Care Coordination/ICC Learning Collaborative

August 18, 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 typically recorded but today's session will be recorded so it can be watched/shared later
  - 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.

Care Coordination and Intensive Care Coordination Services

Regional Care Team (RCT) Overview

Emily Adler, LCSW
Senior Manager, Care Coordination
Healthshare of Oregon (HSO)

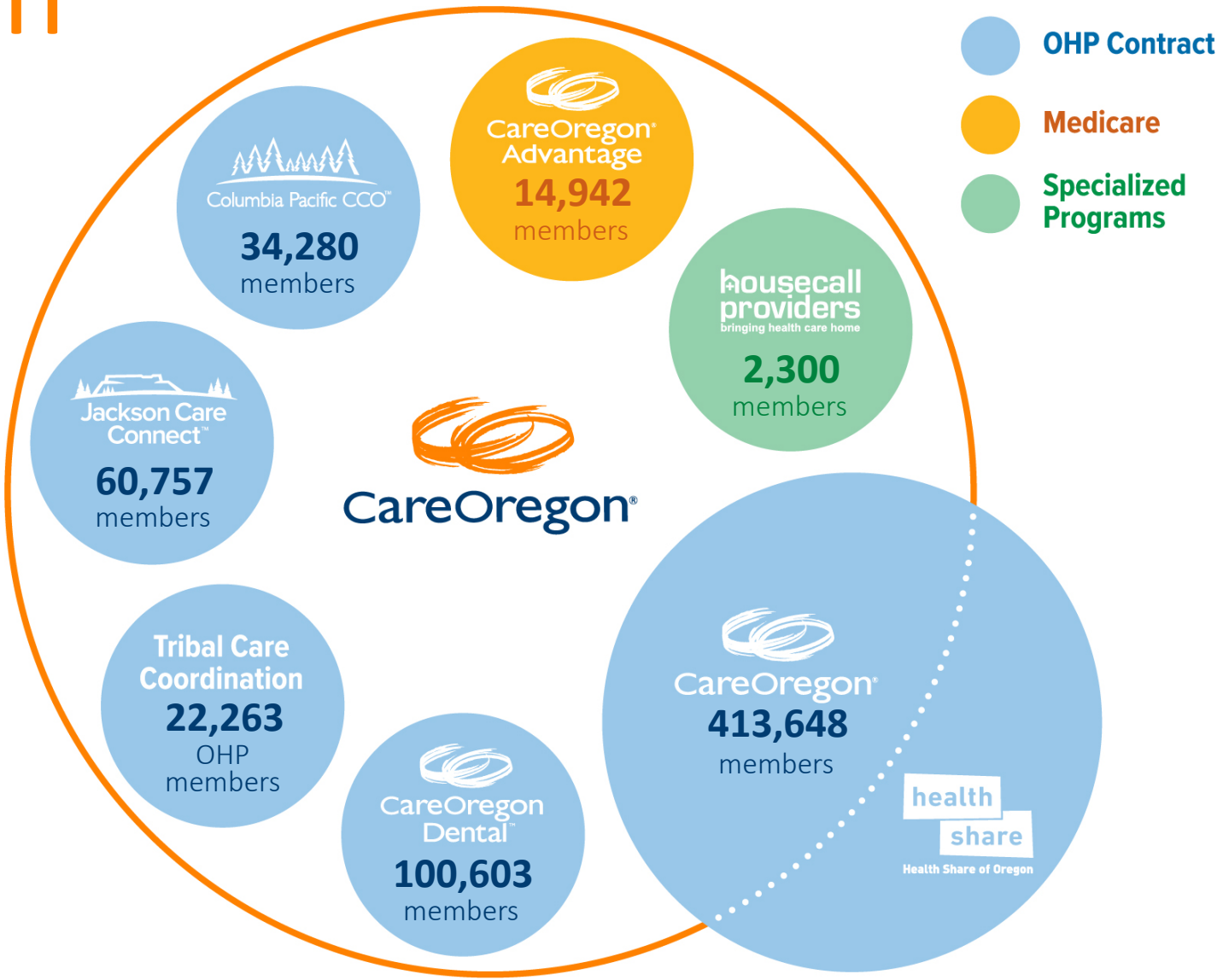
Erica Idso-Weisz, MS, LMFT
Care Team Manager
Jackson Care Connect (JCC)

Learning objectives and agenda

- Regional Care Team Introduction and overview of the team
    - Who we are
    - Who we serve
    - What we do
    - How we can help
    - How you can reach us

The CareOregon Family

CareOregon is a nonprofit health organization serving Oregon's Medicaid and Medicare populations.
Every day, we strive to build stronger communities by making health care work for everyone.



