Care Coordination/ICC Learning Collaborative

The session will begin shortly. While you're waiting, please answer the following question:

What is your best strategy for avoiding distractions when working from home?

(Post your answer in the chat box)

Oregon Health Authority

Care Coordination/ICC Learning Collaborative

February 17, 2022

Oregon Health Authority

Today's Agenda

Time	Topic	Presenter
Noon	Welcome & Meeting Logistics	Jackie Wetzel
12:05 pm	Consumer Perspective	Jackie Wetzel
12:20 pm	Learning Collaborative Priorities and Aspirations Review of OAR Questions	David Simnitt
12:35 pm	Intensive Care Coordination Workflow Model and Alignment with OARs	Annie Wallace
1:05	Break	
1:15	Community Engagement Teams and Working with Members who are Unhoused	Ross Acker
1:45 – 2pm	Wrap up & Feedback	All

Learning Collaborative (LC) Format

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

- Content guided by LC participants
- Sessions are not being recorded
  - Open, candid communication – but please no PHI
  - Session summary (key discussion points & questions) will be shared after each meeting
- LC limitations and plan for ongoing communication to participants
- Input is welcome between sessions:
  - Jackie.Wetzel@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.

Consumer Experience

Heather

- Earned two college degrees and has very strong self-advocacy skills
- Experienced challenges for about two years before getting connected with care coordination
- Has had the same care coordinator for approximately 4 years, including across the transition from:
  - Commercial coverage to OHP enrollment, and
  - OHP to dual coverage
- Recently completed training as a SHIBA* volunteer

SHIBA: Senior Health Insurance Benefits Assistance

Care coordination in Heather's words:

Q: How would you describe care coordination?

*"**A lifeline**. Just very simple. Having so many providers across different companies, individual clinics, hospital systems. They just don't really talk to each other. I try at the patient level. But it's very much appreciated to be able to call the (care coordination) line. It's a direct voicemail to my person."*

Introduction to care coordination

Heather was connected to care coordination by a counselor who noticed that counseling sessions were dominated by healthcare navigation and communication challenges.

“Counselor connected and said hey, I have a patient who is having complex care whatever. And so a nurse case manager reached out to me. It's been the same person I think for 4 years. ***Which is very, very awesome.***”

Early impact of care coordination

“Counseling got easier. I mean - it was more focused on things that weren't involving health care issues.”

“..having someone else step in and navigate communication was awesome.”

“…being able to call and leave a voicemail with the person I've been working with for 4 years and get a very timely response anywhere from a couple hours to maybe 48 hours if it is the weekend. And they have access to all of your information via Epic.”

CC and help accessing providers

"...the biggest use of my care coordination prior to communication issues was specifically with my back surgery and finding pain management..."

"...that was really hard...a lot of times on the provider search tool when they're saying somebody is in contract, you're calling and getting five different ways of saying no so that was a big thing because in order to have the back surgeries that I had, I had to have a reliable pain management, so that that was the biggest use of care coordination."

Active closed-loop CC is appreciated

Heather recently contacted her care coordinator for the first time in several months:

"….I haven't spoken to her since April 2021. I spoke to her 2 weeks ago and she's all yeah, how are you doing? What's going on? What outcome do you want?"

"She helped me communicate with primary care and pain management in a way that a physician would understand what I'm asking for."

Care coordinator stepped in and started calling people when there was no follow through from physicians.

"...not just advice, but also action."

Care coordination and communication

Communication with *"...the private clinics is harder. With the struggles I've had it's a learning experience and I am kind of in very upfront like - Hey, I need you to contact these folks...I do a bit of care coordination myself and don't rely solely on the nurse to do things. But there's times when (I am) chronically ill and with chronic pain, you're just exhausted and so you need that help and you just don't want to advocate for yourself."*

"...it's a little easier now that I have a good primary care who follows up on things...there was a while when I first got the care coordination, the PCP 's were retiring or quitting so I was just moving around a lot and didn't have someone steady. Having a care coordinator has helped a lot."

CC continuity and responsiveness

" … (My nurse manager) is off on Thursday... I know the schedule. I can either leave her a message or if it's urgent someone else will read all of the pertinent case notes and call me back that same day."

"I mean, that's a great level of service."

"I have worked with at least two (other care coordinators)...but it was just almost seamless..."

Transition to dual coverage

"I was really, really nervous ...the letters I was getting were the very scary worded ones, saying we're removing you from OHP...they hadn't figured out the QMB basic yet so it was terrifying, to put it mildly those last 2 weeks of March. And then April 1st - boom, the QMB program got worked out, but that was DHS APD and SHIBA just scrambling."*

*Qualified Medicare Beneficiary program provides financial support to help pay for Part A premiums, Part B premiums, and deductibles, coinsurance, and copayments.

Care coordination access challenge

"As far as how things could be better...not with the nurse case manager but I would have liked to have been able to find out about that program on my own and I to this day I don't think it's advertised anywhere."

Questions

- How do you describe CC/ICC to members?
- What do consumers share as their top priorities for care coordination?

