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

March 2nd, 2021 1-3 PM

Oregon Health Authority OPIP

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.*

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Objectives

- Provide an update on and overview of **extensive and broad work** being done to operationalize components of the InCK model starting in 2022.
- Provide an overview of baseline **Parent, Youth and Young Adult Advisor Care Maps**.
- Provide an overview of InCK requirements related to **Mobile Crisis Services** and current options and strategies being explored and **obtain input**.
- Provide an update on key areas of focus for the **June Partnership Council** meeting and **pre-work requested** from Partnership Council members.

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Today's Agenda

- **Welcome, 2021 Refresher on INCK Model & Visuals from Community Café Informed Sessions**
- **Update on Oregon's Service Integration Needs Assessment** and overview of the baseline **Parent, Youth and Young Adult Advisory Care Maps** for persons identified by Needs Assessment.
- Provide an update and **overview of extensive and broad work being done to operationalize components of the InCK model starting in 2022.**
  Small Group Feedback
- **Overview of Mobile Crisis and Stabilization Services** and review InCK requirements, current options and strategies being explored.
  Interactive Group Activity
- **Stretch Break & Fun Activity**
- Provide an **overview of proposed process for exploring integration and sharing of information required as part of the InCK Model**.
  Small Group Feedback
- Heads up on **June Partnership Council** meeting

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Welcome

Partnership Council Members:

- **Shannon Brister** – Deschutes County Child Behavioral Health Team: Comprehensive Care for Youth and Families – Acting Program Manager
- **Amy McCormack** – High Desert Education District

Oregon Health Authority:

- **Heather Redman**– OHA Community Engagement Coordinator with specific focus on engagement of communities with historical inequitable outcomes.

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VERSION 3.2 2/8/2021

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

Active Monitoring
Preventive care

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

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

Enhanced assessments and screenings
Best Match Care Coordination

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

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

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

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

Regional Activities & Supports Funded by Project

- Regional Partnership Councils.
- Parent & youth engagement.
- Partnerships with racial and ethnic communities most impacted by health inequities led by OHA's Community Engagement Coordinator.
- Provision of system-level risk stratification data by OHA.
- Region-specific Systems Navigator based within PacificSource.
- Health information exchange/ Community information exchange (UniteUs/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/ERD/Pages/Oregon-Health-Authority-awarded-16-million-improve-child-health.aspx.

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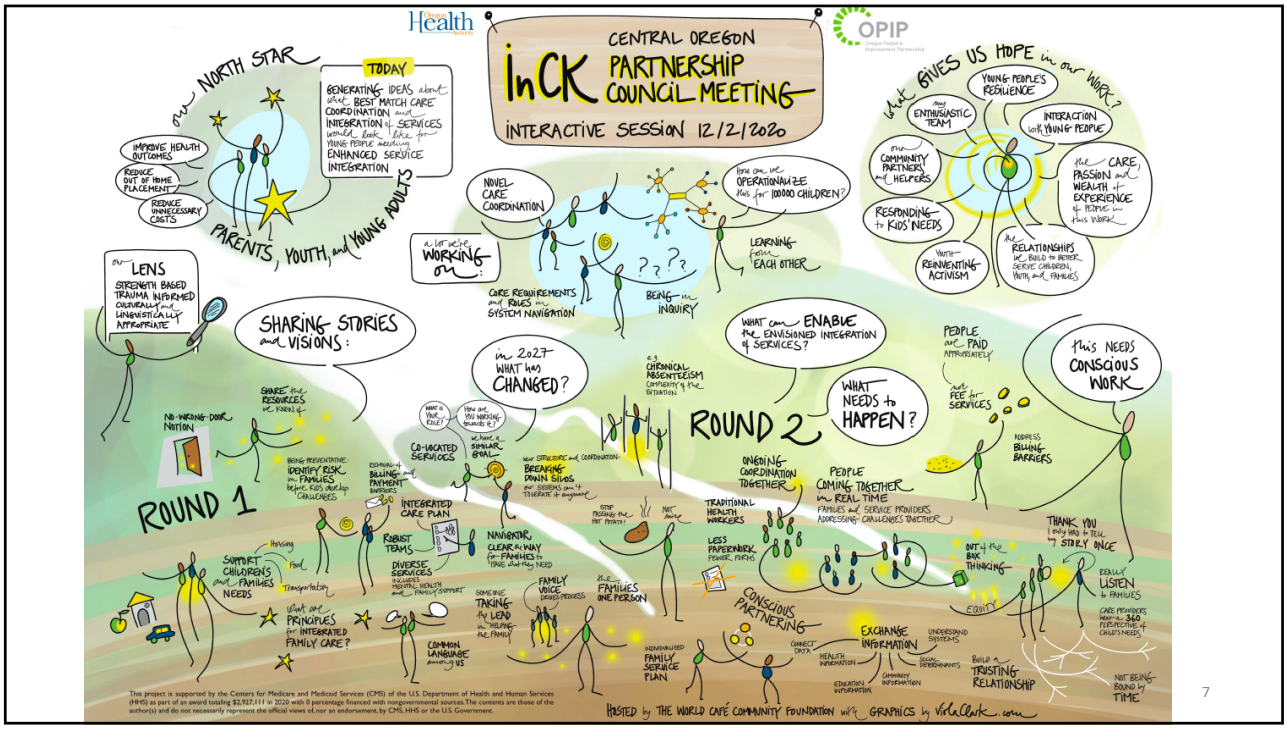