*** Membership numbers updated as of April 2022

Care Coordination

With care coordination through the RCT, we will deliver the right care, at the right time, in the right place, with the right team.

- Integrated (physical and behavioral health) multi-disciplinary care team
- Clinical and non-clinical Care Coordinators
- Focused on the Social Determinants of Health (SDOH) & their impact of health & well-being
- Available to provide telephonic and community-based support
- Also, provide Pharmacy, Non-Emergent Medical Transport (NEMT), support etc.
- Under the Population Health Partnerships Department at CareOregon

What is a Regional Care Team (RCT)?

- CareOregon's Regional Care Teams (RCTs) offer providers a community of resources with a single point of contact for you and your patients. RCTs work closely with providers and members to smooth the way to better care and better outcomes.
- Members will have a consistent care team that will collaborate across disciplines to develop and implement a member-centric care plan through telephonic, electronic or community-based interventions to resolve identified needs and promote healthy outcomes.
- Each RCT is made up of care coordinators with a variety of backgrounds and experience, including:
  - Nursing
  - Behavioral health
  - Substance use disorders
  - Pharmacy
  - Health system navigation
  - Local community resources
  - And others
- With care coordination through RCTs, we will deliver the right care, at the right time, in the right place, with the right team.

RCT: Who are we?

- Triage coordinator
- Health care coordinator
- Health resilience specialist
- RN care coordinator
- Behavioral health coordinator
- Clinical pharmacist
- Intensive care coordinator

Health Care Coordinator (HCC)

- Often, the first point of contact for RCT
- Accepts referrals to the RCT from network partners
- Care coordination activities:
  - Assist in finding new or alternative providers
  - Assist in DME questions
  - Provide information on authorizations and appeals
  - Support in finding and accessing community resources
  - Health plan navigation
  - Health-related services support
  - General questions

RN Care Coordinator (RNCC)

- Offers phone and in-person care coordination support for members and providers:
  - Supports care coordinators in clinics
  - Identifies gaps in care and works with providers and families, implementing care plans that address gaps
  - Coordinates interagency/interdepartmental ICT meetings, create action-oriented care plans
- Creates communication pathways between members, providers, CareOregon and social service agencies
- Provides transitional support for hospital admits and discharges
- Provides both phone and community-based supports
- Provides RN clinical lens to other cases RCT members are working on

Behavioral Health Care Coordinator (BHCC)

- Works by phone with:
  - Members
  - Providers
  - Family
  - Community partners
- Assists with navigating multiple systems:
  - Helps identify behavioral health supports and programs
  - Assists with transitions between providers, programs, and levels of care
  - Works closely with county programs (e.g., ICC, wraparound)
  - Collaborates with RN on team when medical issues are also present

Health Resilience Specialist (HRS)

- Some are embedded in PCP clinics
- Provides phone and in-person support to:
  - Members
  - Providers
  - Family
- Assists with navigating multiple systems:
  - Helps identify behavioral health supports and programs
  - Provides in-person support in clinic and community settings
  - Supports connections back to PCP and specialty medical support
  - Collaborates with RN when medical issues are also present

Intensive Care Coordinator (ICC)

- Provides phone and community-based care coordination for the most vulnerable adult and youth members, including members with complex behavioral concerns, severe and persistent mental illness, and substance use disorders
- Has knowledge of adult and youth systems of care
- Focuses on supporting members as they transition in and out of intensive community and facility-based psychiatric treatment settings
- Embedded for Jackson Care Connect (JCC) & Columbia Pacific CCO on RCTS; Metro ICCs are contracted with Washington and Multnomah Counties for services

Who we serve?

All CareOregon members have access to care coordination and intensive care coordination services. Some populations may be prioritized for care coordination including members identified as aged, blind, or disabled or for members with:

- Special health care needs
- Complex medical needs
- Multiple chronic conditions
- Behavioral health issues/concerns
- Severe and persistent mental illness (SPMI)
- High-risk pregnancy

- DHS Medicaid-funded long-term care services and supports (LTCSS)
- Treatment being provided outside of the CCO catchment area
- Treatment provided in long-term care settings including the Oregon State Hospital

How do we help?

- Care Coordination is a benefit available to all members on the OHP assigned to JCC (CCO), we additionally assist with Transitions of Care for Care Oregon Advantage members (or Dual-Eligible- meaning they have both Medicare & Medicaid)
- We strive to:
- Reduce confusion for members (patients/clients) by navigating them through the health care and social services system.
- Help patients get access to the right care at the right time, and make sure they stay connected to their providers.
- Reduce barriers to member (patient/client) care, treatment engagement and connect them to support services.

