Amerigroup

Medicaid

Tennessee Health Link (THL) Care Coordinator Handbook

THL was "…built to encourage the integration of physical and behavioral health, as well as, mental health recovery, giving every member a chance to reach his or her full potential for living a rewarding and increasingly independent life in the community."

Objectives of Tennessee Health Link

This companion guide is meant to be supportive for THL staff providing care coordination. Always refer to the current Provider Operating Manual on the TennCare website for the most up-to-date information.

Tennessee Health Link

* EyeQuest is an independent company providing vision benefit management services on behalf of the health plan. DentaQuest is an independent company providing dental benefit management services on behalf of the health plan.

https://provider.amerigroup.com/TN

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Select a topic below to jump to that section.

Vocabulary for care coordinators

Gaps in Care (GIC): If a patient has not received recommended services, it is called a gap in care. There are many recommended healthcare best practices for everyone including services such as annual wellness visits and vaccines. Specific health conditions will also have best practice recommendations including patients with some types of chronic conditions or taking some types of medications. When patients receive recommended care, it demonstrates that providers are making sure patients are getting recommended care and *closing a gap*.

HEDIS®: Healthcare Effectiveness Data and Information Set is a registered trademark of the National Committee for Quality Assurance (NCQA). This group uses healthcare best practices and develops specific ways to measure quality of care. The quality metrics used in THL were chosen from the HEDIS measures set specifically for the program. You will see HEDIS definitions for THL quality measures in green tiles in this booklet.

It is important to note that there may be reasons to not include every member in every quality metric (for instance, members in hospice care, or who have cancer will be excluded for many measures).

Managed Care Organization (MCO): An insurance carrier that seeks to provide cost effective/high-quality healthcare. TennCare contracts with three MCOs to provide care: Amerigroup Community Care, BlueCare, and UnitedHealthCare®.

Members: The patients or clients

Patient-Centered Medical Home™ (PCMH): This is a model for providing primary care that includes specific whole-person activities such as coordination of care and meeting quality measures. TennCare encourages partnerships between THLs and PCMHs to deliver integrated care.

Primary care provider (PCP): This is the healthcare provider (doctor, nurse practitioner, or physician's assistant) who takes care of wellness exams, preventative care, and identifies and treats common health problems. Everyone needs a PCP for routine healthcare including vaccines, recommended screenings, and sick visits. PCPs will also usually make referrals for specialty services if needed. It is important that everyone has a PCP that is trusted, has available appointments for care, and is conveniently located.

Commonly, PCPs are internal medicine, family, pediatric, or OB/GYN providers. Typically, patients (or members) will need to transition from a pediatric provider to an adult provider when they reach 18 to 21 years old.

The insurance provider can always assist in finding a PCP.

Quality metrics: These are measures used in healthcare to determine if patients are receiving high quality care. THLs are measured on nine specific quality metrics to compare with other THLs across the state. This ensures that Health Links are meeting specified quality performance levels.

It is important to note that there may be reasons to not include every member in every quality metric (for instance, members in hospice care, or who have cancer will be excluded for many measures).

TennCare Connect: This is a website where Tennesseans can apply for TennCare or manage their coverage. It is critical that members with TennCare keep their information up to date so that they receive communications about their coverage and keep their coverage **(tenncareconnect.tn.gov)**

Healthy Rewards

Amerigroup offers rewards which members can earn when they receive recommended services or close some gaps in care. Providers are also incentivized when they help members meet some quality metrics. When members are getting services to close gaps, it demonstrates that providers are reliably providing high-quality care compared with other providers.

Staying healthy earns you rewards with our Healthy Rewards program.

Amerigroup Community Care rewards its members for making healthy choices.

Healthy Rewards is a no-cost, optional program for eligible Amerigroup members. It encourages you to complete healthy activities and screenings to help you get and stay healthy.

How do I start earning Healthy Rewards?

1. **Register** for Healthy Rewards by logging in to the Benefit Reward Hub at myamerigroup.com/TN. Or call Healthy Rewards toll free at 888-990-8681 (TRS 711) Monday through Friday from 8 a.m. to 7 p.m. Central time.
2. **Complete** eligible appointments and screenings.
3. **Choose** your gift card. Enjoy!

See what you can earn on your Healthy Rewards account home page, and after you finish an activity, we will load the rewards to your account.

