





Oregon's Integrated Care for Kids (InCK):

Distilled Learnings –Session 1

Topic: Care Management (ICC), Wraparound & Behavioral Health

November 17, 2021

Oregon Health Authority

OPIP

PacificSource

Agenda

1. Welcome and Meeting Overview including Overview of Time Keeping
2. Organizational Learnings of key learnings from the InCK model pre-implementation period
   - Pacific Source Sharing Key Findings from Workstreams that relate to ICC, Wraparound, Behavioral Health
   - OPIP Sharing of Key Learnings, Opportunities Related to Care Management/ICC
   - OPIP Sharing of Key Learnings, Opportunities Related to Wraparound
   - OPIP Sharing of Key Learnings, Opportunities Behavioral Health

Overall Framing: Context to OPIP Sharing

- Learnings that led OPIP to spend a year of unfunded time co-writing the InCK grant
  - PCPCH learning collaboratives, integrated behavioral health
  - Behavioral health pathways and supports that exist for children
  - Health complexity- magnitude and breadth of children with needs
  - Pediatric complex **health** management, what is takes

Structure of our Feedback:

✓ Level set of what observed for our starting point.

✓ Summarize themes identified, infused community-level feedback

✓ **Offer solutions**

✓ End with 5 minutes of reflection and questions on themes given 1.5 hour meeting, so hold questions until the end.

Intensive Care Coordination: **OARs and Alignment with CCO 2.0 Requirements**

Per OAR 410-141-3860/3870:

CCO 2.0 Priorities:

ICC elements include assessment and assistance with:

- timely access to and management of medical providers including physical health, behavioral health, oral health, remedial, and supportive care and services coordination with medical and LTCSS providers to ensure consideration is given to unique needs in treatment planning;
- coordination of capitated services and discharge planning;
- coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.

Populations identified for ICC that are Reflected in Health Complexity Data

- Children in foster care or under the custody for DHS
- Incarceration,
- Suicide,
- Unmet mental health needs,
- Substance use disorder,
- Poverty
- Prioritize access for pregnant women and children ages birth through five years to health services, developmental services, early intervention, targeted supportive services, and behavioral health treatment

Learnings from InCK to Inform Meaningful Operationalization of Intensive Care Coordination OARs in Alignment with CCO 2.0 Requirements

As You Look Forward Three Opportunities and Needs Identified by the Community and Parents, Youth and Young Adults

1. **Leverage the Data** You Have to Better **Engage and Outreach** to Children and Families Who Likely Have Care Coordination Needs

2. Refine, Enhance, and Improve ICC model to **Match the Care Coordination Needs of Health Complex** Children and the **Magnitude of Children that Have Those Needs**

3. **Address** Referral Pathways to ICC & Closed Loop Communication with Contracted Providers

#1) Leverage the Data You Have to Better Engage and Outreach to Children and Families Who Likely Have Care Coordination Needs

- **Child health complexity** indicators & other variables (DHS) provided by OHA to all CCOs aligned with populations specifically identified in ICC
  - Review by **region** to ensure equity and fidelity of services
    - Geomapping with attributed population
    - Concern about children in Jefferson County and Polk County specifically
- The populations identified by health complexity (medical and socially complex) are of often people that need **care coordination services beyond the traditional Patient Centered Primary Care Home.**
  - Partnership Council Community Café (December 2020)
  - Baseline Assessments with PCPCH
  - PYAYG feedback
- Build off amazing internal work done by PCS has **created additional variables aligned ICC**.
  - Enhancement to Social Complexity Variables (Parental SUD)
  - Parent/Child Dyadic – Could be used to support dyadic care management
  - Family Unit -- Could be used to support family unit care management
  - Rolling denominator of children new to foster care (Create a new "Child welfare involved" variable).
- OHA could consider **future enhancements to provide the 2A/3A** variable given alignment with focus on child welfare and predicators of out of home placement

PacificSource CCO - Central Oregon

Health Complexity: Categorical Variables Related to Medical and Social Complexity

Page 8 of the CCO-Level Report: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/PacificSource-Central-Oregon-2021-October.pdf

MEDICAL COMPLEXITY (3 Categories)	SOCIAL COMPLEXITY (Total Factors Possible in Preliminary Data Shown Here =12)		
	3 or More Indicators	1-2 Indicators	None in System-Level Data
HIGH Medical Complexity (Chronic, Complex PMCA=1)	5.0% (1,316)	4.1% (1,066)	0.7% (195)
MODERATE Medical Complexity (Non-Complex, Chronic PMCA=2)	8.7% (2,277)	8.0% (2,089)	2.2% (584)
NO MEDICAL COMPLEXITY (PMCA=3)	22.2% (5,811)	27.4% (7,181)	21.6% (5,664) Neither Medically or Socially Complex

Data Source: ICS Data Warehouse and Medicaid/CHIP data sourced from All Payer All Claims (APAC). Children publically insured as of August 2021. Lookback period is lifetime of the child plus one year prior to birth (prenatal period).