RCT offers care coordination and support for members with multiple or complex needs, such as:

- Multiple chronic conditions
- High or special health care needs
- Chronic pain needs
- In-home care needs
- Daily living or social needs
- Medication review and support
- End-of-life support
- Substance use
- Behavioral health concerns

RCT: What do we do?

- A multidisciplinary care coordination team
  - Provide care coordination for CareOregon members, working closely with providers and community partners
  - Coordinate interdisciplinary care team (ICT) meetings,
    create action-oriented care plans
  - Care coordination can provide consistency through multiple systems: hold the story, share the story
- Support members who fall through the cracks and provide access to services

Care Coordination in Action

- JCC Care Coordination on our JCC Website:
- https://jacksoncareconnect.org/for-providers/care-coordination

- JCC RCT Care Coordinator Overview: http://careoregon.org/docs/default-source/jcc/jcc-rct-cc-and-icc-training.pdf

- What is Care Coordination All About? Members
  - Jackson Care Connect – RCT/Care Coordination Video (available in English and Spanish)
  - CareOregon Advantage – RCT/Care Coordination Video (available in English, Spanish, Chinese, Vietnamese, and Russian)

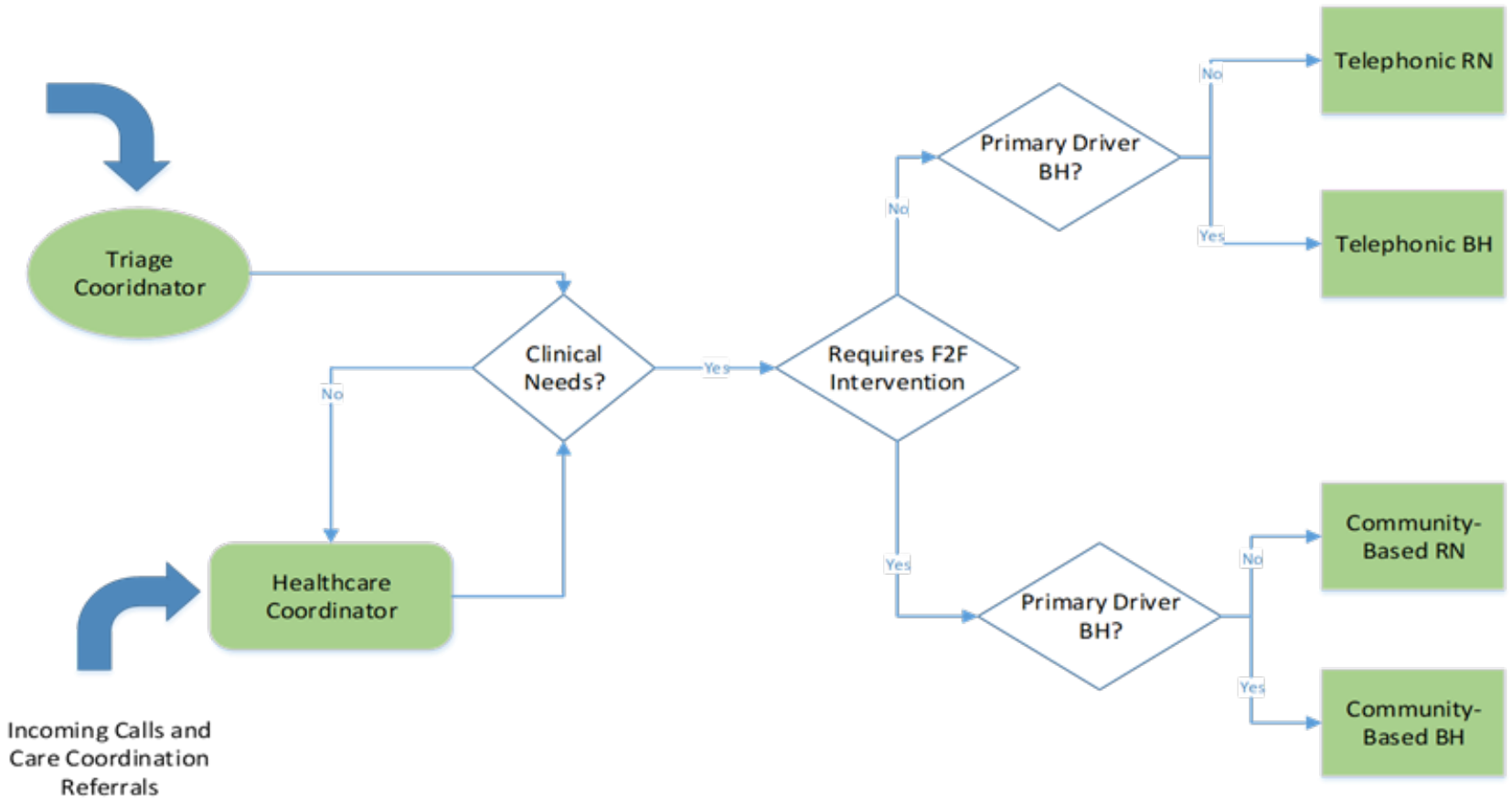
Region Specific Efforts

- HSO-Highlight HRS work
- JCC-Mercy Flights & Fire/Smoke Response

How do I make a care coordination referral?