Choose your gift card from stores like Amazon, Kohl's, and Lowe's.

Healthy Rewards program members can earn rewards for:

Who can earn	Activity	Reward	Limitations
F, ages 13–55	1st prenatal care visit	$25	1 per pregnancy
M, F, ages 21 and older	Adult well visit	$20	1 per 12 months
M, F, ages 18 and older	Antidepressant medication management	$5, max $20	1 per quarter
F, ages 50–74	Breast cancer screening	$50	1 per 24 months
F ages, 21–64	Cervical cancer screening	$25	1 per 36 months
M, F, ages 2–20	Childhood & adolescent wellness visit	$50	1 per 12 months
M, F, ages 18–75	Diabetic A1c screening	$10	1 per 12 months
M, F, ages 18–75	Diabetic retinal eye exam	$50	1 per 12 months
M, F, ages 0–2 (stops on 2nd birthday)	Flu & rotavirus vaccinations	$25	1 per member
M, F, ages 18–75	High blood pressure medication refill	$5, max $20	1 per quarter
M, F, ages 9–12 (stops on 13th birthday)	HPV vaccination	$50	1 per member
F, ages 13–55	Postpartum care visit	$50	1 per pregnancy
M, F, ages 18–75	Quiz (diabetes management)	$5	1 per 12 months

I finished a healthy activity. How do I get my reward?

First, we have to get a claim from your doctor. That can take up to 90 days. Once your claim is received, we will add the reward to your balance if you have joined the Healthy Rewards program and if you have finished the activity requirements.

How will I know when I have a reward? Will I be notified?

We will send updates by text message and/or email when your rewards are available.

If you can't receive text messages or emails, please check your account 90 days after you finish your healthy activity. If you chose not to receive text messages or emails, you can opt back in on the *Notifications* page on the Benefit Reward Hub.

If members need extra assistance, care coordinators can help the member call Healthy Rewards (**888-990-8681**) to get started.

Other MCOs may have similar rewards. Please check with your THL leadership for the most recent opportunities for all TennCare members.

THL Quality Metrics

Quality Metrics: Medication adherence to antipsychotics (SAA) or new antidepressants (AMM)

- Adults who take their antipsychotics 80% of the time
- Adults who stay on their new antidepressants for a full six months

People 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

People 18 years of age and older with a diagnosis of major depression who remained on an antidepressant medication for at least 180 days.

For antipsychotics, members may be included when they have claims with one of these diagnoses and have filled a prescription for antipsychotics once during the calendar year.

For antidepressants, members who start taking an antidepressant (after not being on an antidepressant for at least 105 days) may be included.

Medication adherence quality metric information is captured in prescription claims submitted by the pharmacy or by the practice if giving injections.

Some best practices for care coordinator interventions:

- Ask members what challenges they have with taking medications as prescribed monthly. Address barriers to adherence.
- Ask members what side effects they are experiencing. Encourage member to discuss medication side effects with the prescriber. Discuss concerns with medication management team as needed. This is the most common reason for not taking their prescription medications.
- Help members develop a medication reminder system that works well (such as text messages, alarms, signs on the fridge, pill dispensers, etc.).
- Verify that members have no barriers in picking up the prescriptions monthly. Have the prescriber/nurse help resolve concerns if needed.
- Check with the pharmacy to see if prescriptions are being filled or check medication refills in the Care Coordination Tool monthly.
- Verify that member keeps appointments for medication management and/or injections.

Quality Metric: Early Periodic Screening, Diagnosis, and Treatment/EPSDT (WCV)

This is usually thought of as an annual physical exam or a well-care check-up for members through their 20th year.

Members ages 7 through 20 years of age who had at least one comprehensive well-care visit with a primary care physician (PCP) or OB-GYN within the calendar year.

The EPSDT quality metric is captured when a primary care provider submits a claim with coding for the elements included in the exam.

This measure starts over every 12 months, but members do not have to wait a full year between well visits.

- Remind family that all children newly enrolling in a Tennessee school or entering 7th grade will need an updated immunization certificate with up-to-date vaccines.
- Remind family that students enrolling in college will also typically need updated vaccines to apply.

