updates and the next design collaborative event in the future

# MOM Model Contact Information

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**General:** [mdh.mommodel@maryland.gov](mailto:mdh.mommodel@maryland.gov)

**For resources and updates, check out our website:**  
<https://mmcp.health.maryland.gov/Pages/MOM-Model.aspx>

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