Oregon's Integrated Care for Kids (InCK)
Final Marion County and Polk County Partnership Council Meeting

December 16th, 2021

Acknowledgement of Funding:

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- *The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS, HHS or the U.S. Government.*

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  - **Oregon Health Authority (OHA)**,
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  - **Oregon Pediatric Improvement Partnership (OPIP)**
- **Hearing from the Community**:
  - ❖ High-Level Summary of Learnings and Hopes from **the Parent, Youth and Young Adult Advisory Group** (Includes representative from the PYYAAG at the Meeting)
  - ❖ Hear from those leading **community-level efforts for which we had aimed to build synergy**: Willamette Health Council, CP3, CBEL and BCR, Early Learning of Hub of Marion and Polk/Family Connects, Fostering Hope
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Some themes from partners on what would of value to continue…

InCK brought…

- **state data on children's health complexity** critical to better serving children and families
- **framework** for prioritizing children and families, especially those with complex health needs
- **systems coordination and alignment** focused on children and community-driven
- opportunity for additional alignment and focus on **child-welfare/foster population**
- additional attention to **social determinants of health**
- a **shared commitment to equity** and seeing children, youth, and families through a **strengths-based lens**

Examples of Children, Youth, and Families in the Waiver

If approved by the federal government:

Coverage

- Provide **continuous OHP enrollment** for children until their sixth birthday (age 0-5).
- Establish **two-year continuous OHP eligibility** for people ages six and up.
- Provide a direct enrollment path to OHP for people who apply for **Supplemental Nutrition Assistance Program**

Examples of Children, Youth, and Families in the Waiver

Transitions Services

Develop and fund a defined set **of social determinants of health transition services**

Some examples:

- Youth eligible for Medicaid entering the **juvenile correction system** would retain or acquire Medicaid benefits
- **Youth with Special Health Care Needs (YSHCN)** would retain child eligibility levels and benefit packages **up to age 26**
- Expand and fund access to **Traditional Health Workers, particularly peer delivered services (PDS)**

Some Examples of Children, Youth, and Families in the Waiver

Move to Flexible Spending for Health Equity

Communities can prioritize the needs of children and youth, including **those with health complexity,** through a **stronger community voice** in local health spending decisions.

Some Examples of Children, Youth, and Families in the Waiver

Incentivize Equitable Care

"Upstream" health equity metrics for CCOs that focus on children and youth, SDOH, and system coordination.

Examples:

- **CCO System-Level Social-Emotional Health Metric** (incentivized in 2022)
    - Part of Health Aspects of Kindergarten Readiness
    - Developed by OPIP and Children's Institute
- **Social Determinants of Health Measure** (incentivized in 2023)

Future Opportunities

Children's Health Complexity Data

Policy Opportunities

Community and Cross-Agency Partnerships and Coordination

Thank You

Contact:

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Nikki Olson, Integrated Care for Kids Director Nikki.Olson@dhsoha.state.or.us

Oregon Health Authority

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Integrated Care for Kids (InCK) Reflections

Marion-Polk CCO

PacificSource Community Solutions

Learnings Overall

- This is the right work.
- Child Health Complexity Data is a tool to be leveraged for future care management, population health and quality improvement work.
- We are set up for success on the new Social Emotional Health Quality Incentive Measure (QIM).
- Opportunity for continued alignment with:
  - CCO strategic priorities (e.g. Connect Oregon and Traditional Health Workers); and
  - Cross sector partnership work (e.g. via the Willamette Health Council and local Collective Impact initiatives).

Implications for Future Work – Child Health Complexity Data

- Developing a pediatric health complexity dashboard for use across PCS CCO regions.
  - Ex: Will share with CBEL starting in Q1 2022.
- Opportunity to use the data to:
  - Perform member risk stratification;
  - Identify members for specific programs;
  - Align with on-going health equity efforts;
  - Support CCO-provider population health management; and
  - Inform community health priority setting and investments.

Implications for Future Work – Social Emotional Health QIM

- Launches in 2022.
- Focus is on 0-5 year-olds.
- Components mirror InCK Model requirements:
  - Use of child health complexity data;
  - Asset mapping to understand current programs/services and gaps;
  - Community engagement to inform and monitor the work; and
  - Action planning for targeted improvements.
- Plan to closely partner with the Marion & Polk Early Learning Hub and the Willamette Health Council to establish a community steering body.

Marion-Polk Asset Map

- Overview & key findings
  - Benefit to community partners
  - Resource gaps
- Supporting Connect Oregon network development and Child Social Emotional Health strategic efforts moving forward.
- For a copy of the Asset Map, please email Samantha.Baker@pacificsource.com.

Thank you!