"States are required to assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly, … that informing methods are effective, … and that services covered under Medicaid are available." — CMS, State Medicaid Manual

Some best practices for care coordinator interventions:

- Encourage members to schedule the well visit in their birth month this year. Verify that an appointment is made and kept.
- Verify date of last well visit with the PCP. If there has not been a check-up appointment within the last year, get it scheduled this month.
- Schedule an annual well visit during the upcoming school break (summer vacation, spring or fall break, holidays) within the next month. Schedule early in each calendar year.
- Assist the member with identifying and transitioning to an adult provider after the 18th birthday. Teach member to use the number on the back of the insurance card to help identify in-network providers.
- For members taking antipsychotic medications and who need to have screenings done, contact the PCP to remind that member needs to complete the metabolic monitoring metric at the next visit (see APM details later in this booklet).

Quality Metrics: Retinal eye exam for members with diabetes (EED)

Members 18 to 75 years of age with a diagnosis of type 1 or 2 diabetes who have a retinal eye exam performed and billed by an eye care professional or a PCP if a retinal screening device is available.

- Annual exams for members with evidence of any type of retinopathy.
- Screen those who remain free of retinopathy every other year.

Members may be included if they had 2 diagnoses of diabetes in the previous year or were hospitalized with a diagnosis of diabetes. This quality metric is met when an eye provider submits a code for the reading of a retinal exam.

Remember that a retinal screening is **not** a vision screening and TennCare does not cover vision exams or glasses for adult members over the age of 21.

Diabetic retinopathy (DR) is the leading cause of blindness in American adults. It is characterized by progressive damage to the blood vessels of the retina, the light-sensitive tissue at the back of the eye that is necessary for good vision. "Early diagnosis of DR and timely treatment reduces the risk of vision loss; however, as many as 50% of patients are not getting their eye examined or are diagnosed too late for treatment to be effective."

cdc.gov/visionhealth/basics/ced/index.html#a5

Some best practices for care coordinator interventions:

- Remind member to schedule an eye exam at the beginning of each calendar year. Assist in getting an appointment scheduled with the current eye care professional if needed.
- If your clinic has a retinal camera, coordinate a retinal eye exam appointment in the next month or at the soonest available appointment.
- Help members identify eye care providers by using the **EyeQuest* portal** or by calling the number on the back of the insurance card. (EyeQuest at **800-446-0037**)
- Discuss the importance of maintaining a high quality of life and preventing blindness by caring for their vision and getting recommended screening.
- Be sure members are keeping regular appointments with the PCP (or endocrinologist/diabetes specialist) and are following recommendations monthly.
- Managing diabetes is the best way to prevent the complications of diabetes. Ask what support members may need to follow up with their provider, to take medications and to follow life-style recommendations. Call the PCP to ask!

Quality Metrics: Controlled BP for members with a diagnosis of high blood pressure (CBP)

Members 18 to 85 years of age with a diagnosis of hypertension and Blood Pressure (BP) was controlled.

- Compliant BP is defined as < 140/90 mm Hg for all members.
- The threats from poorly controlled BP include heart attack and heart failure, stroke, kidney disease, and vision loss.
- The latest reading in the calendar year is used to meet the measurement.
- If no reading is recorded for the year, the assumption is that the member's BP is not controlled.
- You can take multiple BP readings at a visit and report the lowest systolic and lowest diastolic to make the compliant BP reading.

Members may be included if they had 2 diagnoses of high blood pressure on different dates in the previous year. This quality metric is met when a provider submits coding on a claim for a compliant BP. This can come from any provider, including THL providers.

CPT®	BP reading (may use the BEST systolic and the best diastolic if more than one BP was taken in a visit)
3074F	Most recent systolic blood pressure < 130 mm Hg
3075F	Most recent systolic blood pressure 130 to 139 mm Hg
3077F	Most recent systolic blood pressure 140 mm Hg
3078F	Most recent diastolic blood pressure < 80 mm Hg
3079F	Most recent diastolic blood pressure 80 – 89 mm Hg
3080F	Most recent diastolic blood pressure 90 mm Hg

Some best practices for care coordinator interventions:

- Review the members' BP readings each month. Remind member that the goal for hypertension 139 or less/89 or less for most people. If they do not have a BP cuff, they can check BP at most pharmacies and grocery stores.

