# Oregon’s Integrated Care for Kids (InCK)
# Central Oregon Partnership Council Meeting

June 1st, 2021

# Acknowledgement of Funding:

- *This **project** is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $5,866,192.*
- *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.*

# Objectives

- Hold a collaborative conversation on the current **InCK approach to engagement of people served by the model (***children, youth and young adults 0-21 on the Oregon Health Plan and their families)*
- Provide an update **federal and state learnings from the pre-implementation period** and opportunities for **refinements and revisions being explored**, obtain input from PC members on the design parameters being used to explore options.
- Provide a brief update on the **extensive and broad work** being done **to operationalize component of the InCK model starting in 2022** in alignment with federal requirements and feedback heard from Partnership Council members to date.
- Provide an update on relevant activities and learnings related to **Central Oregon Health Council (COHC) priority areas** and obtain input and guidance for what may be shared to honor the PC Charter.

# Today's Agenda

- **Welcome, Introductions to New Members, Reflection on a Year of Partnership Council Meetings**
- Collaborative conversation on the current **InCK approach to engagement** of **people served by the model (***children, youth and young adults 0-21 on the Oregon Health Plan and their families)*
  - **Large Group Interactive Discussion**
- Update on **federal and state learnings from the pre-implementation period** and opportunities for **refinements and revisions being explored**, obtain input from PC members on the design parameters and factors being explore.
  - **Small Group Feedback**
- **Stretch Break and Fun Polling**
- Provide a brief update on the **extensive and broad work** being done **to operationalize components of the InCK model starting in 2022**
  - Introduce the System Navigator, Highlight of Current Priorities
  - Update on System-Level Needs Assessments
- Provide an update on relevant activities learnings related to six **Central Oregon Health Council priority areas** (*Address Poverty & Enhance Self Sufficiency, Behavioral Health, Promote Enhanced Physical Health Access, Stable Housing, Substance & Alcohol Misuse, Upstream Prevention*) and obtain input and guidance for what may be shared to committees to honor the PC Charter Service Integration Needs Assessment indicators
  - **Large Group Feedback**

# Welcome

***Partnership Council Members:***

- **Dawn Mautner, MD –** Oregon's Medicaid Medical Director (replacing Lori Coyner)
- **Amy McCormack** – High Desert Education District formally replacing Diana Tipton due to her well deserved retirement
- **Kate Fosburg** – Central Oregon Independent Practice Association, Director of Clinical Quality

***Oregon Pediatric Improvement Partnership:***

- **Vicki Wolff** –Sr. Behavioral Health Improvement Facilitator

# A Year of "Zoom-Based" Partnership Council Meetings

***If you had three words to describe your experience on the Partnership Council to date, what would you say?***

***Type into the chat.***

***We will share the word cloud later.***

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# InCK approach to engagement of people served by the model

*(Children, youth and young adults 0-21 on the Oregon Health Plan and their families)*

**Objective:** To inform development and implementation of Oregon's InCK Model based on lived experience of those served by the model, with a particular focus on communities most impacted by health inequities, including systemic racism.

- **Being informed:** Ensuring alignment with existing efforts and making use of findings that already exist in the community; information gathering and educating ourselves.

- **Engaging populations served by the InCK model:** Connecting and building relationships with partners to collaboratively apply what is known to address the problems that InCK and these organizations/partners are all trying to solve in various ways.

We aren't going to know if our strategy works until potentially impacted populations weigh in on whether this is the right strategy. **Communities have to be part of the creation of the strategy.**

# InCK approach to engagement of people served by the model

*(Children, youth and young adults 0-21 on the Oregon Health Plan and their families)*

- What reactions, advice, or questions do you have about this approach?
- For those of you who have done engagement work like this, what has worked well and what would you do differently next time/ what lessons did you learn?
- Are there elements of community engagement that you don’t see reflected here, that are necessary to make it successful?

# Central Oregon Engagement & Resource Roster

- Youth Era
- Traces
- Deschutes County Behavioral Health
- CAPACES
- Latino Community Association of Central Oregon [working within OHA to identify existing connections with this org]
- Pineros y Campesinos Unidos del Noroeste (PCUN)
- Micronesian Islander Community (MIC)
- Oregon Marshallese Community Association
- Oregon Family Support Network
- Creating Opportunities
- FACT Oregon
- Central Oregon Early Learning Hub
- Asian Pacific American Network of Oregon (APANO)
- Familias en Acción

Other existing efforts to leverage under "Being Informed":

- Community Input for OHA Strategic Plan (2019 report – OHA Office of Equity & Inclusion)

**Who is missing? What additional partners would you recommend?**

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  - Introduce the System Navigator, Highlight of Current Priorities
  - Update on System-Level Needs Assessments
  - Factors Being Explore to Support Care Components
- Provide an update on relevant activities learnings related to six **Central Oregon Health Council priority areas** (*Address Poverty & Enhance Self Sufficiency, Behavioral Health, Promote Enhanced Physical Health Access, Stable Housing, Substance & Alcohol Misuse, Upstream Prevention*) and obtain input and guidance for what may be shared to committees to honor the PC Charter Service Integration Needs Assessment indicators
  - **Large Group Feedback**

# Integrated Care for Kids (InCK) Model: Cooperative Agreement

- Led by Centers for Medicare & Medicaid Innovation (CMMI), Centers for Medicare & Medicaid Services (CMS)
- https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model
- It is a cooperative agreement
  - Provides for substantial involvement between the Federal awarding agency in carrying out the activity contemplated by the Federal award.
  - Three distinct CMMI contractors over the course of the seven-year model: Implementation and Monitoring (I&M), Learning System (LS), Evaluation
- Eight awardees of cooperative agreement

| State | Organization |
| --- | --- |
| Connecticut | Clifford W. Beers Guidance Clinic, Inc. |
| Illinois | Ann & Robert Lurie Children's Hospital |
| Illinois | Egyptian Health Department |
| North Carolina | Duke University |
| New Jersey | Hackensack Meridian Health Hospital Corporation |
| New York | New York Department of Health |
| Ohio | Ohio Department of Medicaid |
| Oregon | Oregon Health Authority |

*Source: CMMI InCK Website*

# Update on activities with Federal CMMI on the Cooperative Agreement

## How a cooperative agreement plays out:

| Requirement | Proposal | Guidance | Alignment And Refinement | Resubmission And Acceptance |
|---|---|---|---|---|
| **CMMI** | **Awardee** | **CMMI** | **CMMI and Awardee** | **CMMI and Awardee** |
| Requires Awardee to propose approaches on measures or model operational components – aligned with **“NOFO requirements”** | Proposes their approach - aligned with requirements | Reviews all awardee responses and issues additional “**guidance**” as needed | Work cooperatively to achieve alignment of proposal | Awardee submits “final” proposal for CMMI review and acceptance. |

Version 4: May 2021

# 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

Preventive care

Active Monitoring & New Screening

- Ensure access to preventive care, mobile crisis response.
- Screening of children & young adults for housing & food insecurity & connection to services. Leverage Connect Oregon.
- System-level data used to create Needs Assessment indicators of a child's medical and social complexity that identify priority populations of children at-risk for at home placement and/or high-costs in Level 2 &3.
- Enhanced data integration across sectors and data sharing (HIE/Connect Oregon)

### 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)

Access to Preventive Care

Screening, Referral & Connection to Applicable Needed Core Services

Establish Care Team, If Applicable Ensure Needed Care Coordination

- Ensure access to services.
- Referrals, follow-up and care coordination.
- Connection to needed core services.
- APM models developed and implemented to support enhanced assessments and coordination components.
- Enhanced data tracking and data integration across sectors (HIE/CIE).

