Care Coordination/ICC Learning Collaborative

June 16, 2022

The session will begin shortly.

Oregon Health Authority

Learning Collaborative (LC) Format

12-month, virtual learning community and forum to support CC/ICC

- Sessions are **not** being recorded
  - Open, candid communication – but please no PHI
  - Session materials will be posted to the OHA Transformation Center-Care Coordination page after each meeting
- LC limitations and plan for ongoing communication to participants
- Input is welcome between sessions:
  - Thomas.Cogswell@dhsoha.state.or.us (OHA Transformation Center)
  - Dsimnitt.dsc@gmail.com (LC Facilitator)

Zoom Logistics

Throughout this learning collaborative, please:

- Use your webcam whenever possible
- Mute your microphone unless you are speaking
- Use the ‘raise hand’ function to share information or ask a question
- Add information and questions to the chat
- If you are having technical Zoom issues, send a chat message directly to Tom Cogswell
- Participate! Collaborate! Engage!

Please do not put your call “on hold” if you are dialed in.

Previous Session Review

May – Traditional Health Workers (THWs)

- Nine THW panelists shared their expertise and experiences working as THWs. Included:
  - Community Health Workers
  - Peer Support Specialists
  - Family Support Specialists
  - Doulas
  - Health Navigators
- Themes from THW Discussions:
  - THWs provide a unique, person-centered approach to helping people navigate through the complex health care and social service systems
  - Significant return on investment both in terms of member outcomes and reduction in cost through prevention and avoiding higher cost services
  - High satisfaction from patients/members
  - Some identified barriers and challenges:
    - Being integrated into the care team
    - Pay
    - Supported and consistent training opportunities

April – CCO OARs and Contract Requirements

ODHS: Family Preservation

- **Lacey Andresen**, Child Welfare Deputy Director, ODHS
- **Maurita Johnson**, MSW, Klamath District Manager, ODHS
- **Geneia Maupin**, Klamath Program Manager, ODHS
- **Alicia Reynolds**, MSW, Alberta Program Manager, ODHS
- **Jessica Amaya Hoffman**, MSW, Program Manager, ODHS
- **Desta Walsh**, Douglas District Manager, ODHS
- **Jessica Hunter**, Douglas Program Manager, ODHS

Objectives

01 → 02 → 03

Understand

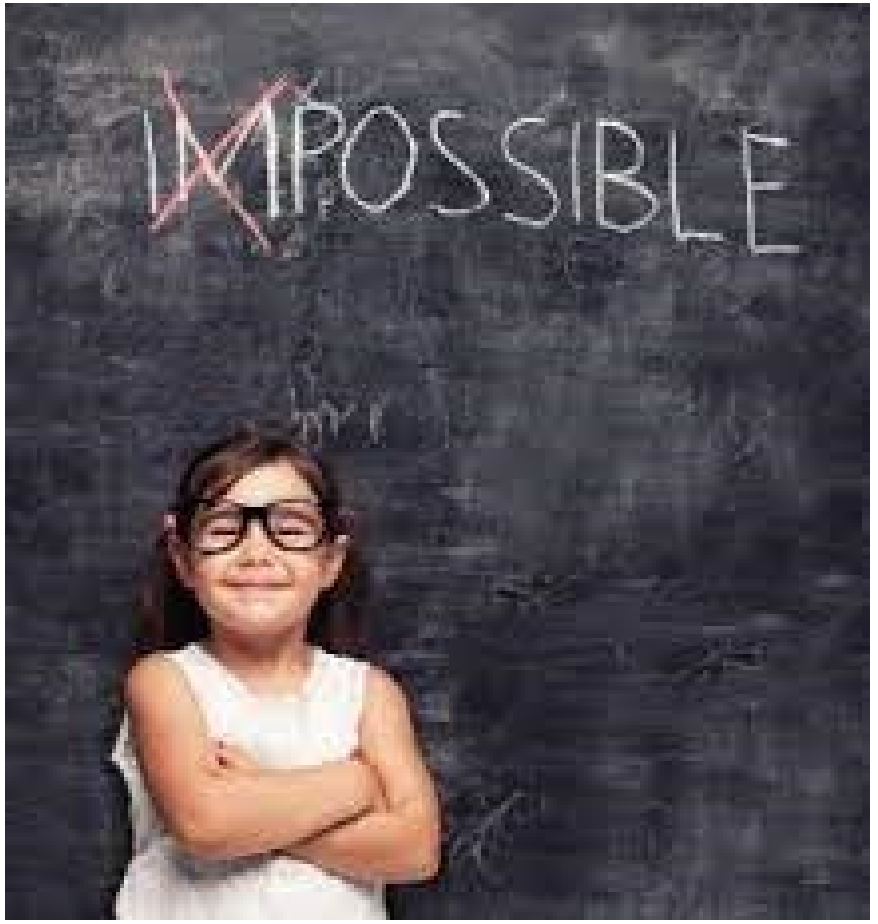
- Understand the goals of the Family Preservation Demonstration