Thank You

Oregon Health Authority

Learning Collaborative Priorities and Aspirations

Sampling of headlines from our Headline Activity last session

- Transitional Housing Services Offered as an OHP Covered Service
- Transgender Services to Ensure Equal Access
- Pre-transitional Housing for Recovery
- Personal Connections Improve Health and Healthcare Experience for Vulnerable Portlanders
- It Takes a Village: Thinking Holistically and Acting Locally
- Innovative solutions to social determinants of health show improved health outcomes for Oregonians
- Care Coordination Shaping Health Outcomes and Bridging Barriers in Systems
- Hospitals see ED utilization drop dramatically as CCOs report on success of innovative Care Management model that connects unhoused members to safe, secure, long-term housing
- A Key to a House is the Key to Health
- Improved Care/Outcomes for Portland's houseless and/or incarcerated populations
- Care coordinators give a voice to those who lost theirs during the pandemic
- People with Lived Experience Sit at Every Decision-Making Table!
- Keeping Families Intact Using Flex Funds
- Clackamas County Choice Program Works Tirelessly to Advocate for Vulnerable Adults, Amidst Systemic and Environmental Challenges and Barriers
- Nothing about them (members) without them

Learning Collaborative Priorities and Aspirations

Learning Collaborative Priorities and Aspirations

Clear commitment of the group to the importance and effectiveness of the care coordination model. Themes emerging from headline activity:

- Using care coordination to address the houseless population
- Including members in discussions about their care
- Addressing social determinants of health and assuring health equity
- Using traditional health workers as part of the care team.

Review of Questions Received so Far

Can you help us get clear guidance on whether (c) and (d) of these rules are related to BH admissions/discharges or if they are for ANY inpatient admission/discharge?

OAR 410-141-4865 (12)

(12) CCOs shall facilitate transition planning for members. In addition to the requirements of OAR 410-141-3860, care coordinators shall facilitate transitions and ensure applicable services and appropriate settings continue after discharge by taking the steps set forth below:

(a) Taking an active role in discharge planning from a condition-specific facility including, without limitation, acute care or behavior rehabilitation services facilities;

(b) For discharges from the State Hospital and residential care, the care coordinator shall do all of the following:

(c) For discharges from an acute care admission, the care coordinator shall have contact with the member on an in-person basis whenever possible or face-to-face by synchronous telehealth as defined in OAR 410-141-3566 for the duration of the Public Health Emergency (PHE), as follows:

(d) Prior to discharge from any residential, inpatient, long-term care, or other similarly licensed care facility, care coordinators shall conduct a transition meeting to facilitate development of a transition plan for both applicable services and appropriate settings. This meeting must be held 30 days prior to the member's return to the CCO's service area or, if applicable, to another facility or program or as soon as possible if the CCO is notified of impending discharge or transition with less than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue;

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Review of Questions Received so Far

Are CCOs required to notify a member who has been determined ineligible for ICC? Often members do not even know they are being assessed.

OAR 410-141-3870 (11)

(11) CCOs shall implement procedures to share the results of ICC assessment including, without limitation, identifications made as a result of the assessment and Intensive Care Coordination Plan (ICCP) created for ICC services. CCOs shall share the results with participating providers serving the member, other parties identified in OAR 410-141-3865 and, for members receiving LTCSS, the results should be shared with the local offices for aging and adults with physical disabilities (APD) and the Office of Developmental Disability Services. Information sharing shall be consistent with ORS 414.607 and applicable state and federal privacy laws and meet timely access standards set forth in OAR 410-141-3515.

Review of Questions Received so Far

The requirement for rescreening for ICC when two or more Z codes are billed in a month is overly broad. Can this be clarified?

OAR 410-141-3870 (9) (K)

(9) For those members not receiving ICC services, and upon the occurrence of any of the reassessment triggering events listed below in subsections (b)(A) through (S) of this section (9), CCOs shall conduct new health risk screenings, and, as applicable, reassess members for ICC eligibility revise care plans, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3865. Contact shall be made with the member by the care coordinator within seven calendar days of receipt of notice of the reassessment triggering event:

(K) Two or more billable primary Z code diagnoses within one month;

Review of Questions Received so Far

Is there any other way to achieve the same service or support, or alternative method that is in line with the OARs to have crisis respite, when needed, for Adult Foster Homes?

Can we use one of these sessions to map out a Visio diagram of the OARs with timelines?

Multnomah County Implementation of ICC OARs

BY ANNIE WALLACE, CARE COORDINATION PROGRAM SPECIALIST SENIOR

What will presentation cover?

- Multco's ICC OAR Review Process
- Multco's ICC OAR Implementation Process from Referral to Initial Care Plan

- OAR Review/Implementation process for requirements post Initial Care Plan
- Detailed Procedures
- Assessment / Care Plan Docs

Two Sets of OARs --

Care Coordination and Intensive Care Coordination

ICC OAR Requirements

410-141-3870 Intensive Care Coordination

(5) All members of prioritized populations shall be automatically **assessed for ICC services within 10 calendar days** of completion of the health risk screening, or sooner if required by their health condition.