PacificSource CCO - Marion/Polk

Health Complexity: Categorical Variables Related to Medical and Social Complexity

Page 8 of the report: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/PacificSource-Marion-Polk-2021-October.pdf

MEDICAL COMPLEXITY (3 Categories)	SOCIAL COMPLEXITY (Total Factors Possible in Preliminary Data Shown Here N=12)		
	3 or More Indicators	1-2 Indicators	None in System-Level Data
HIGH Medical Complexity (Chronic, Complex PMCA=1)	5.5% (3,285)	3.5% (2,085)	0.6% (383)
MODERATE Medical Complexity (Non-Complex, Chronic PMCA=2)	9.4% (5,683)	7.1% (4,263)	1.7% (1,030)
NO MEDICAL COMPLEXITY (PMCA=3)	25.7% (15,456)	30.3% (18,262)	16.2% (9,780) Neither Medically or Socially Complex

Data Source: ICS Data Warehouse and Medicaid/CHIP data sourced from All Payer All Claims (APAC). Children publically insured as of August 2021. Lookback period is lifetime of the child plus one year prior to birth (prenatal period).

PacificSource CCO: Social Complexity Indicators Aligned with ICC Populations

	PCS Central Oregon (n=26,183)		PCS Marion/Polk (n=60,227)	
INDICATOR	**CHILD FACTOR**	**FAMILY FACTOR**	**CHILD FACTOR**	**FAMILY FACTOR**
Poverty – TANF (by Parent)	**30.5%** (n=7,995)	**29.0%** (n=7,592)	**39.3%** (n=23,658)	**34.4%** (n=20,702)
Foster Care – C oster care services DHS ORKids	**8.7%** (n=2,283)		**9.6%** (n=5,803)	
Parent Death – Death of parent/primary caregiver in OR		**1.8%** (n=466)		**1.9%** (n=1,115)
Parental Incarceration – Parent incarcerated or supervised by the Dept. of Corrections in Oregon		**21.7%** (n=5,679)		**22.7%** (n=13,681)
Mental Health: Child – tal health services through DHS/OHA	**38.3%** (n=10,041)		**35.2%** (n=21,182)	
Mental Health: Parent – al health services through DHS/OHA		**44.6%** (n=11,669)		**39.4%** (n=23,759)
Substance Abuse: Child – use treatment through DHS/OHA	**2.7%** (n=712)		**3.2%** (n=1,934)	
Substance Abuse: Parent – use treatment through DHS/OHA		**25.8%** (n=6,758)		**26.0%** (n=15,641)
Child Abuse/Neglect: IC x codes related used by provider	**9.3%** (n=2,425)		**8.5%** (n=5,113)	
Potential Language Barrier: Language other than English listed as primary language		**10.7%** (n=2,795)		**25.9%** (n=15,596)
Parent Disability: Parent is eligible for Medicaid due to a recognized disability		**3.6%** (n=937)		**4.0%** (n=2,387)

Page 6 of the 2021 CCO-Level Reports: Central Oregon and Marion and Polk

Some Groups within Health Complexity You Could Consider to Start With to Focus

		Marion	Polk	Deschutes	Crook	Jefferson
Group #1: HEALTH COMPLEXITY: Medically Complex & **HIGH SOCIAL** COMPLEXITY	Complex Chronic & 3+ Social Complexity	**3045**	**493**	**988**	**165**	**209**
	Non Complex Chronic & 3+ Social	**5563**	**1014**	**1791**	**301**	**373**
Within Group #1: 2B (Was Provided in 2021 Child File, Provided InCK #	*A subset: Medically Complex & Parent Had a Factor of Incarceration, P-SUD, P-MH)*	*7249*		*Complex Chronic: 1433 Non-Complex Chronic: 2374*		
Group #2; HEALTH COMPLEXITY: Medically Complex & **1-2 Social** COMPLEXITY	**Complex Chronic** & 1-2 Social Complexity	2,085		1,066		
	Non Complex Chronic & 1-2 Social	4,263		2,089		

Source: 2021 Child Health Complexity Data

Another Idea: Consider Starting with the Flags You Have Available Related to SIL for ICC First

SIL	Overall	Marion/Polk	Central Oregon
SIL 3A Flag: Newly in Foster + Child Medical Complexity Derived from DHS Custody reports, compiled and deduplicated for M&P and CO CCOs from July 2020-July 2021	**104**	**72**	**32**
	Overall	**Marion/Polk**	**Central Oregon**
SIL 3B Flag: Prolonged Hospitalization in Past 12 Mos + Medical Complexity AND MET SIL2 Factors (Mar 2020 - Feb 2021) **	**35**	**20**	**15**
SIL 3B Flag: Multiple Admissions in Past 12 Mos + Medical Complexity AND MET SIL2 Factors (Mar 2020 - Feb 2021)**	**88**	**50**	**38**
3B TOTAL (Total Unique Members with SIL 3B Flag)	**105**	**60**	**45**
PCS Could Still do The Following Criteria: 2B (Now provided) and 3 or more social complexity.			

Learnings from InCK to Inform Meaningful Operationalization of Intensive Care Coordination OARs in Alignment with CCO 2.0 Requirements

As You Look Forward Three Opportunities and Needs Identified by the Community and Parents, Youth and Young Adults

1. **Leverage the Data** You Have to Better **Engage and Outreach** to Children and Families Who Likely Have Care Coordination Needs

2. Refine, Enhance, and Improve ICC model to **Match the Care Coordination Needs of Health Complex** Children and the **Magnitude of Children that Have Those Needs**

3. **Address** Referral Pathways to ICC & Closed Loop Communication with Contracted Providers

Learnings from InCK to Inform Meaningful Operationalization of Care Coordination: Hearing from Families

Quotes from Parent, Youth & Young Adult Advisory Group facilitated by OPIP

"I wish there was a case manager that oversaw all the services and communicated with all the PCPs, medication management, and school. Someone who oversaw all the pieces."