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Oregon's Integrated Care for Kids Model: Leveraging System Level Data for Needs Assessment to Inform Service Integration Levels (SIL)

- **Page 4 of Pre-Reading Materials.**
- **Aligned with CMMI requirements around factors or "needs" that have to be met.**
- **Purpose is to identify subsets of children** to receive targeted best-matched **supports and care coordination** meant to impact the core outcomes of focus in InCK:
  - ❖ **Out of home placements** such as foster care and residential behavioral health
  - ❖ **Costs** associated with unnecessary ER visits and inpatient stays (Prolonged admissions/ Multiple)
- Termed **Service Integration Level "SIL"** in the InCK Model
- **Implementation begins in Year 3 (2022)**
- Secondary processes for children identified by system-level needs assessment data include:
  - Outreach and engagement of parents, youth and young adults.
  - Parent, youth and young adult assessments of strengths, barriers and needs.
  - Based on this information proposed SIL levels can be modified.
- Later in the agenda we talk about process being developed to share indicators

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Oregon's Service Integration Needs Assessment: Cross-Sector System-Level Health Complexity Data: **Preliminary Findings for Central Oregon**

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 in foster care • *Child has ever been in foster care (DUA under development to share with CCO a 2A indicator)*	Medical Complexity • Complex Chronic (CC), OR • Non-Complex Chronic (NC)	4.2%, N=1,061
2B		Social Complexity that includes • Parent substance abuse, &/or • Parent mental health, &/or • Parental incarceration	Medical Complexity • Complex Chronic (CC), OR • Non-Complex Chronic (NC)	CC: 4.3%, N=1,076 NC: 9.3%, N=2,323
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 • Complex Chronic (CC)	CC: 0.4%, N=102
			Children Birth to Five: • Non-Complex Chronic (NC)	*Birth to Five NC: <0.4%, N=<30*
2D		*Chronic absenteeism, or risk for absenteeism, from Oregon Department of Education data (New variable under construction)*	Medical Complexity • Complex Chronic (CC), OR • Non-Complex Chronic (NC)	*Data not yet available*

Source: Oregon Health Authority. (January 2021). 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 Crook, Jefferson, and Deschutes counties as of May 2020. Total population in Central Oregon as of May 2020 was 25,033 (~82% of children were not flagged using currently available indicator data). See https://www.oregon.gov/oha/HPA/dsi-tc/Documents/DataDictionary-Social-Indicators.pdf

OR InCK Service Integration Levels: Relationship of Factors With Each Other and Out of Home Placement (SIL 2A): Preliminary Findings for Central Oregon

SIL Overlapping Flags (Associations Between and Across Social Complexity Factors)	Percent of Assigned SIL LEVEL (Count of Individuals in SIL Flag Combination Group/Count of Individuals Assigned to SIL)
SIL 2A: Child in foster care or has ever been in foster care	SIL 2A
Child flagged for 2A, 2B *and* 2C: Medically Complex + Foster Care Population, Parent Health Complexity *and* Child Social Complexity	**39.6%** (**420**/1061)
Child flagged for 2A *and* 2B: Medically Complex + Foster Care Population *and* Parent Health Complexity	**44.5%** (**472**/1061)
Child flagged for 2A *and* 2C: Medically Complex + Foster Care Population *and* Parent Health Complexity	**3.8%** (**40**/1061)
Child flagged for 2A ONLY: Medically Complex + Foster Care Population (single flag)	**12.2%** (**129**/1061)
SIL 2B: Social Complexity that includes:1) Parent substance abuse, &/or; 2) Parent mental health, &/or Parental incarceration	SIL 2B
Child flagged for 2B *and* 2C: Medically Complex + Parent Health Complexity *and* Child Social Complexity	**30.0%** (**1018**/3399)
Child flagged for 2B ONLY: Medically Complex + Parent Health Complexity (single flag)	**70.1%** (**2381**/3399)
SIL 2C: Social Complexity that 3 or more indicators of 8 remaining factors not identified in 2A and 2B.	SIL 2C
Child flagged for 2C ONLY: Medically Complex + Child Social Complexity (single flag)	**100.0%** (**118**/118)

Note: **Count of Individual Assigned to SIL** is our current SIL approach with hierarchy and mutual exclusivity applied. Given these insights from the data, Oregon InCK team is proposing that all applicable risk indicators be shared to inform best match outreach, engagement, and care coordination strategies.