Identify

- Identify where the demonstration is happening

Begin

- Begin to think through opportunities for partnering around family preservation

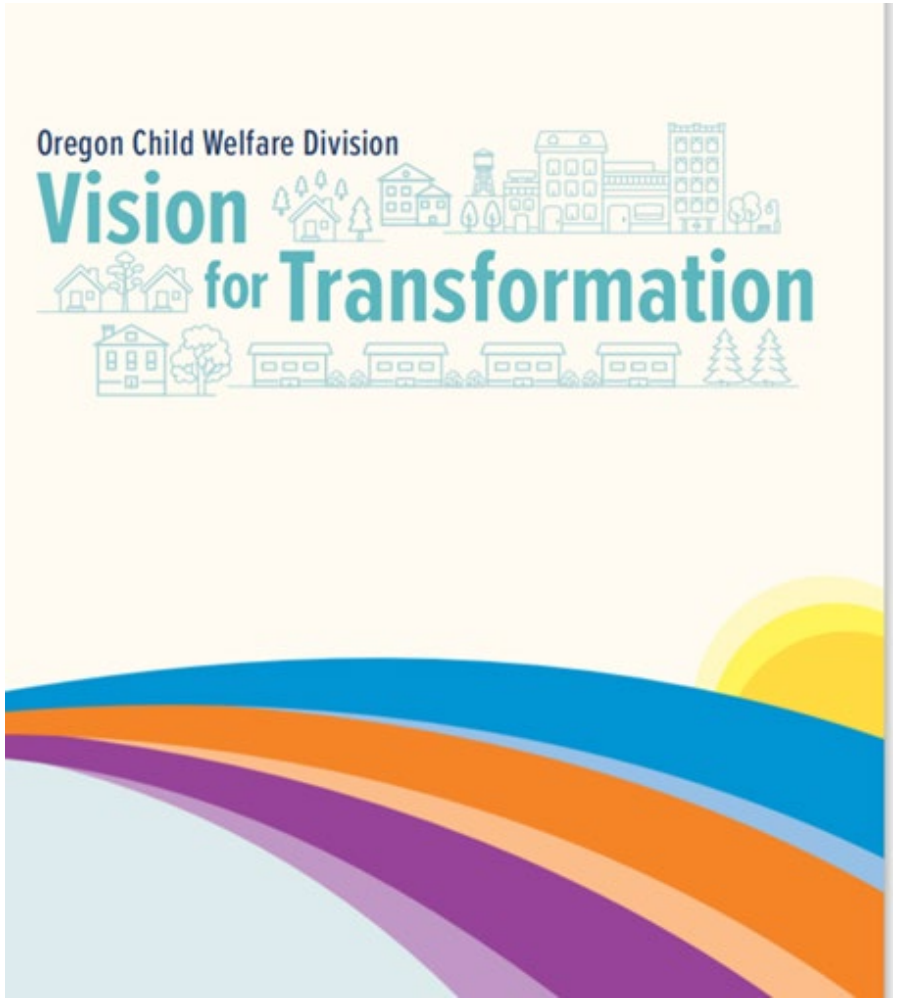


Child Welfare Division Vision for Transformation

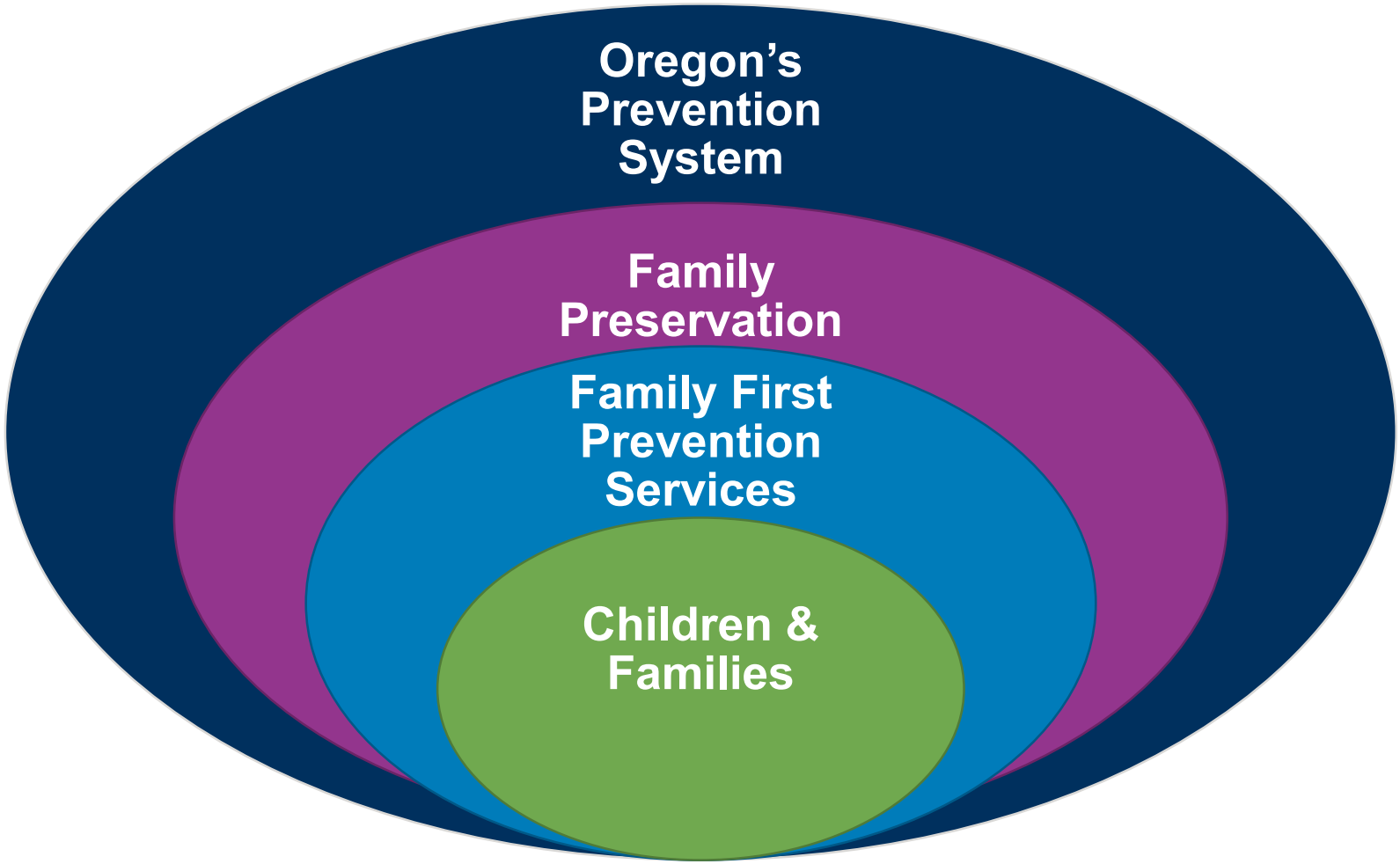
- The Child Welfare Division **Vision for Transformation** is the spirit of what we believe the child welfare system can and should be in Oregon.