"I wish more information existed for the services that are provided. I stumbled upon it on my own. I heard about a specialist from a friend. A lot more information is needed."

"Referral process. It takes so long to process those referrals. It took medication management 2 months to call and another 1 month to get the appointment. There is a lack of care that happens in the meantime."

"Having a case manager or a file that you could go back to that kept all your stuff for you through OHP. Something that would follow you down that road."

"In OR, there is a focus on primary care and that primary care is central. This is not always true."

Learnings from InCK to Inform Meaningful Operationalization of Care Coordination: Feedback from PCPCHs

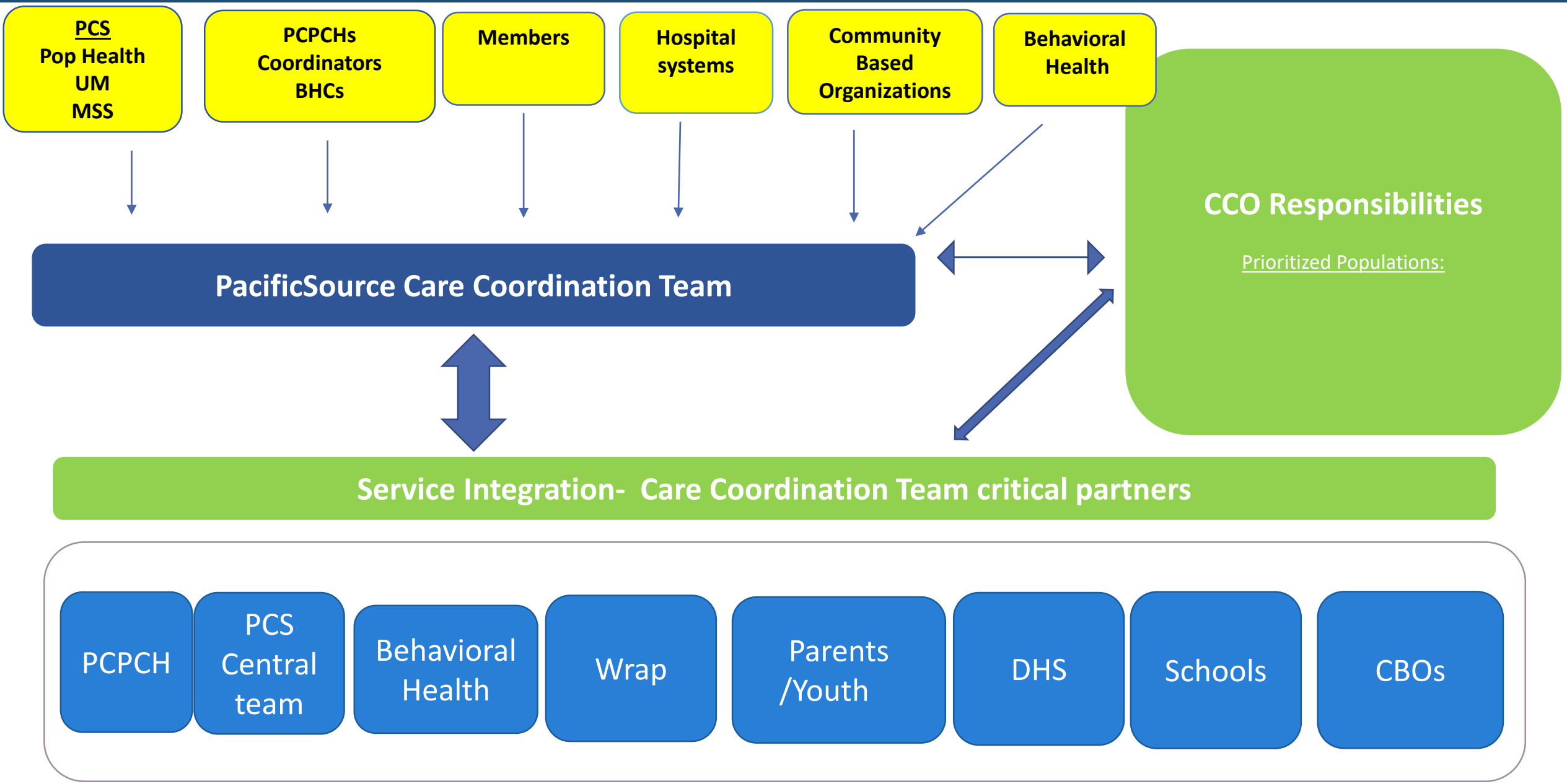
Question: How would you characterize the communication and coordination with Pacific Source's care coordination team?

