Care Coordination/ICC Learning Collaborative

November 17, 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 verbally or ask a question (*found in the “Reactions” section at the bottom right of the Zoom screen*)
- 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.

Oregon Health Authority

October Session Review

Long-Term Services and Supports (LTSS)

- Intellectual and Developmental Disabilities (I/DD) Program
  - Brokerages and Community I/DD Programs

- Aging and People with Disabilities (APD) Program
  - APD Field Offices and Area Agencies on Aging (AAA)

Some Outstanding Work/Issues

- Releases of Information
- Data Sharing

Fidelity Wraparound

Presented by
Nat Jacobs Wraparound Policy and Program Coordinator &
Summer Hunker Complex Clinical Care Coordinator

Child and Family Behavioral Health Unit Health
Services Division

Learning Objectives

- Define:
  - Fidelity Wraparound
  - Family Guided & Youth driven
- Explore the ways in which Fidelity Wraparound is a unique care coordination model
- How Fidelity Wraparound can support youth involved with child welfare
- The differences and similarities between ICC and Wraparound

What is Fidelity Wraparound?

- 1 of 2 care coordination models for young people in Oregon
- A unique comprehensive, holistic youth guided, and family driven way of responding when youth experience significant behavioral health challenges
- Wraparound is relationship based, lasts 18-48 months and seeks to be transformational by centering families and youth in the services and supports that work best for the youth and family

Youth Guided and Family Driven: "Nothing about us without us"

- Fidelity Wraparound practice is based on 10 guiding principles

- The primary principle is to be **Family Driven and Youth guided** which means that family and youth perspectives are **intentionally elicited and prioritized** during all phases of the Wraparound planning process.

- This means that the needs, goals, interventions and planning are grounded in youth and family members' perspectives and culture, and the team strives to provide options and choices to create a plan that reflects family's and youth's values, culture, preferences, and strengths.

What do you get with Wraparound?

- A trained Wraparound Care Coordinator who facilitates the planning process through the 4 phases of Wraparound
- Access to a Youth or Family Partner if the youth or family would like additional support and advocacy
- A crisis and safety plan with prevention and intervention strategies,
- Creation of a Wraparound Plan of Care that spans across 12 domains;
- An initial CANS and 90-day CANS to be used to support planning
- Fidelity measurements; the WFI-EZ and TOM

Reasons why Fidelity Wraparound Works

- Thrives on “outside the box” strategies – individualized/strengths based
- Creates a place to slow down, to invent, evaluate and reinvent a plan that creates pathways for change and sustainability.
- Is an evidenced based, fidelity model that serves youth with complex needs and multi system involvement
  - Wraparound is outcome based and ends when the team mission has been met
- Differentiates a need from a service

Child Welfare & Wraparound

Fidelity Wraparound can't:

- Be rushed and adhere to fidelity
- Resolve immediate placement needs
- Guarantee access to services and supports
- Operate without the input of youth and their family

Fidelity Wraparound can:

- Provide crisis and safety planning
- Offer Youth and Family Partners
- Identify what the need is vs. a service
- Create outside the box strategies
- Be a resource for case workers
- Support and partner with resource and bio family

Eligibility

Wraparound is available to children and youth who are:

- On Medicaid (FFS/CCO)
- Have mental health assessment completed within the last year
- Are involved in 2 or more child serving systems
- Experience serious behavioral health concerns
- Exiting Secure Children's Inpatient Program, Secure Adolescent Inpatient Program, Psychiatric Residential Treatment Services, or the Commercial Sexually Exploited Children's residential program
- 17 and younger (once enrolled you do not age out of Wraparound)

Child and Family Bx Health Complex Care & ICC/Wraparound

- **Complex Care Coordinator:** Child & Family BH case specific staff to support youth specific cases
  - Temporary Lodging, Secure Inpatient & additional support in bringing in system partners

- **ICC vs Wraparound**
  - Clinical services/system navigation or creative solutions

- **Lessons learned**
  - Plan ahead!
  - Youth and guardian engagement

ICC and Wraparound Comparison

Oregon	ICC	Fidelity Wraparound
Type of Process	Care Coordination	Fidelity Care Coordination Model
Population Focus	Child & Adult priority populations per OAR 410-141-3870 Ages: All	Youth with complex and intensive multisystem needs and their families Ages: 0-25/ referred by age 17
Primary Function	Convene care teams to ensure timely access to and management of medical providers, coordinating necessary and appropriate linkage of community, social service, and medical care systems.	Youth and family centered intensive care coordination that is team-based culturally and linguistically responsive, individualized and strength based
Caseload Size	Ideal Caseloads: 20-30	Caseloads: 12-15
Length of Stay	Varies	Average 18-24 months
Frequency of contact		Planning meetings can be daily, weekly, or monthly
Crisis response; safety planning	Ensures there is a crisis and safety plan	Ensures there is a crisis and safety plan
Eligibility Criteria		Oregon Health Plan Members MHA completed within one year and Involvement with one other child serving system
Exit/Discharge criteria		When the team mission has been completed.