- We envision a child welfare system built on our mission, core values, and a belief that children do best growing up in a family and their community.

- The Vision for Transformation was created through collaborative discussions with our workforce, community partners and Oregon Tribal Nations.



Supporting families and promoting prevention



Family Preservation Long-term Goals

- Serve more children in their homes and communities than in foster care
- Impact disproportionality and disparity
- ODHS is seen as a partner in family stability not separation

- **Phased approach**
  - Phase 1: Demonstration – collaborate, design, learn, adapt
  - Phase 2: Demonstration – identify & set the model
  - Phase 3: Statewide Rollout

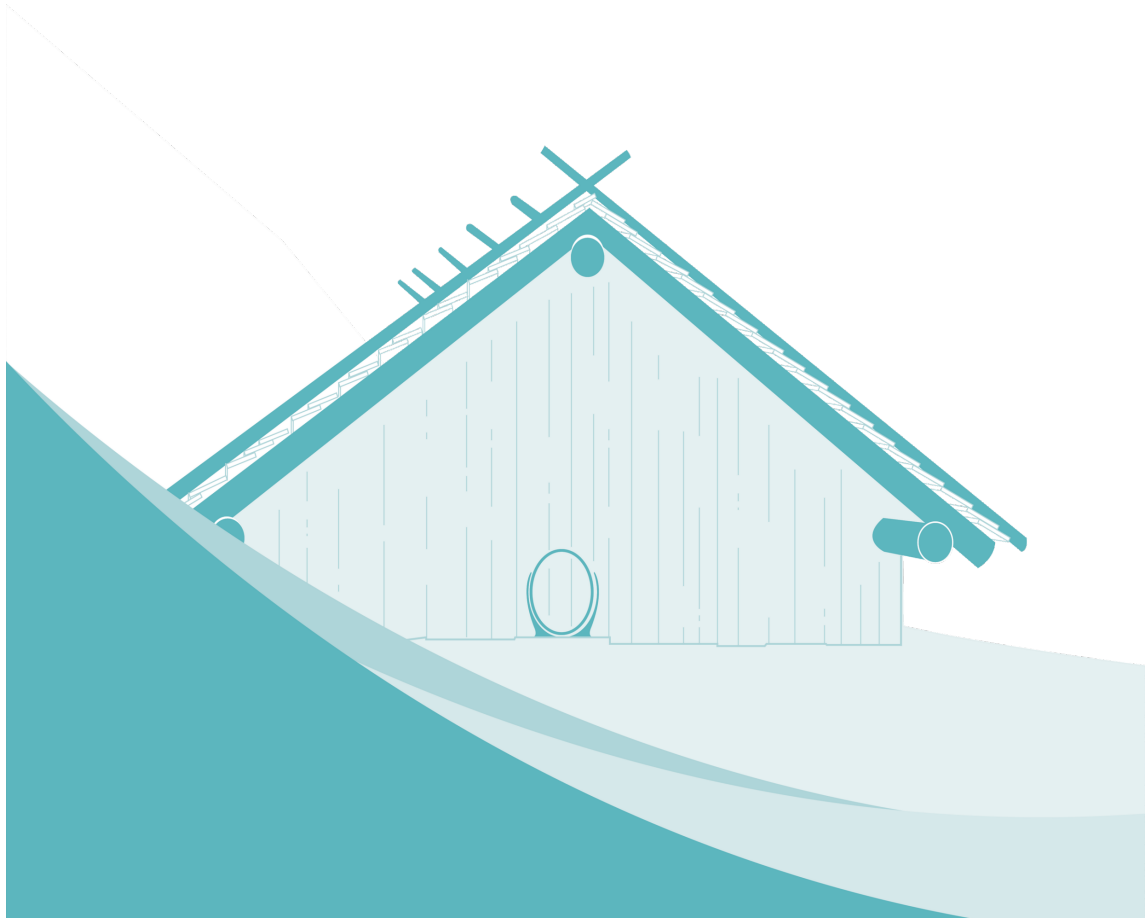
Family Preservation

Families – Phase 1 – Narrow scope

- Safety Threat identified
- In-home criteria are or may be met
- Cooperative or Court Involved
- Family Support Services: post-adoption/post-guardianship
- Expecting, Pregnant, & Parenting Teens