- "Unsure how they would contact the PCS team or have been contacted by the PCS team. At the monthly population health meetings with PCS, care coordination is not normally present." –Primary Care Site in Central Oregon

- "Have had a number of issues helping to ensure coverage, Care Coordination team seems less aware of current services and plans which makes them less solution oriented." -- Primary Care Site in Marion/Polk Region

- "Refer kids back to PCS ICC - Generally our RNCC refer when families have multiple specialties and struggling with connection to services or having avoidable inpatient and ED visits, escalating in condition. Generally medical or behavioral health related - no referral specific SDoH needs." –Primary Care Site in Central Oregon

REFERRAL ENTRY POINTS FOR INTENSIVE CARE COORDINATION



#2: Refine, Enhance, and Improve ICC model to Match the Care Coordination Needs of Health Complex Children and the Magnitude of Children that Have Those Needs

Opportunities:

- Leverage **engaged front line managers** and strength that Care Coordinators and Member Support Specialists work across disciplines and collaborate on care.
- Looks for ways to **increase capacity** and **focus on children**
- Know that **adult models don't work for health complex children** & their families..many of the families you will focus on for children have adults in the CCO :
  - Continue refinement of Pediatric High Risk assessment and shared plan of care.
  - Determine team training needs for Strengths Based Family Needs Assessments and Trauma Informed approaches.
- Develop ICC team that **includes THWs** with community based visiting.
- Incorporate family communication preferences: texting, community based visits
- Build in **time needed for "pre-engagement"** outreach work.
- Consider **dyadic models of care management** (Child and Adult) and FAMILY models of engagement for parents who have more than one health complex children.
- Highly **socially complex families with children in hospital** with any type of medical complexity benefit from care planning that addresses root causes that is at that point of are and transition, but that knows local community connections

Curriculum & Opportunities PCC ICC Development & Training

Quarter 1: *Trauma informed approaches to review needs assessment flags, design outreach approaches, identify practice-level priority populations*	• Booster coaching likely needed to HIE methods on receiving Needs Assessment Flags given ICC noted use of MIPI
Quarter 2: *Strength-based, family-informed needs assessments for core service connection & care coordination*	• Asset maps to be spotlighted here. • Potential meet & greet with centralized supports noted in document. • Roles of traditional health workers.
Quarter 3: *Strength-based, family-driven care coordination; pathways to SIL 3 care*	• Meet and greet connections with other SIL 3 providers and PCPCHs. • Care Transitions for beneficiaries and family.
Quarter 4: *Strength-based, family-centered closed loop referrals & connection to services*	• Potential for Connect Oregon to support closed loop referrals. • Roles of traditional health workers

Activity that Had been Proposed
• Schedule biweekly team meetings • PCS Care Management leadership/OPIP
• **Establish Teams and Structure, Outline Key Functions and Roles Specific to Attributed Population**
• Determine housing and food approved screening tool for CMMI requirements
• **Review PCS CM assessment**
• Review shared plan of care and confirm how data will be received for reporting requirements
• **Identify team needs for learning curriculum and additional training**
• Develop curriculum supports and training
• **Determine CM training timeframe**
• Kickoff meeting with PCS CM teams
• **Provide learning curriculum and coaching/support for intervention**
• Year End Meeting: Key success, learnings

Learnings from InCK to Inform Meaningful Operationalization of Intensive Care Coordination OARs in Alignment with CCO 2.0 Requirements

#3) Address Referral Pathways to ICC & Closed Loop Communication with Contracted Providers

- Connection with and outreach to referring providers
  - Enhancements to model
  - Refinements for these populations
  - Community-specific resources
- Closed loop communication and shared care plans with the agencies/services providing services to the child
  - Shared platforms of communication, but don't rely solely on technology given input we have heard to date.
  - Recognition that just a "push" strategy of information will not work
  - Consider leveraging and building off the calls you have with sites for the foster care metric

1. **Leverage the Data** You Have to Better **Engage and Outreach** to Children and Families Who Likely Have Care Coordination Needs

2. Refine, Enhance, and Improve ICC model to **Match the Care Coordination Needs of Health Complex** Children and the **Magnitude of Children that Have Those Needs**

3. **Address** Referral Pathways to ICC & Closed Loop Communication with Contracted Providers

Questions and Reflections on the Three Teams:

- PacificSource
- OHA

Agenda

1. Welcome and Meeting Overview including Overview of Time Keeping
2. Organizational Learnings of key learnings from the InCK model pre-implementation period
   - Pacific Source Sharing Key Findings from Workstreams that relate to ICC, Wraparound, Behavioral Health
   - OPIP Sharing of Key Learnings, Opportunities Related to Care Management/ICC
   - OPIP Sharing of Key Learnings, Opportunities Related to Wraparound
   - OPIP Sharing of Key Learnings, Opportunities Behavioral Health

Wraparound Services: OARs and Alignment with CCO 2.0 Requirements

Per OAR 309-019-0163, youth meet eligibility for Wraparound services if they are served in

- *Two or more child-serving systems and experiencing complex needs*
- *Enrolled in any of the following: Secure Children's Inpatient Program, Secure Adolescent Inpatient Program, Psychiatric Residential Treatment Services, or the Commercial Sexually Exploited Children's residential program funded by the Division.*

Behavioral Health CCO 2.0 Priority:

- *Require wraparound is available to all children and young adults who meet criteria*

Wraparound providers may not:

(a) Require Medicaid-eligible youth to receive services or supports prior to applying for Wraparound;

(b) Exclude a youth who is not a CCO member from receiving Wraparound if funding is available from other payors;

(c) Place a youth on a waitlist to receive Wraparound.