(7) CCOs shall have policies and procedures in place that enable early identification of members who may have ICC needs. CCOs shall have established process for responding to all requests for ICC assessments or services, which shall include, without limitation, the requirement to **respond to all requests or referrals for ICC assessments or services within one business day.**

(8) **ICC assessments shall identify the physical, behavioral, oral and social needs of a member.**

(10) Members eligible for ICC shall be assigned an ICC care coordinator:

(a) **ICC Care coordinator assignments must be made within three business days of determining a member is eligible for ICC services**;

(c) **CCOs shall notify members of their ICC status by at least two means of communication within five business days following the completion of the ICC assessment. Notifications shall include details about the ICC program and the name and contact information of their assigned ICC care coordinator.**

(11) **CCOs shall** implement procedures to **share the results of ICC assessment** including, without limitation, identifications made as a result of the assessment and Intensive Care Coordination Plan (ICCP) created for ICC services. CCOs shall share the results **with participating providers serving the member, other parties identified in OAR 410-141-3865 and, for members receiving LTCSS, the results should be shared with the local offices for aging and adults with physical disabilities (APD) and the Office of Developmental Disability Services.** Information sharing shall be consistent with ORS 414.607 and applicable state and federal privacy laws and meet timely access standards set forth in OAR 410-141-3515.

(13) ICC Care coordinators must provide the following services:

(a) Meet face to face with the member, or make multiple documented attempts to do so, for the initial and exiting appointments.

(c) Contact the member's Primary Care Provider (PCP) within one week of ICC assignment, no less than once a month thereafter, or more often if required by the member's circumstances, to ensure integration of care;

Care Coordination OAR Requirements

410-141-3865 Care Coordination

(7) A member's care plan must at a minimum:

(a) Incorporate information from treatment plans from providers involved in the member's care, and, if appropriate and with consent of the member, information provided by community partners;

(b) Contain a list of care team members, including contact information and role, compiled in cooperation with the member;

(c) Make provision for authorization of services in accordance with OAR 410-141-3835;

(d) For members enrolled in ICC or a condition-specific program, intensive **care coordination plans (ICCP) must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner if health care needs change.**

(8) Care plans must reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals:

(a) Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered;

(b) To ensure engagement and satisfaction with care plans, care coordinators shall:

(A) Actively engage members in the creation of care plans;

(B) Ensure members understand their care plans; and

(C) Ensure members understand their role and responsibilities outlined in their care plans.

(c) Care coordinators shall actively engage caregivers in the creation of member care plans and shall ensure that they understand their role as outlined in the care plan and that they feel equipped to fulfill their responsibilities;

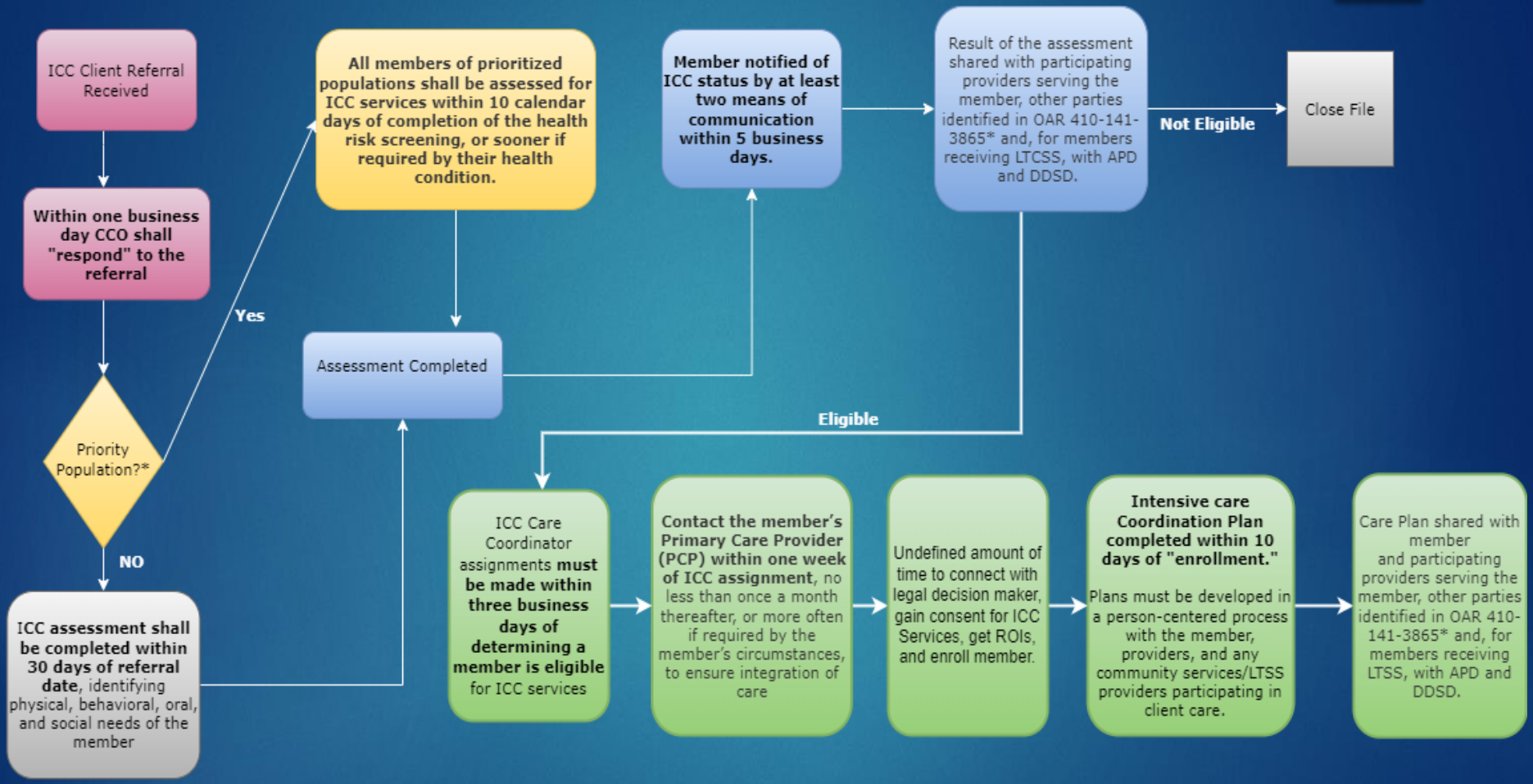
(d) If participation in creating a member's care plan would be significantly detrimental to the member's care or health, the member, the member's caregiver, or the member's family may be excluded from the development of a care plan. The CCO must document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue the exclusion shall be documented as above;