- Review BP medications and importance of taking daily. Stress that it is important to take the medication every day as prescribed even if they are feeling fine.
- Help members identify barriers to taking medications such as cost, concern about prescription limits, or side effects. Share feedback with the medical providers to address barriers.
- Call the PCP to find out if BPs have been at goal and if there are any lifestyle recommendations that the care coordinator can support (such as low-salt diet, losing weight, using CPAP for sleep).
- Regularly discuss with members that even if they feel fine, high BP puts stress on the body and medications can help prevent complications. We cannot rely on symptoms to know when the BP is at goal.
- Check with the pharmacy monthly to be sure members are picking up meds. Assist in setting up a reminder system if needed.
- Ask members what recommendations their primary care providers have made regarding lifestyle changes such as diet or exercise. See if the member would include lifestyle modifications in the care plan.

Quality Metrics: Diabetes Screening for adults taking antipsychotics (SSD) and Metabolic Monitoring for children/adolescents taking antipsychotics (APM)

Annual diabetes screening for members 18 to 64 years with schizophrenia, schizoaffective disorder, or bipolar disorder if they receive an antipsychotic medication at any time during year and *do not* have a diagnosis of diabetes.

The percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year (blood glucose and cholesterol testing).

Included members are:

- ✓ Adults who have a diagnosis of schizophrenia and filled at least 1 antipsychotic medication prescription.
- ✓ Adolescents who have filled at least 2 prescriptions of an antipsychotic in the measurement year.
- These quality metrics are met when a provider submits a code for the laboratory test.
- Many antipsychotic medications increase the risk of diabetes and hyperlipidemia.
- Testing may be ordered by mental health providers or may coordinate with a primary care provider to obtain the labs.
- It is the responsibility of the prescriber of the antipsychotic to have the screenings ordered and documented.

who.int/publications/i/item/978-92-4-155038-3

Some best practices for care coordinator interventions:

- Provide member education and reminders of the increased risk of cardiovascular diseases and diabetes for those taking antipsychotics, so screening and monitoring of these conditions are important to maintain a high quality of life and prevent complications.
- Follow up in the Care Coordination Tool or gaps in care report to assure that screenings are completed early in the calendar year.
- Be sure members are scheduled to get screenings done (at the THL or at the PCP) and keep appointment annually.
- Identify small goals with member to support healthy lifestyle choices (adherence to treatment, diet, and exercise) to develop habits that reduce risks of diabetes and high cholesterol. Keep the care plan updated with member goals.
- Remind members that these tests can be accomplished with just a finger stick in the THL office or other provider office. Be sure to take advantage of the most convenient way for a member to have this done and combine the testing with a provider visit.

Quality Metric: Follow up appointments after psychiatric inpatient stays (FUH) and Readmissions within 7 or 30 days

The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses (including self-harm) and who had a follow-up visit with a mental health practitioner within 7 days after discharge.

Psychiatric hospital or residential treatment facility readmission within seven and 30 days after discharge

Members may be included if they had an inpatient psychiatric admission. These quality metrics are measured by inpatient hospitalizations for a psychiatric diagnosis and then by seeing a licensed mental health provider within seven days after discharge (this may be met with a telehealth visit) and if they have a psychiatric readmission within 7 or 30 days.

- Be sure to have available educational materials regarding crisis lines, and walk-in or open-door policies should urgent situations arise for all members.
- For members with a history of frequent readmissions, request case management support from the insurance carrier.

Some best practices for Care Coordinator interventions:

- Use psychiatric census reports and ADT (Admissions/Discharges/Transfers) reports from the Care Coordination Tool to outreach to members, even while still inpatient. Be sure members know about the follow-up appointment.
- Develop relationships with local hospitals so that you can collaborate with members and discharge teams. Be sure discharging members have all the information needed for follow-up appointments and that you have good contact information for the members.

- Ensure that members are able to pick up medications and that there were no problems with authorizations or prescription limits. Communicate with the medical management team to help be sure medications can be continued if members experience any barriers.
- Ensure that follow-up appointments are made with a licensed mental health practitioner before members leave the hospital and that appointments are scheduled within seven days of discharge.
- Provide materials and resources to members regarding after-hours options and appropriate use of the Emergency Department should concerns arise before the follow-up appointments.
- Call member within three days of hospital discharge. Ask what side effects the members may be experiencing from new medication and what barriers they are experiencing to pick up medications.