Source: Oregon Health Authority. (January 2021). 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 Crook, Jefferson, and Deschutes counties as of May 2020. Total population in Central Oregon as of May 2020 was 25,033 (~82% of children were not flagged using currently available indicator data). See https://www.oregon.gov/oha/HPA/dsi-tc/Documents/DataDictionary-Social-Indicators.pdf

OR InCK Service Integration Levels: Relationship of Factors With Each Other and Avoidable High Costs Events: Preliminary Findings Based on Central Oregon Data

Ambulatory Care: Avoidable ED Visits

Complexity Factor	Rate per 1,000
Overall CCO Member Level File	*6.1*
Overall Child Health Complexity Population	*5.3*
Social	
3 or more indicators	7.5
1-2 indicators	4.6
None in System-Level Data	2.8
Medical	
Complex Chronic	8.9
Non-complex Chronic	6.1
No Medical Complexity	4.4
Health	
Complex Chronic, 3+ Social Factors	12.2
Complex Chronic, 1-2 Social Factors	6.0
Complex Chronic, 0 Social Factors	4.4
Non-Complex Chronic, 3+ Social Factors	7.4
Non-Complex Chronic, 1-2 Social Factors	5.4
Non-Complex Chronic, 0 Social Factors	3.6
Healthy, 3 + Social Factors	6.5
Healthy, 1-2 Social Factors	4.1
Healthy, 0 Social Factors	2.6

Key Takeaway:

- Social complexity as predictive of avoidable ED as medical complexity
- Children with both medical and social complexity have the highest rates

Source: Oregon Health Authority. (January 2021). 2019 CCO member-level file and 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 Crook, Jefferson, and Deschutes counties as of May 2020. Total population in Central Oregon as of May 2020 was 25,033. See https://www.oregon.gov/oha/HPA/dsi-tc/Documents/DataDictionary-Social-Indicators.pdf

Parent, Youth & Young Adult Advisory Group (PYYAG)

- No requirements in the CMMI grant.
- Deep commitment from the OPIP to ensure the work is grounded in, centered to the input of parents, youth and young adult.
  - OHA will be leading additional community-level engagement
- Propose to have this PYYAG through the life of the grant. Payment provided.
- Comprised of 10 members total, five in each region.
- Recruitment of parents, youth and young adults that have lived experience and would be identified by the System-Level Needs Assessment Data for **Service Integration Levels 2 or 3.**
- Summaries from the PYYAG will be a standing item in the Partnership Council agendas from here on out.

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Parent, Youth & Young Adult Advisory Group: Current Status

- Onboarding current confirmed parents, youth and young adults
  - First step is hearing and learning from them
  - Completion of Care Map (https://www.childrenshospital.org/integrated-care-program/care-mapping)
- Still recruiting (Need your help!)
- Once all members are on boarded and CMMI approves Carry Forward request:
  - Community café informed session of the PYAYG