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OPIP's Learnings from Pre-Implementation

- InCK was and remains the **right work, for the right population, at the right time**.
  - For work OPIP was involved, we wrote InCK to address and build off last decade of experience of needs and opportunities.
  - Pre-implementation confirmed it was the right direction, magnitude of children identified in Service Integration Levels 2&3 was significant when paired with the low numbers receiving services.
- Authentic **Collective Impact Model is needed**: Shared vision, language and metrics
  - Value of neutral convener, bringing different groups to the table
    - ❖ Reason OPIP proposed leading the Partnership Council and work, Given our past experiences.
  - Need for **facilitation across sectors**
  - Non Medicalized Models of Population Approaches, "No Wrong Door", Anti-Stigma, Build Family Confidence and Community
  - Within each core service there are systems & processes, yet some have gaps

OPIP's Learnings from Pre-Implementation

- **Community** and **person-level** use of the data to **BUILD and support integrated systems** that children and families experience
  - Need for a **community- and population-based** approach
    - Need to go beyond the medical model
  - **Sharing, "sense making" and applied USE of the data** at a child-level, across partners
  - Need to address **gaps in the systems and services that support health complex children**
    - InCK implementation was going to be focused on **enhancing and expanding** services
  - Need for efforts that go beyond **screening/passing data flags,** but that focus on **connection and integration** of services
  - Need for **curriculum, coaching and supports** of what it takes to serve health complex children
    - Unique needs & strategies for health complex children, importance of strength-based approach
    - Support **authentic collaboration and awareness** of services that makes closed loop referrals possible
  - Need for **proof pilot models** of authentic **family- based** approaches and **dyadic-based approaches** to care and care coordination that address the needs of the **adult and the child (or children in the family)**
  - **Need** to be informed **by persons with lived experience**

OPIP's Plans for 2022 and Beyond

OPIP has a **unique skill set** we want to leverage in our work moving forward which includes:

- **Leading collective impact work** focused on children
- Supporting technical assistance and facilitation to **operationalizing implementation on the ground-level for children and families**
  - Good idea → to action that impacts children
  - Expertise on what is needed specifically for children with health complexity
  - This work is **relational and "relationships matter"**
- Supporting an approach that **centered in & considers health equity**
  - Location, Race-Ethnicity, Tribal, Level of Social Complexity

Given OPIP is funded through grants and contracts, we plan to explore work that:

- Possibly within the region if funding and partners identified, outside region give feasibility of finding funding
- Leverages **OPIP's unique skill sets** to lead **cross-sector, system and front-level** improvement efforts
- Supports **work aligned with the priorities and needs identified**
- Engages with **community partners ready and committed** to improve systems for health complex children
- Ensures **parent, youth and youth adult voice** and oversight

Examples of Areas OPIP is Considering

- Our team is listening to areas highlighted today with deep curiosity
- Informed by individual interviews with Partnership Council members, starting point partners, and **Parent Youth and Young Adults**
  - Reflecting on the December 2020 Community Café , Spotlighting need for InCK's Support of **Cross Sector Work,** Non Medicalized Models of Population Approaches, "No Wrong Door", Anti-Stigma, Build Family Confidence and Community
- Considering population based approaches to facilitate **community improvement efforts** focused on **areas such as:**
  - **Birth to Five**: Models to build health and resilience for young children with health complexity
    - Early identification and meaningful connection to the right services.
    - Dyadic plans of care that focus on attachment and root cause parental factors (behavioral health, SDOH factors)
  - Care coordination and integration models for children with health complexity that involve multiple sectors (physical, behavioral, public health) and **peer to peer** supports, **including schools**
    - "Conscious Partnering"
    - Integrated care plan
    - Navigation supports
  - **Care coordination models for highly medically complex & socially complex** for which the primary care home is not the central node

Oregon's Integrated Care for Kids (InCK) Parent, Youth, and Young Adult Advisory Group:

High-Level Summary of Learnings and Hopes from the Parent, Youth and Young Adult Advisory Group

OPIP

Opportunities We Had to Learn from the PYYAAG in 2021

1) Care maps each member developed

- Who they put in their care map and who they didn't
- Services members wished were on the care map
- Given the goal of InCK was to better integrate care and take the burden off parents, youths and young adults to coordinate care, OPIP considered how much the care maps reflected whether that was happening already or not

2) Individual follow-up meetings

3) October 2021 group meeting- Across regions

- **Pre-reading including word clouds from the meeting.**

Best Match Care is Person & Family Centered, Strength-Based

- Each of the PYYAG members have individual and family characteristics that impact their ability to access and manage care.
  - Health care is one part of their life, not the central part.
- Many families have multiple children with multiple needs; importance of taking into account and understanding the family unit when participating in care planning
- Connection to community and addressing social connections & supports is critical to health

Punchline:

- Care plans that are centered around a specific kind of provider or a specific medical or health condition miss other factors that impact the family
- Burden to connect all pieces falls upon families
- Accessible and covered behavioral health services are a priority

Learnings relative to policies, structure, processes and opportunities within OHA overall and for CCOs like PacificSource Community Solutions:

- Value of an **advisory council** of **parents, youth and young adults** that can share specific issues relative to children with medical complexity and behavioral health needs.
  - Advise their care coordination programs, centralized supports, efforts focused on children
- Policies, metrics, and care coordination models should focus on ways to view the **family as a unit** – parent(s) and child(ren) - and support the whole group overall.
  - Focus on the strengths of the family, then ask about their needs and obtain context.
  - Consider using care maps to understand context and balancing act.
  - Peer to peer models that are in places you trust and go to in the community.
- Strong **primary care homes are necessary, but not sufficient to meet the coordination needs** of children with medical complexity and behavioral health needs.
- Consider ways that **paperwork and eligibility criterion** can be streamlined. Easier and faster ways to ensure coverage of services for children with medical and behavioral health needs.

