Care Coordination/ICC Learning Collaborative

June 21, 2022

The session will begin shortly.

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)

Oregon Health Authority

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.

Oregon Health Authority

Previous Session Review

June – Pediatric Transitions

- **Oregon Department of Human Services (ODHS)**
  Family Preservation Demonstration
  - 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
  - Demonstration Sites:
    - Alberta Branch (Multnomah County)
    - Douglas Branch
    - Klamath Branch
    - Confederated Tribes of Grande Ronde
    - Confederated Tribes of the Umatilla Indian Reservation

- **Oregon Center for Children and Youth with Special Health Needs (OCCYSHN)**
  Transition from Pediatric to Adult Health Care for Young Adults with Medical Complexity
  - Transition Structure:
    - **Preparation**: • Payment • Staff Coordination • Links between CCOs & Clinics
    - **Transfer**: • Identification of Adult Providers • Transfer Package • Warm Handoff
    - **Follow-up**: • Pre-visit Outreach • No-Show Follow-up • Suggestions for First Clinic Visit

Oregon Health Authority

EDIE / Collective Platform Overview

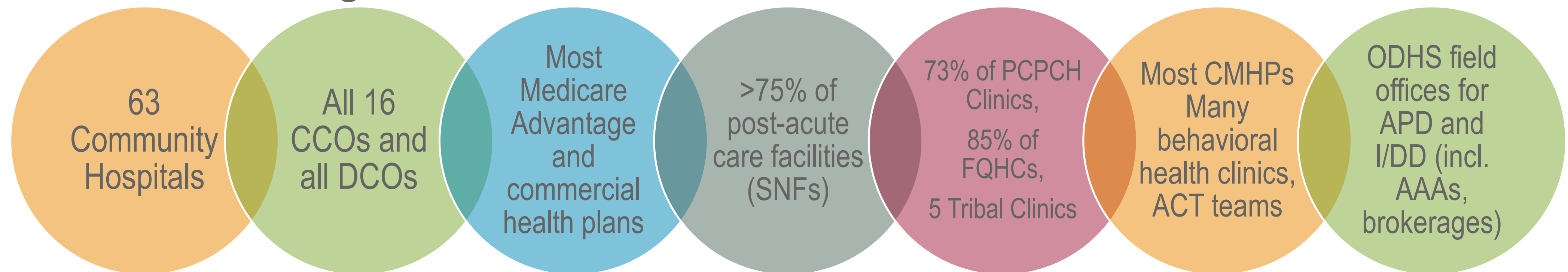
Luke Glowasky, Health Information Exchange Programs Manager
Oregon Health Authority

What is the Collective Platform
(aka EDIE and PreManage)?

The Collective Platform is Oregon's statewide infrastructure to share critical information across the healthcare system

- **Emergency Department Information Exchange (EDIE):** pulls in real-time hospital admit/discharge data and notifies EDs about high-risk patients at the point of care
  - Connected to all Oregon hospitals (except VA), all Washington hospitals, and some other neighboring states' hospitals
- **Collective Platform (fka PreManage):** access to EDIE's real-time information for the broader care continuum to coordinate care and share care recommendations for individuals at risk for high utilization

Who is on and using Collective in Oregon?

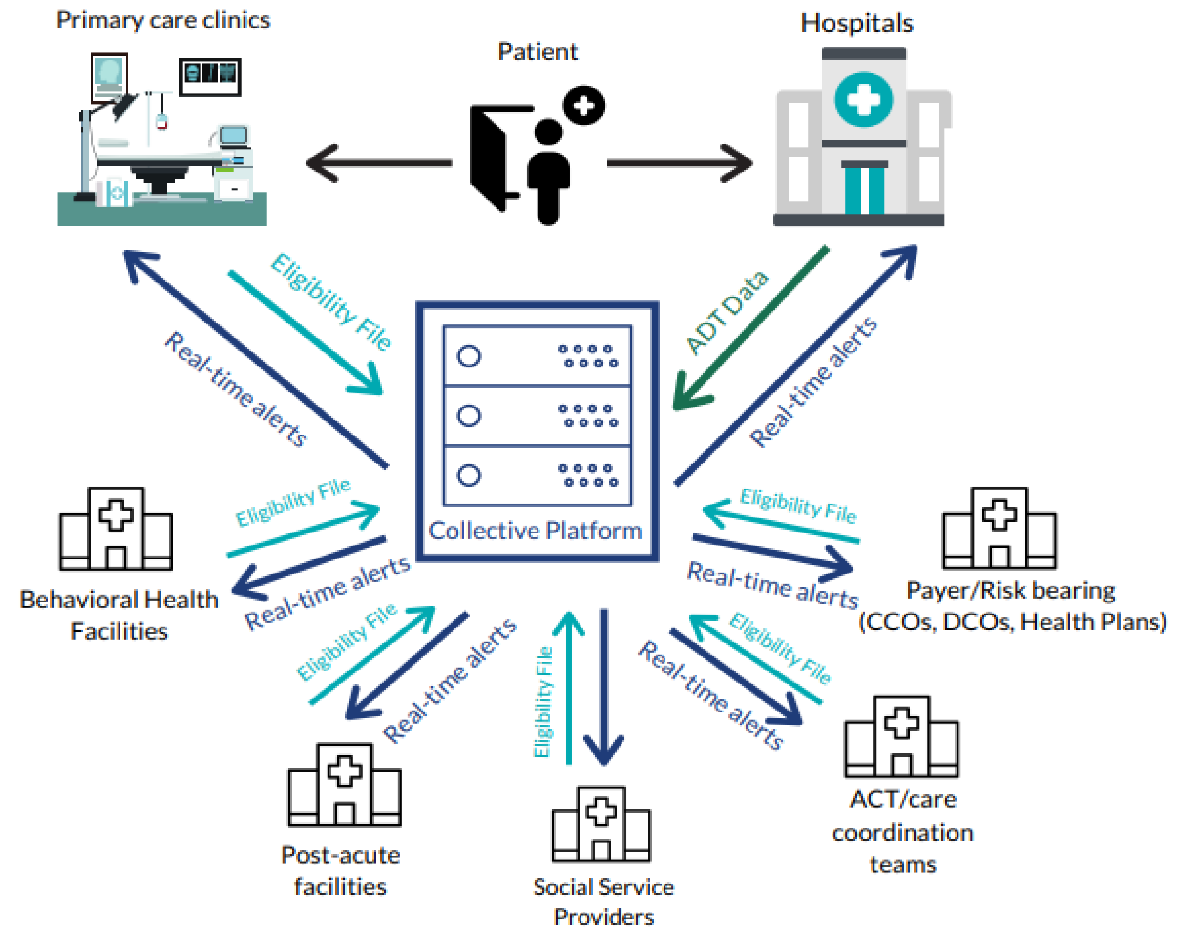


Overview of Collective Medical

EDIE notification: real-time notifications within the ED workflow (EMR integration, etc.)

