



Maryland Medicaid's Maternal Opioid Misuse Model: Evidenced-Based Practices for Participant Engagement Strategies

Background

The Maryland Department of Health (the Department) launched its Maternal Opioid Misuse (MOM) model in January 2020, with funding from the Center for Medicare and Medicaid Innovation (CMMI) and in collaboration with the Centers for Medicare and Medicaid Services (CMS). Maryland's MOM model addresses fragmentation in the care of pregnant and postpartum Medicaid participants with OUD through a statewide approach involving collaborative work with its nine managed care organizations (MCOs), improved data infrastructure, and strengthened provider capacity in underserved areas of the state. The MOM model aims to increase utilization of ambulatory and behavioral health care, such as medication-assisted treatment (MAT), through enhanced MCO case management.

The Department will provide an additional per member, per month (PMPM) payment to MCOs for enhanced care coordination and for MCO case managers to serve as the defined case manager as MOM model participants move through different systems of care and through the continuum of recovery from OUD. MOM model funding will support enhanced health information technology (health IT) and data-sharing capabilities including a Care Coordination Module.

MCOs will be responsible for initial enrollment in the MOM model, and for employing creative strategies to achieve ongoing participant engagement levels that meet the minimum service delivery criteria necessary to receive the enhanced PMPM for MOM model participants. MOM model minimum service delivery criteria include, for each month the participant is enrolled in the MOM model: 1) participants attending at least one behavioral health or somatic health appointment; and 2) the MCO case manager providing at least one contact. Additionally, in an effort to maximize engagement, the Department will continue to pay MCOs a PMPM for substantial outreach to MOM model participants enrolled in the MOM model and subsequently lost to follow up for a period of up to two months. Potential strategies for substantial outreach and engagement will include: deployment of certified peer recovery specialists and/or qualified community health workers to the participant's home and community; communication with a participant's somatic and behavioral health providers; monitoring CRISP hospital utilization care alerts; or, connecting with Local Health Departments (LHDs) and Administrative Care Coordination Units (ACCUs), among others.

This document outlines best practices for engaging the target population into the MOM model at various stages of their participation and is meant to serve as a resource for MCOs to consider while developing their participant engagement strategies.

Strategies for Identifying and Enrolling Participants

The Department expects MCOs to leverage multiple sources to identify eligible individuals to participate in the model, including through the Maryland Prenatal Risk Assessment (MPRA). Additional information related to participant identification can be found on the MOM model website (<https://mmcp.health.maryland.gov/Pages/MOM-Model.aspx>). MOM model partner organization Maryland Addiction Consultation Service (MACS) will initiate its scope of work during year two of the model. MACS will provide invaluable technical assistance in an effort to educate and train providers in the identification and treatment of OUD within this population. Once individuals are identified, MCOs will be responsible for conducting an initial contact with potential participants, including the invitation to voluntarily go through the consent and enrollment process. Additional guidance to outline case management workflow related to confirming clinical eligibility, screening participants, and conducting informed consent will be issued in subsequent design collaboratives.

Engagement Strategies

Engaging participants into the MOM model will be the responsibility of the case managers within the participants' MCOs. There are recognized barriers in engaging the vulnerable pregnant and postpartum populations, such as frequent address changes, outdated phone contact information, lack of culturally responsive care,¹ 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.

Studies have demonstrated a large majority of persons grappling with substance use do not seek OUD treatment due to perceived bias and lasting stigma.² 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 (*e.g.*, using language such as 'person with an opioid use disorder' rather than using the more stigmatizing term 'addict'). Person-first language is "non-judgmental and separates the individual from their disease, rather than defining them based on their medical condition."³ Co-location of behavioral health and somatic health services has been demonstrated to increase participant comfort level and improve coordination of services.⁴ The MOM model will work with MACS to assess provider readiness and create plans for Ob/Gyn providers and behavioral health

¹ Culturally responsive care is described as the delivery of high-quality care that includes paying close attention to social and cultural factors in managing medical encounters with patients from diverse backgrounds.

² Hasin DS, Grant BF. The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) Waves 1 and 2: review and summary of findings. *Soc Psychiatry Psychiatr Epidemiol.* 2015; 50(11): 1609-1640. doi:10.1007/s00127-015-1088-0.

³ Ibid.

⁴ Evolving Models of Behavioral Health Integration in Primary Care: <https://www.milbank.org/wp-content/uploads/2016/04/EvolvingCare.pdf>

practice integration.