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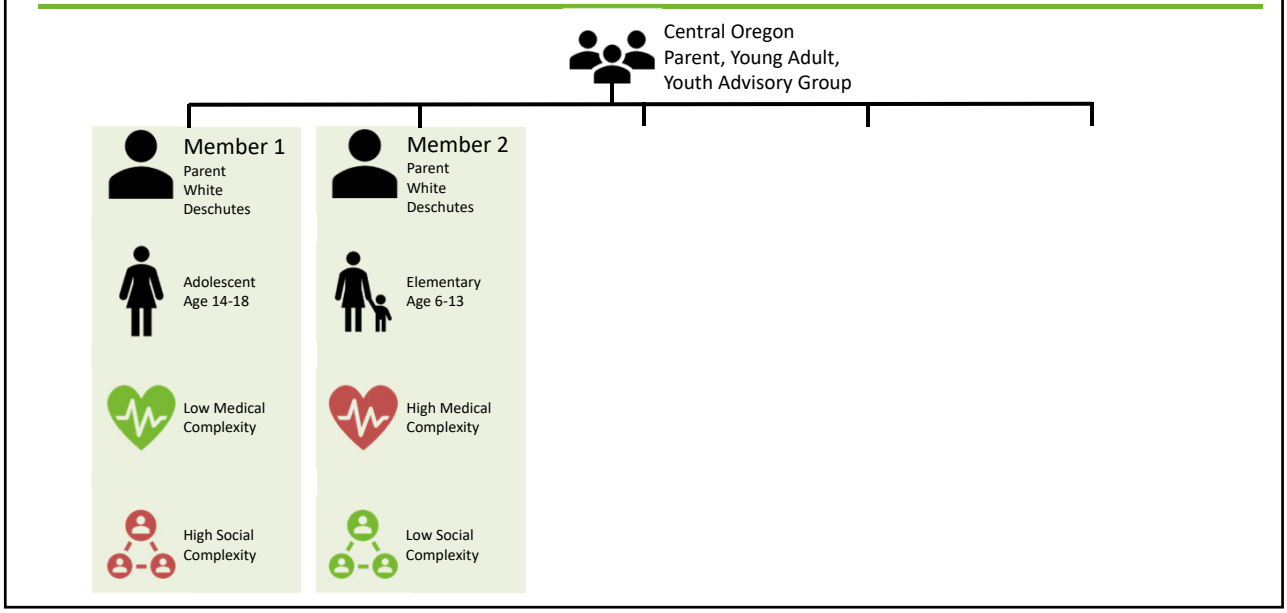
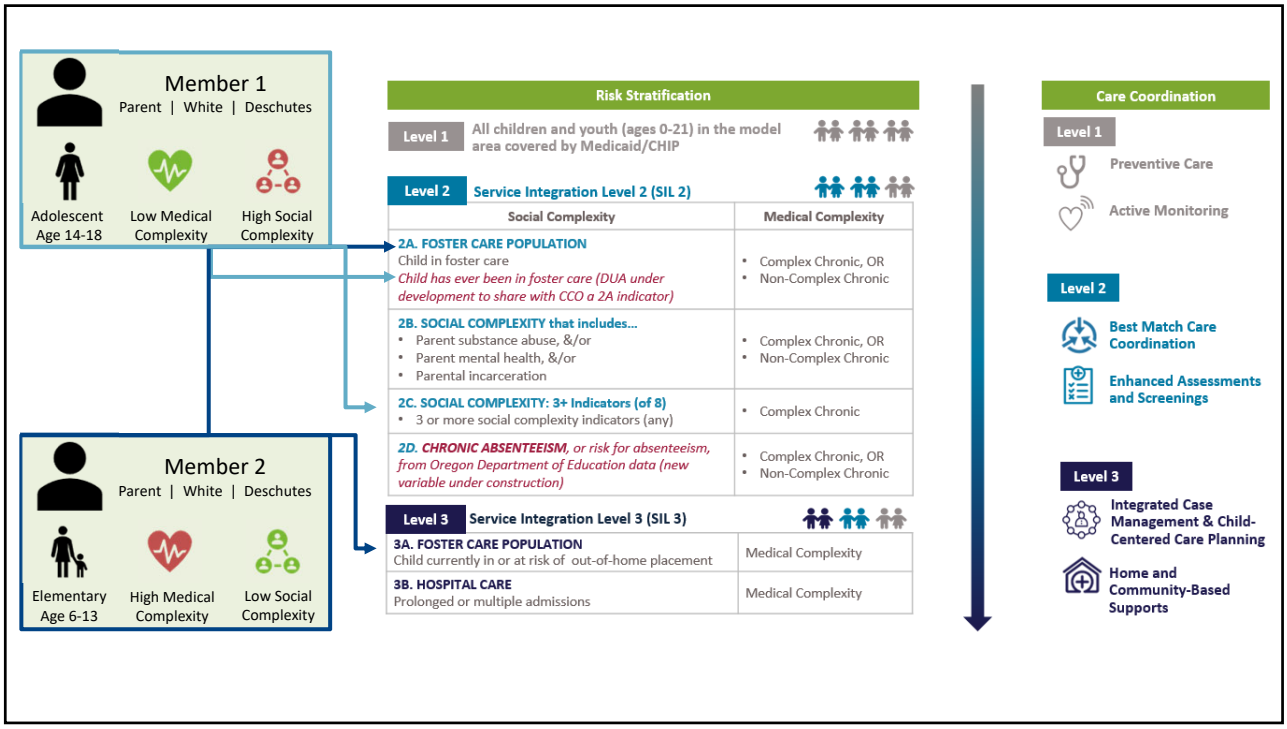
Oregon's Integrated Care for Kids Model: **Parent, Young Adult, Youth Advisory Group**





Oregon's Integrated Care for Kids Model: Parent, Young Adult, Youth Advisory Group

Family 1

- Parent 1
- Parent 2
- Foster daughter (18 years old)
- Biological daughter (5 years old)
- Biological daughter (8 months old)