- Common notification criteria:
  - 5+ ED visits in the past 12 months
  - 3+ visits in different EDs in 90 days
  - Active care insight on the patient
  - PDMP Criteria

Collective Medical 'platform:' web-based portal accessible by all system users



EDIE/Collective Funded Collaboratively

- Hospital access is funded via contributions from Medicaid (OHA), health systems, and health plans (utility model)
- Collective Platform/PreManage use is sponsored by payers:
  - Clinics and post acute providers typically pay no cost – use is sponsored by CCOs/payers
  - OHA sponsors CCOs, Medicaid FFS, Tribal clinics and OHA/ODHS users
  - CCOs and health plans pay to extend their subscriptions to their key clinics.
- Due to this funding partnership with CCOs, the Collective Platform includes a huge swath of clinics across Oregon.

EDIE/Collective Platform is a core program of HIT Commons, a public-private partnership of OHLC and OHA

CCO Requirements and Collective Platform

CCO 2.0 contract requires CCO use and support for clinic access to "hospital event notifications" tool, describe progress in annual HIT Roadmaps to OHA

Supports:

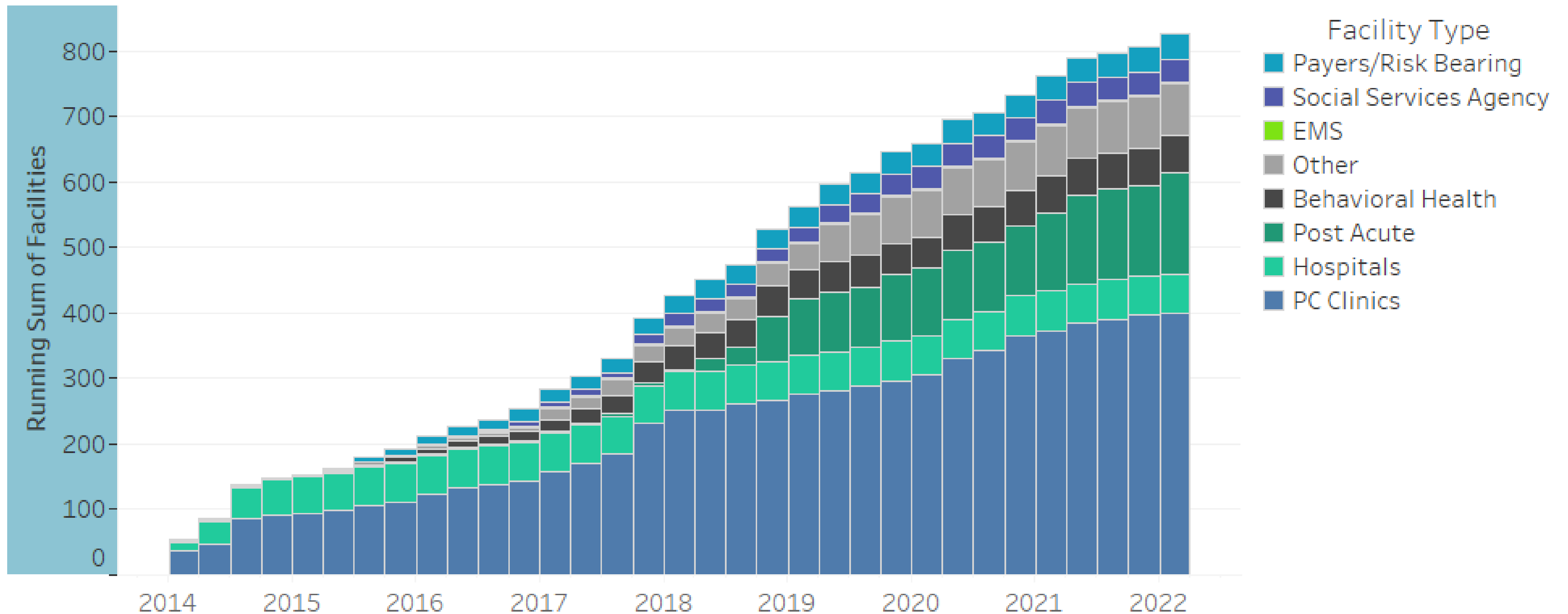
- Targeting high-risk populations, including many that face inequities due to racism and other social factors.
- Developing cohorts to track and notify CCO
- Follow up from ED/hospital events
- Proactive identification of high utilizers, population management and analytics
- Support value-based payment arrangements

Highlighted Use Cases from CCOs:

- Coordinating care plans across hospital, PCPCH, BH home, CCO
- SUD-IET metric
- Identifying homeless/at risk individuals
- Sharing public health data

Oregon Health Authority

Adoption of Collective Medical platform in Oregon over time



Collective Platform – Evolving Scope over time

2014-2015: Hospitals establish real-time data network and notifications in the emergency department (ED)
Key Goal: Address avoidable ED Utilization statewide

2016-2022: CCOs and Health Plans implement Collective, sponsoring primary care and behavioral health clinics
Key Goal: Risk stratification and patient care coordination to drive better health outcomes across health continuum

2022 and beyond: expanding data capabilities and collaboration opportunities with long-term post acute care and non-health care entities
Key Goals: 1) incorporation of social determinants of health; 2) addressing transitions of care and readmissions to assist with cost and affordability of care

For more information

Oregon's EDIE/Collective Platform Collaborative at HIT Commons:
http://www.orhealthleadershipcouncil.org/edie/

OHA's contact:

Luke Glowasky, Health Information Exchange Programs Manager,
luke.a.glowasky@dhsoha.state.or.us

Oregon Health Authority

Collective Overview: Leveraging the Tool in Care Coordination

Summer Sweet
Triage and Data Integration Manager
Population Health Partnerships
CareOregon

careoregon.org
twitter.com/careoregon
facebook.com/careoregon

Collective Medical Overview*

The Collective Network and Platform

Collective Network

*Image/Information sourced from Oregon Health Leadership Council

Groups, Tags and Flags

Member Profile in ‘Premanage’ view allows you to see:

- Member demographics across multiple agencies
- Flags – shared tags from state and other entities
- Tags – these are the groups you have populated/added to the member profile

bers Given Elsewhere

	Facility	Type	Last Updated
209	Oregon DHS APD-AAA_		6/29/22, 9:24 AM
873	Cascadia Behavioral Healthcare		6/29/22, 5:01 AM
209	OCHIN		6/28/22, 3:06 PM
209	CareOregon		6/25/22, 7:24 AM
813	CareOregon Behavioral Health Population		6/25/22, 6:11 AM
209	Oregon Health Authority (OHA)		6/15/22, 8:17 AM
625	Legacy Salmon Creek		6/6/22, 12:50 PM
873	Legacy Salmon Creek		6/6/22, 12:50 PM
209	Cascadia Behavioral Healthcare		5/3/22, 10:01 AM
625	Reliance HIE		4/7/22, 3:03 AM
209	Providence_		2/8/22, 1:33 PM
209	Multnomah County Primary Care		1/25/22, 12:22 PM
209	Legacy Salmon Creek		1/17/22, 10:00 PM
209	Oregon Health and Science University		1/7/22, 4:18 PM
209	HealthShare		12/27/21, 9:15 AM
209	Adventist Health System	Primary Residence Number	11/16/21, 2:58 PM

Do Not Re-Disclose 42 CFR Part 2 or state confidentiality law

View More

CCD | Download PDF

Address	Phone			Gender
View More	View More	View More	View More	Male

Shared Flags from outside your Organization

Tags: COVID-19 Vaccine Moderna Dose 2 | COVID-19 Vaccine Moderna Dose 1 | BH and Diabetes | Oregon ED Disparity Measure

Active | Alert-DM | Alert-HTN | BH-Member/Provider Support | COBH-Multnomah | DUAL | EligCat-ABAD-MED | Extremely Complex | HS-ODS Dental | Medicare | MTMP | Plan-COA Plus | Plan-HSO-CO PH/MH/Dental | Primary Language -ENGLISH | RCT-Tilikum | Readmit Risk

Groups that are assigned by the Organization (also known as tags) - used to further identify populations to achieve more targeted cohorts.

Cohorts Page

Enables care team members to identify patients with a ‘visit of interest’ based on a specified criteria

Collective

Search for someone..

- Cohorts
- Census
- Scheduled Reports
- Groups
- Notifications
- Manage Facility
- Madeline's Skilled Nursing

Cohorts

0 Selected | Fri 10:27AM - Now | Sorted By: Count

Cohort	Events	Change	Activity
ED Admit Post SNF Discharge	Events 15	Change ↑67%	Activity
New Admissions	Events 8	Change ↑700%	Activity
2+ ED Visits 6 Months Prior to SNF	Events 7	Change 0%	Activity
Security Event	Events 6	Change ↑500%	Activity
IP Admit Post SNF Discharge	Events 1	Change 0%	Activity
Care Guidelines	Events 1	Change 0%	Activity

Learnings with Cohorts

Not Every Hospital Reports the Same, i.e. some report Chief Complaint (not able to capture in cohort) vs a Diagnosis

Diagnosis may be a 'Working' Dx or Self-reported and not a true Diagnosis. Consider dx codes as ***presumptive*** diagnosis

Need to be concrete on the criteria and specific, either use REGEX code sets or build off facilities and/or 'tags' or conditions

Can supplement the cohort with your own groups(tags or flags) provided

Cohorts may not be accessed at the same time each day therefore a ***'Daily Report'*** is recommended with at least a week to month lookback period (anchors off admit date)

Insights – Care History

Simple and Objective Patient History that is up to date

SUMMARY | MEDICAL/SURGICAL | INFECTION/CHRONIC | SUBSTANCE ABUSE/OVERDOSE | BEHAVIORAL | SOCIAL | RADIATION

+ Add Information

Medical/Surgical History

0 | 0 2016-09-01 Twin County Regional Healthcare James Fallon

- Asthma, uses inhaler 1-3 times a week.
- Eczema
- Food allergies

0 | 0 2016-08-03 Twin County Regional Healthcare James Fallon

Hospitalization today for asthma exacerbation.

COLLECTIVE HEALTH PLAN

Care Recommendation:

Patient previously responded well to 8 puffs of albuterol. After 1 hour had markedly improved retractions (still mild intercostal), good air movement in anterior and porterior lung fields, breathing in 20s with good oxygenation. Counsel family on at home asthma management plan and return precautions; verbalize understanding.

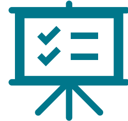
These are guidelines and the provider should exercise clinical judgment when providing care.

Created by James Fallon on Nov 16, 2017

Reports from Cohorts to Improve Workflow

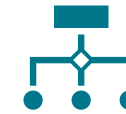
Recommend a week to month lookback period for OBS/IP– to catch members who may have not hit cohort prior – as the anchor date is based off 'admit date'.

Recommend a 1–7-day lookback period for ED – this is dependent on workflow, keep in mind ability to capture weekends in needed timeframe and prevents from needing to pull past reports.



Recommend including 'Flags Shared' in the report – this will include the ED Disparity, CareOregon RCT's, etc.

Include any of clinic's tags to identify populations, groups, priorities, etc.



Can include lookback periods for ED and IP utilization (i.e., counts of ED visits in 12 mths)

Can pull in multiple cohorts so have 1 file to process – dependent on Excel skills and potential reduction of duplication for outreach attempts.

Optimization of Your Collective Portal

What you can do to leverage the Collective Platform to improve your Workflows

- Move to Daily File Load from Monthly/Quarterly
- Include your entire clinic population
- Add tags to further identify and/or refine cohorts and reporting
- Use Cohorts to Target Unengaged Populations
- Add Care Guidelines for hard-to-reach population
- Add Insights to support a member's care plan/contract
- Leverage the Reporting to incorporate in case finding

For more information

CareOregon
Summer Sweet, Triage and Data Integration Manager
sweets@careoregon.org

Collective Medical
support@collectivemedical.com
801-285-0770

CareOregon®

Care Coordination/ICC Learning Collaborative

We are currently taking a short break.

We will resume the session soon.

Care Coordination Activities Reporting: January – June 2022 Reporting Period

July 21, 2022

Presented by:

Carrie Williamson and Dan Rembert

Reporting Template Changes

- Defined numerators and denominators with the intention of improving clarity of reporting elements and consistency in reporting.
- Reduction in narrative reporting elements and allowing for complementary reporting to quantitative data elements.
- Refinement of elements based on feedback from CCOs (e.g. “reassessment triggers” to “known reassessment triggers”).
- Refinement of template formatting for ease of use.

