TennCare Health Plan Meeting Highlights Report

June 22, 2023

Division of TennCare

Qsource®

Meeting Objectives

As Tennessee's designated External Quality Review Organization (EQRO), Qsource facilitates health plan meetings to benefit TennCare and its managed care contractors (MCCs). These triannual meetings provide opportunities for learning from guest subject matter experts who can share success stories and best practices, for earning nursing and the Certified Professional in Healthcare Quality (CPHQ) continuing education units (CEUs), and for networking to stay abreast of pertinent topics to Medicaid and managed care. Objectives for February attendees were the following:

- Increase understanding of Sickle Cell Disease (SCD), the unique challenges that patients of SCD face, and how the longstanding health inequalities affect these patients specifically;
- Increase understanding of the mental health crises facing adolescents as well as discuss efficient ways of maximizing cooperation across disciplines and services to reach and treat the greatest number of in-crisis adolescents; and
- Examine the intersection between Long-Term Supports and Services (LTSS) and overall health disparities as well as methods to bridge those barriers.

While our shared goal has always been to improve the quality of care and services provided to TennCare members, this program was informed by your feedback and suggestions, and carefully designed by Qsource and TennCare to cover topics relevant to the requirements, needs and concerns of your health plan. It is our hope that you will find the presentations both helpful and informative when preparing procedures and crafting policies. This document contains highlights for a quick refresher on the day's speakers and topics.

Sickle Cell Disease: A Comprehensive Overview

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Nurse Practitioner and Subject Matter Expert

- "Sickle cell disease (SCD) is an umbrella term that defines a group of inherited diseases called hemoglobinopathies characterized by mutations in the gene encoding the hemoglobin subunit β (HBB)" (Nature Reviews Disease Primer 4). SCD is characterized by mutations in the red blood cell. A misplacement in the gentetic coding—GLU switched to VAL—causes the cell to change shape and, from there, deoxygenate and polymerize.
- Regularly shaped, healthy red blood vessels last up to 100 days in the body; SCD red blood cells only last 10-20 days and burst in hemolysis. A patient with SCD can quickly go into aplastic crisis, where the bone marrow cannot produce blood vessels quickly enough to keep up with the lysing of old blood cells. This causes severe anemia.
- When using an emergency severity index (ESI) triage system to judge a patient's level of pain, a patient with SCD should be triaged as ESI level 2—the same ESI level as a patient with a heart attack.
- Sickled cells are stiff, occlude blood vessels more easily due to their stiffness and stickiness, and are more prone to lysis. Due to the decrease in oxygen that is a signifier of the sickled shape and the decrease in blood flow due to the occlusion of arteries, anywhere that blood flows in the body can become a crisis point.
- Despite the prevalence of SCD and the fact that it was discovered relatively long ago, there is still only two known treatments for SCD (not counting gene therapy which is still being studied) and four medications that have been approved by the FDA. This is likely due to the fact that SCD is more prevalent in medically underserved communities. These medications and treatments include:
    - Blood transfusions—this serves to dilute the sickled red blood cells with non-sickled red blood cells. The fresh blood actually decreases viscosity, and it lowers the risk of stroke and occlusion in SCD patients;
    - Bone marrow transplants—because bone marrow is the site of red blood cell production, the introduction of new bone marrow typically allows for the production of non-sickled red blood cells in a patient with SCD;
    - Hydroxyurea—this medication stimulates the production of fetal blood, or the blood that is typically produced by the human body in utero and up to six months post-birth. Fetal blood does not sickle, so stimulating the production of fetal blood acts to dilute the sickled blood cells, much like a transfusion would;
    - Oxbryta—this medication causes the hemoglobin to 'grab' onto oxygen harder so that sickled cells can hold more oxygen;
    - Adakveo—this medication sticks to the 'sticky factor' of sickled cells, making it harder for sickled cells to stick to each other or the sides of arteries; and

- Endari—this medication helps the cells become more tolerant to oxidative stress through the production of excess glutamine and relieving the sickled cells of some of its rigidity.