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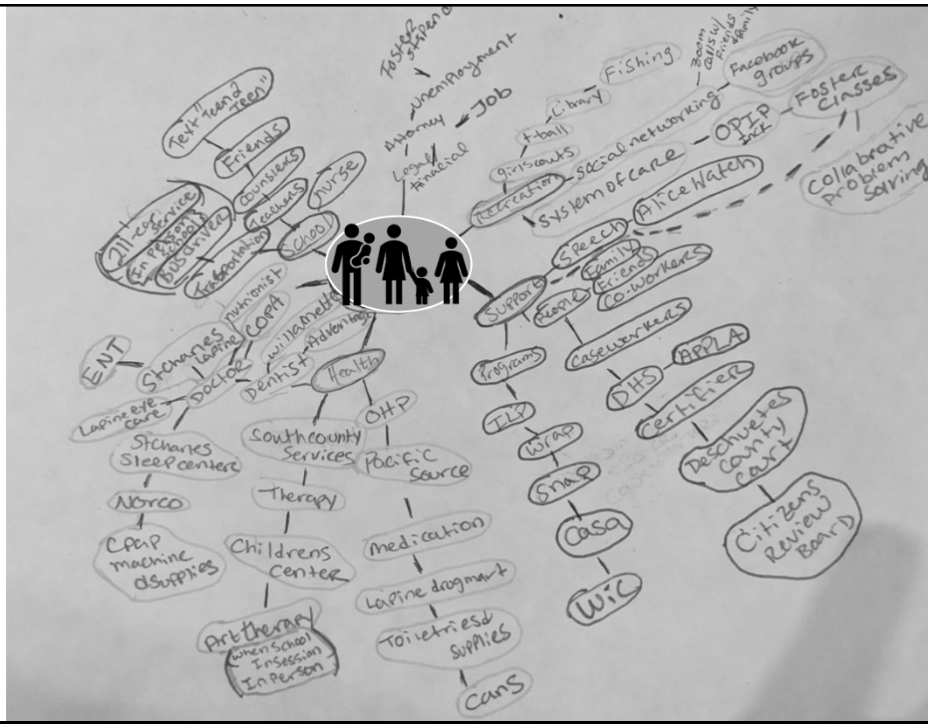
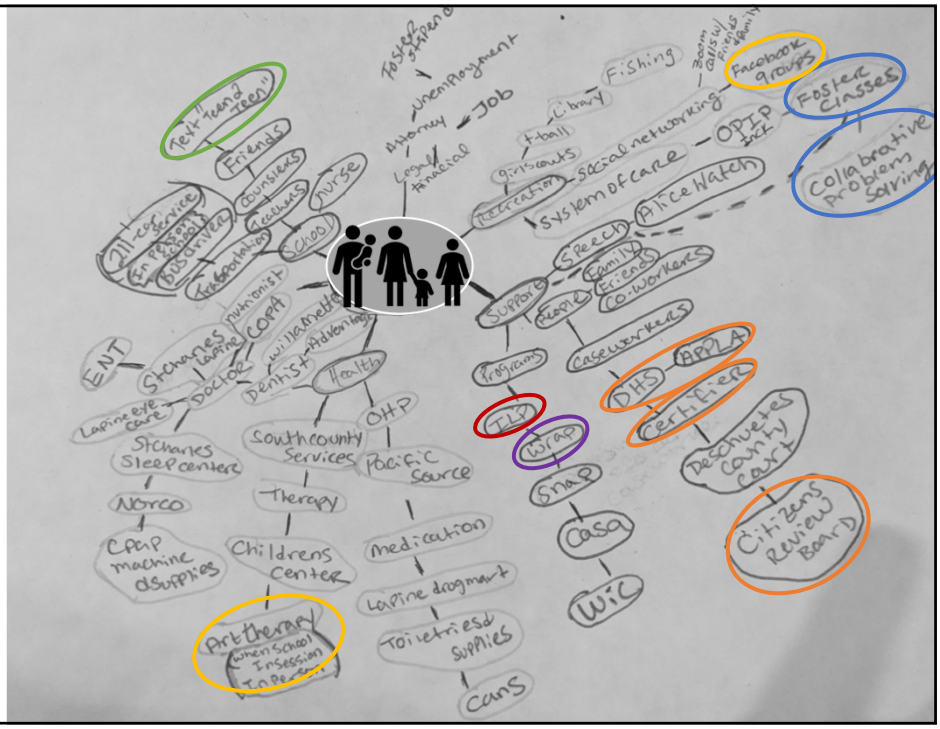

Text Teen 2 Teen
Friends
Counslers
Teachers
nurse
School
Transportation
Bus driver
211
Legal Financial
Attorney
Unemployment
Job
Library
Fishing
Facebook groups
t-ball
girlscouts
Recreation
Social networking
System of care
OPIP
Foster classes
Collaborative problem solving
Alice Watch
Speech
Family
Friends
Co-Workers
Support
People
Caseworkers
Programs
DHS
APPLA
Certifier
ILP
Wrap
Snap
Casa
WIC
Deschuetes county court
Citizens Review Board
nutrionist
COPA
Willamette
Dentist
Health
ENT
StCharles
Doctor
Lapine eye care
StCharles Sleep center
Norco
CPAP machine &supplies
South county Services
Therapy
Childrens Center
Art therapy
when school Insession In Person
OHP
Pacific Source
Medication
Lapine drugmart
Toiletries&supplies
Cans