***Remember: TennCare has a Provider Operating Manual posted on the Tennessee Health Link website. Please monitor for updates and always follow the direction of your organization regarding documentation, billing, and THL panel management.**

Evaluation of THL services

Health Link is a behavioral health program and, as such, care coordinators should always work to support behavioral health goals which foster recovery and resiliency skills. Current Care Plans must have active behavioral health goals and the member must be receiving behavioral healthcare such as therapy or medication management to continue to receive Health Link care coordination. Helping members engage in behavioral healthcare services is a key role for care coordinators and evaluations are conducted to assure that the program is implemented for that purpose.

1. For each Health Link (HL) provider, each insurance carrier will conduct an Engagement Evaluation (EE) twice a year, reviewing charts of members enrolled in HL services at each EE.

2. The in-depth chart reviews will assess effort as well as outcome. A clear indication that the provider has identified needs, incorporated them into the individualized plan, and is actively attempting to address those needs would be considered in assessing whether the enrollee is benefiting from the HL program.

3. All insurance carriers use a standardized evaluation tool to assess required elements in the chart including referral, consent, care plans,

functional needs assessments, and detailed progress notes to support claims.

- **Initial paperwork all within 30 days of the consent:**
    - Consent signed by member (or noted as verbal consent)
    - Referral signed by a licensed provider with supporting documentation for the need for THL services
    - Functional Needs Assessment (FNA)
    - Comprehensive care plan signed by care coordinator, member, and licensed provider
- **Care plans and FNA at least every 6 months**
    - SMART goals
    - Were care plans updated and unmet goals modified?
    - Were barriers addressed?
- **Progress notes for last 6 months or longer, generally looking for:**
    - Were emotional/behavioral health needs addressed?
    - Were gaps in care addressed and was there collaboration with PCP/specialist if needed?
    - Were community supports offered?
    - Was there follow up after an inpatient stay or ER visit?
    - Was health promotion provided and were there efforts to promote recovery and resiliency?
    - Did member make progress or were barriers addressed? What interventions did the care coordinator provide?
    - Were there good attempts to reach and engage member regularly?

Care coordination billing and activity encounter codes*

To the extent possible, file the billing code (S0280) once a month with all applicable encounters.

If there are additional activity codes (encounters) after the billing code has been submitted in a month, they may be submitted without the billing code.

Code	Activity
G9004	**Comprehensive care management**: Initiate, complete, update, or monitor the progress of a comprehensive person-centered care plan. Activity examples: • Creating or updating or reviewing a care plan • Referencing the care plan, identifying barriers
G9005	**Care coordination**: Participate in member's physical health treatment plan, support scheduling and reduce barriers to adherence for medical and behavioral health appointments, facilitate and participate in regular interdisciplinary care meetings, follow up or outreach to with PCP, and follow up with other behavioral health providers or clinical staff. Activity examples: • Coordination and collaboration with external providers including PCPs, specialists, and outside psychiatric services • Collaborate and coordinate with your therapy and medication management team * Not just appointment reminders
G9006	**Health promotion**: Educate the member and his/her family. Activity examples: • Providing psycho educational materials • Conversations around health conditions • Being sure health appointments are being kept • Being sure to care for general health such as dental, vision, smoking cessation, weight management • Supports/education for chronic conditions • Preventative health resources and counseling

Code	Activity
	• Developing health lifestyle habits
G9007	**Transitional care**: Provide additional high touch support in crisis situations, outreach to members in inpatient settings, participate in development of discharge plans, develop a protocol to assure timely access to follow-up care, and communicate and provide education. Activity examples: • Discussion about specific follow-up plans after inpatient or emergency room visits • Assuring follow-up and education is provided or available
G9010	**Patient and family support**: Provide high-touch in-person support, provider caregiver consultation or training, identify resources to assist individuals and family supporters. Activity examples: • Psychoeducation in general • Smoking cessation line • Providing community resources • Linking to external providers and resources (for example, dental and vision providers)
G9011	**Referral to social supports**: Identify and facilitate access to community supports, communicate member needs to community partners, and provide information and assistance in accessing services. Activity examples: • Identify and support social needs such as housing food, transportation

Person	Method
UA: Member **UB**: Collateral	**UC**: Face-to-face **UD**: Indirect

***tn.gov/content/dam/tn/tenncare/documents2/HealthLinkProviderOperatingManual.pdf**

THL attribution and panel management

How members are attributed:

1. Newly eligible members: May be identified from a diagnosis, utilization, or a psychiatric hospital discharge. Members are assigned by the insurance carrier by geographic address or by previous engagement with a THL.