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

**Integrated Case Management & Child-Centered Care Planning**

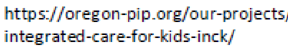
**Home and Community-Based Supports**

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

## Regional Activities & Supports Funded by Project

- Regional Partnership Councils.
- Partnerships with racial and ethnic communities most impacted by health inequities led by OHA's Community Engagement Coordinator.
- Parent, youth and young adult advisory committee.
- Provision of system-level needs assessment data by OHA.
- Region-specific System Navigators based in PacificSource.
- Health information exchange/ Community information enhancements (Connect Oregon).
- 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/HPA/InCK/Pages/index.aspx

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# Focus of Work within Pre-Implementation Period to Prepare for 2022 Start of Implementation

- Goal of the Two Year Pre-Implementation Period (2020-2021) is:
  - Plan for how to OPERATIONALIZE the model for implementation.
  - Adjust the proposed implementation based on feedback from CMMI, CMMI contractors, and CMMI evaluation team (Note: Evaluation contractors not hired until 2021)
  - Develop the systems and processes to start and scale up implementation
  - Engage clinical and core services providers in activities, ensure buy and preparation
- This work has involved:
  - ❑ Hiring staff
  - ❑ Onboarding PacificSource Community Solutions
  - ❑ **Adjusting to COVID, COVID Response**
  - ❑ Data analysis to inform implementation planning and model design
  - ❑ Baseline assessments of current systems/process, readiness and capacity within:
    - ❑ OHA, OPIP, PacificSource (InCK Team)
    - ❑ Clinical partners
    - ❑ Core Service Providers
    - ❑ Health Information
    - ❑ Community Information Exchange
    - ❑ State-systems and data platforms to support data sharing

# Focus of Work within Pre-Implementation Period to Prepare for 2022 Start of Implementation & Identify Scale Up Approach

Informed by this work, considering best ways to start the work in 2022 and consider a scale up approach that takes into account:

1. Current **levels of need, 20% increase** in populations
2. Current systems and processes within **PacificSource Community Solutions (PCS)** targeted to Children Requiring Level 2 (SIL) and Level 3 Service Integration (SIL3), including PCS contractors
3. Current system & processes within **clinical providers** to serve SIL2/3 Children (PCPCH, Behavioral, Specialty)
4. Opportunity to Align SIL 2 Intervention and Services with **PCPCH Standards** and **Related Payment Models Required in CCO 2.0**
5. Focus on **most critical elements** of model that need to be ready for 2022 given **Needs Assessment and Service Integration Level Provision** is required to START in 2022.
6. Prioritize elements of **alignment with community level priority goals** and CCO 2.0
7. Phase in population size to **better meet annual targets** and provide a manageable ramp up of anticipated care coordination supports/services and manageable build up time in SIL2/3 providers
8. Consider **provider burden**, particularly during start-up during a COVID19 Response, for reporting and care coordination as we anxiously wait for CMMI clarifications.

## Figure 1.0 Overview of Oregon's Integrated Care for Kids Needs Assessment and Service Integration Strategy

### Needs Assessment

**Level 1** All children and youth (ages 0-21) in the model area covered by Medicaid/CHIP

**A. System-level Health Complexity Data**
Includes data from multiple health and non-health care sources.

**B. Housing and Food Insecurity Screening**
Population-based approaches to screening InCK Model population for housing and food insecurity.

**Level 2** Service Integration Level 2 (SIL 2)

| | Point 1: Exhibited need for two core child services | | Point 2: Functional symptom of impairment |
|---|---|---|---|
| | Child had 1+ core service | ...and exhibited need for add | |
| 2A. | Child had physical or behavioral health service | Child has been in foster ca | |
| 2B. | | Social Complexity that inc<br>• Parent substance abus<br>• Parent mental health, a<br>• Parental incarceration | |
| 2C. | | Social Complexity: 3 or m factors not identified in 2A and 2B<br>(Includes factors such as TANF, child use of metal health or substance | • Complex Chronic<br>• If child under five, also |

**Example of Level 2 Providers:**
- Patient Centered Primary Care Homes
- Behavioral Health Providers with Role to Coordinate Care
- Pacific Source Centralized Care Coordination Supports

**Example of Level 3 Providers:**
- Patient Centered Primary Care Homes With Child-Serving Care Coordination Staff Responsible for Work with External Agencies
- WRAP
- NICH Behaviorist
- Pacific Source Centralized Care Coordination Supports

### Service Integration

**Level 1**

Preventive Care

Active Monitoring & New Screening

**Level 2**

Access to Preventive Care

Screening, Referral & Connection to Applicable Needed Core Services

Establish Care Team, If Applicable Ensure Needed Care Coordination

**Level 3**

Integrated Case Management & Care Planning Team Established, Shared Plans of Care

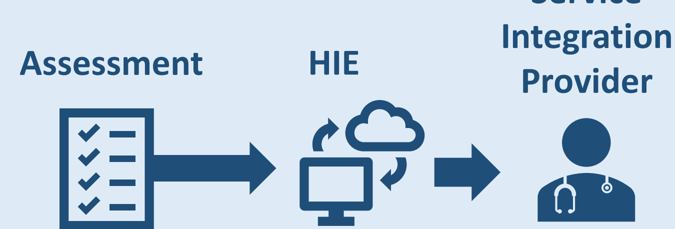
Home & Community-Based Supports

# High-Level InCK Model Steps Needing to Start in 2022: Needs Assessment & Service Integration

## Needs Assessment

**OHA Needs Assessment + PacificSource Data Enhancements**

**PacificSource Shares Needs Assessment and Proposed SIL Level to Service Integration Provider**

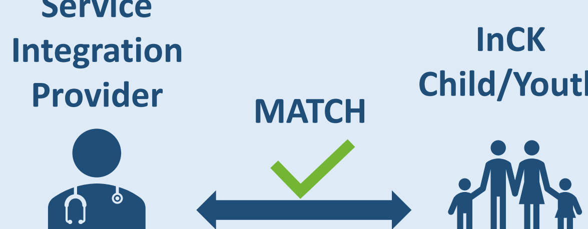



***Currently Identified SIL providers:***

- Clinical Providers
- Internal PCS Care Mgmt. Staff
- PCS Contracted Entities for SIL 3

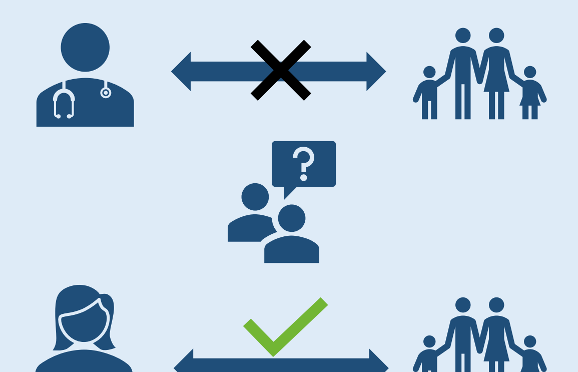
## Service Integration Provider Established