(e) **Members shall be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan.** However, if providing the member with a copy of their care plan would be significantly detrimental to their care or health, the care plan may be withheld from the member. CCOs must document the reasons for withholding the care plan, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue withholding the care plan shall be documented as above.

(9) **A member may decline care coordination and ICC. CCOs shall explicitly notify members that participation in care coordination or ICC is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.**

Mapping

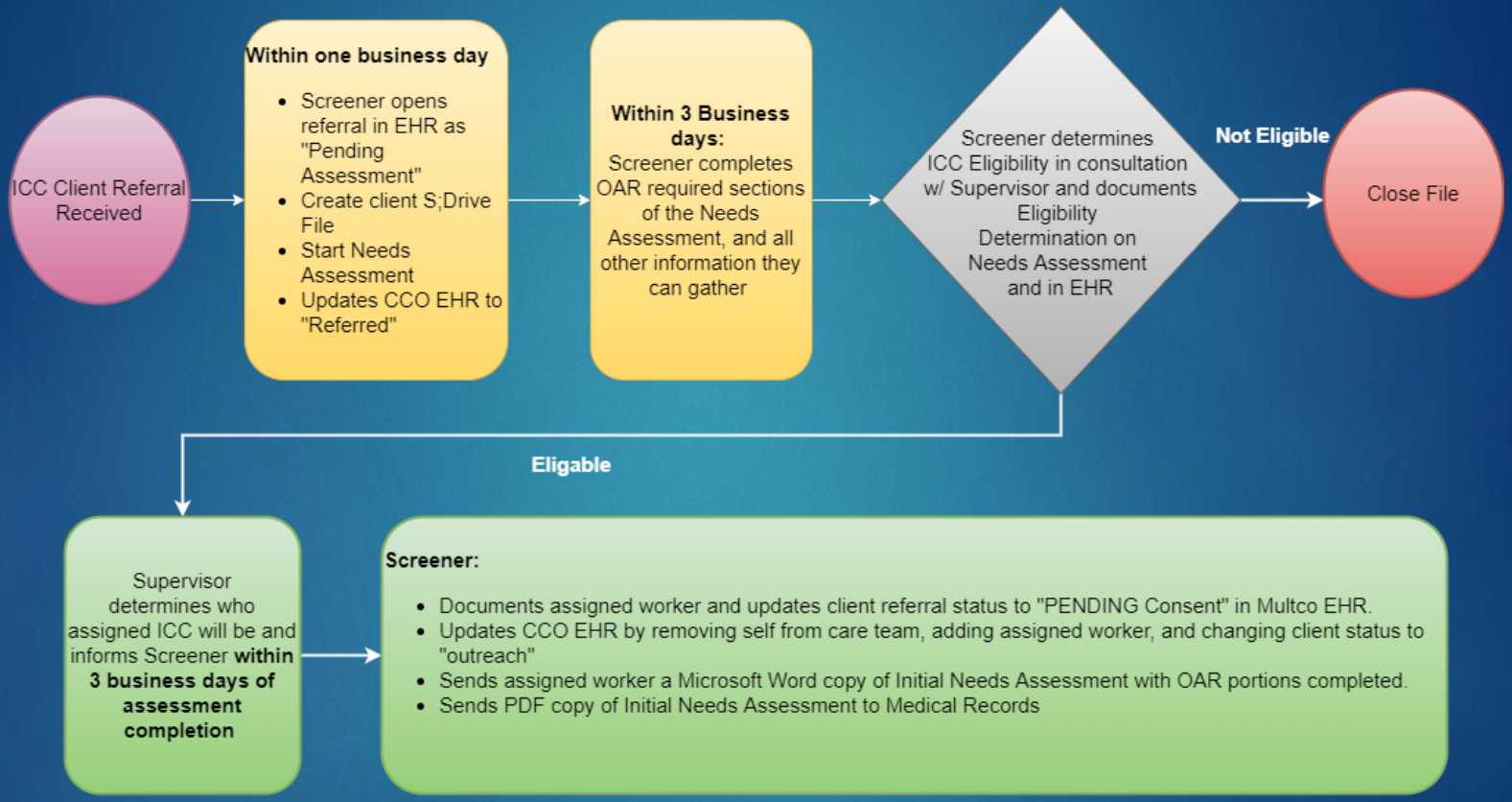
How CC and ICC OARs Work Together


ICC Client Referral Received
Within one business day CCO shall "respond" to the referral
Priority Population?*
Yes
NO
All members of prioritized populations shall be assessed for ICC services within 10 calendar days of completion of the health risk screening, or sooner if required by their health condition.
Assessment Completed
ICC assessment shall be completed within 30 days of referral date, identifying physical, behavioral, oral, and social needs of the member