2. Newly attested members: Identified by the THL provider as being eligible for HL services based on medical necessity criteria, can be attested in the Amerigroup website. Before submitting attestation, providers should check the current HL attribution status of the member to see if the member may be getting services elsewhere.

3. Members requesting a switch: New HL provider may be attested in the Amerigroup website and will become attributed to the new THL on the first day of the following month.

How members are removed from attribution or enrollment:

1. Discharged: Enrolled members may be discharged if the HL provider is unable to identify, as evidenced in documentation and using medical necessity criteria, member progress toward treatment goals in response to HL interventions or member completes treatment goals in response to HL interventions. Discharge requests must be entered in the Amerigroup website for members to be removed from the attribution list.

2. Opted-out: Members may choose to opt-out of HL by notifying their MCO or the HL. The decision to opt-out must be member-initiated and the interaction with the member should be documented. The provider may then submit an opt-out request via the Amerigroup website.

3. Switched: Members can choose to switch to a different HL organization and receive care coordination from another HL. The new THL must attest the member in the portal.

4. Removal by insurance carrier: THL attribution may be removed if the member is deceased or has lost/changed TennCare coverage.

How members will have suspended THL attribution or enrollment:

- The member has 90 consecutive days of residential treatment or nursing home stay.
- The member is receiving CTT or CCFT services determined by service authorization. The member must be discharged from CTT or CCFT to become eligible for the HL program again.
- The member is enrolled in Systems of Supports (SOS) Level 1 or Level 2 for more than 30 consecutive days

How to communicate with primary care offices

THL was "***built to encourage the integration of physical and behavioral health."*** Care coordination activities should focus on helping members to become more resilient, and support recovery whenever possible. Members with behavioral health diagnoses die significantly sooner than those with the same physical health diagnoses but without behavioral healthcare needs. They also are more likely to be hospitalized and to use the ER. Finding a good primary care provider who the member can trust and who provides high quality care is an important role for care coordinators.

The THL does not need specific consent to communicate with the assigned PCP. PCMHs can see who the attributed THL is in the Care Coordination Tool. If a consent is requested, you can fax the consent form. Also share medication and diagnoses lists if possible.

To communicate about gaps in care, it will usually be best to choose the nurse line option. Provide the member's name and date of birth, and the role of the THL. In your conversation, you will want to discuss:

- When was the last well visit? Can you assist in getting the appointment scheduled if due?
- Were there any recommendations that need follow-up? (diet/exercise, sleep, specialists, medications, vaccines, etc.)
- When is the next follow-up appointment? Is it scheduled?
- Are chronic conditions controlled or at goal? What was the last A1c, BP, medication change? What lifestyle recommendations were there?
- Share open gaps (diabetes or metabolic screening, diabetic eye exam, well visits, etc.).

- If a member has been in the hospital or ER for a physical health problem, share that information and verify if a follow-up appointment has been or needs to be scheduled.

How to communicate with members: Motivational Inteveiwing

A proven way to improve communication is to establish trust and rapport using techniques that affirm and encourage members to be open and honest. Two common techniqes are reflection and open-ended questions.

Builiding rapport: ask permission to talk about things:

- What do you think we should work on today?
- These were the goals that are on the plan from our last discussion. What changes do you think we should make?
- Have you had situations (home/family/PCP) that you would like to discuss since our last conversation?

Reflection: Be curious about their perspectives and let them hear their perspectives out loud.

- I noticed that you mentioned…
- Sounds like this situation is hard for you.
- Sounds like taking care of your health is hard for you.
- There are good reasons to make the changes that you mentioned.

Open-ended questions let members drive the discussion and plans:

- Can you tell me more about what you wish was different about…?
- What do you think would increase the likelihood of reaching your goals?
- What have you tried that worked or didn't work?"
- What did your PCP/therapist recommend that you think might be helpful?
- How would you like things to be better about …?
- What change seems most possible?

- What is the downside of the way things are going?
- What are your hopes for the future?

Resources

You can contact your MCOs if you have questions about resources or need additional member support. Your leadership will have contact information for your THL coach with each organization (Amerigroup, BlueCare, or UnitedHealthCare), or use links below to help find services for your members.

Dental Resource

TennCare members have dental services that include cleanings, fillings, extractions, crowns, and dentures.