MOM model grant guidelines require a Patient Activation Measure (PAM) screening of all MOM model participants; in Maryland, this will be conducted by MCO case managers. The PAM is a 10- or 13-item survey that assesses a person’s underlying knowledge, skills and confidence integral to managing their own health and healthcare.⁵ PAM can help predict future health behaviors and outcomes and is a requirement of the MOM model. The PAM score can illuminate the case managers’ understanding of the participants readiness to adhere to the care plan and assist case managers in developing a strategic plan for participant engagement based on participant’s activation level. The initial Social Determinants of Health (SDOH) screening—also a requirement of the MOM model—will also guide the case managers’ approach to linking participants with various resources. Follow up screenings of the PAM and SDOH will reveal further outreach actions the case managers may need to take to fully engage participants in their person-centered care plan.

In accordance with COMAR 10.67.05.03 (Access Standards: Outreach), an MCO is responsible for delivering health care services even when an enrollee is “difficult to reach or misses appointments.” Once the MCO has made documented attempts to contact the enrollee and bring them into care without success, the MCO can reach out to the LHD for assistance, as another resource. The regulation also speaks to specific criteria for outreach to pregnant and postpartum populations, such as requirements for an MCO to provide written notice of appointment dates and telephonic attempts to notify the enrollee of upcoming or missed appointments. After these attempts, an MCO shall ensure the enrollee’s provider makes a written referral to the LHD for collaborative assistance in connecting the enrollee with care.⁶ MCOs should still adhere to COMAR regulations regarding outreach for the MOM model participants.

Strategies for Continued Retention, Engagement, and Outreach

Motivational Interviewing

Case managers can combat reluctance to join or remain in the MOM model by deploying a motivational interviewing (MI) approach. 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 can be used to help individuals struggling with OUD to make meaningful behavioral changes to support their overall health, such as remaining consistent with MAT throughout the pregnant and postpartum periods.⁷

Shared Decision-Making

Shared decision-making (SDM) is an additional tool that can be used by providers and case

⁵ Patient Activation Measure: <https://www.insigniahealth.com/products/pam-survey>

⁶ COMAR 10.67.05.03: <http://www.dsd.state.md.us/comar/comarhtml/10/10.67.05.03.htm>

⁷ U.S. Department of Health and Human Services, Health Resources and Services Administration. (2018). HRSA’s Home Visiting Program: Supporting Families Impacted by Opioid Use and Neonatal Abstinence Syndrome. Rockville, Maryland: U.S. Department of Health and Human Services. Retrieved from:

<https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/MIECHV-Opioid-NAS-Resource.pdf>

managers to support continued retention in the MOM model. SDM is an approach where participants and clinicians collaboratively work towards making informed clinical treatment decisions based on evidence and the participant’s preferences. Widely accepted in the clinical realm, this evidenced-based approach is considered integral to achieving person-centered care and has demonstrated positive outcomes such as increased participant satisfaction, treatment adherence and engagement in many chronic conditions such as HIV and diabetes.⁸ Additionally, research available suggests this approach can be successful when applied to treatment decisions pregnant individuals with OUD may have to make about their care and social needs.⁹

MCO Incentives

Providing incentives to plan participants has been shown to enhance health outcomes, reduce health care costs, and influence healthy behavior.¹⁰ The Department conducted interviews with four MCOs who serve a combined 80 percent of potential MOM model-eligible participants. To promote appropriate health care utilization, Maryland’s MCOs reported utilizing tools such as incentives—ranging from diapers, baby supplies, and gift cards for major retailers to baby showers—to participants for completing various care milestones, such as completing a timely postpartum visit. Other examples of incentives for participants are offering free parenting classes, bus passes to help with transportation to appointments, or pre-loaded debit cards to use for supplies or food. The Department encourages MCOs to creatively think through use of incentives that would most effectively benefit participants and support engagement and retention in the MOM model services. While MOM model funds cannot be used for participant incentives, MCOs have the flexibility to provide appropriate incentives for participants.

Lay Health Workers

For the MOM model, MCOs may choose to include lay health workers such as certified community health workers (CHWs)¹¹ or certified peer recovery specialists (CPRS) in outreach and engagement strategies. CHWs typically belong to the same communities as the individuals they serve and are an evidenced-based provider type in improving the quality and cultural responsiveness of care.¹² Similarly, CPRS offer non-judgmental, practical information for individuals with OUD and provide unique insights through their lived experiences.^{13,14} Evidence demonstrates that engagement of peer recovery specialists and other paraprofessionals is a promising practice for continued

⁸ Marshall T, Kinnard EN, Hancock M, et al. Patient engagement, treatment preferences and shared decision-making in the treatment of opioid use disorder in adults: a scoping review protocol. *BMJ Open* 2018;8:e022267. doi:10.1136/bmjopen-2018-022267