CCO Question

Q: Report 1 of 3 (Data) A3 - Member identified for care coordination outreach and engagement by REALD. In theory - all members of the CCO's are supposed to be in care coordination, however this question is asking how many we identified. Does that mean that it is acceptable for all members to not have care coordination?

A: All members are indeed eligible for care coordination. OHA recognizes that care coordination activities are varied with varying levels of engagement. The intent of this reporting element is to capture those members the CCO identified specifically for active outreach and engagement with care coordination programming/activities (e.g. engagement in condition-specific programs based on member needs).

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Баярлалаа
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Children's Health Complexity

07/21/2022

Intensive Care Coordination – CCO Learning Collaborative

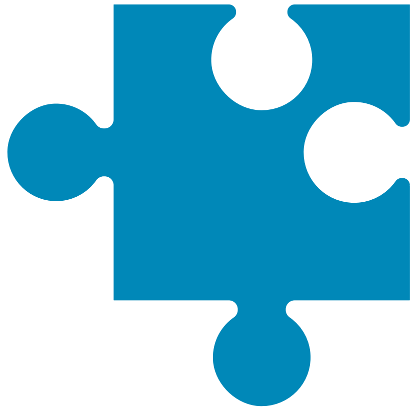
About Children’s Health Complexity

What is Children’s Health Complexity?

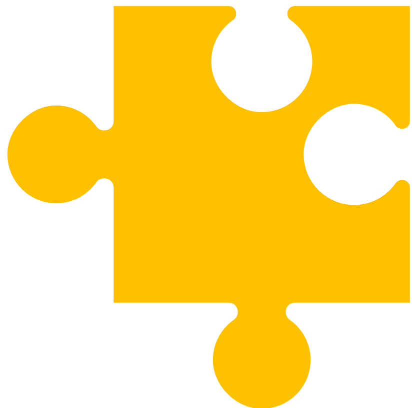
Children’s Health Complexity uses system-level data to identify **medical and social complexity factors** for children with Medicaid and CHIP in Oregon.

By identifying families that may experience barriers, we hope to create better systems, targeted services, and improved supports.

Children’s Health Complexity considers both medical and social complexity.



Medical complexity describes individuals who have a health condition or multiple conditions that require on-going specialized care. Chronic conditions, behavioral health conditions, and developmental disabilities are examples of conditions that can contribute to medical complexity.



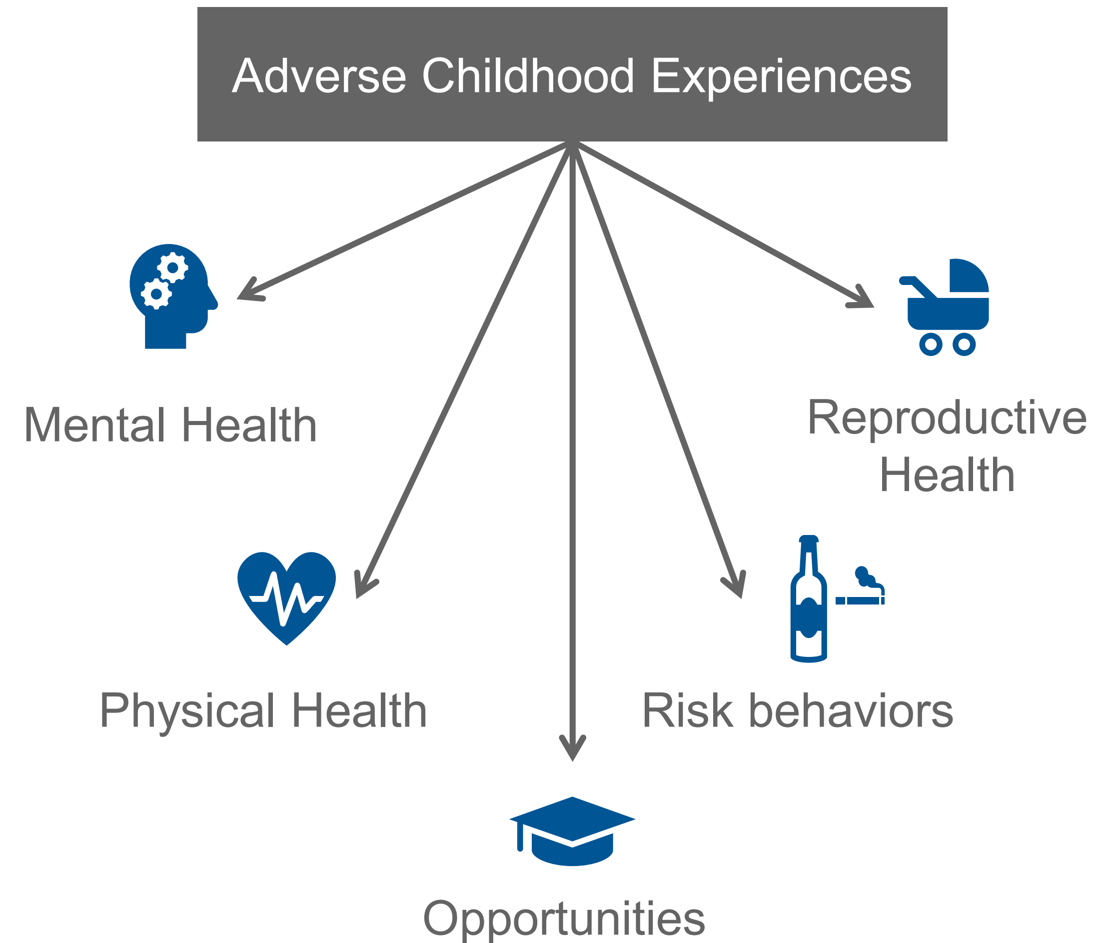
Social complexity refers to a set of individual, family, or community characteristics that impact a child’s health outcomes and may affect a family’s ability to access and engage in care.

We focus on health complexity for children because…

Lifelong health and well-being starts in childhood.

Social determinants of health, disparities, and adverse experiences are particularly impactful for children.

Children who experience complexity are at greater risk for poor health and social outcomes and have higher health care costs.



The program currently generates these products.