Approach

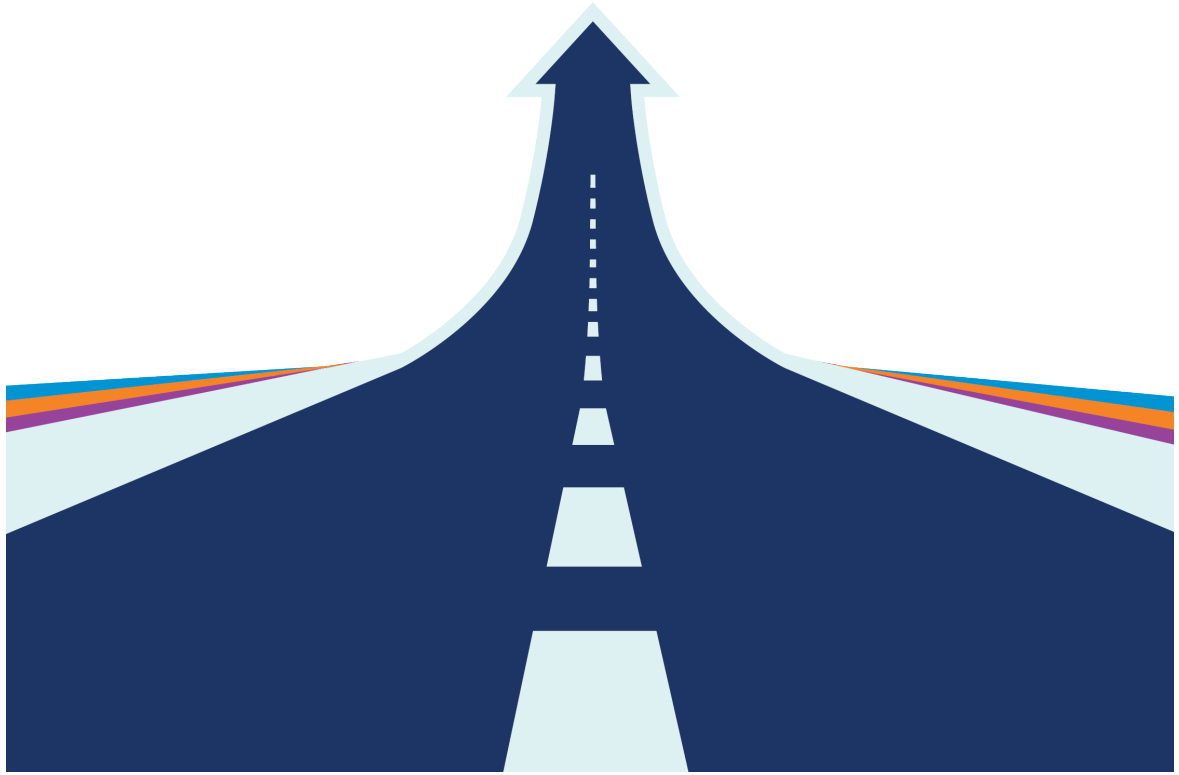
- Values-based Engagement
  - Strengths-based
  - Trauma-informed
  - Culturally responsive
  - Parent Driven/Youth Guided
- Intentional and informed collaboration with SSP and other community partners before and during initial contact
- More voices in decision-making
- What will it take to keep this family together



Demonstration Sites

- Alberta Branch (Multnomah County)
- Douglas Branch
- Klamath Branch
- Confederated Tribes of Grande Ronde
- Confederated Tribes of the Umatilla Indian Reservation

The Family Preservation Demonstration began on March 28th, 2022



Opportunities:
Systemic

Joint priorities on providers & services

- What services are Medicaid and are we duplicating services?
- Inventory of services = prevention
- Coordinate when we utilize services for biggest bang for the buck

Opportunities: Local

Opportunities to improve care coordination for local families identified/supported under Family Preservation

- Overlapping with CCO members who are eligible for Intensive Care Coordination
- Quick response
- Types of services needed for families
- Understand the families at risk and how to partner with them

Brainstorm

- **Question:** What opportunities do you see for us to work together, align, streamline our systems to become a connected system for families?

Thank you!

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Jessica Hunter: Jessica.Hunter@dhsoha.state.or.us

Care Coordination/ICC Learning Collaborative

We are currently taking a short break.

We will resume the session soon.