Given it is a county based program, fidelity of the program in each county that CCO serves

County-Level Reports – Health Complexity Breakdown by County: Children Who Would Like Benefit from WRAPAROUND

Page 8 of the county-level reports: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Child-Health-Complexity-Data.aspx

	Central Oregon Counties			Marion/Polk Counties	
	Deschutes	Crook	Jefferson	Marion	Polk
Complex Chronic, 3+ Social Factors	988	165	209	3,045	493
Non-Complex Chronic, 3+ Social Factors	1,791	301	373	5,563	1,014
Complex Chronic, 1-2 Social Factors	937	111	111	2,018	378
Non-Complex Chronic, 1-2 Social Factors	1,796	215	249	4,058	650

Learnings from InCK: Hearing from Families about Wraparound Servi

Quotes from Parent, Youth & Young Adult Advisory Group facilitated by OPIP

- *"We have a wrap coordinator that does a lot of communication and makes suggestions. That is going away. They are teaching some of those skills. It's been such a helpful service to have in place."*

- *"I work full time and having people have flexible hours. It's so tough to get my kids to counseling in my work schedule."*

- *"Better wraparound services for families. There are so many people involved in one persons life if everyone could come together monthly to stay on the same page that support would be huge".*

Learnings from InCK: PCPCH and Behavioral Health Provider Feedback about Wraparound Services

Question: How would you characterize the communication and coordination with Wraparound?

- "Unaware if a patient has received wraparound or where that communication would come from or to if not the care coordination team". -- Primary Care Site in Central Oregon
- "Attend Wrap meetings as needed." --Primary Care Site in Marion/Polk Region
- "RNCC generally attends these meetings to help add support. BHC will attend these meetings as well for more focused behavioral health. Wrap will communicate back to help provide updates on kids. Have found the relationship/communication to be consistent and there have been consistent communication from other providers that they are then communicated back". —Primary Care Site in Central Oregon
- "I refer to Wrap and they are never eligible, and worse they tell the family that they are fine and doing well and I am back to square 1." –Primary Care Site in Central Oregon
- "The don't talk to us ever, they never coordinate" – –Primary Care Site in Central Oregon
- "It takes a certain level of function for families to engage and participate in Wraparound. Families need "skill builders", supportive services and advocates which do not have to be done by a licensed clinician." –Central Oregon BH provider.
- "County WRAP services need to be more than just meetings. It took several weeks for one of my clients to get a Wrap meeting scheduled and all they did was refer to Intercept who then referred to Sagebrush which took 6 months to get an opening. Meanwhile parent was calling with reports of increased social anxiety, aggression, and unmet medical needs. " – Central Oregon BH provider

Wraparound Services: Learnings from InCK to Inform Meaningful Operationalization

1. Better **Leverage and Use Data** Reported on Wraparound to Reduce Reporting Burden
   - Across OHA
   - Within PCS

2. Consideration of **models that make access to and fidelity wraparound possible in underserved regions and for underserved children**

3. Consideration of **models that make fidelity wraparound possible**

4. Support **Closed Loop Pilots of Referrals** from PCPCH to Wrap **Given Pain Points** Identified

Learnings from InCK to Inform Meaningful Operationalization of Wraparound Services OARs in Alignment with CCO 2.0 Requirements

#1 Better Leverage and Use Data Reported on Wraparound to Reduce Reporting Burden

- CMHPs have multiple documentation requirements that impact clinician time and service delivery. Administrative burden on CMHPs with duplicative paperwork.
    - WRAPSTAT, REDCAP, Electronic health records, CCO
- Despite multiple reporting requirements, child specific data on whom is enrolled in WRAP is lacking at the CCO level.
- PCS had already starting brainstorming innovative solutions to support assignment to wrap of those served, collection and use of that data should be considered further

Learnings from InCK to Inform Meaningful Operationalization of Wraparound Services OARs in Alignment with CCO 2.0 Requirements

#2 Consideration of **models that make access to and fidelity wraparound possible in underserved regions and for underserved children**

- Need to enhance access to these critical services for health complex, communities of color and children who live in rural regions.
  - **Consider pilots to support engaged and meaningful referrals IN to services**
  - **Pilots of how to engage families in these regions to the critical services, including peer to peer supports of families that have experiences of wrap within the region.**
- PCS has already starting brainstorming innovative solutions to support fidelity in underserved region in Central Oregon by hiring Wrap coordinator for Jefferson County.
- Developing and evaluating methods for more consistently connecting wraparound enrolled youth to effective clinical and other services is a major priority.
- Providers and policymakers must attend carefully to concerns around wraparound specific issues such as training, supervision, and fidelity controls as well as system issues (availability of high quality clinical interventions).

OPIP

3. Consideration of **models that fidelity wraparound possible**

Models of care

Families need flexible scheduling/alternative hours to maintain engagement. Many parents/guardians are working, navigating services for more than 1 child, children trying to maintain education. Consider models that demonstrate:

- Flexible hours of operation (move beyond Monday-Friday, 9-5pm)
- **Services within community so families do not get separated.**
- **Coordinate with school system (encourage school attendance/retention)**
  - **(Biggest priority raised by families)**
- Services that support skill building and training family partners
- Use travel time as part of an active intervention

#4 Support Closed Loop Pilots of Referrals from PCPCH to Wrap Given Pain Points Identified

Referral Pathways

There is variation among referring providers on how eligibility is defined and determined (System of care website, PCPCH, WRAP coordinators).