- Online: Submit a completed Care Coordination Referral form and we'll route it to your assigned RCT.
- Email: Send us a completed form to ccreferral@careoregon.org.
- Collective: If your clinic uses this online platform, check the RCT tag after searching for your patient.
- Call: Check the list below to see where your clinic is assigned and call that number.
- Not sure which RCT to contact? Call our general care coordination line at 503-416-3731 or Customer Service at 503-416-4100 and we'll connect you to your assigned team.

What happens when I submit a referral?



Questions, issues or concerns?

Emily Adler
adlere@careoregon.org

Erica Idso-Weisz
idso-weisze@careoregon.org

Oregon Health Authority | PATIENT CENTERED PRIMARY CARE HOME PROGRAM

PCPCH program complex care coordination

August 18, 2022

The mission of the PCPCH Program is to be a trusted partner in primary care, collaborating with stakeholders to set the standard for transformative, whole-person, and evidence-based care.

Presentation agenda

- Patient-Centered Primary Care Home (PCPCH) program
  - History of the program
  - PCPCH characteristics and location
  - PCPCH model
  - Verification site visits
  - Future PCPCH program work
- PCPCH Standard 5.C – Complex Care Coordination
- Resources and upcoming learning collaborative

Patient-Centered Primary Care Home Program

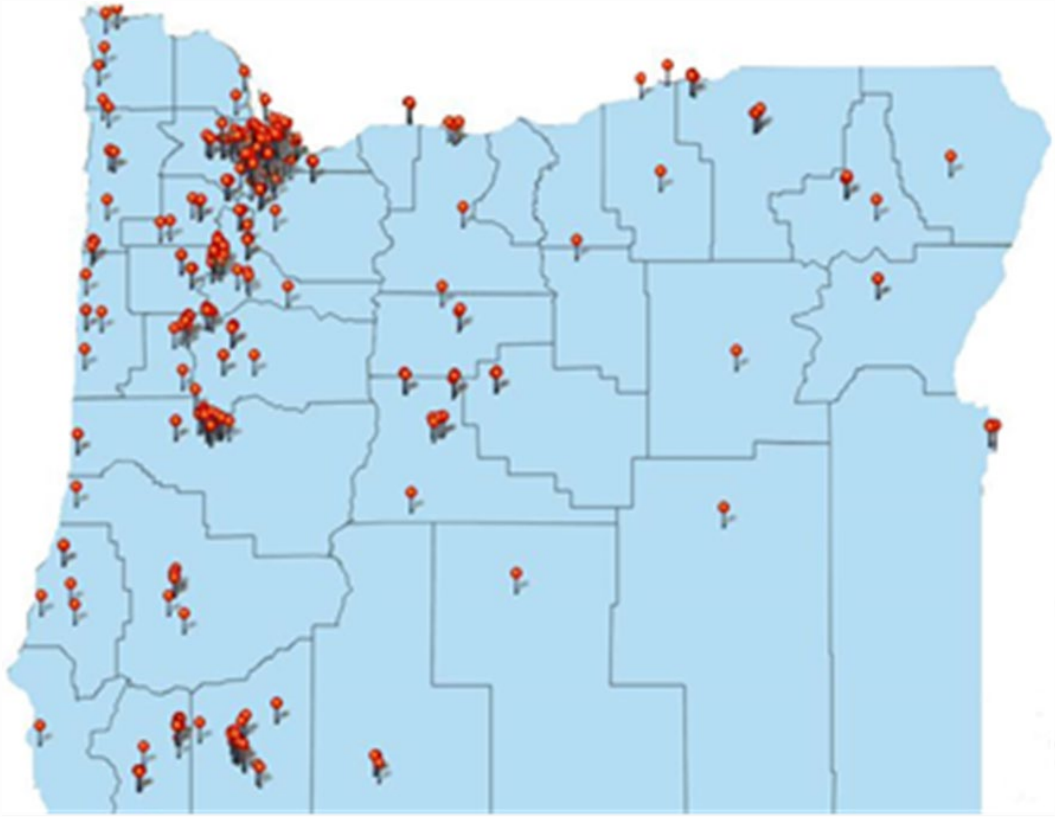
- Established in 2009 by the Oregon Legislature to support the Triple Aim and to set standards of care for primary care practices
- PCPCH standards are developed by OHA in partnership with a Standards Advisory Committee
- Central to advancing Oregon's health system transformation for over a decade
- Aligns with national programs but is uniquely Oregon

Who can apply for PCPCH recognition?

