

Oregon's Integrated Care for Kids (InCK) Model: Overview

Seven Year Cooperative Agreement from the Centers for Medicare and Medicaid Services (CMS) to the Oregon Health Authority, with the Oregon Pediatric Improvement Partnership*. Pre-implementation and planning period: 2020-2021 • Implementation : 2022-2026

Goals

1. **Improve health outcomes** of children/youth age 0-21
2. **Reduce out of home placements** such as foster care and residential behavioral health
3. **Reduce costs** associated with unnecessary ER visits and inpatient stays

Population of Children to Receive InCK Model

All **Medicaid/CHIP** enrolled children ages 0-21 residing in **Crook, Deschutes, Jefferson, Marion and Polk** counties. Efforts will target prevention and needs screening for children in order to provide enhanced access and service connection. The implementation of a stratification plan will identify subsets of at-risk children to receive targeted best-matched supports and care coordination.

InCK Model Components For All Children and for a Subset of Children

Level 1: All Children (ages 0-21) in the Model Area Covered by Medicaid/CHIP



Active Monitoring
Preventive care

- Ensure access to preventive care, mobile crisis response.
- Screening of children and their families for housing & food insecurity and connection to services.
- System-level data used to create indicators of a child's medical and social complexity in order to identify priority populations of children at-risk for at home placement and/or high-costs.
- Enhanced data tracking and data integration across sectors.

Level 2: Children Identified Through System-Level Data or Front-Line Screening as At-Risk for Out of Home Placement and High-Cost Events (Subset of Level 1)



Enhanced
assessments
and screenings
Best Match Care
Coordination

- Strength and needs assessment conducted with child and family.
- Connection to services if need identified.
- Provision of care coordination.
- APM models developed and implemented to support enhanced assessments and coordination components.
- Enhanced data tracking and data integration across sectors.

Level 3: Children Identified in Level 2 Needing More Intensive Supports (Subset of Level 2)



Integrated Case
Management &
Child-Centered
Care Planning
Home and
Community-
Based Supports

- Provision of more intensive supports addressing health and care needs.
- APM models developed and implemented to support enhanced complex care coordination.

Regional Activities & Supports Funded by Project

- Regional Partnership Councils.
- Parent & youth engagement.
- Partnerships with racial and ethnic communities most impacted by health inequities.
- Provision of system-level risk stratification data by OHA.
- Region-specific Service Integration Coordinators.
- Health information exchange/Community information enhancements.
- Infrastructure supports to operationalize screening.
- Training on best-match care coordination supports.
- Development and implementation of Alternative Payment Models (APM), in collaboration with PacificSource Community Solutions in Central Oregon & Marion and Polk to align payment with care quality and accountability for improved child health outcomes.

*<https://www.oregon.gov/oha/ERD/Pages/Oregon-Health-Authority-awarded-16-million-improve-child-health.aspx>.