Public Facing Reports

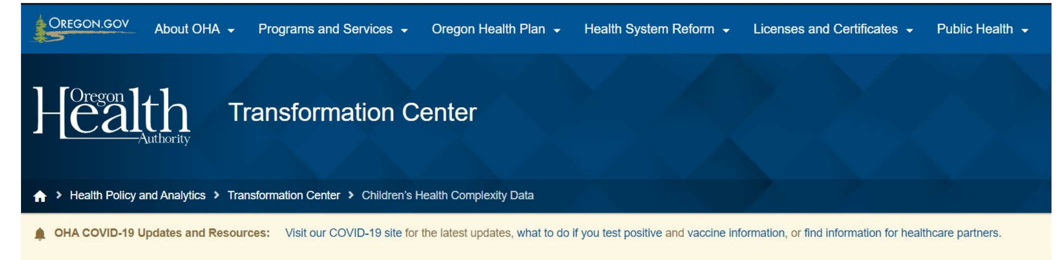
- State, county, and CCO
- Aggregate data
- Updated annually

Child-level Files (CCO's Only)

- Individual-level data for grouped indicators
- Currently enrolled CCO members
- Updated annually

Data Requests

- Ad hoc requests from CCOs and others



Statewide report

Health-Complexity-Cover-Letter-October-2021

Statewide-Report-2021-October

County reports

Baker-2021-October

Benton-2021-October

Clackamas-2021-October

Clatsop-2021-October

Columbia-2021-October

Coos-2021-October

Crook-2021-October

Curry-2021-October

Deschutes-2021-October

Douglas-2021-October

CCO reports

Advanced-Health-2021-October

AllCare-2021-October

Cascade-Health-Alliance-2021-October

Columbia-Pacific-2021-October

Eastern-Oregon-2021-October

Health-Share-2021-October

InterCommunity-Health-Network-2021-October

Jackson-Care-Connect-2021-October

PacificSource-Central-Oregon-2021-October

PacificSource-Gorge-2021-October

Children's Health Complexity data can help communities better support children and families.

- Identify service needs and gaps
- Engage partners across sectors
- Develop community-based solutions
- Address social determinants of health
- Connect children and families to tailored supports and services

Acknowledgements

The Oregon Pediatric Improvement Partnership (OPIP) has been a key partner in developing the methodology and providing technical assistance to communities. OPIP received funding from the Lucile Packard Foundation for Children's Health to support this work.

Office of Reporting, Research, Analytics, and Implementation (ORRAI) played an instrumental role in developing the methodology, providing data, and calculating indicators.

Office of Forecasting Research & Analysis - Integrated Client Services Data Warehouse

Health Policy and Analytics – Coordinates efforts, conducts analytics, manages data use agreements, communications, and distribution of data/reports

Health Complexity Data Indicators

Medical complexity is measured using the Pediatric Medical Complexity Algorithm (PMCA).

Using the PMCA, children fall into one of three categories:

No chronic condition/ healthy	Non-complex chronic condition	Complex chronic condition

Social Complexity is measured using both child and family level factors:

Child Level Factors	Family Level Factors
Child poverty	Parent poverty
Child abuse or neglect	Parent death
Foster care	Potential language barrier
Child mental health	Parent disability
Child substance abuse	Parent incarceration
	Parent mental health
	Parent substance abuse

Two-generation view on social complexity.

Data Sources

Indicator	Data Source	Data Provider
Medical complexity	Health care claims, OHA	All Payer All Claims (APAC) database
Child/ parent poverty	Temporary Assistance for Needy Families, ODHS	Integrated Client Services (ICS) database
Foster care	Child Welfare, ODHS	ICS database
Parent death	Vital Statistics, OHA	ICS database
Parent incarceration	Department of Corrections	ICS database
Child/ parent mental health	Mental Health, OHA	ICS database
Child/ parent substance abuse	Alcohol and Drug, OHA	ICS database
Child abuse and neglect	Medicaid claims, OHA	MMIS
Potential language barrier	Medicaid enrollment, OHA	ICS database
Parent disability	Medicaid enrollment, OHA	ICS database

2021 findings

Key findings from the 2021 statewide report

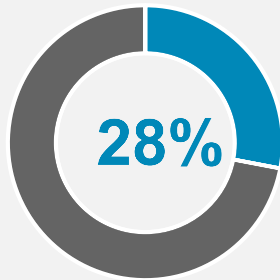
518,076

children and youth ages 0-20 with Medicaid or CHIP coverage are included in the 2021 report.

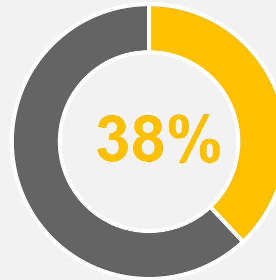
1 in 5 children has a parent who has been incarcerated during the child's lifetime.

2.4

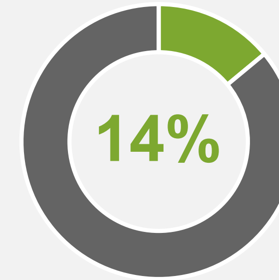
Children in this population have an average of 2.4 social complexity indicators.