Oregon Health Authority

Transition from Pediatric to Adult Healthcare for Young Adults with Medical Complexity

Reem Hasan, MD PhD

Shreya Roy, PhD

Alison J. Martin, PhD

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Oregon Center for Children and Youth with Special Health Needs

OHSU

Disclosures

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Oregon Center for Children and Youth with Special Health Needs

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Who we are

OCCYSHN

Oregon Center for Children and Youth with Special Health Needs

OCCYSHN's mission is to improve the health, development and well-being of all Oregon's children and youth with special health needs

Objectives

- Recognize transition from pediatric to adult health care as a structured 3-stage process
- Describe infrastructure for effective provider transfer
- List actions CCOs can take to support members and providers engaged in transition

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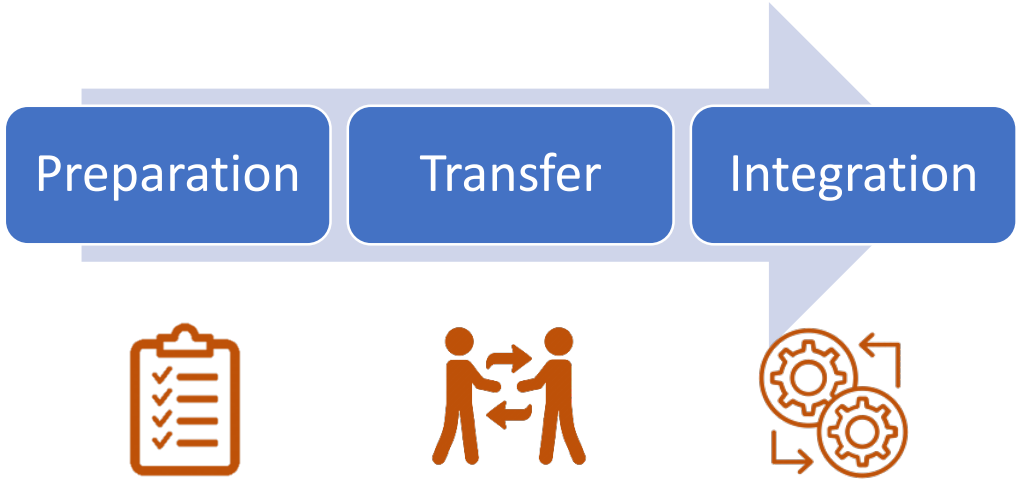
Supporting Transition

- Transition defined
- Transfer vs Transition
- Early and Often: Family recommendation



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Current reality…

Our goal…

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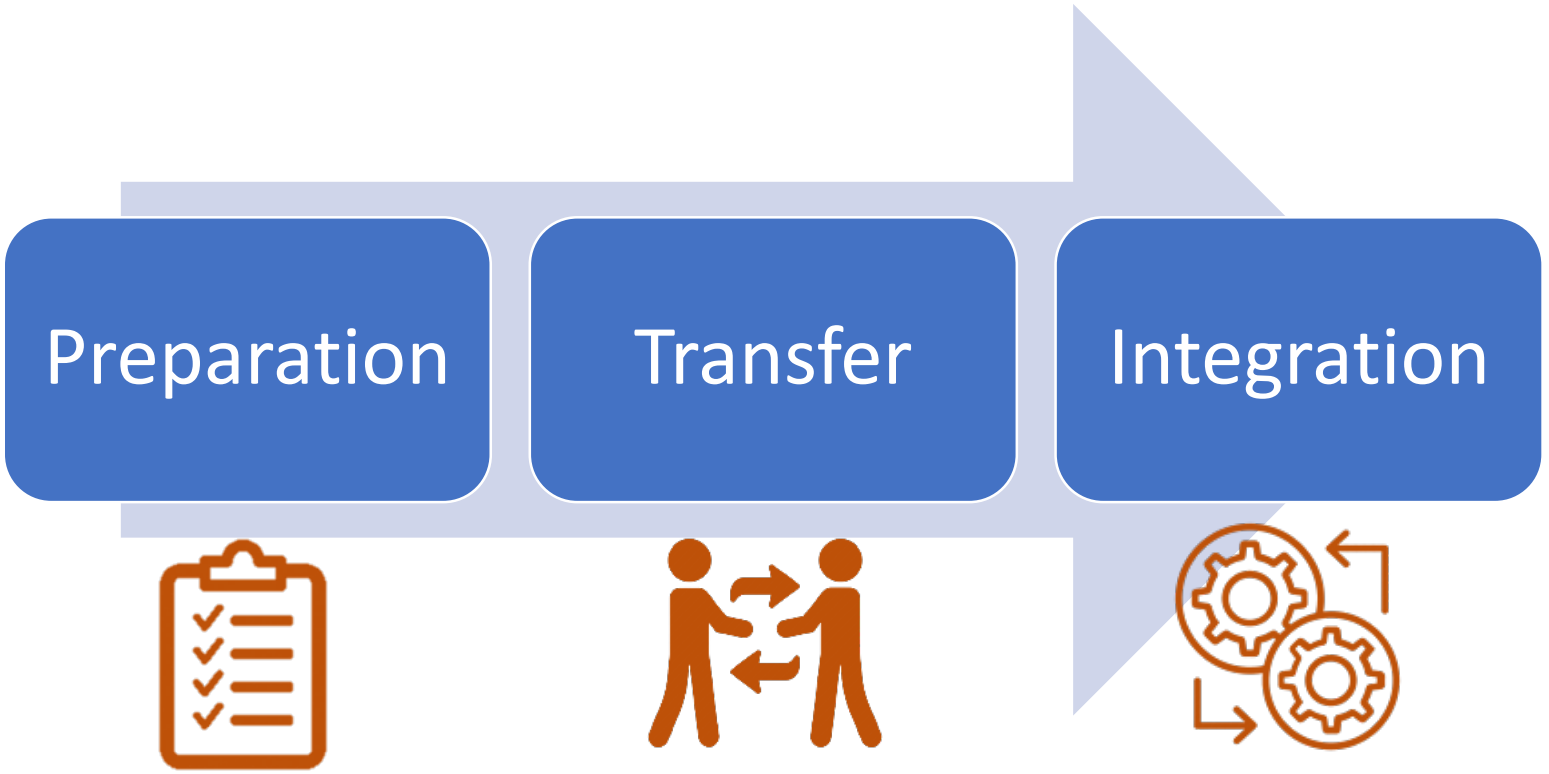
Transition Timeline