You can do a search for a dental practice by city, county, or zip code for members on their website: **Dentaquest.com***

- Click on **Find a Dentist** in the upper righthand corner
- Location box: Type in an address, city, county, or zip code
- Type of Plan: Choose Medicaid
- Choose your plan: Choose TennCare (select adult or children)
- You can scroll through the list, or you may click on **Download** in the upper right corner to create a document

Retinal eye exams resource

Under the age of 21, vision services, including eyeglasses are covered.

21 and older, vision services are not covered for normal eyes or only for the purpose of fitting eyeglasses.

How to find an EyeQuest Provider:
> DentaQuest.com
How to find an EyeQuest Provider:

> DentaQuest.com

- Below the Find a Dentist button you will see “Are you a vision member? Click on Learn more.
- Select **Find a Vision Provider** tile
- Location > type in a zip code, city, or address
- Specialty >*See below
- Select **Find**
-

This will generate a list. You can create a document by clicking on Download PDF in the upper right corner.

***Note!** You can leave this box blank. However, some providers may only provide glasses and would be unable to do a retinal eye exam.

You can select the name of the provider to see details about the practice, including a map, office hours, and services provided.

If a retinal exam is needed, be sure that the provider is an optometrist or ophthalmologist and offers full services. You can select Optometrist or Ophthalmologist in the Specialty box after adding the zip code if you specifically need a retinal exam.

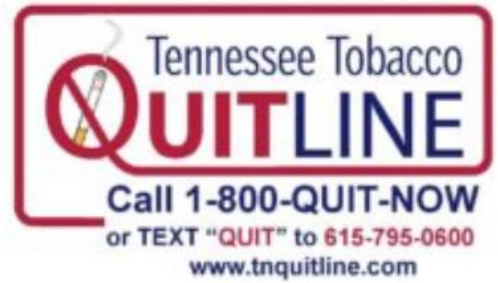
Tobacco Cessation Programs

Many services are available to assist members who desire to stop using tobacco.

TennCare supports prescriptions to assist cessation including nicotine gums, lozenges, and patches. There are also medication treatments. Members should discuss these options with their primary care providers.

Additional resources:

- **TN Quitline™**
  - **tnquitline.com**
  - **800-QUIT-NOW**, **615-795-0600**
- **EX Truth Initiative™**
  - **thetruth.com**
  - **800-273-TALK** (**8255**)
- **BABY & ME - Tobacco Free Program™ (*Pregnant/Postpartum*)**
  - **babyandmetobaccofree.org**
  - This program can support pregnant women AND family members



Transportation

Non-emergency medical and dental transportation is provided to Amerigroup members through Tennessee Carriers. Members (or a designee) can call the Reservation Center at **866-680-0633**, preferably with a 72 hour notice. Transportation can also be scheduled on-line at **tenncarriers.com/schedule/**

Be prepared with the member's information and details of the appointment (provider name/date/time/location/mobility). A pharmacy stop can also be scheduled after appointments.

Bus passes and mileage reimbursement are also covered for nonemergency medical transportation. In special circumstances, Tennessee Carriers may utilize Uber or Lyft services which would be scheduled by them and not directly by the member. Call Tennessee Carriers for details for these services.

Behavioral health case management

Our case managers help make healthcare easier and less overwhelming.

Our case managers may call our members if:

- They, or you, their healthcare provider, think case management might help support the member.
- They've just gotten out of the hospital and need help with follow-up visits with mental health.
- They're going to the emergency room often for non-urgent care.
- They call our 24-hour Nurse HelpLine and need more follow-up for ongoing care.

Case managers can also help with:

- Setting up healthcare services for the member
- Getting referrals and prior authorizations
- Checking and supporting a member's plan of care

For referrals or concerns for theBehavioral Health Case Management team, please email us AGPBehavioralHealthRef@amerigroup.com

*"The journey of recovery is an on-going, personal process, which aims to allow a person to have a satisfying life despite the limitations posed by their condition. Several factors are important in permitting it, ranging from learning how to manage one's condition, to improving self- esteem. However, the central tenet in recovery is **hope**- it is the catalyst for change, and the enabler of the other factors involved in recovery to take charge. Therefore, we must work even harder to ensure this belief is instilled in those suffering from mental illness because **hope** offers the means by which a better future can be perceived; and therefore, achieved."*

pubmed.ncbi.nlm.nih.gov/28953841