28% of children have some level of medical complexity

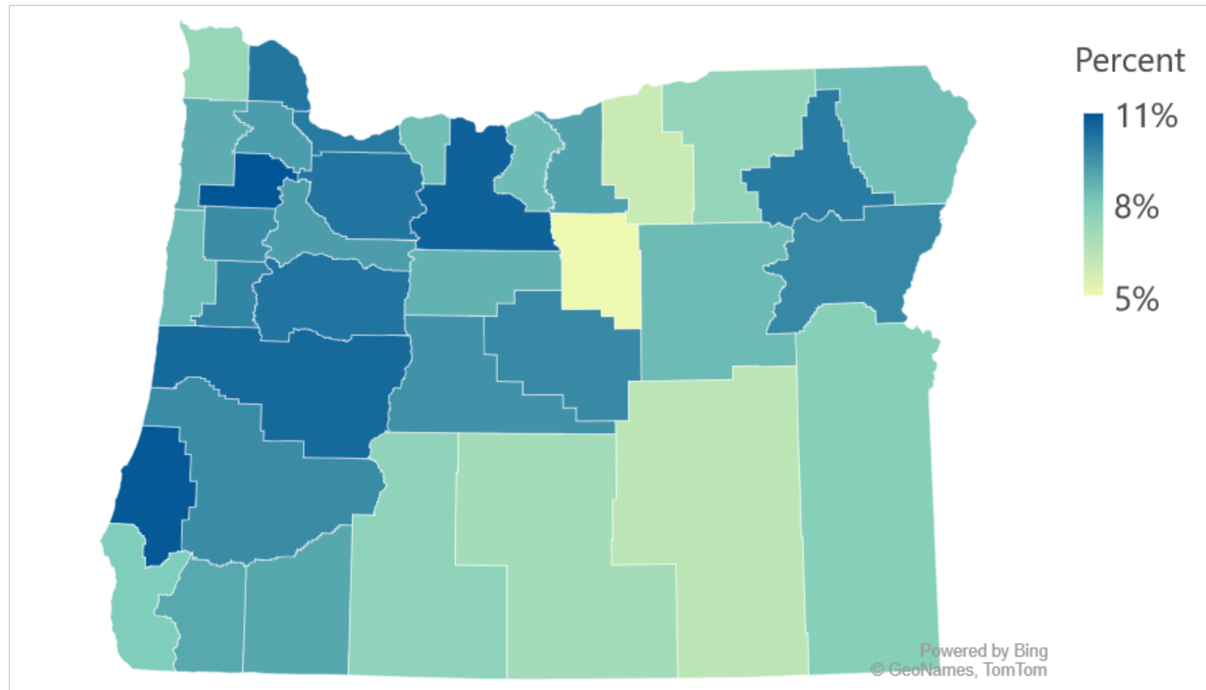


38% of children have had 3 or more social indicators in their lifetime

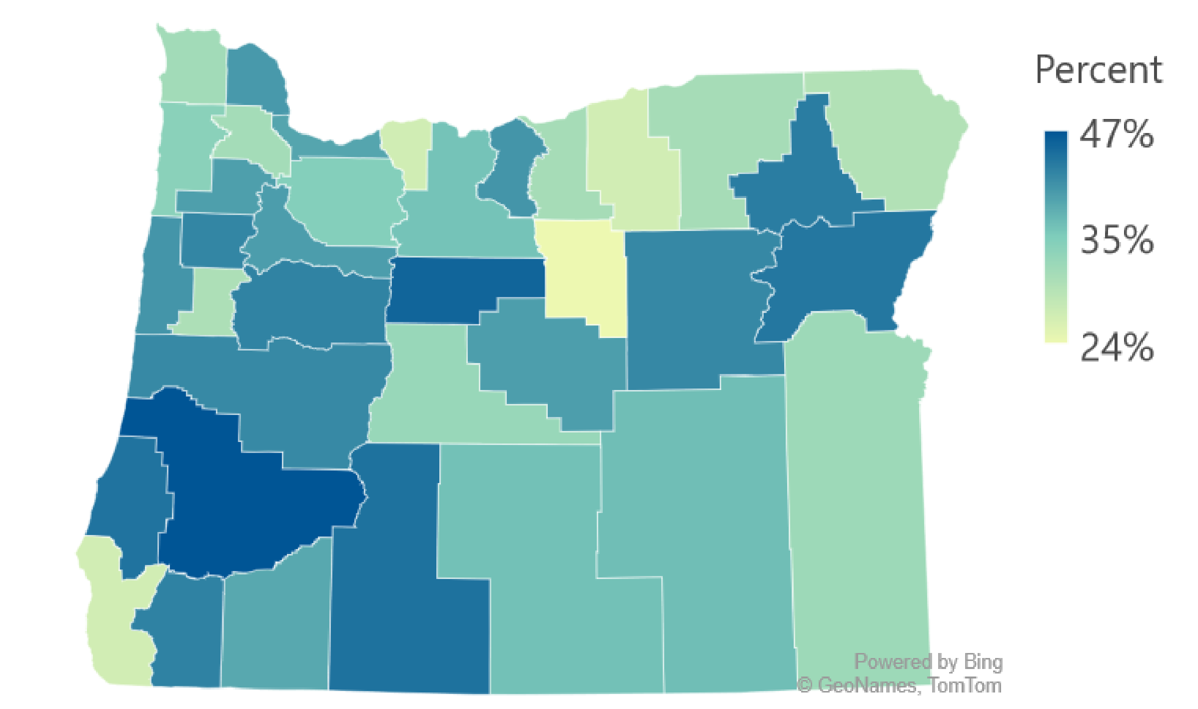


14% of children have both medical complexity AND 3 or more social indicators

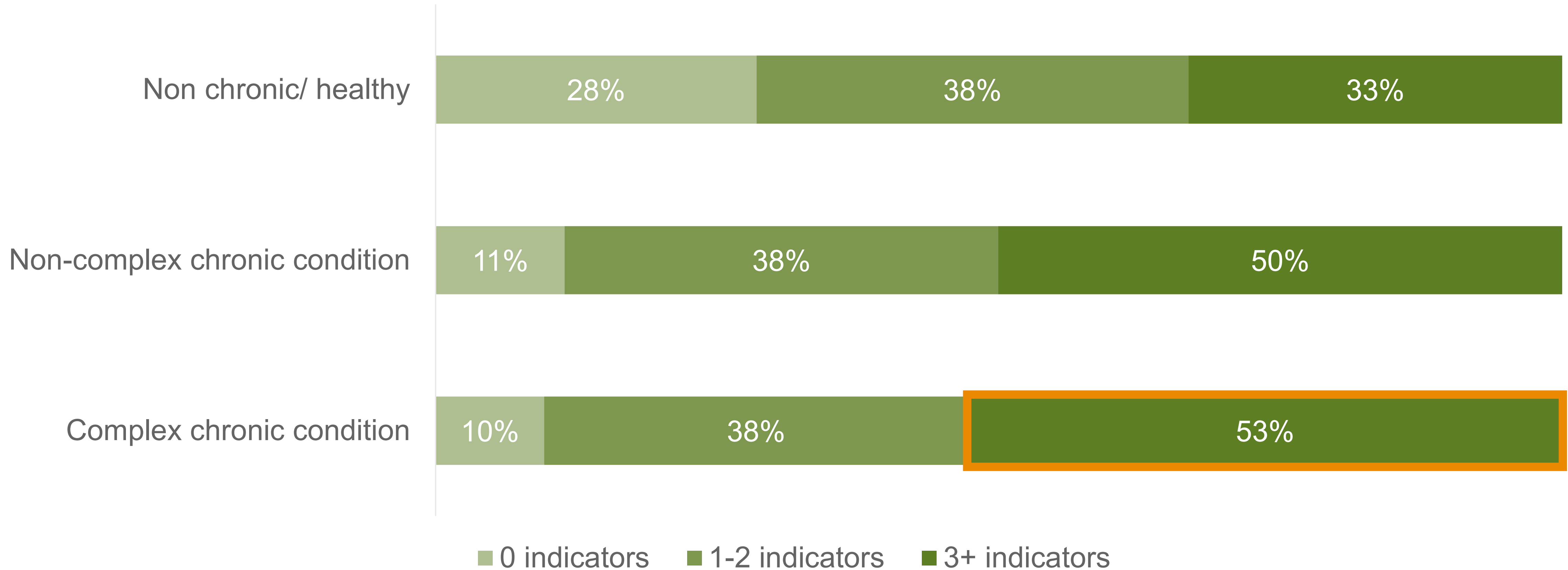
In Oregon, 10% of children statewide have complex chronic conditions.