- Any type of health care practice that provides comprehensive primary care services
- PCPCH recognition is voluntary and there is no cost to participate
- Practices do not have to be based in Oregon but do have to see patients who live in Oregon
- Practices are not required to serve individuals with Medicaid or have a sliding fee scale

Where PCPCHs are located

- Over 630 PCPCH practices - ¾ of all primary care practices
- 35 of 36 counties
- 92% of Medicaid Coordinated Care Organization (CCO) members get their care at a PCPCH

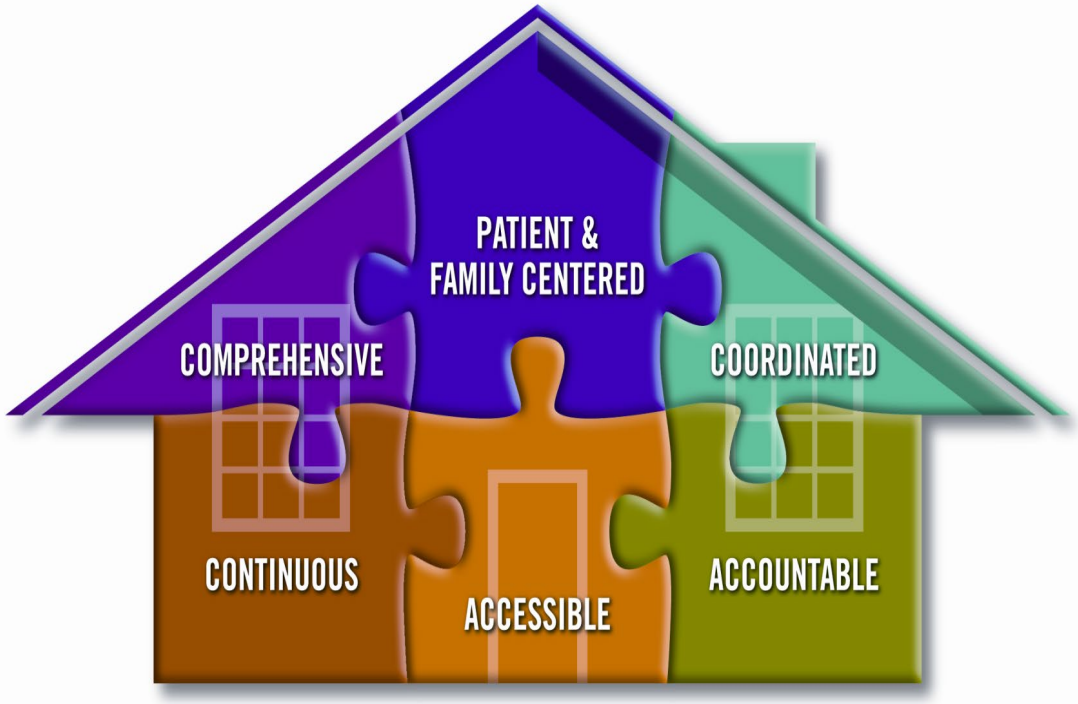


PATIENT CENTERED PRIMARY CARE HOME PROGRAM

Oregon Health Authority

Oregon's PCPCH model

- Six core attributes, each with specific standards and measures
- 11 "Must-Pass" measures all clinics must meet
- Five tiers of recognition based on which measures a clinic meets
- Tier 5 (5 STAR) has unique requirements