**For those able to assign:**




**For those we are unable to assign:**

Note: 20% of SIL2 attributed to a PCPCH have not seen that PCPCH



## Service Integration Provision**

**(Meet Annual InCK Care Milestones)**

**Service Integration Level 2 (SIL2)**

- Access to preventive care
- At visit, screen and assess needs
- Referral and connect to core services
- Coordinate with core service providers
- Identify care coordination needs
- If care coordination team providing SIL care, adjudicate to SIL 3 as needed

**Service Integration Level 3 (SIL3)**

- Integrated case management across clinical and core service providers
- Care planning team established across core service providers
- Shared plans of care

**System Navigator**

- Support to SIL2 and SIL3 providers
- Coordination across core service provider needs & unmet core service provider needs

***** Note: Oregon InCK Model team awaiting clarifications on reporting requirements which could have a significant impact.***

## Figure 2.0 Oregon's Needs Assessment: Cross-Sector System-Level Health Complexity DRAFT Data of PacificSource Community Solutions of Central Oregon Medicaid/CHIP Insured Children and Young Adults (Birth to 21)

**Level 1** All children and youth (ages 0-21) in the model area covered by Medicaid/CHIP | Population-based approaches to screening InCK Model population for housing and food insecurity | N= 20,866

**Level 2** Service Integration Level 2 (SIL 2)

| | Point 1: Exhibited need for two core child services | | Point 2: Functional symptom of impairment MEDICAL COMPLEXITY | Total Children with Combined Indicators Current Available HEALTH COMPLEXITY |
|---|---|---|---|---|
| | *Child had 1+ core service…* | *…and exhibited need for additional services* SOCIAL COMPLEXITY | | |
| 2A | Child had physical or behavioral health service *Data Not Yet Available* | • Child has previously been in foster care<br>• Child currently in foster *care (This will be moved to 3A. However, it is included with 2A data at this time.)* | Medical Complexity<br>• Complex Chronic (CC), OR<br>• Non-Complex Chronic (NCC) | 3.7%, N = 974 |
| 2B | | Social Complexity that includes<br>• Parent substance abuse, &/or<br>• Parent mental health, &/or<br>• Parental incarceration | Medical Complexity<br>• Complex Chronic (CC), OR<br>• Non-Complex Chronic (NCC) | CC: 5.5%, N = 1,433<br>NCC: 9.1%, N = 2,374 |
| 2C | | Social Complexity: 3 or more indicators of 8 remaining factors not identified in 2A and 2B. *(Includes factors such as TANF, child use of metal health or substance abuse services, diagnosis of child abuse and neglect, parental death, and non-English primary language, parent disability)* | Medical Complexity<br>• Complex Chronic (CC) | CC: 0.95 %, N = 246 |
| | | | Children Birth to Five:<br>• Non-Complex Chronic (NCC) | *Birth to Five NCC: 0.44%, N = 114* |
| TOTAL | | | | N = 5,141 |

These estimates are based on a combined analysis of OHA system-level indicators as well as PacificSource person-level indicators. PacificSource indicators in some cases included more recent (up-to-date) data or provided a different way of capturing a similar indicator to OHA's from a different lens (for example, identifying parents through head of household information rather than birth record). PCS data sources primarily included Medicaid claims and enrollment data. PCS Medical complexity results were based on 1-year look back of Medicaid data for 2020-Jan 2021. Oregon Health Authority leveraged 2020 Child Health Complexity data: Medical complexity based on APAC claims from January 2017-December 2019. Social complexity based on social indicators for life of the child + 1 year as of May 2020. Population includes children and youth residing in Marion and Polk counties as of May 2020. See https://www.oregon.gov/oha/HPA/dsi-tc/Documents/DataDictionary-Social-Indicators.pdf

# Children with Multiple Needs Assessment Flags by Medical Complexity

OPIP

| InCK Service Integration Level Flags Based on Social Complexity or Hospitilizations | |
|---|---|
| 2A | **Child has previously been in foster care** |
| 2B | **Social Complexity that includes**<br>• **Parent substance abuse, &/or**<br>• **Parent mental health, &/or**<br>• **Parental incarceration** |
| 2C | **Social Complexity: 3 or more indicators of 8 remaining factors not identified in 2A and 2B.** |
| *3A* | ***DRAFT/Temporary Indicator: Children/Youth CURRENTLY in Foster Care*** |
| *3B* | ***DRAFT/Temporary Indicator: Child has had 1 or more hospitalizations in past 12 mos*** |

| Central Oregon | | |
|---|---|---|
| **Count of Indicators (2A/2B/2C/3A/3B)** | **Complex Chronic Population** (Count) | **Non-Complex Chronic Population** (Count) |
| **1** | **702** | **2,389** |
| **2** | **1,016** | **605** |
| **3** | **297** | **48** |
| **4** | **84** | **-** |
| **5** | **n < 10** | **-** |

# CMMI Option for Scaled Up Implementation Related to Needs Assessment & Service Integration

**Parameters We Have Considered**:
- Different readiness by clinical providers
- Starting with ready and able providers
- Starting with a subset of the children identified from the system-level needs data, matches of care models with needs
- Pilot of models in 2022 to inform spread and investments
- Ensuring enough population included in 2022 to ensure CMM approval
- Honoring Health Equity Approach (e.g., clinics in rural region clinics that serve diverse populations)

2022 2023 2024 2025 2026

**Small Population Served by Service Integration Providers Ready in 2022 (Subset of N=5141)**
*Need to confirm our parameters for proposal that could consider the Region, Clinical Sites, and Other Strategies*

**N= 5,141** Kids Identified in Need Assessment and Provided Service Integration Level

**Increases in Service Integration Levels within Existing Providers, Enhanced Capacity of Existing or New Providers Who Can Provide SIL2 and/or SIL 3 Level of care; If applicable new contracted providers**

# Small Group Discussion: Opportunity to Ask Questions or Provide Input

1. What questions or need for clarity do you have?
2. Given the context and thinking we've shared on phasing in our work during InCK implementation (*particularly how we would ensure children identified through the needs assessment have their needs met*) **what would you like to us to know or consider as we think through this approach?**

# Break

- Optional activity
  - Brain game/word puzzle
  - Self-led
  - Share how many you got right in the chat!

# What do these three words have in common?

Orange = Easy  Blue = Medium  Purple = Hard

1. Picnic – card – pool
2. Candy – crab – caramel
3. Onion – napkin – wedding
4. Days – continents – seas
5. French – car – unicorn
6. Turtle – M&Ms – ocean
7. Florist – furniture store – obstetrician
8. Bicycle tire – toothpaste – chemistry lab
9. Radio – car engine – piano

# What do these three words have in common?

Answers

1. Picnic – card – pool > ***Types of tables***
2. Candy – crab – caramel > ***Types of apples***
3. Onion – napkin – wedding > ***Types of rings***
4. Days – continents – seas > ***Seven of each***
5. French – car – unicorn > ***Types of horns***
6. Turtle – M&Ms – ocean > ***All have shells***
7. Florist – furniture store – obstetrician > ***All make deliveries***
8. Bicycle tire – toothpaste – chemistry lab > ***All have tubes***
9. Radio – car engine – piano > ***All are tuned***

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  - **Large Group Feedback**

# Introduction to Central Oregon System Navigator

Tanya's Bio Can be Found in the Pre-reading on **page 7 of the Pre-Reading Materials**

Central Oregon's System Navigator is Tanya Nason!