- Pilot methods of referral pathways with PCPCHs in areas with access and equity disparities. Jefferson, Crook, Polk
  - Use of warm (and/or facilitated) referrals among PCPCH providers.
  - Utilize "no wrong door" approach and the use of soft entry points.

1. Better Leverage and Use Data Reported on Wraparound to Reduce Reporting Burden
   - Across OHA
   - Within PCS

2. Consideration of **models that make access to and fidelity wraparound possible in underserved regions and for underserved children**

3. Consideration of **models that make fidelity wraparound possible**

4. Support Closed Loop Pilots of Referrals from PCPCH to Wrap Given Pain Points Identified

Questions & Reflections from:

- OHA
- PacificSource

Agenda

1. Welcome and Meeting Overview including Overview of Time Keeping
2. Organizational Learnings of key learnings from the InCK model pre-implementation period
   - Pacific Source Sharing Key Findings from Workstreams that relate to ICC, Wraparound, Behavioral Health
   - OPIP Sharing of Key Learnings, Opportunities Related to Care Management/ICC
   - OPIP Sharing of Key Learnings, Opportunities Related to Wraparound
   - OPIP Sharing of Key Learnings, Opportunities Behavioral Health

Role of Behavioral Health in InCK

Goal of InCK was to ensure that children's physical, behavioral and social determinant needs are met

For Children and Families Identified in Service Integration Level 2 and **Level 3**

(So they had social complexity that would warrant at least an assessment)

- **Only 20% of Children had documentation of behavioral health services**
  - Despite demonstrating risk factors for children and parent(s)/guardian who would likely benefit from dyadic services, parent/guardian would likely benefit from adult services and supports

Learning and Opportunities Related to Behavioral Health

I. Increase Knowledge about Behavioral Health Services That Exist
   - Increase documentation and awareness of behavioral health services and capacity for children within:
     - Internal Behavioral Health
     - Specialty Behavioral Health that serve children

II. Barriers and **Opportunities** to Supporting Person Centered Pathways to Services
   - Parental Engagement
   - Billing Practices to Support Internal Behavioral Health
   - Availability of Services That Are Culturally and Linguistically Appropriate
   - Multiple “Referral” Pathways to Specialty Behavioral Health Providers
   - Coordination with Schools
   - Proof Pilots of Coordination and Collaboration with DHS

Knowledge of Internal Behavioral Health Services: PCS APM and VBP Supports

Learnings–

- Even with PCS supporting PMPMs **not all Primary Care sites have Internal Behavioral Health Staff** – common barriers include barriers in hiring process, training and billing to sustain position
- Of the 6 Phase 1 sites receiving the BHI PMPM during the onboarding period, **half (N=3) provide service to their pediatric population and they were selected as they saw the most kids**

Opportunity –

- Help identify, recruit, train and sustain IBH staff for Primary Care sites
- Stratify BHI claims by age to understand where services are being provided
- Ensure that higher tier payments to PCPCHs are tied to serving full population they are attributed

Knowledge of Behavioral Health Services

In alignment with CCO 2.0 requirements: A CCO is “fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity. This includes ensuring an adequate provider network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities”

Learnings on Ability to Understand CAPACITY to accept referrals:

- To support this requirement PCS has a survey provided to the contract Behavioral Health providers
- Survey is not always filled out to fidelity which leads to barriers in real time understanding of capacity

Opportunity:

- Consider requiring reporting access and capacity in more frequent intervals in a standardized way across contracted providers
  - Consider alignment with the 2022 System Level Social Emotional Metric capacity definition
  - Consider capacity relative to age groups.

Learning and Opportunities Related to Behavioral Health

I. Increase Knowledge about Behavioral Health Services That Exist
   - Increase documentation and awareness of behavioral health services and capacity for children within:
     - Internal Behavioral Health
     - Specialty Behavioral Health that serve children

II. Barriers and **Opportunities** to Supporting Person Centered Pathways to Services
   - Parental Engagement
   - Billing Practices to Support Internal Behavioral Health
   - Availability of Services That Are Culturally and Linguistically Appropriate
   - Multiple “Referral” Pathways to Specialty Behavioral Health Providers
   - Coordination with Schools
   - Proof Pilots of Coordination and Collaboration with DHS

Learnings from Common Barriers in Supporting Person Centered Pathways to Services: **Parental Engagement**

Learnings:

- Importance of dyadic based supports and services
  - We know of no provider that develops a care plan and that considers the adult services COMBINED with services focused on improving parent-child attachment and emotional regulation (adult plus their child)
    - For Adolescents, services that address and support that adolescent
- Currently most Primary Care providers are not “trained” on best practices to support pathway to Internal Behavioral Health and Specialty Behavioral Health, can’t partner with parents
  - Need to understand ways to do brief assessments, brief engagement and coaching
- Parents reported long and hard journeys to find the right behavioral health

Learnings from Common Barriers in Supporting Person Centered Pathways to Services: **Parental Engagement**

Opportunities:

- Develop asset maps and tools that help support IBH in engaging and communicating about these services.
- Listen to and work with parents from diverse background to develop parent engagement materials about the services, Develop tools that help them find the right care for their child's needs
- Investment in peer to peer supports for the health complexity factors that parents experience
- "Park the services" at the settings where "the cars are parked"
- Offer Trainings to Primary Care sites that have Internal Behavioral Health that address common pain points in health complex CHILDREN
- Leveraging the System Level Data to better identify and serve children and families
    - By actively identifying population of at-risk kids, members can be provided proactive developmental promotion and behavioral health support, which could help build resiliency and attachment in these socially complex families.