Member notified of ICC status by at least two means of communication within 5 business days.
Result of the assessment shared with participating providers serving the member, other parties identified in OAR 410-141-3865* and, for members receiving LTCSS, with APD and DDSD.
Not Eligible
Close File
Eligible
ICC Care Coordinator assignments must be made within three business days of determining a member is eligible for ICC services
Contact the member's Primary Care Provider (PCP) within one week of ICC assignment, no less than once a month thereafter, or more often if required by the member's circumstances, to ensure integration of care
Undefined amount of time to connect with legal decision maker, gain consent for ICC Services, get ROIs, and enroll member.
Intensive care Coordination Plan completed within 10 days of "enrollment."
Plans must be developed in a person-centered process with the member, providers, and any community services/LTSS providers participating in client care.
Care Plan shared with member and participating providers serving the member, other parties identified in OAR 410-141-3865* and, for members receiving LTSS, with APD and DDSD.

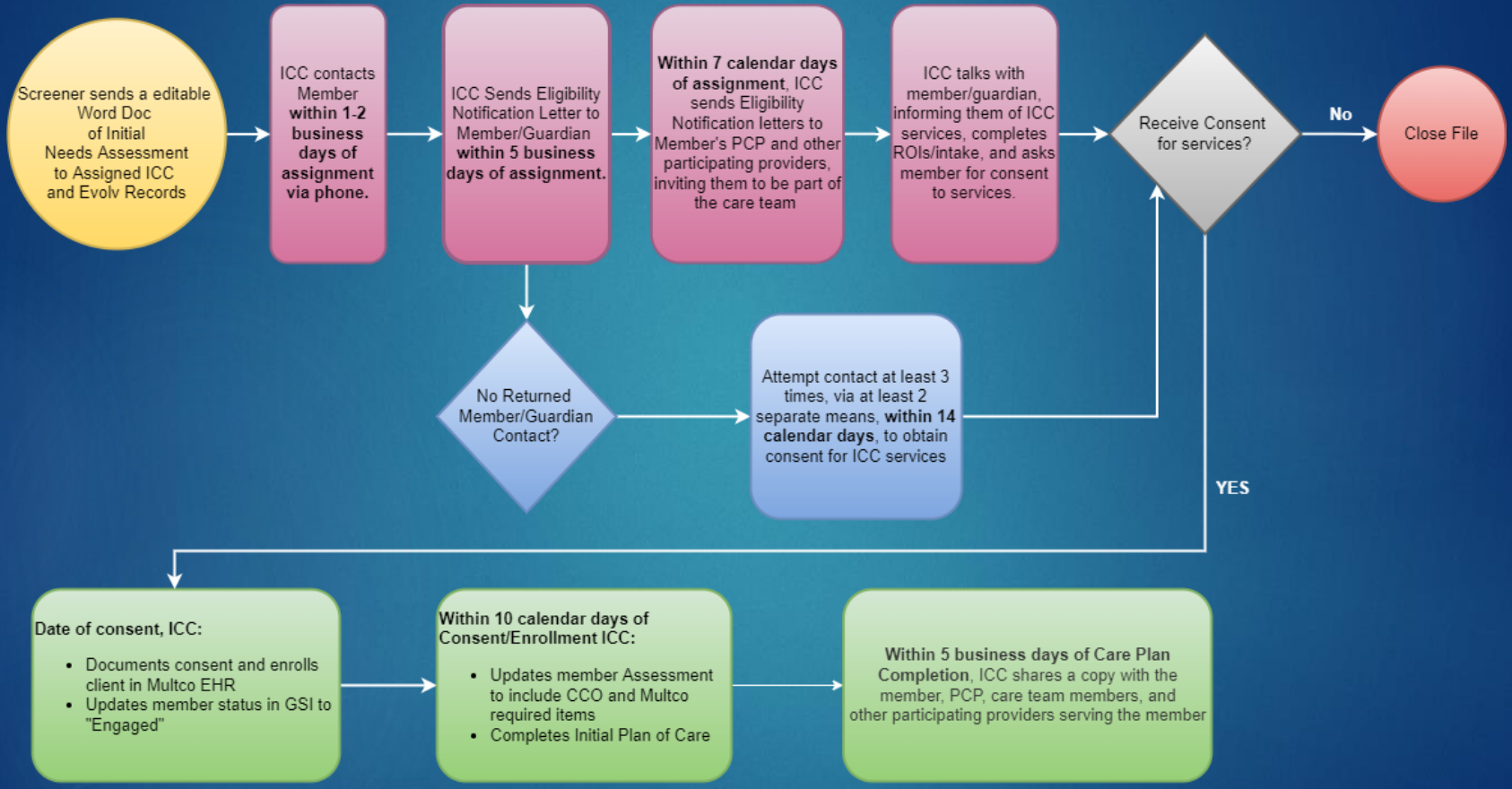
Implementation

What does the workflow look like?

