Coordinating Across Systems: Coordinated Care Organizations and Long Term Services and Supports Examples of Care Coordination Activities across Oregon December, 2014

With the completion of new memorandum of agreement between Coordinated Care Organizations (CCOs) and Long Term Services and Supports offices in June, 2014, implementation of joint care coordination activities across systems has flourished. The following paragraphs describe some of the activities occurring across the state.

Deschutes, Crook & Jefferson

Pacific Source Community Solutions (PSCS) is working in collaboration with the Oregon Department of Human Services (DHS) Aging and People with Disabilities (APD) offices to provide Integrated Care Management (ICM). The goal of ICM is to create a member care team focused on forming an individualized care plan addressing the diverse needs of prioritized members in common, considering high risk and utilization algorithms and using targeted referrals. The ICM process increases care coordination and collaboration for members in common. PSCS and APD partner in building relationships with diverse providers such as the Primary Care Physician's office as well as behavioral health and community health workers. PSCS designates action plans and distributes them to each entity represented on the member's care team for activity follow-up and to evaluate the impact of health outcomes, client preferences and increased informed collaborations. Mechanisms are in place for tracking outcomes, early data reflects a considerable impact on both utilization and reduction in risk scores for these identified high priority members in common. Primary drivers of target referrals are: high utilization claims data, risk score, member goals and preferences as well as APD case management service priorities.

Eastern Oregon

Eastern Oregon APD offices and Eastern Oregon CCO held their first joint care coordination meeting in the last quarter. The staff felt very positive about the meeting and both organizations are keen to work out some process barriers and continue the work. In September, Eastern Oregon APD held a transition of care meeting with Eastern Oregon CCO case management staff to address barriers and identify opportunities to improve the transition processes. Additionally, APD is reaching out to EOCCO Patient Centered Primary Care Coordinators and conducted a survey on the current working relationship and care coordination needs between patient centered primary care coordinators and APD staff. The survey results identified the need for more cross communication among systems and resulted in the implementation of APD and EOCCO participating in the first joint care meetings. Other joint care meetings are scheduled for additional counties in December.

Hood River & Wasco Counties

PacificSource Community Solutions (PSCS) is working in collaboration with the APD District 9 on care coordination activities such as including the Long Term Services and Supports Innovator Agent in their Community Health Team (CHT) meetings and in providing Integrated Case Management (ICM). The CHT staffs consumers of mutual concern and holds mini-care conferences. ICM activities are similar to those described above for Deschutes, Crook & Jefferson counties. In addition, PSCS with APD involvement has formed a Systems Innovation Team to break down barriers across organizations. This team is just beginning its work and is expected to improve quality and access.

Jackson, Josephine and Douglas Counties

Bi-weekly care conferences on mutual consumers with high risk or complex circumstances have been established with PrimaryHealth of Josephine County, the Rogue Valley Council of Governments (RVCOG) and Douglas County Senior and Disability Services. AllCare has started provider partner and other coordination meetings such as Transitions of Care in Jackson and Josephine Counties. Joint care plans are developed and implemented. .Jackson Care Connect has begun proactively reviewing cases of mutual consumers with high emergency department utilization at its care conferences with RVCOG. Umpqua Health Alliance and Western Oregon Advanced Health have also begun regularly scheduled care conferences or Interdisciplinary Care Team meetings in partnership with local long term services and supports (LTSS) offices. Umpqua meets and partners with the APD Diversion Transition team to develop processes for transitions, plan transitions and review past transitions.

Klamath County

Cascade Health Alliance (CHA) and APD District 11 are working to provide Case Conferences and Case Staffing on identified complex members in common. A communication plan is in place guiding contact around high priority members in common identified by the CCO, APD, the member and/or a medical provider. CHA innovatively approaches collaborations engaging the member directly with an invitation to attend the conference in person or by phone to personally represent their preferences, personal health goals and concerns. The goal of Case Conference/Staffing is to build an interdisciplinary member care team, increase care coordination and collaboration supports and improve health outcomes, client health literacy and plans reflecting member preferences and goals.

Lane County

Trillium Community Health Plans and Lane Council of Governments Senior and Disability Services (LCOG) have staffed numerous care conferences over the years.

Trillium and LCOG are working to create a standardized process for member care teams and care conferences.

Linn, Benton, & Lincoln Counties

Intercommunity Health Network Coordinated Care Organization and Oregon Cascades West Council of Governments Senior and Disability Services are working to develop a common set of expectations and guidelines regarding interdisciplinary care team meetings. Currently, Care coordination activities happen as the need arises.

Marion, Polk, Yamhill, Columbia, Clatsop, & Tillamook Counties

Northwest Senior and Disability Services (NWSDS) and Columbia County APD office have been working with the CCOs in their areas to address service needs of community members residing in their 6-county region (Marion, Polk, Yamhill, Tillamook, Clatsop, and Columbia Counties). Specifically, for Marion and Polk counties, NWSDS co-facilitates with WVP Health Authority (contracted with WVCH-CCO to provide utilization management services) monthly meetings to discuss high utilizers and challenging cases living or moving into the community. Regular attendees are representatives from WVCH CCO, Case Managers from NWSDS, Marion County MH, Polk County Mental Health, and workers from the Developmentally Disabled (DD) services. In Yamhill County, in meetings facilitated by the area manager for NWSDS, representatives from Care Oregon, the Yamhill CCO, and the provider community have begun to identify common cases for joint case management. In Tillamook, Clatsop and Columbia Counties, meetings are held every other month to facilitate coordination of care of cases that are common to everyone. Regular attendees at these meetings are staff from the Aging Offices (NWSDS for Tillamook and Clatsop, and Columbia APD for Columbia County), Care Oregon representing Columbia Pacific CCO, and the local community mental health office. In the Tillamook area, the local hospital has expressed interest to send representatives from both their Mental Health and Physical Health departments.

Multnomah, Clackamas, Washington Counties

Regular interdisciplinary care coordination conferences are being conducted each month with HealthShare's Care Oregon. Additional ad hoc conferences are occurring with Kaiser, APS Healthcare, FamilyCare and Providence as well. HealthShare will soon release a monthly dashboard report that integrates data from their system as well as LTSS data, for consumers with high priority needs. Local health systems are working with the the LTSS staff to map transitions processes occurring across systems within the health plans as well as at hospital and primary care clinic settings. The goal of this mapping process is to identify areas where increased collaboration and coordination will enhance the services available to at risk members of the health plans.