Adolescent Depression, Self-Harm, and Suicide

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- According to the APA Clinical Practice Guidelines, less than 1% of children/adolescents receive outpatient treatment for depression each year despite the fact that 1 in 5 teenagers have a depression at some point during adolescence.
- According to the CDC, in the 2018-2019 reporting year, 15.1% had a major depressive episode, 36.7% had persistent feelings of sadness or hopelessness, 18.8% seriously considered attempting suicide, 15.7% made a suicide plan, 8.9% attempted suicide, and 2.5% made a suicide attempt requiring medical treatment. In the 2020-2021 reporting year, 30% of females had reported having seriously contemplated suicide, with 44% overall teenagers reporting feeling persistently hopeless.
- Tennessee is ranked 7th in the country in terms of youth with at least one major depressive episode (MDE) in the last year but is ranked 50th in the country in terms of youth with severe MDE who received consistent treatment.
- Barriers to accessing care for youth/adolescents with emotional disturbance are limited resources for families, a lack of behavioral health workforce (mainly due to the rise in mental health needs during the COVID-19 pandemic combined with many medical workers leaving the field due to the same pandemic), insurance barriers, and transportation challenges for parents.
- Some key strategies that Cherokee Health Systems sees for helping overcome the above barriers include: building capacity for screening for emotional disturbances or mental health challenges into schools, training emergency responders to child/mental health crises, working with insurance and medical providers to create better access to psychiatric beds, expanding the behavioral health workforce through trainings and expanding the state-licensed programs, and working across institutional boundaries by partnering with pediatricians and primary care physicians to expand access to behavioral health screenings and services.
- In order to meet the above strategies, further training for school counselors, EMTs, primary care physicians, and pediatricians are needed, as depression and other behavioral or emotional health disturbances manifest differently based on the age group. Younger children may exhibit more somatic complaints, physical agitation, and separation issues, while teens and older children may exhibit opposite behaviors such as an increase in sleep and appetite.
- Once a child has been screened and is found to have a problem with their behavioral or mental health, treatment strategies include: early intervention, diagnostic evaluation, providing acceptance and validation through open communication, the treatment of

primary psychiatric disorders first (as the symptoms of depression can, at times, be a confounding variable), Cognitive Behavioral Therapy and/or Dialectical Behavior Therapy interventions should be initiated, and assisting caregivers (often the parents) should also be given support.

Understanding the Intersectionality of Disability, LTSS, and Equity

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- Individuals may require Long-Term Supports and Services (LTSS) for many reasons: physical disability, intellectual and developmental disability (I/DD), cognitive impairment, serious mental illness, and other factors. LTSS encompass a broad spectrum of paid and unpaid assistance and support that can be provided at home, in the community, or in a facility setting and include personal care, adult day centers, day habilitation, pre-vocational services, transportation, or home modifications that support individuals with everyday activities.
- 8.9 million Medicaid recipients used LTSS in 2019, with 3.3% of that number receiving both institutional and Home- and Community-Based Services (HCBS). This comes to $2.6 billion, or 25% of the total Medicaid spent in the state. Each state balances the amount of Medicaid spent on LTSS against the whole Medicaid budget; Tennessee balances spending on LTSS as approximately 50%.
- Medicaid covers LTSS for the lowest income level and private pay covers LTSS for the highest income level, but there is no mechanism to help all the individuals who need LTSS in between those levels. According to the Kaiser Family Foundation, approximately $470 billion worth of LTSS is provided by unpaid family or friends of individuals who need help.
- Within LTSS settings of care, there exist disparities across race, ethnicity, and other identity characteristics:
    - 81% of LGBTQ+ adults fear entering LTSS institutions because of potential discrimination;
    - Black and Latino Medicare beneficiaries are more likely to report difficulty with two or more activities of daily living (ADLs) as well as experiencing social determinants of health (SDOH) that may exacerbate their LTSS needs;
    - BIPOC adults receiving LTSS often receive lower quality of care and experience worse health outcomes than white adults receiving LTSS, including being admitted to nursing facilities that have limited financial and staffing resources and a high re-hospitalization rate; and
    - BIPOC individuals receiving LTSS are more likely to experience Alzheimer's disease and related dementia due to past trauma, discrimination, and unmet medical needs.
- Medicaid managed care programs provide an infrastructure to address equity among people using LTSS:

- Assessments—inquire about and be sensitive to demographics, identity, linguistic, and cultural preferences;
- Incorporate member experiences—ensure feedback to patients reflects attributes of culture, language, and identity;
- Data—develop common data collection frameworks and analyses to better understand the intersection of demographics, culture, and disabilities;
- Provider development—develop a provider workforce and network responsive to the needs and demographics of the population;
- Integration—provide whole-person care to address LTSS needs alongside physical, behavioral, and social needs; and
- Reinvestment and innovation—reinvest excess profits into community infrastructure responsive to demographic, linguistic, cultural, and identity-based supports and providers.