Trainings to Primary Care sites that have Internal Behavioral Health that address common pain points

Below is a Sample from a Training OPIP has facilitated previously on this topic:

1. **Who** to Send to Internal Behavioral Health Services
2. **How to Engage Family in Services**
   - Talking point for providers
   - Developmental promotion materials to consider
3. **Connection to Integrated Behavioral Health**
   - Understanding the brief assessments and interventions
   - Identifying children to refer to Specialty Behavioral Health
4. **What Specialty Behavioral Health Services Exists in their Area**

Learnings from Common Barriers in Supporting Person Centered Pathways to Services: **Billing Practices to Support Internal Behavioral Health**

Learnings:

- Integrated behavioral health struggle with billing practices that allow for them to be available for warm handoffs and provide services at a rate that sustains their position
- Prioritized List of Health Services on OHA's Health Evidence Review Commission (HERC) guides funding decisions for Medicaid coverage, but important to understand proper coding and pairing as practices cant not differentially bill
  - Given practices cannot differentially bill, a particular issue for that see publicly insured children
- Payment models don't reimburse the process of engagement and obtaining buy-in

Opportunities:

- Consider trainings for Integrated Behavioral Health providers on billing practices informed by appropriate diagnostic and CPT code pairing
- Consider sustainable payment models that support warm hand off's, knowing best practices suggest 50% of an IBH's schedule should be "open" for warm hand-offs

Learnings from Common Barriers in Supporting Person Centered Pathways to Services: **Availability of Services That Are Culturally and Linguistically Appropriate**

Learnings:

- Timely access to care among behavioral health services is a significant challenge within InCK regions, but especially limited in Marion/Polk
- Behavioral Health providers report lack of timely availability and wait lists that exceed 2 months for initial BH appointments
  - This does not take into account when there are additional cultural or linguistic needs
- Lack of “Step Up” resources in the region for children with more acute behavioral health issues including IOP, ICTS & residential
- Need for diverse modalities to engage different groups of children and their families and to address stigma of individual therapy.

Learnings from Common Barriers in Supporting Person Centered Pathways to Services: **Availability of Services That Are Culturally and Linguistically Appropriate**

Opportunities:

- Maintain the asset map of Behavioral Health services, in a way that highlights:
  - **Behavioral health services** available for the birth – 21 population
  - **Modalities of behavioral health services available** and
  - **Overview of factors** to consider when referring including: Capacity, service location and service provider demographic information (including race and language spoken)
- Consideration of co-location in community based services or in school settings
- Hear from communities with historical inequitable outcome and of color about what and where services should be provided.

Learnings:

- A strength of PCS's Behavioral Health contracting model allows for breadth of services providers
- Each contracted entity has preferred methods for "referral" and allows for a wide variation in infrastructure and approaches to pathways to services
  - This then requires each primary care site to manage the nuances of referrals to each provider
  - Many don't allow for "referrals" from Primary Care , ask Primary Care to tell the parent to self refer and come
- Unintended consequences of referrals form and need for evaluations within a time period when there are limited staffing.

Opportunity:

- Ensure child-specific and child-relevant referral forms that support "warm" hand off, consider adolescent rights
- Develop HIPAA compliant and provider-centered closed loop communication feedback templates that indicate
  - If able to be engaged
  - If engaged, services being provided
  - When they disengage in services
- Need to address the pain point that providers have shared in managing nuance in different referral pathways between providers
  - A key component of this work needs to include closed loop referrals to understand **outcome of referral** so that primary care can encourage engagement in services
- Innovate ways to support children and families in these pathways

InCK Learning & Opportunities:
Coordination with Schools

"For kids in school whose families who work full time- it's hard to access services and make it to appointments. If school were involved and there were flexible hours. This has been a barrier for us in the past and I've given up. "- Parent

"If there could be a direct link between school and medical records, that would make stuff so much easier. Immunizations, diagnosis, medications. I work with families who have struggled to get shots records."