ICC Screening/Initial Assessment



ICC Eligibility > Enrollment > Initial Care Plan



Any Questions?

Annie Wallace: annie.wallace@multco.us, 503-319-5992

Care Coordination/ICC Learning Collaborative

We are currently taking a short break.

We will resume the session soon.

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Intensive Care Coordination

Ross Acker, MS, LPC
Licensed Professional Counselor

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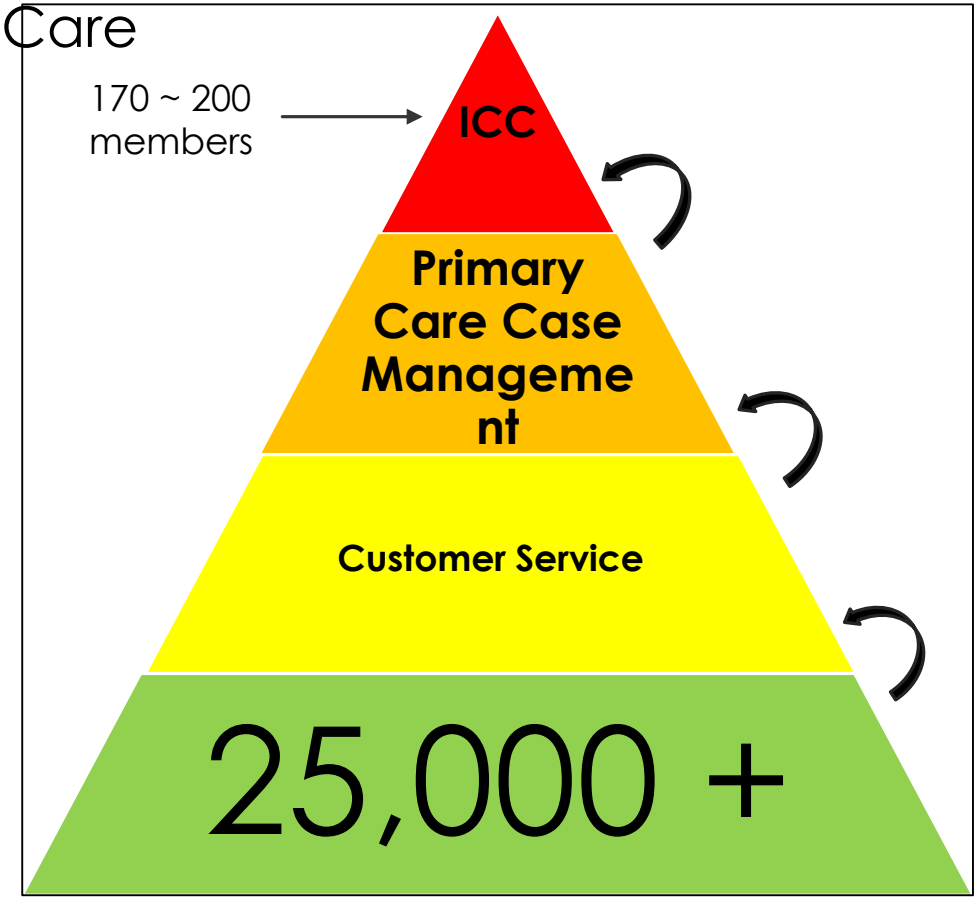
OHP membership Continuum of Care



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Advanced Health ICC Model/Team structure

- Utilize wraparound multi-disciplined approach
- Director – LPC
- Program Manager – MSN, QMHP
- THW Program Manager
- Staff - 5 THWs and 3 RNs
- Flex Fund Coordinator
- Huddle weekly to problem solve cases
- Meet once a month to review 170 cases
- Use of Activate Care – cloud based care planning software tool