# *Current Priorities of the System Navigator Position*

***Summary of Job Duties be Found in the Pre-reading on pages 7-8***

Since being **hired at the end of March, the priorities of the System Navigator** have been focused on:

- **Onboarding** and understanding the InCK Model
- Development of a **framework to document asset mapping** of core services providers
- Developing a **work plan for outreach and engagement of care coordinators** and case managers that support children birth-21

**Current focus on development of the Behavioral Health Asset Map**

- Based on the Needs Assessment of Children in SIL 2 and 3 about 20% had evidence of a behavioral health assessment or service
- All children in SIL 2/3 would benefit from at least a BH assessment, so we know this pathway to services will be a priority for implementation in 2022 and there seems to be barriers to services

# What is an Asset Map?

| Version 17 May 5, 2021 | Current Assessment of Specialty Mental Health Providers Who See Children Birth-5 in Central Oregon | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | County in Which the Services are Available | | | | | | | | | | | | | | |
| | Deschutes | | | | | Deschutes & Crook | | Crook | | Jefferson | All Counties | Home Visits Across All Counties | | | |
| Company | Deschutes County[2] | Cherie Skillings (09/2020) | Starfish Counseling[1] | The Child Center[1] | Treehouse Therapies[2] | Forever Family Therapy[1] | Rimrock Trails[2] | Crook County BestCare[2] | Prineville Counseling Center[2] | Jefferson County BestCare[2] | Brightways Counseling[2] | Amy Bordelon, LMFT[1] | Now and Zen[1] | Blossom Therapeutic Collective: Saul Behavioral[2] | Youth Villages[1] |
| Office Location | Redmond (7) Bend (6) LaPine (2) | Bend | Bend | Bend(4), La Pine (3), Redmond(2), Sisters (1) | Bend, Redmond | Bend, Prineville | Bend , Redmond & Prineville | Prineville | Prineville | Madras | Redmond (3), Madras (2), Bend (1) | Bend | Redmond & Sisters | Bend | Redmond |
| # of Providers | 15 | 1 | 1 | 10 | 4 | 4 | 4 | 2 | 2 | 6 | 6 | 1 | 1 | 2 | 6 |
| Case Load (per week) | 114 | 24 | 25 | 134 | 80 | 40 | 75 | * | 40 | * | 160 | 12 families + 9 groups | 30 | 30 | 24 |
| Capacity for New referrals | 25 families | 12 families | At Capacity | At Capacity | 20 families | 16 families | 25 families | 6 families | 0 families | 20 families | 45 families | Limited | 3-5 families | 1-2 families | 2 families |
| Provider Race, Ethnicity | 14 White, 1 White/ Hispanic | White | White | White | White, Asian | 3 White, 1 African American | White | White | White | White | White | White | White | 1 White | 1 Japanese-American, 5 White |
| Provider Language Spoken | 14 English, 1 Spanish/ English | English | English | 9 English, 1 Spanish/ English | English, 1 Spanish | English | 3 English, 1 Spanish | English | English | English (Has staff that can support Spanish translations) | English | English | English | English | English |
| Payer | OHP/ Private | OHP/ Private | OHP/ Private | OHP/ Private | OHP/ Private | OHP/ Private | OHP | OHP/ Private | OHP/ Private | OHP/ Private | OHP/Private | Private/ Sliding scale | OHP/ Private | Patient submits claims | OHP/ Private |
| Tele-services | Yes | Yes | Yes | Yes | Yes | Yes | 1 Nurse Practioner | Yes, during COVID-19 | Yes | Yes, during COVID-19 | Yes | * | * | Yes | * |

# What is an Asset Map?

**The information that will be collected during the asset mapping process includes:**

**Organization/Provider Overview**
- Service(s) provided to support children by different age categories 0-5, 6-11, 12-17, 18-21

**Staff Capacity**
- Waitlist Time
- Number of PCS members provider is able to service
- Slots available now

**Service Location** - (city/county)

**Spoken Language(s) of Providers**

**Does this provider identify as white? - Y/N, if no, how do they identify**

**Payor(s) Accepted**
- Telehealth

# Next Steps in Asset Mapping

We want to ***understand other priorities the Systems Navigator*** should consider for the scaled up development of the regional the asset map

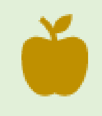
## Clinical Care

**Clinical Care (Physical)**
- Hospitals/Specialists
- Contracted Entities for SIL Coordination (e.g. NICH, Other Models)
- Occupation/Physical Therapy
- Speech Therapy
- Applied Behavioral Analysis
- Durable Medical Equipment

**Clinical Care (Behavioral)**
- Internal Behavioral Health
- Specialty Behavioral Health
- Substance Use Treatment Providers

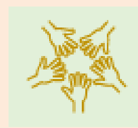
**Mobile Crisis**

## Community-Based Services



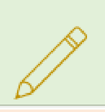
**Food**
- TANF/WIC/SNAP
- Community Based Organizations

**Housing Community Based Organizations**



**Title V Agencies & Maternal and Child Health Services**

**Child Welfare**



**Early Care and Education**

Keep an eye out for the poll that will be popping up to select your priority areas!
Please type into the chat if you have other priority areas we should consider

# Today's Agenda

- **Welcome, Introductions to New Members, Ice Breaker Related to a Year of Partnership Council Meetings**
- Collaborative conversation on the current **InCK community engagement approach** of **people served by the model (***children, youth and young adults 0-21 on the Oregon Health Plan and their families)*
  - **Large Group Interactive Discussion**
- Update on **federal and state learnings from the pre-implementation period** and opportunities for **refinements and revisions being explored**, obtain input from PC members on the design parameters and factors being explore.
  - **Small Group Feedback**
- **Stretch Break and Fun Polling**
- Provide a brief update on the **extensive and broad work** being done **to operationalize components of the InCK model starting in 2022**
  - Introduce the System Navigator, Highlight of Current Priorities
  - Update on System-Level Needs Assessments
- Provide an update on relevant activities learnings related to six **Central Oregon Health Council priority areas** (*Address Poverty & Enhance Self Sufficiency, Behavioral Health, Promote Enhanced Physical Health Access, Stable Housing, Substance & Alcohol Misuse, Upstream Prevention*) and obtain input and guidance for what may be shared to committees to honor the PC Charter Service Integration Needs Assessment indicators
  - **Large Group Feedback**

## Figure 1.0 Overview of Oregon's Integrated Care for Kids Needs Assessment and Service Integration Strategy

### Needs Assessment

**Level 1** All children and youth (ages 0-21) in the model area covered by Medicaid/CHIP

**A. System-level Health Complexity Data**
Includes data from multiple health and non-health care sources.

**B. Housing and Food Insecurity Screening**
Population-based approaches to screening InCK Model population for housing and food insecurity.