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Transition Structure

- Payment
- Staff coordination
- Links between CCO and clinics

- Identification of adult providers
- Transfer package
- Provider communication, warm handoff

- Welcome packet, pre-visit outreach
- No-show follow up
- Suggestions for first clinic visit

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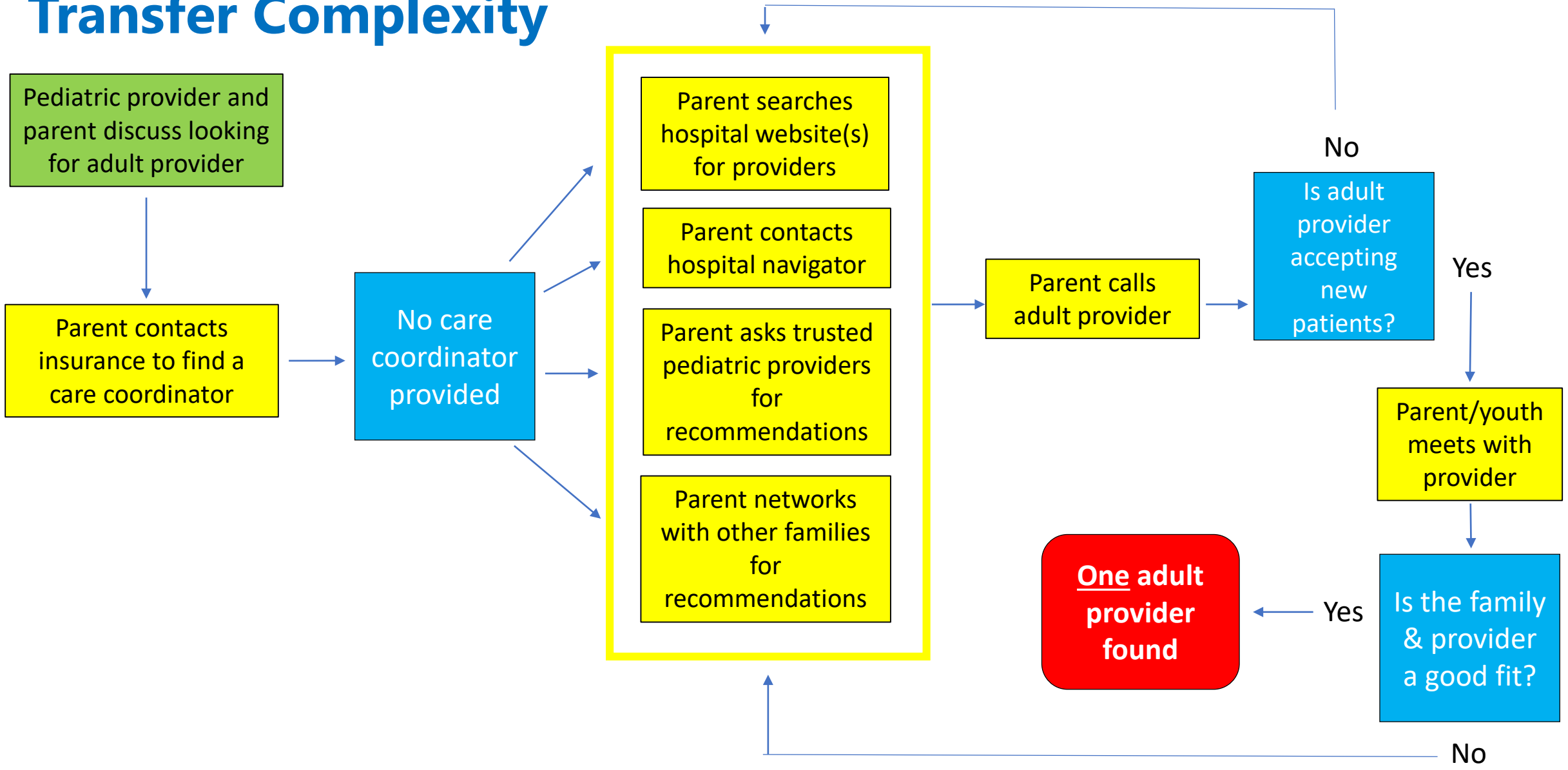
Transfer Complexity