⁹ Guille, C., Hendree, J., Abuhamad, A., & Brady, K. (2019). Shared Decision-Making Tool for Treatment of Perinatal Opioid Use Disorder. Retrieved from: <https://prcp.psychiatryonline.org/doi/10.1176/appi.prcp.20180004>

¹⁰ 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>

¹¹ Community Health Worker Certification: <https://pophealth.health.maryland.gov/Community-Health-Workers/Pages/Certification-Program.aspx>

¹² American Public Health Association. Community Health Workers. (n.d.). Retrieved from: <https://www.apha.org/apha-communities/member-sections/community-health-workers>

¹³ Certified Peer Recovery Specialists: https://bha.health.maryland.gov/Documents/CPRS%20Overview%20Guide_comms_030518.pdf

¹⁴ Dardess, P., Dokken, D. L., Abraham, M. R., Johnson, B. H., Hoy, L., & Hoy, S. (2018). Partnering with patients and families to strengthen approaches to the opioid epidemic. Bethesda, MD: Institute for Patient- and Family-Centered Care.

engagement among individuals with OUD.¹⁵ While recognizing that Medicaid does not provide reimbursement for CPRS services outside of bundled payments for Institutions of Mental Disease, MCOs could consider using PMPM payments towards supporting CHWs or CPRS in their staffing model. The Department will work collaboratively with MCOs to define what provider types will be engaged and their qualifications needed to engage with MOM model participants.

Outreach Strategies

The target population may pose difficulty in identifying due to the sensitive nature involved in participating and other barriers noted above, thus substantial outreach services may need to be deployed once a participant is lost to follow-up. COMAR 10.67.01.01 defines outreach services as efforts to contact enrollees and bring them into care.¹⁶ As stated previously, the Department will continue to pay MCOs a PMPM for up to two months after a participant disengages from services to encourage aggressive outreach and re-engagement activities. The Department will mandate a minimum number of outreach efforts necessary for the MCO to continue receiving the \$208 PMPM during the design process in Year 1, and will provide a finalization of protocol and outreach standards prior to the implementation phase of the model. Potential outreach strategies may include the following:

- 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 primary care provider and other providers to assist with re-engagement;
- Connecting with local ACCUs or other connected departments and community programs participant is involved with; and
- Monitoring CRISP hospital utilization alerts to check inpatient admissions and emergency encounters.

Additionally, the Department encourages MCOs to examine their current policies and outreach procedures and adopt strategies that could facilitate more effective outreach such as embedding substance use disorder counselors into primary care practices, which has been shown to improve collaboration between providers and increase participant engagement.¹⁷

Warm Handoffs

Finally, MCOs are encouraged to look at their current clinical workflows and adopt warm handoff

¹⁵ Ibid.

¹⁶ COMAR 10.67.01.01 <http://www.dsd.state.md.us/comar/comarhtml/10/10.67.01.01.htm>

¹⁷ U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. Best Practices and Barriers to Engaging People with Substance Use Disorders in Treatment. (2019). Retrieved from <https://aspe.hhs.gov/pdf-report/best-practices-and-barriers-engaging-people-substance-use-disorders-treatment>

practices where possible to foster a participant's engagement during transitions in care. A warm handoff is a transition in care between two members of the participant's healthcare team for the purpose of improving the connection and reducing the gaps in services that the participant will receive.¹⁸ Warm handoffs are ideally done in-person and in front of the participant and allows for the participant to take a more active role in their treatment and have more agency in their healthcare decisions. Warm handoffs can be completed at any point in a participant's treatment but can be especially important to provide during the discharge planning process from the MOM model.

Warm handoffs can be a vital strategy deployed to enhance collaboration between the MOM model participant's various care team members and reduce unintended consequences such as fragmentation in care and service duplication. Specific tactics to consider include having assigned care team members provide introductory calls acknowledging the name and contact information of the participant prior to transferring the call to a new provider. Additionally, the case managers should follow up with the participant in a timely manner to ensure they were connected to needed social resources and offer to schedule appointments with the participant present to address unmet needs. The Department encourages MCOs to explore resources available on implementing warm handoffs into their clinical workflows such as using verified resource directories and building in triggers to follow-up with participants after being referred to services directly into their electronic health record systems.

¹⁸ Pennsylvania Department of Health. (2017). Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training: Referral to Treatment for Substance Use Disorder Related to Opioid Use. Pennsylvania Department of Health. Retrieved from: https://www.health.pa.gov/topics/Documents/Programs/PDMP/5-PDMP_Referral-Guide_F.pdf