In Oregon, 38% of children statewide have 3+ social complexity indicators.

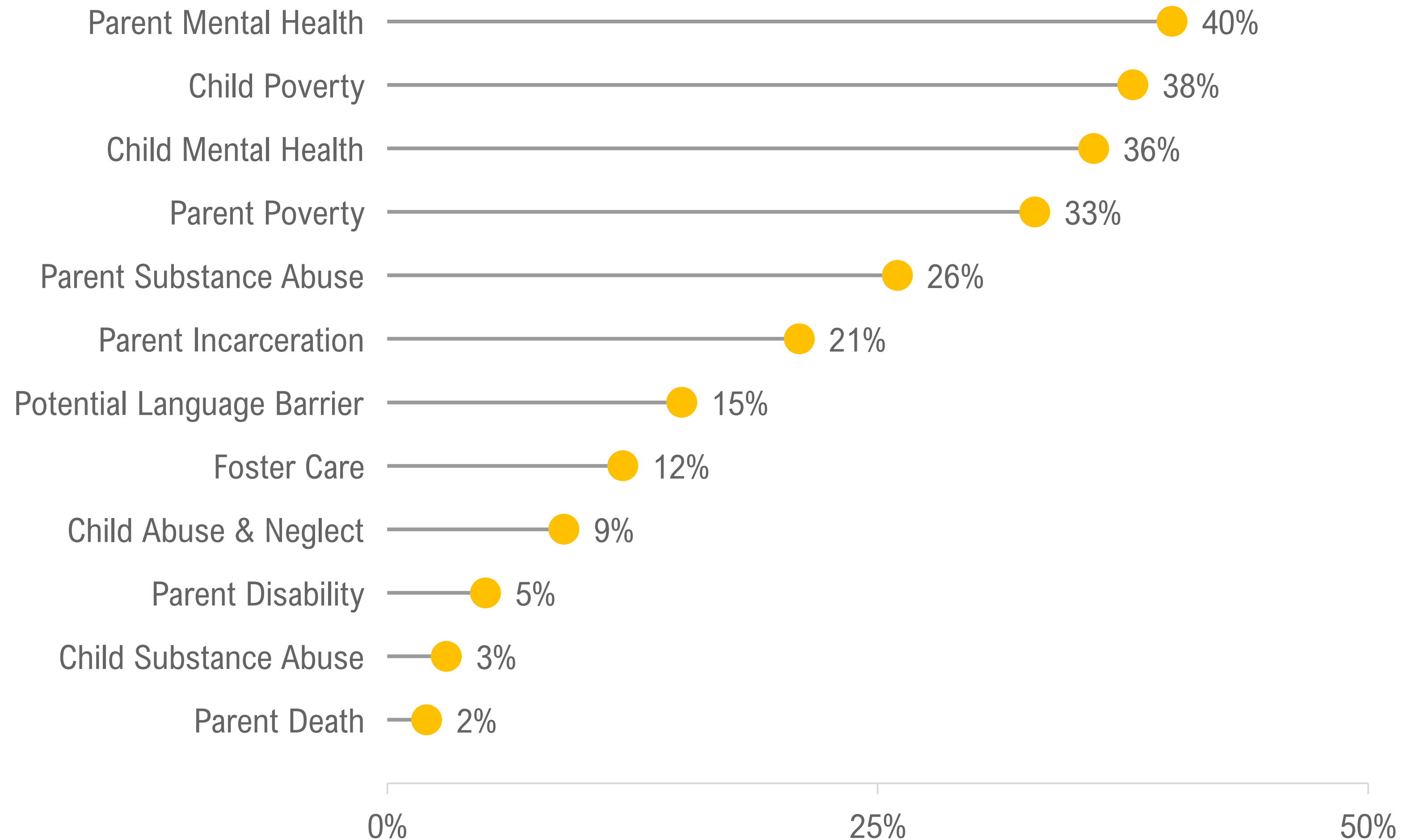


Children with medical complexity also tend to have more social indicators.

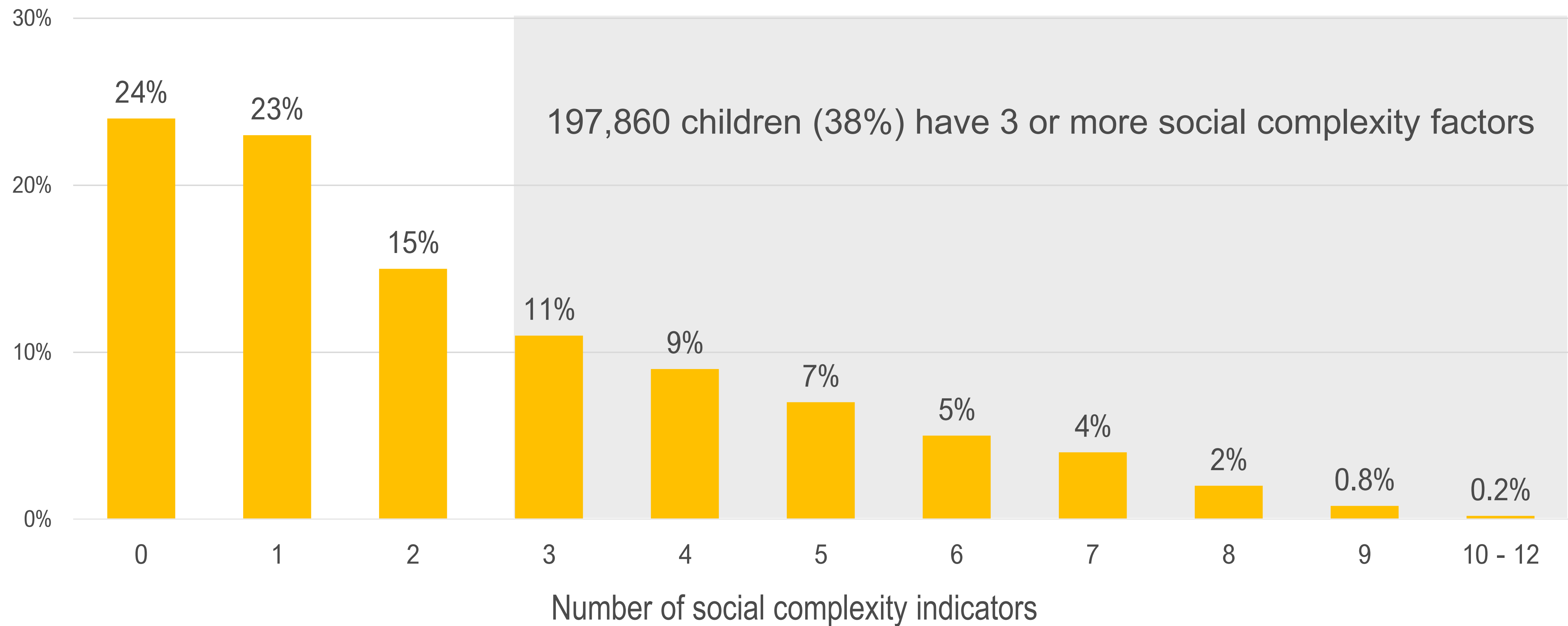


OPIP 9-part categorical variable developed by OPIP

Parent mental health is the most prevalent social complexity factor.