**Level 2** Service Integration Level 2 (SIL 2)

| | Point 1: Exhibited need for two core child services | | Point 2: Functional symptom of impairment |
|---|---|---|---|
| | Child had 1+ core service | ...and exhibited need for additional services (Social Complexity) | |
| **2A.** | Child had physical or behavioral health service | Child has been in foster care previously in their lifetime | Medical Complexity<br>• Complex Chronic, OR<br>• Non-Complex Chronic |
| **2B.** | | Social Complexity that includes<br>• Parent substance abuse, &/or<br>• Parent mental health, &/or<br>• Parental incarceration | Medical Complexity<br>• Complex Chronic, OR<br>• Non-Complex Chronic |
| **2C.** | | Social Complexity: 3 or more indicators of 8 remaining factors not identified in 2A and 2B<br>(Includes factors such as TANF, child use of metal health or substance abuse services, diagnosis of child abuse and neglect, parental death, and non-English primary language, parent disability) | Medical Complexity<br>• Complex Chronic<br>• If child under five, also includes Non-Complex Chronic. |

**Level 3** Service Integration Level 3 (SIL 3)

| | | |
|---|---|---|
| **3A.** | Child Currently in Foster Care or Other Applicable Out of Home Placement | • Complex Chronic, OR<br>• Non-Complex Chronic |
| **3B** | One or More Social Complexity Factors | Hospitalization or Prolonged Hospitalization |

### Service Integration

**Level 1**

Preventive care

Active Monitoring & New Screening

**Level 2**

Access to Preventive Care

Screening, Referral & Connection to Applicable Needed Core Services

Establish Care Team, If Applicable Ensure Needed Care Coordination

**Level 3**

Integrated Case Management & Care Planning Team Established, Shared Plans of Care

Home & Community-Based Supports

## Figure 2.0 Oregon's Needs Assessment: Cross-Sector System-Level Health Complexity DRAFT Data of PacificSource Community Solutions of Central Oregon Medicaid/CHIP Insured Children and Young Adults (Birth to 21)

Central Oregon InCK Population Total = 20,866
Central Oregon SIL 2 Total = 5,141 (25% of Total)

**Level 2** Service Integration Level 2 (SIL 2)

| | SOCIAL COMPLEXITY | MEDICAL COMPLEXITY | Total Children with Combined Indicators Current Available HEALTH COMPLEXITY |
|---|---|---|---|
| 2A | Child has previously been in foster care | Medical Complexity<br>• Complex Chronic (CC), OR<br>• Non-Complex Chronic (NCC) | N = 974 (3.7%) |
| 2B | Social Complexity that includes<br>• Parent substance abuse, &/or<br>• Parent mental health, &/or<br>• Parental incarceration | Medical Complexity<br>• Complex Chronic (CC), OR<br>• Non-Complex Chronic (NCC) | CC: N = 1,433 (5.5%) |
| | | | NCC: N = 2,374 (9.1%) |
| 2C | Social Complexity: 3 or more indicators of 8 remaining factors not identified in 2A and 2B. *(Includes factors such as TANF, child use of metal health or substance abuse services, diagnosis of child abuse and neglect, parental death, and non-English primary language, parent disability)* | Medical Complexity<br>• Complex Chronic (CC) | CC: N = 246 (.95%) |
| | | Children Birth to Five:<br>• Non-Complex Chronic (NCC) | *Birth to Five* NCC: N = 114 (.44%) |

*Source:* These estimates are based on a combined analysis of OHA system-level indicators as well as PacificSource person-level indicators. PacificSource indicators in some cases included more recent (up-to-date) data or provided a different way of capturing a similar indicator to OHA's from a different lens (for example, identifying parents through head of household information rather than birth record). PCS data sources primarily included Medicaid claims and enrollment data.

# Children with Multiple Needs Assessment Flags by Medical Complexity

OPIP

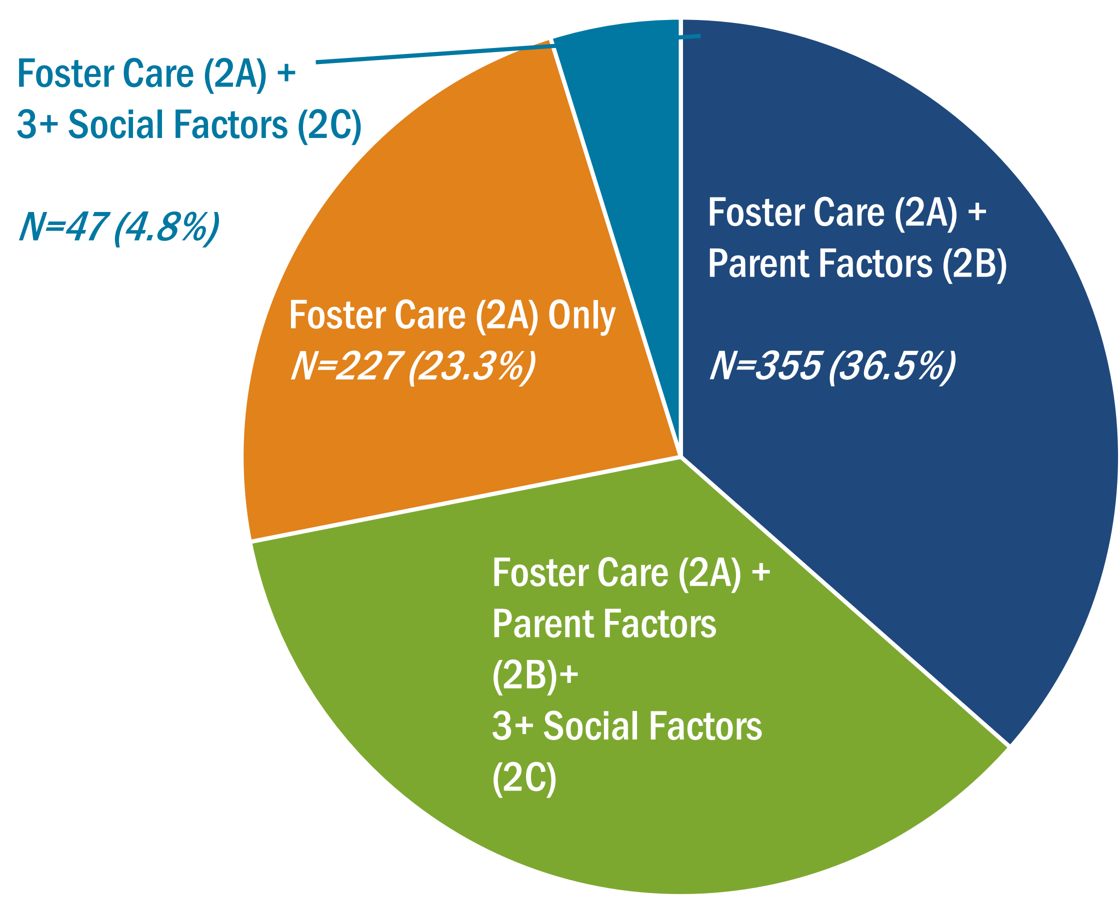
| InCK Service Integration Level Flags Based on Social Complexity or Hospitilizations | |
|---|---|
| 2A | **Child has previously been in foster care** |
| 2B | **Social Complexity that includes**<br>• **Parent substance abuse, &/or**<br>• **Parent mental health, &/or**<br>• **Parental incarceration** |
| 2C | **Social Complexity: 3 or more indicators of 8 remaining factors not identified in 2A and 2B.** |
| *3A* | ***DRAFT/Temporary Indicator: Children/Youth CURRENTLY in Foster Care*** |
| *3B* | ***DRAFT/Temporary Indicator: Child has had 1 or more hospitalizations in past 12 mos*** |

| Central Oregon | | |
|---|---|---|
| **Count of Indicators (2A/2B/2C/3A/3B)** | **Complex Chronic Population** (Count) | **Non-Complex Chronic Population** (Count) |
| **1** | **702** | **2,389** |
| **2** | **1,016** | **605** |
| **3** | **297** | **48** |
| **4** | **84** | **-** |
| **5** | **n < 10** | **-** |

# Oregon's Needs Assessment for Pacific Source Community Solutions of Marion and Polk Medicaid/CHIP Insured Children and Young Adults (Birth to 21)

## Relationship and Correlation of Factors With Each Other and Out of Home Placement (SIL 2A):

### Within Foster Care + Medical Complexity (SIL 2A) Population
(% of population with overlapping factors)
N = 974




**77% of Children/Youth Currently or Ever Been in Foster Care <u>are flagged with additional factors.</u>**



*Source:* These estimates are based on a combined analysis of OHA system-level indicators as well as PacificSource person-level indicators. PacificSource indicators in some cases included more recent (up-to-date) data or provided a different way of capturing a similar indicator to OHA's from a different lens (for example, identifying parents through head of household information rather than birth record). PCS data sources primarily included Medicaid claims and enrollment data.