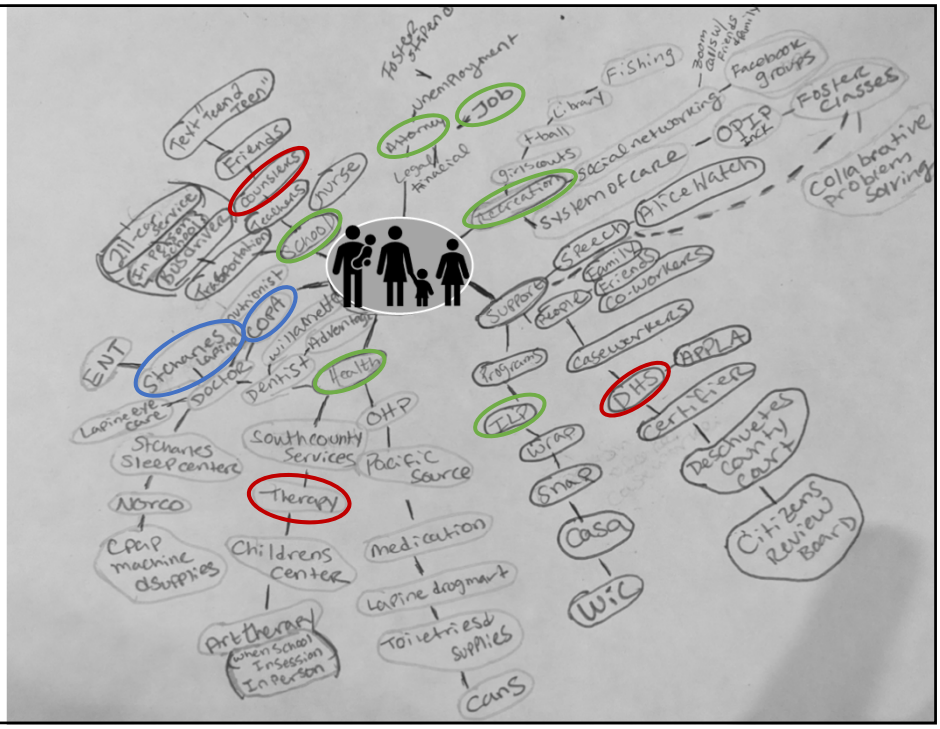
Most Helpful Supports

- Independent Living Program (ILP)
- DHS + Certifier + Citizen Review Board
- Facebook groups
- Text “Teen 2 Teen”
- Foster classes + collaborative problem solving
- WRAP, “if it works”



Important Notes

- **Different PCPCHs for family unit**
- **Lack of communication across sector**
- **Transition to adulthood, parents still navigating how to best support**



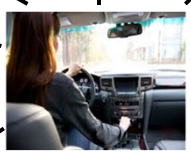
Oregon's Integrated Care for Kids Model: Parent, Young Adult, Youth Advisory Group

Family 2

- **Parent 1**
- **Foster/adopted daughter (12 years old)**
- **Foster/adopted daughter (10 years old)**

2011-2012
Single working mom
Has 2 girls come into her life:
A 3 year old and a one year old through the foster system in Klamath County

2014-2015
Foster care dropped as adoption completed transition to school age for older daughter/younger daughter mental health in Klamath County