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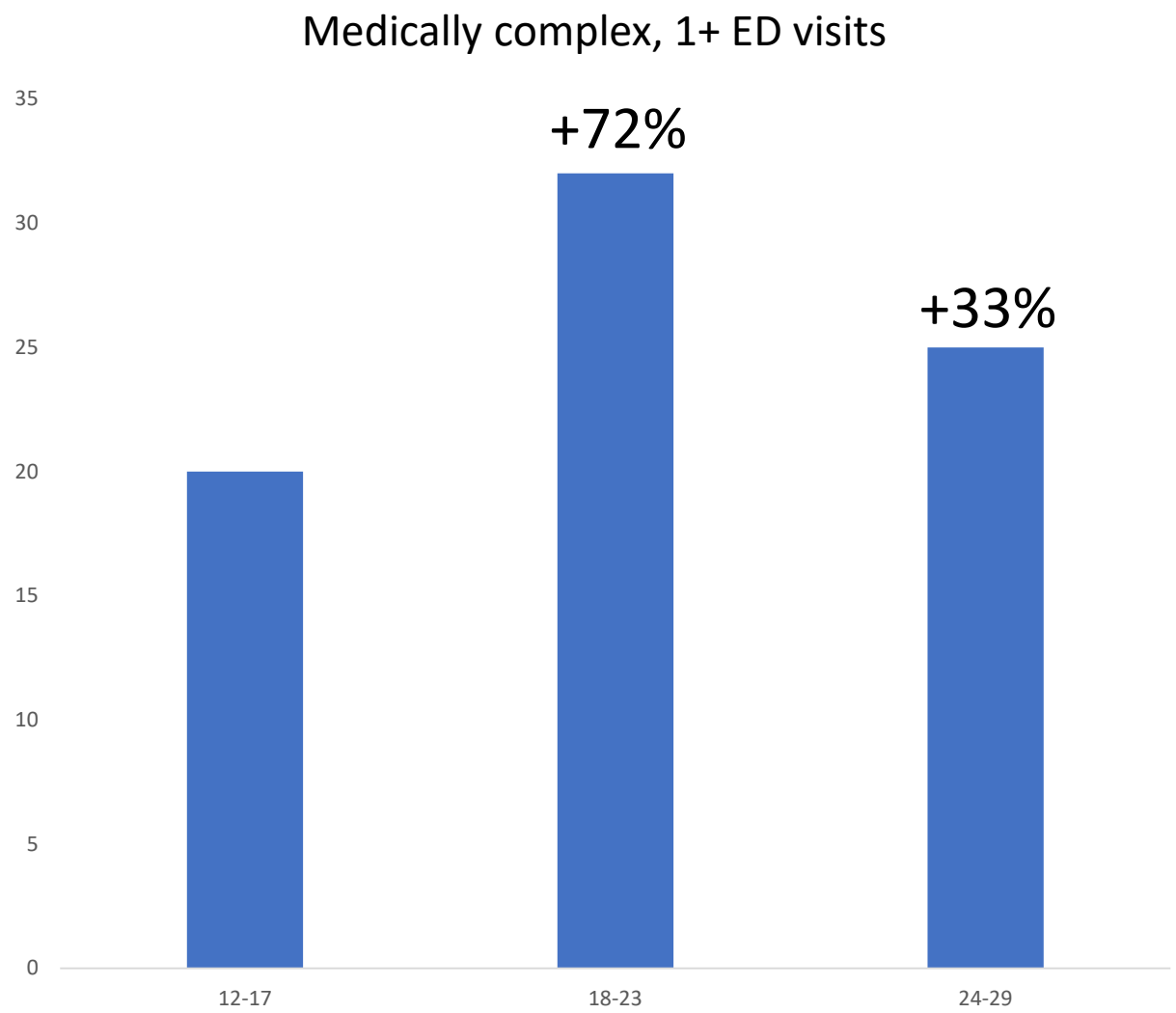
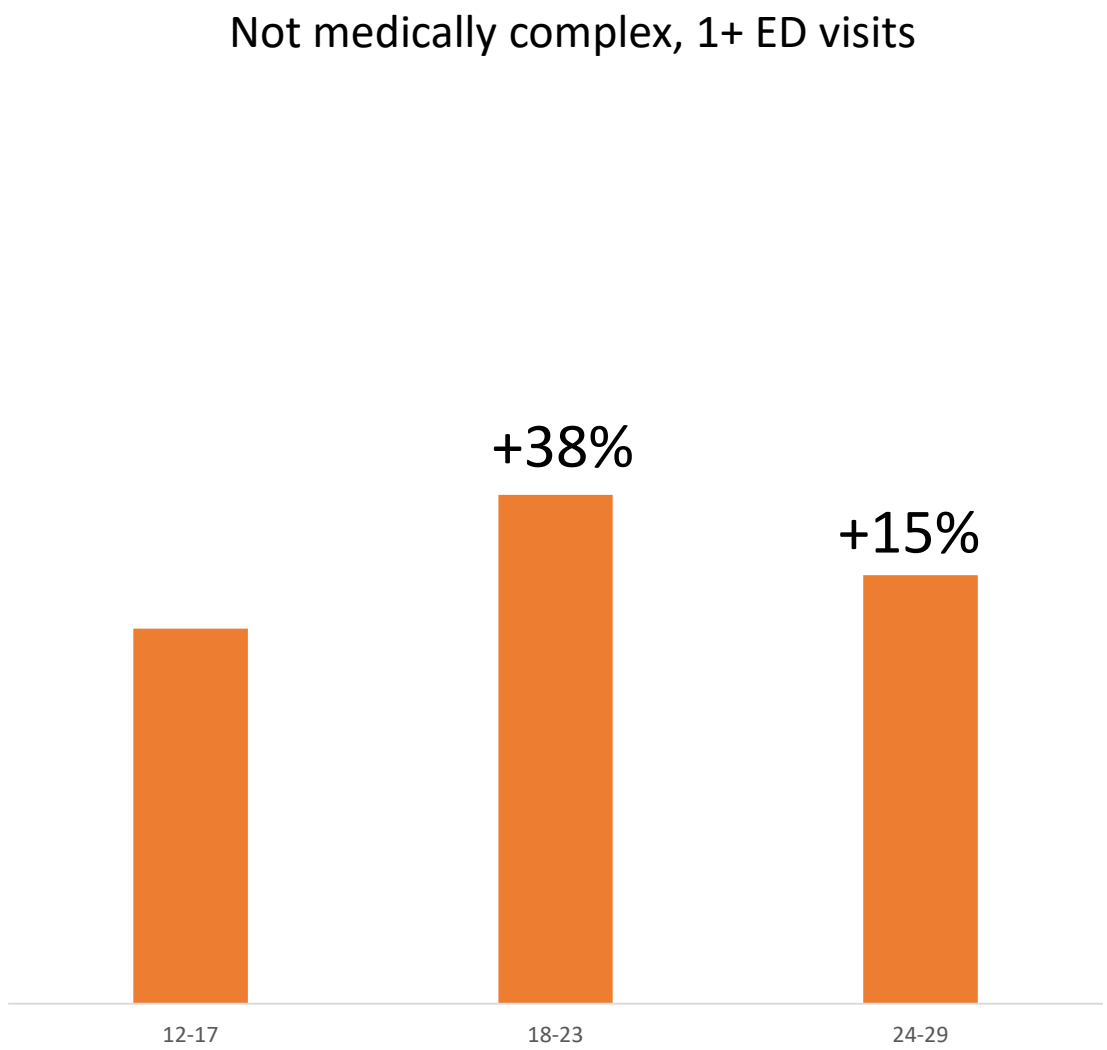
Peak ED Visits at Time of Transfer for Primary Care Patients