More learnings relative to policies, structure, processes and opportunities:

- **Specific gaps in access to, services for, and coverage of**:
  - Behavioral health
  - Wraparound or comprehensive care supports
  - Inpatient behavioral health
  - Oral health
- Targeted focus on **community engagement and coordination with schools** for children with medical and behavioral needs for which the system doesn't coordinate well.
- For **adolescents transitioning to young adults**, supports for the primary role of overseeing health care and health care services and for supports that address work and life.
- **Centralized case Management** was requested by all members, across services, and positively received by those who had a case manager in the past.
  - Important to note: for these medically and socially complex, the PCP was not the right place
- An online **Centralized Hub** for sharing information across specialists and school professionals was recommended by group members.

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Willamette Health Council

Justin Hopkins

CP3

Najia Hyder

Family Connects & Fostering Hope

Lisa Harnisch

CBEL & Building Community Resilience

Jim Seymour

Break

- Optional Self-Led Activity: 2021 Reflection
  - Grab a piece of paper and a pen
  - Spend a few moments reflecting on the following questions:
    - **What were the top three 'highs' and three major 'lows' of the year?**
    - **What enabled us to reach those 'highs' and how did we successfully move through the 'lows'?**
  - When completed, type in the chat box ***one word*** that expresses your intention for work as we enter a new year.

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If you could wave your magic wand, ***where would you want to see funding and efforts explored*** *to sustain elements of InCK* (ideas we heard from members during close out interviews). **CHECK ALL THAT APPLY FOR YOU.**

1. **Community-Level Meetings** to Ensure Shared Focus, Synergy of Efforts Across Stakeholders (*Shared language, Shared Metrics*)
2. **Data Sharing**: Community-level, practice-level sharing of data AND supports for USE of the data
3. **Implementation Project** : Ensure Health Complex Children Get **Physical, Behavioral and Health** Related Needs Met.
4. **Implementation Project**: Complex HEALTH care coordination
5. **"Proof Pilot": Dyadic** (Parent and Child)/Family Based Approaches to **Behavioral Health** Supports
6. **"Proof Pilot":** Building Health and Resilience For **Birth to Five**
7. Others – SHARE at your break out group

Small Group Conversation:

Three Questions We Have for You:

1. Is there anything that you would like to **share about the impact that the INCK** effort had in your region?

2. Of the broad and deep efforts that were proposed with InCK, what were the most **essential activities** or **populations** that you think should be considered to sustain or support a focus on for the future?

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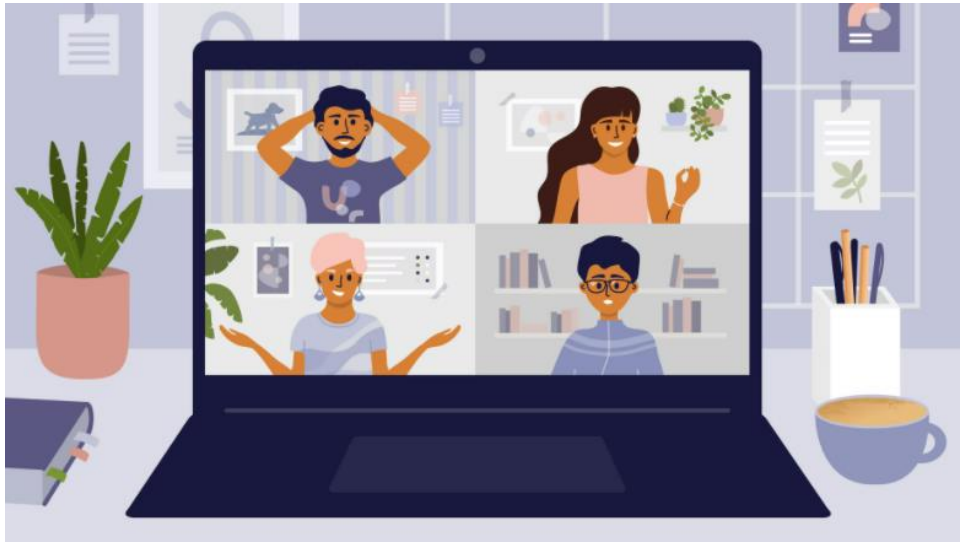


THANK YOU!