PCPCH verification site visits

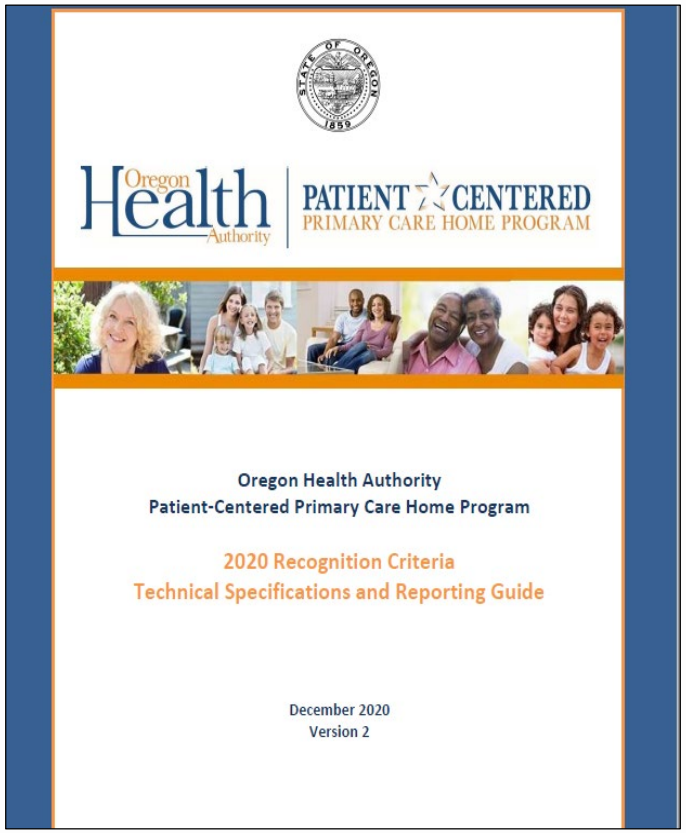
- PCPCH program conducted more than 450 site visits since 2012
  - Each PCPCH will receive a site visit at least once every 5 years
  - Team includes a Verification Specialist, Improvement Specialist, and a Clinical Transformation Consultant (provider) when available.

- During a site visit, the team:
  - **Verifies** that the practice is meeting the measures they attested to
  - **Assesses** the practice operations to understand if the intent of the patient-centered care model is integrated into the PCPCH
  - **Collaborates** to identify areas of improvement and to connect clinics with colleagues and technical assistance
  - **Provides** technical assistance following a site visit for up to six months

- Site visits have been virtual since the start of the pandemic

Resources and support for PCPCHs

- Assistance to practices applying for PCPCH recognition
- Post-site visit practice coaching to PCPCHs for up to six months
- Webinars and learning collaboratives
- Technical assistance library resources on PCPCH program website
- Monthly email program update



PATIENT CENTERED PRIMARY CARE HOME PROGRAM

Oregon Health Authority

What's next for the PCPCH program

- Revise PCPCH standards to advance health equity
  - COVID-19 pandemic highlighted inadequacies in the primary care health system for people experiencing inequities
  - Ensure the PCPCH Program supports a primary care system that addresses community-identified needs
  - Convene a standards advisory committee to partner with OHA to revise the PCPCH standards

- Evaluation of PCPCH program's impact
  - This fall, Portland State University researchers will evaluate the PCPCH program's impact on the health system
  - Previous evaluation found significant cost savings to the health system

Gelmon, S., Wallace, N., Sandberg, B., Petchel, S. & Bournis, N. (2016). Implementation of Oregon's PCPCH Program: Exemplary Practices & Program Findings. http://www.oregon.gov/oha/HPA/CSI-PCPCH/Documents/PCPCH-Program-Implementation-Report-Sept2016.pdf

Core Attribute 5 – Coordination and Integration
PCPCH Standard 5.C – Complex Care Coordination

Measures - Check all that apply

5.C.1 PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients. PCPCH tells each patient, as well as their family or caregiver if relevant, the name of the team member(s) responsible for coordinating the patient's care. (5 points)

5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of diverse patients with complex care needs. (10 points)

5.C.3 PCPCH collaborates with diverse patients, families, or caregivers to develop individualized written care plans for complex medical or social concerns. (15 points)

Intent of PCPCH Standard 5.C – Complex Care Coordination

Care coordination is an essential feature of a primary care home. The intent of this standard is to ensure that PCPCHs deliberately consider care coordination functions, explicitly assign these functions to specific staff members, take extra steps to coordinate the care of diverse patients with complex care needs, and communicate clearly to patients, families, and caregivers about who they can contact at the practice to help coordinate their care.

This standard also promotes the development of individualized care plans for diverse patients with complex medical and social needs to help coordinate and integrate their care. Identifying patients with higher health risks, implementing a strategy to help those most in need, and effectively coordinating and managing care for higher risk sub-populations can help prevent exacerbations of illness and other health complications.

PCPCH Measure 5.C.1

PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients. PCPCH tells each patient, as well as their family or caregiver if relevant, the name of the team member(s) responsible for coordinating the patient's care.

Specifications for PCPCH Measure 5.C.1

A practice is meeting measure 5.C.1 if:

- it has a person(s) responsible for care coordination
- A written description of their role/functions
- A method for notifying patients, families, or caregivers of who is responsible for coordinating their care.

PCPCH Measure 5.C.2

PCPCH describes and demonstrates its process for identifying and coordinating the care of diverse patients with complex care needs.