"Coordination between school and healthcare is a big one. I wish this happened for my kid. I have to let them [the school] know what my kid's health issues are. It falls in my lap to get an IEP and communicate all the issues. That coordination would be really helpful."- Parent

- **Coordinate with school system (encourage school attendance/retention)**
  - **(Biggest priority raised by families)**
  - **"A lot can be done within IEP process."- CO BH provider**

Opportunities:

- **Payment models to support care coordination by behavioral health providers**
- **Centralized supports in working with schools**

InCK Learning & Opportunities:
Proof Pilots of Coordination & Collaboration with DHS

- Developing and piloting models of care coordination with DHS was going be a large focus of InCK
  - Parents noted large disconnected and needing to repeat information, processes that make it unsustainable
  - Behavioral health providers noted lack of collaboration and sometimes follow-through when noted an issue
  - PCPCH reported noted little and sometime refusal to coordinate and collaborate
- Opportunity:
  - Develop care coordination pilot that goes beyond the DHS metric of screening to services and coordination
  - Build of existing meetings to explore models of collaboration.
  - Assign someone within Care Management to oversee this population

Questions & Reflections from:

- PacificSource
- OHA

Additional Feedback Information Gathered, But Not Shared Due to Time Constraints

Learnings from InCK

Feedback Obtained in Close Out Calls with CMHPs

- InCK has had positive impact on community mobilization around BH.
- Biggest blow of InCK closing is “expansion of system of care”.
- Concerns about losing momentum and starting over.
- “How are you thinking about equity in Polk, Jefferson, Crook counties?”
- Any proof pilots should be about implementation without burdening families.

We’ve been working in single systems, and you cannot solve problems that way.
What good does it do to send a caseworker out to fix a problem in one system when the problem spans multiple systems and multiple generations?”– Paul DiLorenzo,

Health Complexity Data: Reflections & Questions

What do we know

SIL Flags and SIL Total	Overall
	Count of Children/Youth with by SIL Flag and Total by SIL*
SIL 2A Flag: Previous Foster Care Placement and/or Child Welfare-Involved + Child Medical Complexity	2899
SIL 2B Flag: Parent History of SUD, MH and/or Incarceration + Child Medical Complexity	13256
SIL 2C Flag: 3+ Social Complexity Factors + Child Medical Complexity	5664
Total SIL 2 (Total Unique Members in SIL 2)	**14887**
SIL 3A Flag: Newly or Currently In Foster Care Placement and/or Child-Welfare Caseload (at Imminent Risk of Out of Home Placement) + Child Medical Complexity	626
SIL 3B Flag: Multiple and/or Prolonged Admissions + Child Medical Complexity	105
Total SIL 3 (Total Unique Members in SIL 3)**	**720**
TOTAL SIL 2 and 3 POPULATION	**15,607**

Notes

*Count of Children/Youth with SIL Flag and by SIL: children/youth can have more than one SIL flag, but total SIL count represents unique members in that SIL level.

** To be in SIL 3, child/youth must meet criteria for SIL 2. For children who were newly in foster care or currently child welfare-involved + medical complex but didn't have any other SIL 2 flags, OHA counted them as qualifying SIL 2a (and therefore sufficient to be in SIL 3).

** 11 children/youth have both a 3a and 3b flag.

National Care Coordination Standards for CYSHCN

- Care coordination for CYSHCN is based on the premise of health equity, that all children and families should have an equal opportunity to attain their full health potential, and no barriers should exist to prevent children and their families from achieving this potential.
- Care coordination addresses the full range of social, behavioral, environmental, and health care needs of CYSHCN.
- Families are co-creators of care coordination processes and are active, core partners in decision making as members of the care team. CYSHCN, families, and care coordinators work together to build trusting relationships.
- Care coordination is evidence based where possible, and evidence informed and/or based on promising practices where evidence-based approaches do not exist.
- Care coordination is implemented and delivered in a culturally competent, linguistically appropriate, and accessible manner to best serve CYSHCN and their families.
- Insurance coverage of care coordination for CYSHCN allows for it to be accessible, affordable, and comprehensive.
- Performance of care coordination activities is assessed with outcome measures that evaluate areas including:

a. process of care coordination (e.g., number of families with a shared plan of care);
b. Family experience with integration of care across medical, behavioral, social and other sectors and systems;
c. Quality of life for CYSHCN and families; and
d. Reduction in duplicative and/or preventable health care utilization.

Intensive Care Coordination: Learning and Opportunities

Identified Needs during Pre Implementation

- Need to revise our Pediatric Assessments to enhance the following:
  - Strengths
  - Parent Priorities
- Workflows Enhancements
  - Identification of Service Integration Level
  - Ability to share plan of care with care team involved with the member
  - Identification of population- Social Complexity: Chronic absenteeism from K-12 education
  - Timeline expectations for care management activities/outreach
- Staffing Analysis
  - Volume of caseloads and support for the anticipated population of SIL2-SIL3 for the health plan

*As reported during April, 14 2021: **Oregon's Integrated Care for Kids (InCK): Workgroup with PacificSource on InCK Complex Care Coordination**

Intensive Care Coordination: Learning and Opportunities

Identified Pre Implementation Proposal

- Gather best practice Pediatric Assessments
- Identify workflow strategies to capture food and housing insecurity assessments for all SILs
- Identify workflow strategies in collaboration with IT to share plan of care to core service providers involved in managing cases in conjunction with the health plan
- Identify workflows and data exchange enhancements to identify the Social Complex: Chronic absenteeism from K-12 education
- Clarify timelines for care management/outreach strategies
- Clarify expectations for Length of Stay (LOS) in care management programs
- Gather data on population expected to be managed by the health plan and agree upon caseload volume
- Develop a staffing model and analysis based on predicted volume to support additional staffing justification

*As reported during April, 14 2021: **Oregon's Integrated Care for Kids (InCK): Workgroup with PacificSource on InCK Complex Care Coordination**