Youngest Daughter

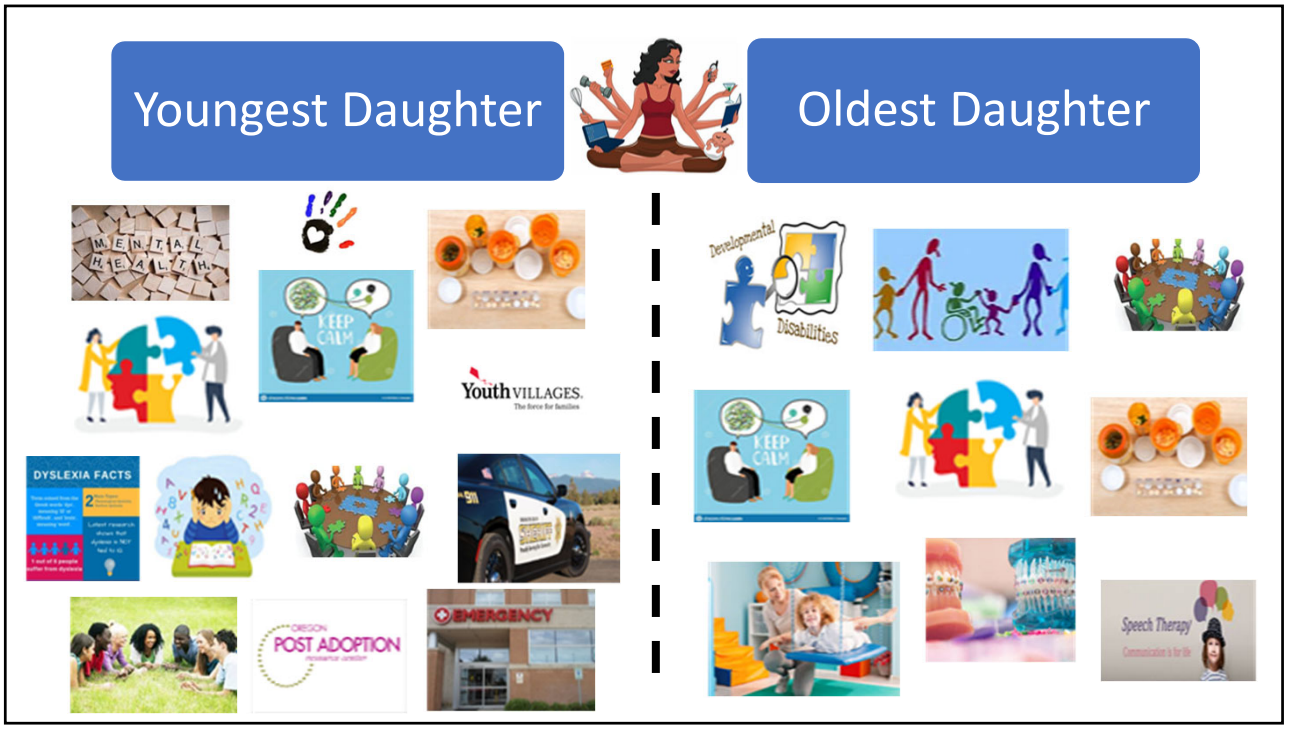
Oldest Daughter

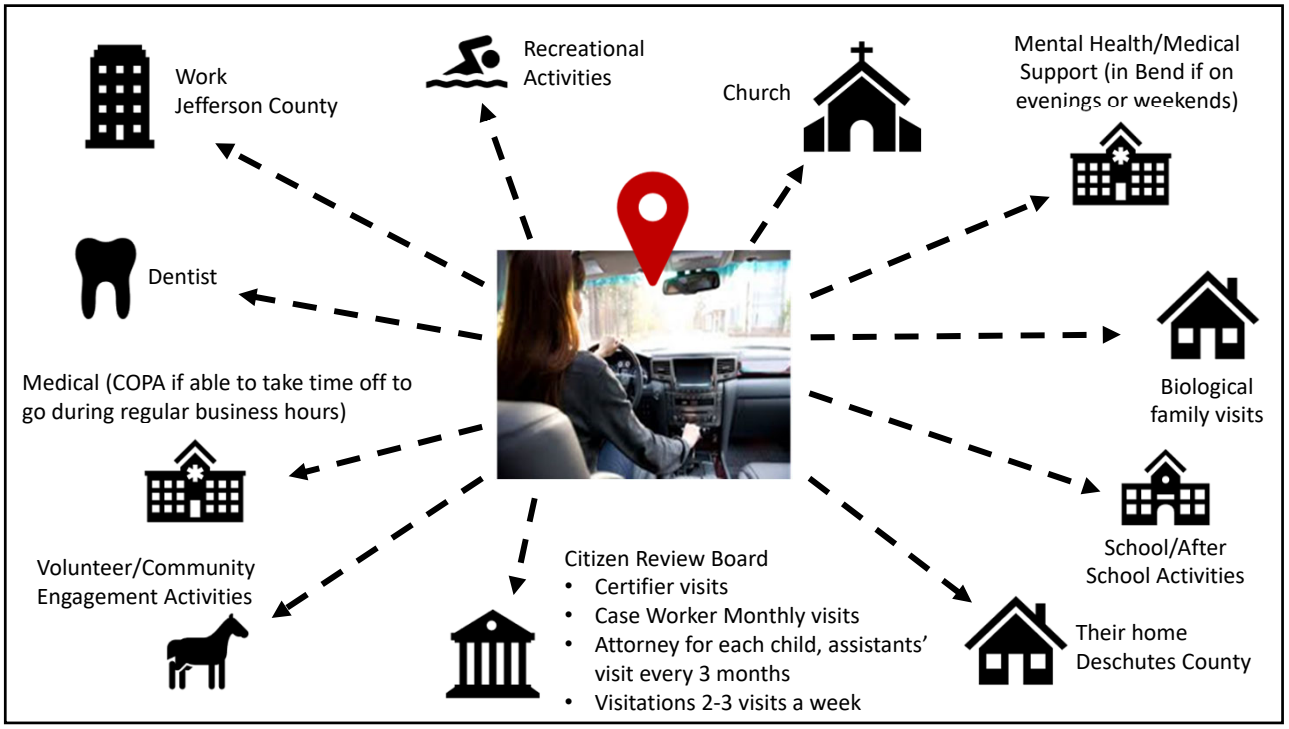
Youth VILLAGES.