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  - **Large Group Feedback**

# Partnership Council Charter

**Central Oregon Health Council**

OPIP will facilitate the Partnership Council and the activities will be aligned with the Central Oregon Health Council mission and structure.

- Coordinate with the Central Oregon Health Council (COHC) Executive Director and related COHC Project Managers to obtain input and review from the Community Advisory Council, Operations Council, and Central Oregon Diversity, Equity and Inclusion Committee.
- Routinely present InCK Model components that impact or will engage front-line providers to the COHC Provider Engagement Panel for review and input.
- Routinely present applicable components of in the InCK Model to the topic-specific Regional Health Improvement Plan (RHIP) workgroups to obtain input, guidance and review of related materials. For example, for components of the InCK Model development that related to behavioral health will be presented for review to the Behavioral Health: Increase Access and Coordination workgroup.

# Central Oregon
# Regional Health Improvement Priorities

*Page 15-16 of the Pre-Reading Materials*

1. Address Poverty & Enhance Self Sufficiency
2. Behavioral Health: Increase Access & Coordination
3. Promote Enhanced Physical Health Across Communities
4. Stable Housing & Supports
5. Substance Abuse & Alcohol Misuse
6. Upstream Prevention

# COHC:
# Address Poverty & Enhance Self Sufficiency

## Address Poverty and Enhance Self-Sufficiency

**AIM**

Individuals and families in Central Oregon experiencing poverty are provided equitable access and connected to appropriate resources that help them overcome obstacles to self-sufficiency and address health-related challenges.

**METRICS**

1. Increase high school graduation rates among economically disadvantaged students
2. Decrease food insecurity
3. Decrease percent of individuals living at poverty level and income constrained
4. Decrease housing and transportation costs as a percent of income

# InCK Efforts Related to **Address Poverty & Enhance Self Sufficiency Metric**

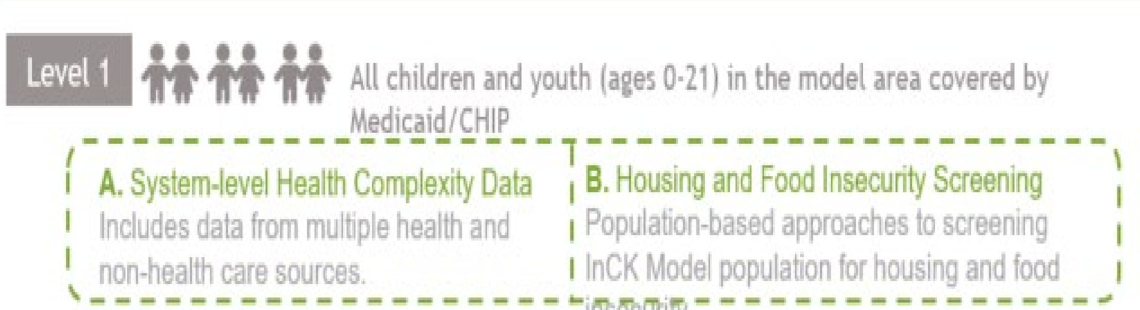
| AIM | Individuals and families in Central Oregon experiencing poverty are provided equitable access and connected to appropriate resources that help them overcome obstacles to self-sufficiency and address health-related challenges. |
|---|---|
| METRICS | 1. Increase high school graduation rates among economically disadvantaged students<br>2. Decrease food insecurity<br>3. Decrease percent of individuals living at poverty level and income constrained<br>4. Decrease housing and transportation costs as a percent of income |

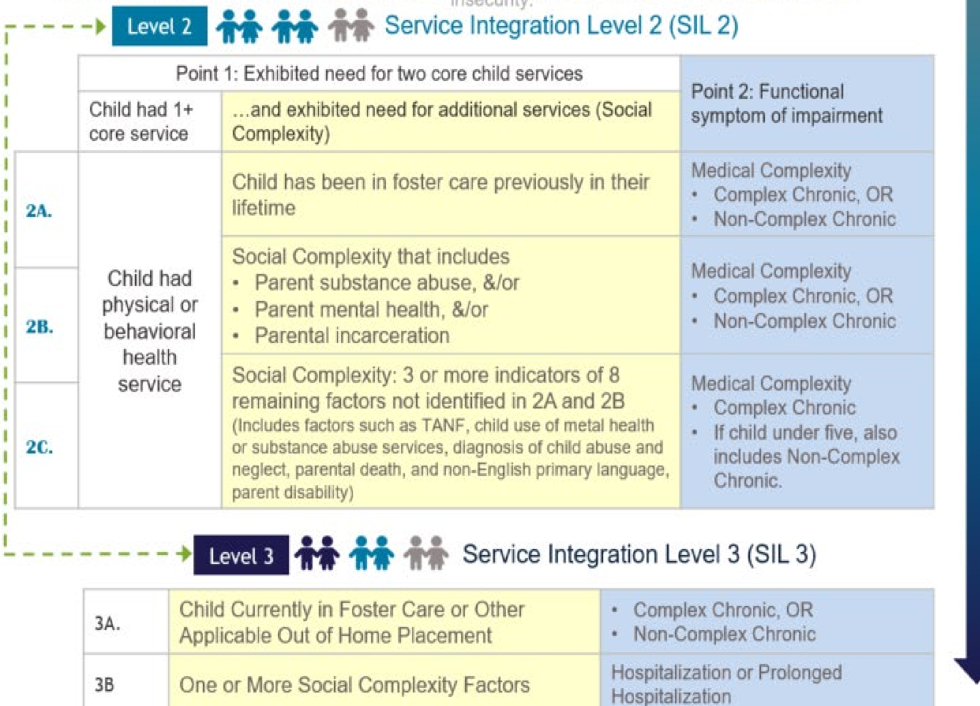
## Synergistic Activities within InCK or for the Population that InCK Will Call Out A Focus:

- Population based approaches to screening for food insecurity
  - *Opportunity to consider pilot that go beyond provision of WIC, SNAP, TANF*
  - *E.g. Food boxes at point of care, Culturally diverse food options*
- System-Level Needs Assessment Identifies Children/Youth/Young Adults with Medical and Social Complexity Factors that have been shown to be associated with Chronic Absenteeism from School, Potential for Service Integration to Address Root Barriers.
  - *Opportunities for potential pilot support in specific schools for specific students*
- High health care costs for children with medical complexity is a primary driver of bankruptcy for families

# InCK Efforts Related to **Address Poverty & Enhance Self Sufficiency Metric**

## Example: Assessing for Food Insecurity Screening



Level 2 — Service Integration Level 2 (SIL 2)

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Level 3 — Service Integration Level 3 (SIL 3)

| | | |
|---|---|---|
| 3A. | Child Currently in Foster Care or Other Applicable Out of Home Placement | • Complex Chronic, OR<br>• Non-Complex Chronic |
| 3B | One or More Social Complexity Factors | Hospitalization or Prolonged Hospitalization |

# InCK Efforts Related to **Address Poverty & Enhance Self Sufficiency Metric**

- What other opportunities do you see for synergy with this COHC Priority?
- If you are  involved in this track of work, what opportunities to you see that were not listed?
- What barriers do you expect we will encounter in INCK related to screening for food insecurity and in connecting children, youth and young adult to services that address their food insecurity?