Thind et al, Journal of Adolescent Health, 70(1):77-82 2022

Impact of transfer

- Subset of ~100 patients with medical complexity who transferred in the study period

- ED utilization increased 1.5x
- Hospitalizations increased 2x

Transfer Complexity #1: Psychiatric care

- Psychiatric transition
- Family given information about an adult psychiatrist, but “facility does not have the capacity or knowledge to take on the care for a youth with the type of condition that [her] daughter has”
- Parent willing to pay cash to get appropriate care for daughter, wondered if having Medicaid was the obstacle
- Found a Psych NP: “NP was hard to reach and there was a miscommunication regarding the prescribed medications and the severity of the side effects”

Transfer Complexity #2: Medication

- Kidney transplant as a teen, Medicare is primary for 3 years post transplant
- Mom has had to call OHP with son on the line because of lapses in coverage, which prevented authorization of his medications. Mom couldn’t afford the medications
- Mom shared that she would be taking her son to the emergency room and stay at the hospital, where he would be able to get all his medications – this added urgency to the person she spoke with to do an emergency authorization of his medications

Transfer Complexity #3: Adult provider access

- Seizure transition
- Took over 2 years to find an adult neurologist
- During this time, youth hospitalized three times for near-death events requiring intensive care, related to seizures or complications

Transfer Complexity #4: DME authorization

- DME transition

- Patient who is non-verbal, non-ambulatory, and has had a G tube/been NPO since birth (also needs ventilation support at night and has extremely high needs).

- Adult provider received a notice from OHP that “medical necessity” of G tube needed to be established with a formal swallow study prior to authorization

Successful transfer experience

- Recent transfer pathway pilot – pediatric to FM/IM Clinic in Beaverton
- Pediatric providers completed a medical summary
  - Estimated ~30 min-3.5 hours to complete

- Adult clinic panel coordinator outreach to families, send welcome letter
  - Average of 3.6 attempts to reach families to schedule new appt
  - Time from initial outreach to appt: 2 months
  - 1 patient still has not responded

- Resources are needed to support this work!

CCO Support to Clinics

- Payment for activities supporting transition
  - Preparing patients for transition
  - Identifying potential adult providers
  - Preparing patient documentation for new providers
  - Consulting with [pediatric – adult] provider on individual patient care
- Identification of adult providers – who are open to new patients, close to home, AND take the patient's insurance and support scheduling appointments for patients
- Developing and incentivizing clinic staff training about transition
- Developing and incentivizing quality metrics focused on transition

Return to Objectives

- Recognize transition from pediatric to adult health care as a structured 3-stage process
- Describe infrastructure for effective provider transfer
- List actions CCOs can take to support members and providers engaged in transition

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Questions?

- Thank you

- Please email Reem (hasanr@ohsu.edu), Shreya (roysh@ohsu.edu), or Alison (martial@ohsu.edu) with any follow up items. We are happy to hear from you!

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Upcoming Sessions

July 21: OHA Data for CC/ICC

- Collective Tool
- Children's Health Complexity Data
- CCPO Care Coordination Activities Report

Aug 18: Combined Session with PCPCH Practices

- Overview on program approaches and strategies for coordinating care
- Successes and challenges of coordination between CCOs and PCPCHs

Sept 15: Continued Discussion on OARs/Contract Requirements

THANK YOU!

See you next month
July 21, Noon – 2pm

Please provide learning collaborative feedback in our quarterly survey: https://www.surveymonkey.com/r/SRT8J2W