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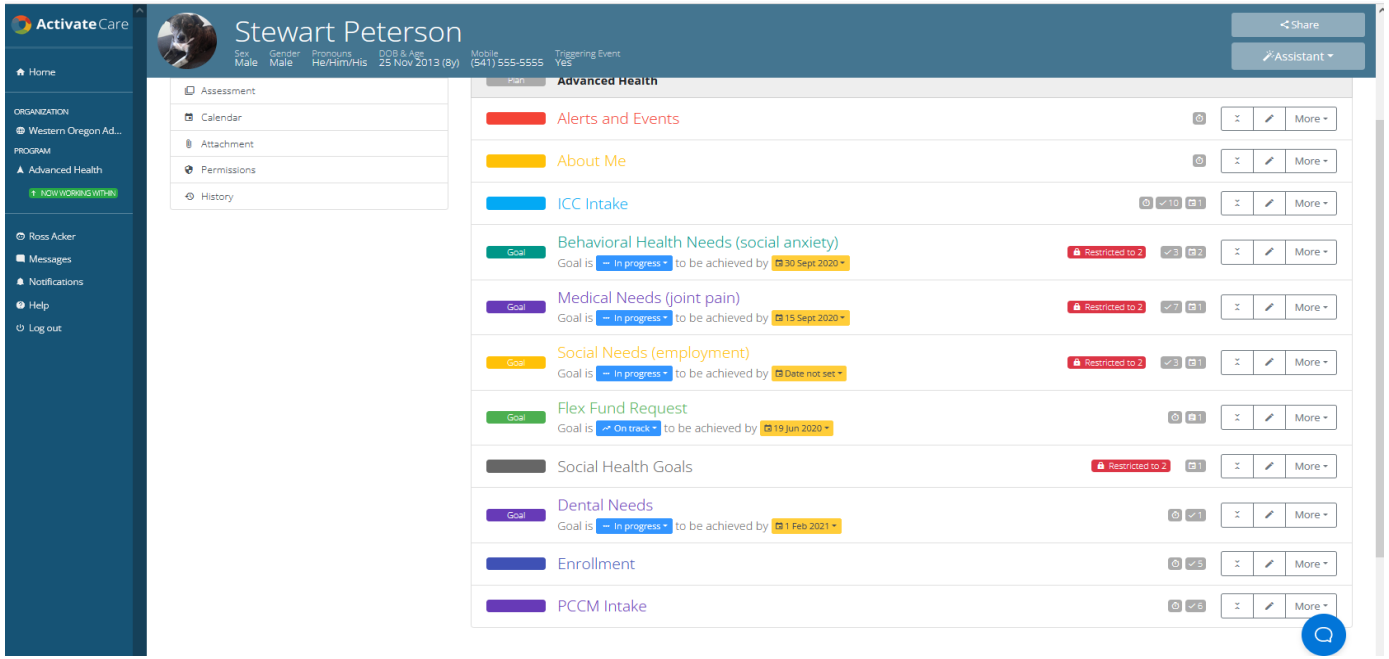
Activate Care “Care Plan”



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The numbers of Care Coordination

- 25,000 members / 9 coordinators
- Approx. staff to member ratio is 1:20
- Make 3 contacts a month
- Length of care is approximately 6 to 18 months
- Spent 40,000 in flex funding in 2020
- Spent 110,000 in flex funding in 2021

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Flex Funding

- Flexible services (FS): Services delivered to an individual OHP member to address social needs and improve their health and well-being

- Cell phone, minutes
- Tablet
- Grocery store gift cards
- Bed, mattress
- Refrigerator
- Pest extermination
- Cleaning supplies
- Past due rent
- Temporary motel stay
- Short term utility payment
- Storage unit fees
- Camping equipment
- Moving services
- Attorney fees
- Medication dispenser
- Weighted blanket
- Shoes
- Gym memberships
- Pool pass
- Fishing license
- Bus passes
- Gas cards
- Car insurance payment
- Car repairs
- Bicycle
- License fee
- Denture replacement
- Eye-glasses
- Clothes
- Solar panel system
- CPAP battery
- Blended funding for a used car
- Utilities

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What are some of the Common Problems that our Members experience?

- Not feeling understood
- Not being treated fairly
- Getting to their appointment
- Finding a doctor
- Housing supports, Food/Nutrional insecurities and transportation barriers
- Scheduling appointments
- No communication between their providers
- Needing diabetic supplies or durable medical equipment
- Getting medicine
- Accessing the right services
- Finding a specialist
- Finding a counselor
- Getting the right tests and treatment

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ICC Referral Pathways

- Referral sources
  - Internal
    - Medical case management
    - Customer service
    - Claims
    - Pharmacy
    - Behavioral Health
    - Utilization Review
  - Self referral
  - Primary Care Provider
  - Bay Area Hospital Nursing case management
  - FQHC – Coast Community and Waterfall clinic
- Juvenile and Adult Probation
- Medical Clinics
- Collective Medical
- Private Practice Therapists
- DHS APD and Child Welfare
- Homeless services
- Community Living Case Management (I/DD)
- Alcohol and Drug Services
  - ADAPT
  - Bay Area First Step (peer run)

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Strategies for member and provider engagement

- Match ICC cases to the best staff (insight into staff strengths/limitations)
- Balance weight of ICC staff caseload for sustainability of staff well being/reduce burnout
- Create and distribute ICC and THW brochures to socialize ICC education
- Work directly with CCO provider relations team to introduce ICC to PCPs
- Maintain consistent ICC presence at community and contractual partner meetings
  - Hospital complex care
  - Monthly meeting with APD, CCO, MH and AAA
  - Monthly to weekly meeting with county mental health partners
  - Internal clinical meeting between nursing, THW, pharmacy, medical director and mental health

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TRADITIONAL HEALTH WORKERS

Oregon Health Policy Board recommends increased integration and utilization of THWs that either work in a clinic or community-setting. THWs provide holistic and culturally competent care to diverse populations, by addressing Social Determinants of Health and Health Equity.