# COHC:
# Behavioral Health Access and Coordination

## Behavioral Health: Increase Access and Coordination

**AIM**

Increase equitable access to skilled and coordinated care between specialty behavioral health* and the larger health system, including primary care, while decreasing barriers to ensure an effective and timely response.

*Specialty behavioral health: behavioral health, substance abuse, and developmental services that are delivered outside of primary care.

**METRICS**

1. Increase availability of behavioral health providers in marginalized areas of the region
2. Increase timeliness and engagement when referred from primary care to specialty behavioral health
3. Standardize screening processes for appropriate levels of follow-up care across services

# InCK Efforts Related to
# **Behavioral Health Access and Coordination**

| AIM | Increase equitable access to skilled and coordinated care between specialty behavioral health* and the larger health system, including primary care, while decreasing barriers to ensure an effective and timely response.<br>*Specialty behavioral health: behavioral health, substance abuse, and developmental services that are delivered outside of primary care. |
|---|---|
| METRICS | 1. Increase availability of behavioral health providers in marginalized areas of the region<br>2. Increase timeliness and engagement when referred from primary care to specialty behavioral health<br>3. Standardize screening processes for appropriate levels of follow-up care across services |

## Synergistic Activities within InCK or for the Population that InCK Will Call Out A Focus:

- Asset map of services for the InCK Population
- Children/Youth Identified with Service Integration Level 2 and Level 3 Needs Likely Will Benefit for Behavioral Health Assessments and Services (N=5,101)
  - *Trainings to support best match care*
  - *Pilots of closed loop referral pathways*
  - *Addressing gaps in the asset mapping identified by region and to ensure culturally and linguistically appropriate care*
- Dyadic approaches to behavioral health providers in one organization that serve the adult and that connect with providers that focus on attachment of that adult and that child.
  - *Pilots of this model.*
  - *Development of care plans that incorporate both components of care*

- What other opportunities do you see for synergy with this COHC Priority?
- If you are  involved in this track of work, what opportunities to you see that were not listed?
- What barriers do you expect we will encounter in INCK to ensure access to behavioral health?
- What barriers do you expect we will encounter in INCK to ensure coordinated behavioral health care?

# COHC Priority Area:
# Promote Enhanced Physical Health Across Community

Promote Enhanced Physical Health Across Communities

**AIM**

Equitably and measurably support all Central Oregonians to prevent disease by improving health behaviors and reducing risk factors that contribute to premature death and diminish quality of life.

**METRICS**

1. Decrease asthma, cancer, cardiovascular disease, and diabetes rates
2. Decrease obesity rates in adults
3. Increase fruit/vegetable consumption and physical activity in youth
4. Decrease risk factors for cardio-pulmonary and/or preventable disease
5. Decrease sexually transmitted infections
6. Increase individuals receiving both an annual wellness visit and preventative dental visit

Oregon Health Authority

# InCK Efforts Related to **Promote Enhanced Physical Health Across Community**

| | |
|---|---|
| AIM | Equitably and measurably support all Central Oregonians to prevent disease by improving health behaviors and reducing risk factors that contribute to premature death and diminish quality of life. |
| METRICS | 1. Decrease asthma, cancer, cardiovascular disease, and diabetes rates<br>2. Decrease obesity rates in adults<br>3. Increase fruit/vegetable consumption and physical activity in youth<br>4. Decrease risk factors for cardio-pulmonary and/or preventable disease<br>5. Decrease sexually transmitted infections<br>6. Increase individuals receiving both an annual wellness visit and preventative dental visit |

## Synergistic Activities within InCK or for the Population that InCK Will Call Out A Focus:

- System-Level Needs Assessment Identifies Children with High Aces that is Associated with Chronic Conditions Listed Above and Will Aim for Behavioral Health Supports
- InCK includes a focus on increased well-visit access for the InCK Population (Birth-21)

InCK Efforts Related to

# Promoting Enhanced Physical Health Across Community

- What other opportunities do you see for synergy with this COHC Priority?
- If you are  involved in this track of work, what opportunities to you see that were not listed?
- What barriers do you expect we will encounter in INCK related to access of well-child care?

# COHC:
# Stable Housing & Supports

Stable Housing and Supports

**AIM**

Central Oregonians experiencing homelessness and those most at-risk of homelessness will have increased and equitable access to housing and supports that offer opportunities for housing stability and increased individual well-being.

**METRICS**

1. Decrease severely rent and mortgage-burdened households
2. Increase Housing Choice Voucher holders able to find and lease a unit
3. Accurately capture Central Oregonians experiencing homelessness

# InCK Efforts Related to **Stable Housing & Supports**

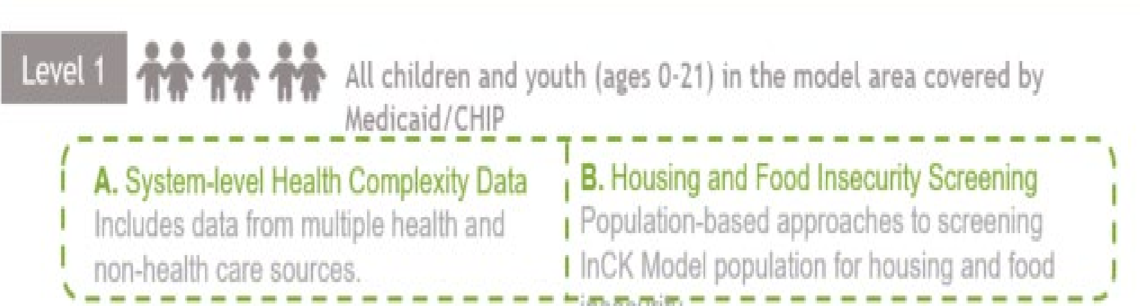
| | |
|---|---|
| AIM | Central Oregonians experiencing homelessness and those most at-risk of homelessness will have increased and equitable access to housing and supports that offer opportunities for housing stability and increased individual well-being. |
| METRICS | 1. Decrease severely rent and mortgage-burdened households<br>2. Increase Housing Choice Voucher holders able to find and lease a unit<br>3. Accurately capture Central Oregonians experiencing homelessness |