Specifications for PCPCH Measure 5.C.2

A practice is meeting measure 5.C.2 if:

- It can describe its criteria for identifying diverse patients with complex care needs for care coordination
  - Examples of diverse patients with complex health care needs include children with special health care needs, individuals taking multiple medications, individuals seeing several specialists, individuals with multiple recent hospitalizations, etc.
  - Strategies for identifying these patients might include EHR reports, risk stratification scores, ED reports, etc.
- It can describe the activities performed by staff to assist with care coordination.
  - These staff must have received specific training on these activities, such as providing patient-specific education or supporting behavior change.

PCPCH Measure 5.C.3

PCPCH collaborates with diverse patients, families, or caregivers to develop individualized written care plans for complex medical or social concerns.

Specifications for PCPCH Measure 5.C.3

A practice is meeting measure 5.C.3 if:

- It collaborates with its identified complex patients to develop and implement whole-person, culturally and linguistically appropriate, personalized, written complex care plans.
- The care plans should include, at a minimum:
  - Patient-specific short-term and long-term health goals
  - The action plan for achieving these goals or managing the patient's condition
  - Three elements from across the lists of primary and supportive services determined to be most impactful to individual patients and their overall treatment and management plan
- Care plans should also:
  - Be developed collaboratively with the patient, family, and caregiver.
  - Be written at an appropriate health literacy level, accessible by individuals with disabilities, documented in the medical record, and updated regularly.

Additional resources and care plan templates

Patient-Centered Primary Care Home Program

https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/Resources-Technical-Assistance.aspx

Agency for Healthcare Research and Quality (AHRQ)

https://integrationacademy.ahrq.gov/products/playbooks/behavioral-health-and-primary-care/implementing-plan/develop-shared-care-plan

Upcoming PCPCH program learning collaborative

September 9th (12-1pm): PCPCH Measures 5.C.1 - 5.C.3

- PCPCHs will share their strategies for structuring care teams, identifying complex patients for care coordination, and improving patient-centered care plans. To register, copy the link below into your browser: https://www.zoomgov.com/meeting/register/vJIsdeChqTkjHRO6pxEVxk_ITdBHYqsWydE

September 23rd (12-1pm): PCPCH Measure 5.C.3

- PCPCHs will share their strategies for creating care plans for patients with complex medical or social needs. To register, copy the link below into your browser: https://www.zoomgov.com/meeting/register/vJItf-GsqzwvEzl0S0tWYEUg24oxYw8n7VI

For more information

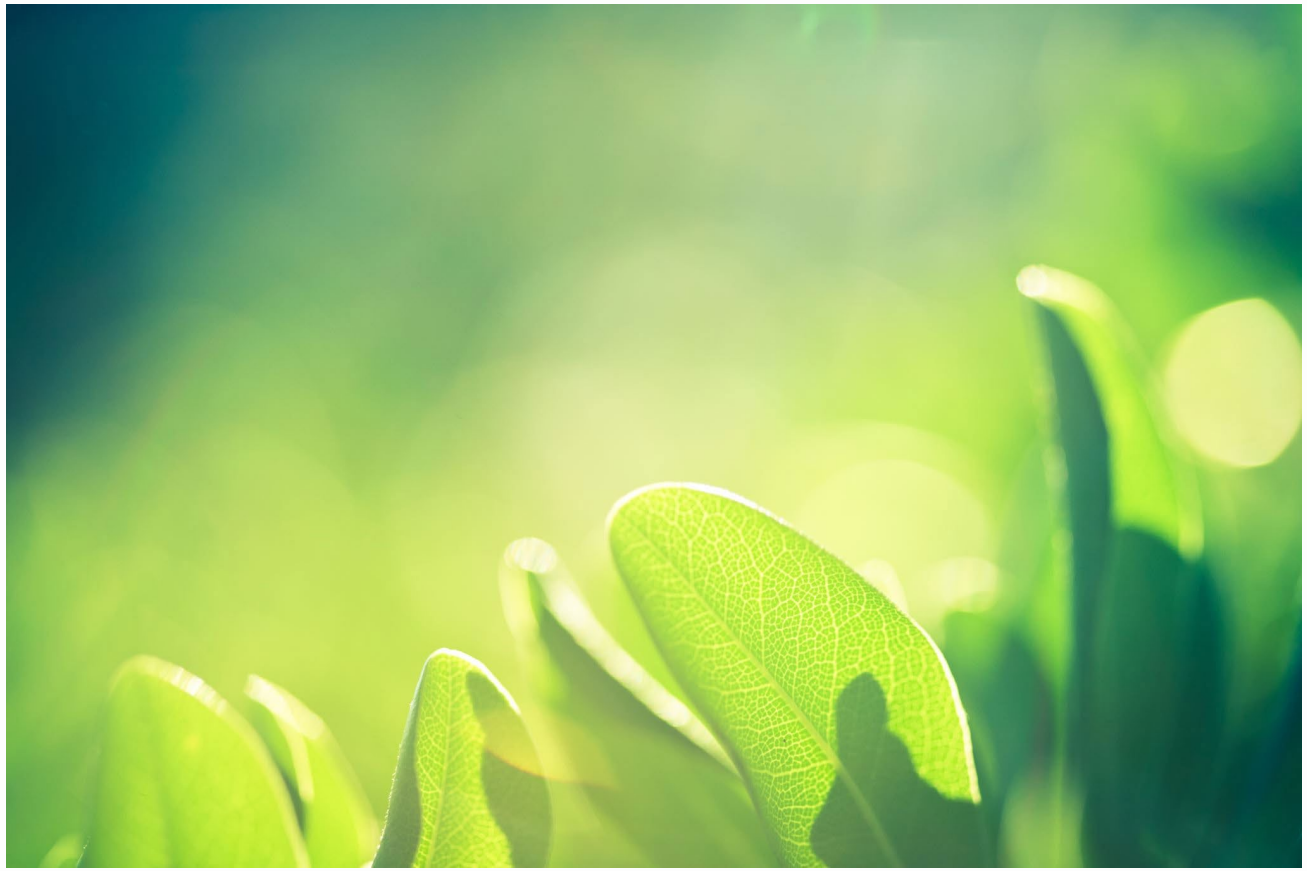
Patient-Centered Primary Care Home Program