COMMUNITY HEALTH WORKER

Purpose - to provide services with an understanding of the community being served

PEER SUPPORT SPECIALIST

Purpose - to help people become and stay engaged in the recovery process and reduce likelihood of relapse through shared understanding, respect, and mutual empowerment

PEER WELLNESS SPECIALIST

Purpose - to provide peer services as part of a person-driven, health home team, integrating behavioral health and primary care to assist and advocate for individuals in achieving well-being

PERSONAL HEALTH NAVIGATOR

Purpose - to provide information, assistance, tools and support to enable a patient to make the best health care decisions

BIRTH DOULA

Purpose - to provide personal, non-medical support to women and families throughout a woman's pregnancy

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BENEFITS

Benefits that Providers and Members might receive from utilization of THWs

THW	MEMBER	PROVIDER
THW assists Members' social needs	Members' social needs are met	Provider can prioritize Members' needs
THW follows-up with Member about appointments	Member makes it to appointments	Reduced missed appointments
THW provides Member with emotional support	Member feels more comfortable	Increased understanding during appointment
THW assists Provider with questions about the Member	Improved quality of care/ Greater personalization of care	Provider can identify gaps in needed care
THW assists in communicating Member's cultural background	Increased access to culturally appropriate services/ care	Provider can reinforce education to Member
THW coordinates across agencies involved in individual's care	Coordinated communication improves services Member receives	Provider can track follow-up and is included in coordinated effort

QUICK LINKS

THWs - Oregon Health Authority: https://www.oregon.gov/oha/OEI/Pages/index.aspx

Peer Delivered Service - A Broad Exploration: https://www.youtube.com/watch?v=zVqMXWVQx8g

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Outcomes and Challenges

- Almost tripled use of flex funding dollars from 2020 to 2021
- Built wraparound team in 2.5 years of development (1 to 11 staff)
- Continue to increase referral pathways and referral rate
- Staff case load sizes are smaller
- Standing monthly meeting between CCO and DHS APD
- Population health vs. individualized care
- Balancing tension between social work and nursing staff
- New project – Medical respite/sheltering at Coal Bank Village, Coos Bay, Oregon

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Medical Sheltering at Coal Bank Village

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Medical Sheltering Population

As the rate of homelessness increases, resources have been strained. The homeless individuals referred for ICC services from acute care settings seem to fall into four general categories:

- Older individuals, post CVA, homeless, and not meeting criteria for APD services.
- Homeless individuals struggling with liver or renal disease, with either a relapse on alcohol or a worsening of alcohol or substance abuse, with recurrent episodes of acute liver related crisis (ascites, liver failure, encephalopathy) or acute renal failure.
- Homeless individuals with cancer.
- Homeless individuals who have been unable to manage diabetic needs, who are now experiencing non-healing lower extremity ulcers and, in some cases, amputations.

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The post acute discharge scenario:

The availability of post-acute stay services has become increasingly limited:

- A discharge referral to wound care may take 1-3 weeks for an initial appointment.
- PCP offices are unable to meet the need for close follow-up post hospital discharge, due to offices being inundated with needs and staffing shortages.
- Outpatient infusion, cancer treatment, dialysis providers, and home health all have limited capacity to accept new referrals.
- Homeless individuals, particularly those experiencing substance use/behavioral health concerns referred to SNF's, LTCF's and RTF's, are routinely passed over and declined admission, resulting in discharge to the street or to inadequate housing situation.

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Medical Sheltering Expectations

- Individuals will have an acute care discharge need to manage complex medical concerns along with Behavioral Health/SUD concerns.
- Individuals will be active participants in their own care plans.
- Individuals will receive ICC and RN Case Management supports, including addressing SDOH barriers.
- Individuals will have an expected length of stay in a medical shelter of 1-2 weeks, depending on needs and resources. Stays may be extended.

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Medical Sheltering: Early Outcomes

- Eight individuals served to date.
- 6 of 8 referred directly into supported housing situations with associated treatment supports.
- 1 individual experienced Death with Dignity (terminal cancer)
- 1 individual returned to hospital due to Behavioral health needs.
- Of the 6 referred into supported housing, 5 of those individuals have had continued success 1-2 months post discharge, with no additional acute care stays.
- All individuals referred for medical Sheltering were deferred from motel stays.

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Wrap-Up and Feedback

March 17 Session

- Focus on Difficult Transitions
  - Oregon State Hospital
  - Corrections
  - Residential Care

Wrap-Up and Feedback

OARs and contract requirement questions

Details could include:

- Specific question written as clearly and concisely as possible
- The OAR or contract requirement (for example, the OAR # and section, contract page #, or specific rule/requirement language)
- Reasons and details about why this requirement is creating confusion, problems, etc.
- Any solutions or workarounds that you've been able to implement or tried to implement to solve the issue
- Any recommendations you have that would solve the issue
- Supporting documentation or details that help explain the issue and/or your proposed solution

THANK YOU!

See you next month
March 17, Noon – 2pm

Please provide session feedback here:

https://forms.office.com/r/GLb65w38d1

Or using the QR code function on your phone:

Oregon Health Authority