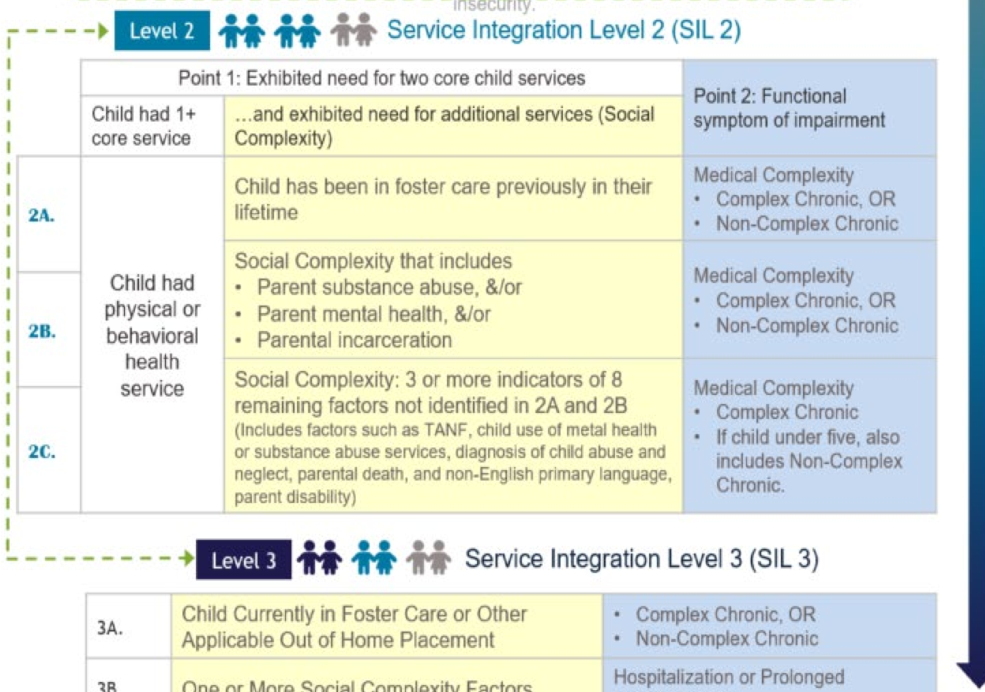
Synergistic Activities within InCK or for the Population that InCK Will Call Out A Focus:

- Population based approaches to screening for housing insecurity
  - *Opportunity to consider how to prioritize children and families*
  - *Housing that address children with medical complexity*
- Service Integration for Levels 2 and Level 3 will include screening for housing insecurity
  - *Opportunities for potential pilot to support housing for these families at increased risk.*

# InCK Efforts Related to **Stable Housing & Supports**

## Example: Assessing for Housing Insecurity



Level 2 Service Integration Level 2 (SIL 2)

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Level 3 Service Integration Level 3 (SIL 3)

| | | |
|---|---|---|
| 3A. | Child Currently in Foster Care or Other Applicable Out of Home Placement | • Complex Chronic, OR<br>• Non-Complex Chronic |
| 3B | One or More Social Complexity Factors | Hospitalization or Prolonged Hospitalization |

Screening

Level 2

- Access to Preventive Care
- Screening, Referral & Connection to Applicable Needed Core Services
- Establish Care Team, If Applicable Ensure Needed Care Coordination

Level 3

- Integrated Case Management & Care Planning Team Established, Shared Plans of Care
- Home & Community-Based Supports

# InCK Efforts Related to **Stable Housing & Supports**

- What other opportunities do you see for synergy with this COHC Priority?
- If you are  involved in this track of work, what opportunities to you see that were not listed?
- What barriers do you expect we will encounter in INCK to addressing housing instability?
- Are children and families a identified priority in current efforts to focus on housing instability?

# COHC:
# Substance Abuse & Alcohol Misuse

## Substance and Alcohol Misuse: Prevention and Treatment

**AIM**

Create and enhance cross-sector collaborations and programming so that all Central Oregonians have equitable access to skilled, evidence-based substance and alcohol misuse prevention, intervention, treatment, and recovery services that are culturally responsive and trauma-informed.

**METRICS**

1. Decrease binge drinking among adults
2. Decrease vaping or e-cigarette use among youth
3. Increase additional services for alcohol or drug dependence for individuals newly diagnosed
4. Reduce mental health/substance abuse emergency department visits in Madras, Prineville and Warm Springs

# InCK Efforts Related to
# **Substance Abuse & Alcohol Misuse**

**AIM**

Create and enhance cross-sector collaborations and programming so that all Central Oregonians have equitable access to skilled, evidence-based substance and alcohol misuse prevention, intervention, treatment, and recovery services that are culturally responsive and trauma-informed.

**METRICS**

1. Decrease binge drinking among adults
2. Decrease vaping or e-cigarette use among youth
3. Increase additional services for alcohol or drug dependence for individuals newly diagnosed
4. Reduce mental health/substance abuse emergency department visits in Madras, Prineville and Warm Springs

<u>Synergistic Activities within InCK or for the Population that InCK Will Call Out A Focus:</u>

- Service Integration for Levels 2 explicitly include identifying CHILDREN whose parent has accessed substance or mental health services?
  - *Opportunities for potential pilot to support dyadic approaches to care*
- Service Integration for Levels 2 and Level 3 will include YOUTH and Young Adult that are newly diagnosed?
  - *Opportunities for potential pilot specific those INCK population.*

# InCK Efforts Related to **Substance Abuse & Alcohol Misuse**

- What other opportunities do you see for synergy with this COHC Priority?
- If you are  involved in this track of work, what opportunities to you see that were not listed?
- What barriers do you expect we will encounter in INCK to providing Service Integration to the populations that include factors associated with substance abuse and alcohol misuse?

# COHC:
# Upstream Prevention

## Upstream Prevention: Promotion of Individual Well-Being

**AIM**

All communities in Central Oregon have equitable access and opportunities to health, education, healthy relationships, community support, and experiences necessary to thrive at every stage of life from prenatal to adulthood.

**METRICS**

1. Increase letter name recognition at kindergarten
2. Increase third-grade reading proficiency
3. Increase proportion of pregnancies that are intended
4. Increase two-year-old immunization rates
5. Increase the number of people who feel they belong in their community

# InCK Efforts Related to **Upstream Prevention**

| | |
|---|---|
| AIM | All communities in Central Oregon have equitable access and opportunities to health, education, healthy relationships, community support, and experiences necessary to thrive at every stage of life from prenatal to adulthood. |
| METRICS | 1. Increase letter name recognition at kindergarten<br>2. Increase third-grade reading proficiency<br>3. Increase proportion of pregnancies that are intended<br>4. Increase two-year-old immunization rates<br>5. Increase the number of people who feel they belong in their community |

## Synergistic Activities within InCK or for the Population that InCK Will Call Out A Focus:

- InCK Focus on Birth to Five and the Factors Associated with ACES aligns with deep upstream work
- Focus on provision of physical, behavioral and health related needs for the birth to five population level in Service Integration Level 2 and Level 3 is key component of upstream approaches
  - *Opportunities for potential pilot to support dyadic approaches to care*
- Partnership Council noted at December 2020 lack of connections and supports for socially complex families

# InCK Efforts Related to **Upstream Prevention**

- What other opportunities do you see for synergy with this COHC Priority?
- If you are  involved in this track of work, what opportunities to you see that were not listed?

# Priority Next Steps

- Refine 2022 goals and aims and stagger strategy
- Deep focus on operationalizing implementation components to 2022 start points for the Needs Assessmentnt and Service Integration Levels
- Multiple and intense CMMI reporting requirements due by July
- Community Engagement of Persons with Lived Experience, Further recruitment of PYYAYG
- Next meeting is **September 14th 1-3 PM: Fingers Crossed We Can Do An In-Person Meeting in 2021**

- We **CAN and ARE DOING HARD THINGS!**
- **This is only possible through collaboration and engagement!**

THANK YOU