This chart shows the distribution of children by how many social complexity factors they have.



Avoidable ED Visits

Complexity Factor	Rate per 1,000
Overall CCO Member Level File	***6.1***
Overall Child Health Complexity Population	***5.8***
Social	
3 or more factors	7.0
1-2 factors	5.5
None in System-Level Data	4.1
Medical	
Complex Chronic	8.6
Non-complex Chronic	6.7
No Medical Complexity	5.0

Key Takeaways

Avoidable ED visit rates are **higher** among populations with **more social factors.**

Avoidable ED visits rates are **higher** among populations that are **more medically complex.**

Avoidable ED Visits

Complexity Factor	Rate per 1,000
Overall CCO Member Level File	***6.1***
Overall Child Health Complexity Population	***5.8***
Health	
Complex Chronic, 3+ Social Factors	9.8
Complex Chronic, 1-2 Social Factors	7.7
Complex Chronic, 0 Social Factors	6.0
Non-Complex Chronic, 3+ Social Factors	7.2
Non-Complex Chronic, 1-2 Social Factors	6.3
Non-Complex Chronic, 0 Social Factors	5.7
Healthy, 3 + Social Factors	6.1
Healthy, 1-2 Social Factors	5.0
Healthy, 0 Social Factors	3.7

Key Takeaways

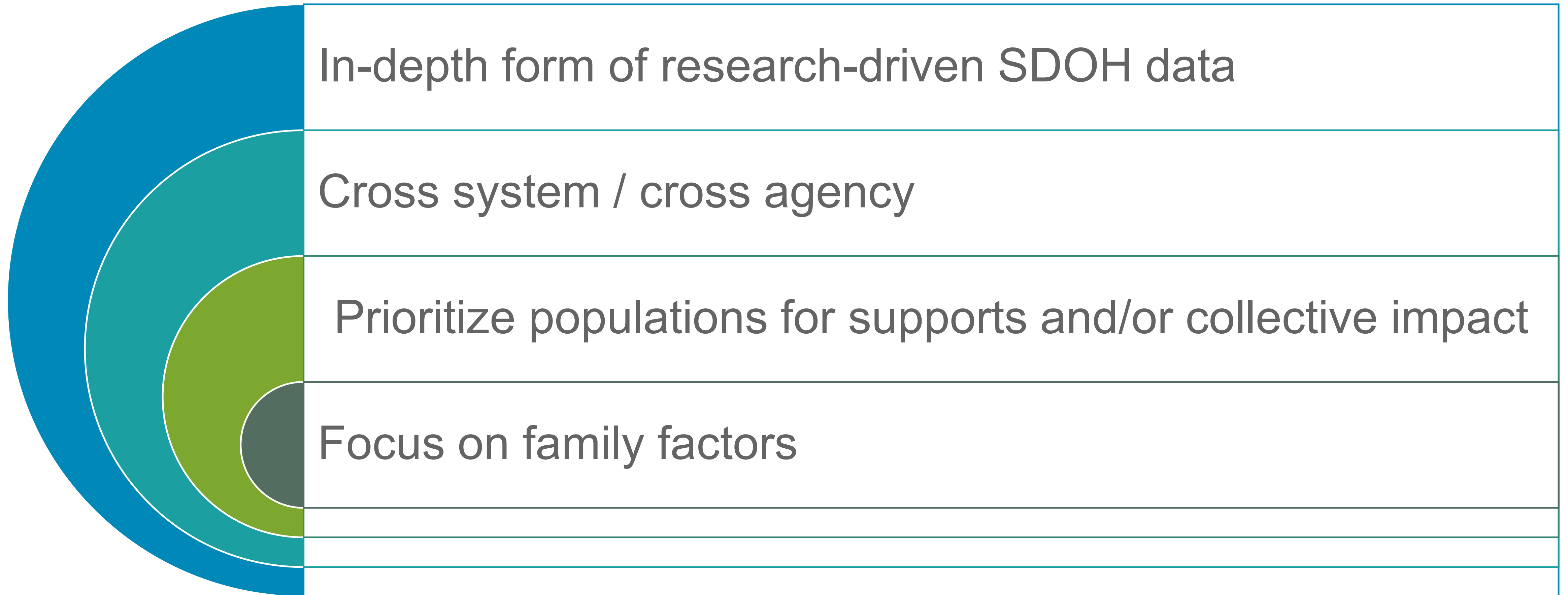
Children with **Medical and Social Complexity** have highest avoidable ED visit rate.

For **medically complex children**, avoidable ED visit rate is higher as social factors increase.

Medically complex children have similar avoidable ED visit rate as **healthy children with high social complexity.**

CCO Feedback and Discussion

Unique Value of Children's Health Complexity



Children's Health Complexity uses system-level data.

Data Uses

Sources capture enrollment in programs and service utilization

Data represent most children and youth who have Medicaid/CHIP coverage

Data can be linked across programs

Data Limits

Data do not well represent the resiliency and self-efficacy of children and families

Data do not provide a complete view of how children and families interact with systems

Data do not capture all of family needs

Questions and Discussion

1. Questions about the data?
2. Do you currently use this data source? How? If not, why – feedback on what would be of most value.
3. Other data used to guide outreach and engagement of children/families facing medical and social complexity?
4. More generally to best service children and families managing health complexity:
   - Data you wish you had?
   - Things that could be improved?

Thank you!
HealthComplexity.Program@dhsoha.state.or.us
https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Child-Health-Complexity-Data.aspx

Upcoming Sessions

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

Oct 20: TBD

Nov 17: TBD

Dec 15: TBD

What would you like to have covered during final three months of the LC series?

Oregon Health Authority

THANK YOU!

See you next month
August 18, Noon – 2pm

Please provide learning collaborative session feedback and input on final three session topic areas:

https://forms.office.com/r/CW2pn5Z0uf

Oregon Health Authority