www.primarycarehome.oregon.gov

Subscribe to receive the monthly PCPCH Program updates by email

pcpch@dhsoha.state.or.us

Thank you!



Care Coordination/ICC Learning Collaborative

We are currently taking a short break.

We will resume the session soon.

Oregon Health Authority

Cascades East Family Medicine Center and Cascade Health Alliance (CCO)

Collaboration with community partners improves care!

Cascades East Family Medicine Center

- Rural family medicine clinic in Klamath Falls OR
- 46 providers (24 resident physicians, 13 faculty, 7 APPs, 2 BH)
- RN Care Management Team of 3.5 FTE
- 12,700 active patients

CEFM Care Management

- Jeanne McDaniel, RN, CCM
- Kara Caldwell, RN
- Loralee McKoen, RN CCM
- Debbie Crawford, RN (Not pictured)

CCO Cascade Health Alliance

- Provider-owned coordinated care organization.
- Locally owned and works to deliver care with provider partners in the community.
- Sole CCO in Klamath County
- 46% of Cascades East patients are on the CHA benefit plan

Cascade Health Alliance

Behavioral Health Case Manager

Shelly Morton

Collaborative Care Weekly Meetings

Formed in 2017

- Wednesdays 0930-1130 in person

Stakeholders

- Cascades East Family Medicine (Oct 2017)
- Sky Lakes Outpatient Care Management Department (Nov 2018)
- Klamath Basin Behavioral Health (KBBH) (Jan 2019)
- CCO: Cascade Health Alliance (Apr 2019)
- Sky Lakes Behavioral Health (2021)
- Atrio (7/2022)

Collaborative Meeting Goals:

- Coordination of Care to support patients fully
- Complementary strengths and delegation to eliminate duplication of services
- Explore barriers
- Learn about other resources
- Brainstorming
- Patient Accountability

The Meeting…

- Preparation
  - Identify high risk patients (provider/staff referral)
- Time and Location
  - Weekly standing meeting on Wednesdays at CEFM
  - Hybrid- In person and Webex
  - 30-45 minutes

Outcomes

- Streamlined care coordination
  - DME, Referrals, Pharmacy
- Reduction in duplication of services
- Relationship Building
  - Points of contact
  - Embedded OPCM Intake Coordinator
- Knowledge and Resource sharing
- Reduction in ED visits by identification of high utilizers

Challenges

- Establishing trust initially
- Authorization to Discuss
  - Mental Health (KBBH)
- Keeping meeting on point
- Pandemic
  - Distancing requirements
- Lack of Resources
  - Rural
  - Temporary and ever-changing

Future Plans

Identify other community partners

Utilize IET reports

Invite patients to participate in the meeting

Upcoming Sessions

- Sept 15: Continued Discussion on OARs/Contract Requirements
- Oct 20: Long-Term Services and Supports
- Nov 17: Wraparound + TBD
- Dec 15: TBD

Anything else you recommend be covered at remaining sessions in the LC series?

THANK YOU!

See you next month
September 15, Noon – 2pm

Please provide session feedback here:

https://forms.office.com/r/9BU3jxE0gx

Or using the QR code function on your phone:

Oregon Health Authority