Have any questions?

Please reach out to: Nat Jacobs they/them:
nat.jacobs@dhsoha.state.or.us

Summer Hunker she/her:
s.hunker@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

KEPRO OREGON

OREGON HEALTH PLAN CARE COORDINATION (OHPCC) & OREGON COVID SURGE (ORCS)

November 17, 2022

Kepro Oregon

OHPCC Contract Overview

- **Program Description:** Kepro provides a full range of care coordination and evaluation services to high-risk populations:
  - Services: Case Management, Disease Management, Care Coordination, ABA evaluations, CAWEM evaluations, Physician Reviews, ATP Consult, Dental Malocclusion, Nurse Advice Line, Newsletters, Welcome Packets
  - **Eligibility Requirements:** Medicaid FFS (non-indigenous) and Dual Eligible (QMB) and for specific carve-out members
- **Program Length:** 13+ Years
- **Contract Term:** 7/1/2020 – 12/31/2024
- **Key Kepro Employees:** Rae Bauman, Jeffrey McWilliams, Raj Dinavahi, Paula Pennington
- **Key Client Contacts:** Dana Hittle, Natasha Martin, Dawn Mautner, Brenden McGee

ORCS Contract Overview

- **Program Description:** Kepro provides assistance to DHS in response to needs driven by emergency events:
  - Services: Targeted Outreach, Hospital discharge planning and coordination, Decompression Unit discharge planning and coordination, community assessments for Medicaid services, and referrals for ongoing services
  - **Eligibility Requirements:** Eligibility for DHS services, Medicaid, and others depending upon the event
- **Program Length:** 14 months
- **Contract Term:** 8/27/2021 – 6/30/2023
- **Key Kepro Employees:** Rae Bauman, Jessica Pinkerton (ORCS), Jeffrey McWilliams, Raj Dinavahi, Paula Pennington
- **Key Client Contacts:** Jane-Ellen Weidanz, Rachel Currans-Henry

Kepro Oregon

OHPCC Key Member Activities

- Monthly High-Risk Outreach Campaigns based on risk stratification of our entire membership.
- Specialty Outreach Campaigns based on specific needs or priorities set by OHA.
- Weekly Disease Management outreach:
  - Tobacco Cessation
  - Hep C
  - Priority Rx Refills
  - Nurse Triage Referrals
- Clinical Reviews ABA, CWM, Physician.
- Case Management Services based on provider/community referral, self-referrals, inpatient status, high-risk, complex care needs, and OHA Referrals:
  - Intensive and Clinical Case Management Evidence-based, Person-centered POC, Social, and Health Assessments, IDT approach.

ORCS Key Member Activities

This is a dynamic contract and team who pivot to areas of crisis or need by DHS serving the entire state of Oregon in response to emergencies or public health events, as well as other factors as they arise. Target populations are redefined based on the current events or need.

- Phase 1: Discharge planning coordination, detailed discharge assessments for tracking, reconciliation, placement as well maintaining options for discharge.
- Phase 2: Decompression Unit facility coordination with admit and discharge assessments for case management, reconciliation, community placement as well tracking options for discharge.
- Phase 3: Assistance with technology and teams for post-discharge community assessments for ongoing services and related support for DHS teams statewide for Oregonians. This includes outreach to DHS members for air purifier/air conditioner distribution.

Kepro Oregon

Program Features

- **Quality Metrics**
  - Limited to data available for the FFS population
  - No incentive attached
  - Metrics are aligned with CCO's
- **Community Advisory Committee**
  - In progress – delayed due to public health emergency
- **MOU – Language – Equity Reports**
  - In Progress
- **Warm Hand-Offs (WHO):** New document in development
- **Lead Coordinating Entity (LCE)**
- **Social Determinants of Health (SDOH) integrated into our inbound and outbound calls, member engagement, and plans of care**
- **Planned Community Birth (PCB) case management**

CCO Intersections

- **Eligibility Transitions**
  - To CCO from FFS
  - To FFS from CCO
  - Special circumstance
  - Healthier Oregon postpartum members
  - High churn
- **Community Care Conferences with OHA in unique circumstances**
- **Shared members:**
  - Physical Health Coordination
  - Dental Health Coordination
  - Mental Health Coordination
  - PCB
  - CAWEM
- **Lead Coordinating Entity (LCE)**
- **Planned Community Birth (PCB) transition back to CCO**
- **Warm Hand-Offs (WHO):** New document in development
- **Barriers:**
  - Being asked for our NPI
  - Case Management referrals
  - PCB shared case management


Discussion

Final Session!

- **Dec 15**: LC Series Recap and Planning for Future

Anything specific you would like to discuss at the December session?

THANK YOU!

See you next month
December 13, Noon – 2pm

Please provide session feedback here:

https://forms.office.com/r/Xpj6F9Kw81

Or using the QR code function on your phone:

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