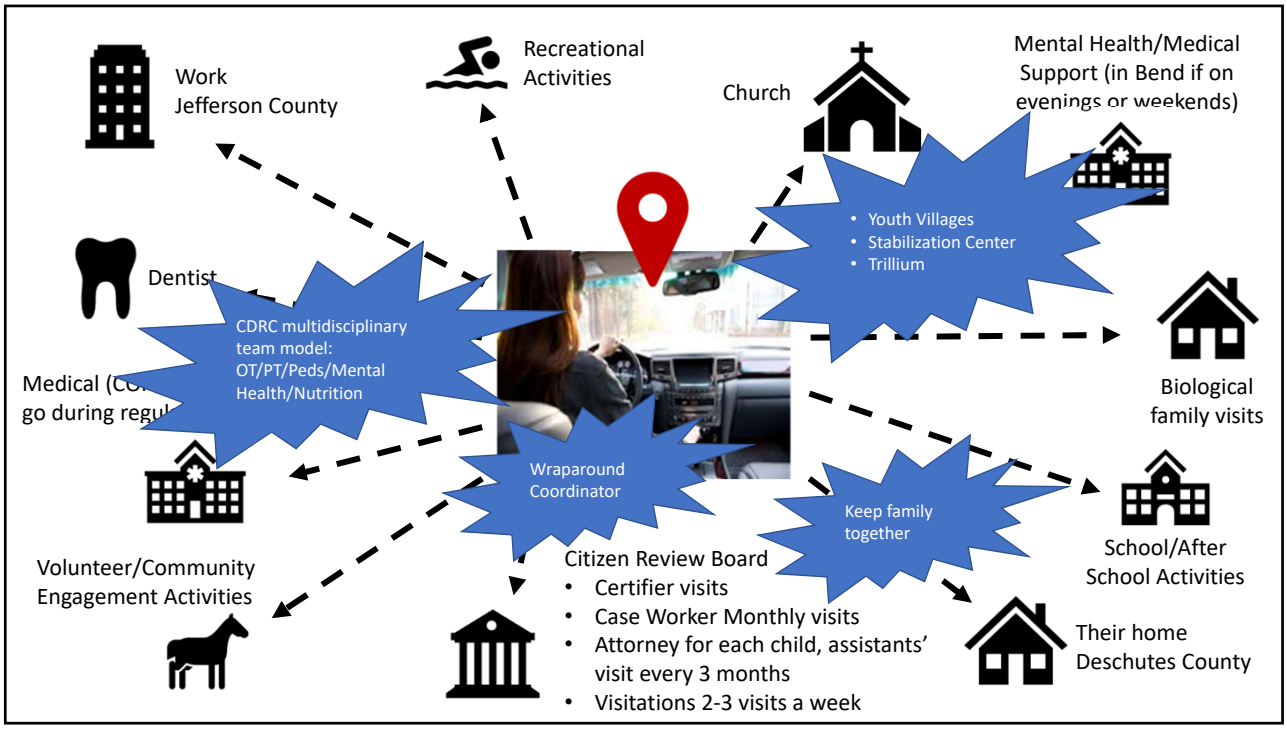
OREGON POST ADOPTION

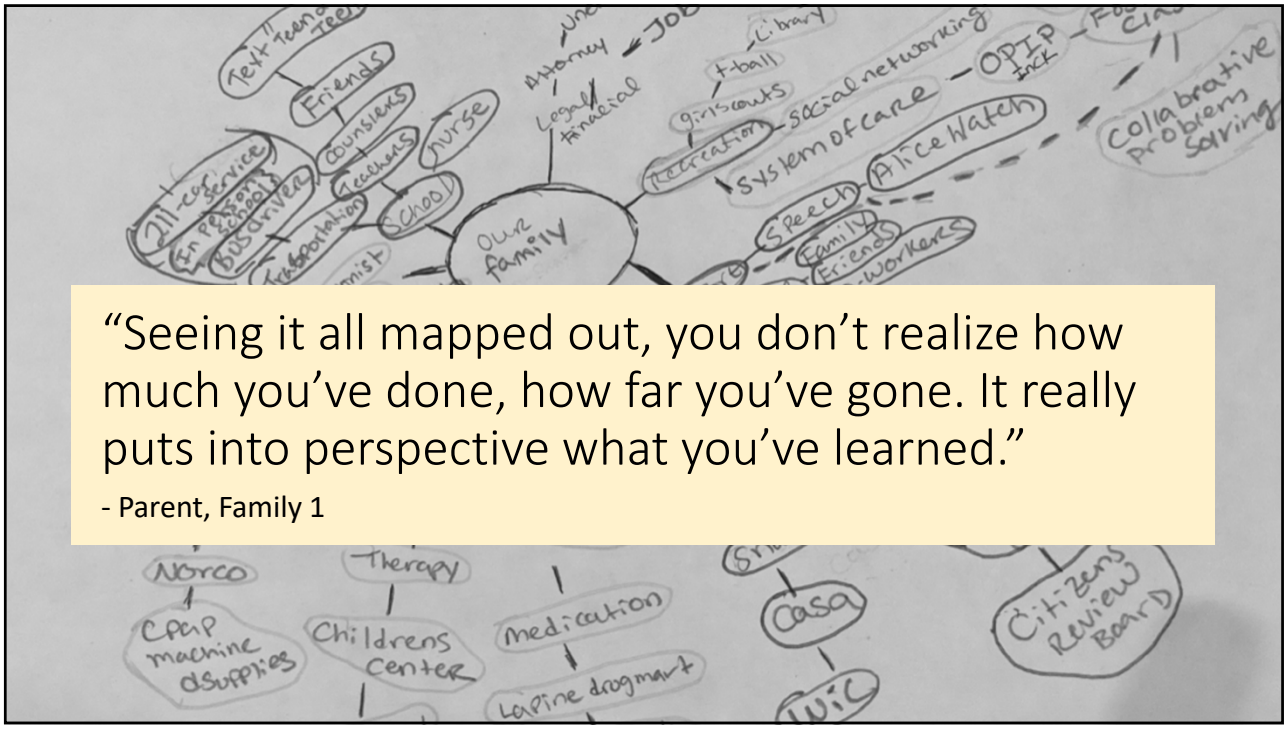
Youngest Daughter

Oldest Daughter


Youngest Daughter
Oldest Daughter
MENTAL HEALTH
KEEP CALM
Youth VILLAGES.
DYSLEXIA FACTS
POST ADOPTION
EMERGENCY
Developmental
DiSabilities
KEEP CALM
Speech Therapy


Work
Jefferson County
Recreational
Activities
Church
Mental Health/Medical
Support (in Bend if on
evenings or weekends)
Dentist
Medical (COPA if able to take time off to
go during regular business hours)
Biological
family visits
Volunteer/Community
Engagement Activities
Citizen Review Board
• Certifier visits
• Case Worker Monthly visits
• Attorney for each child, assistants' visit every 3 months
• Visitations 2-3 visits a week
School/After
School Activities
Their home
Deschutes County

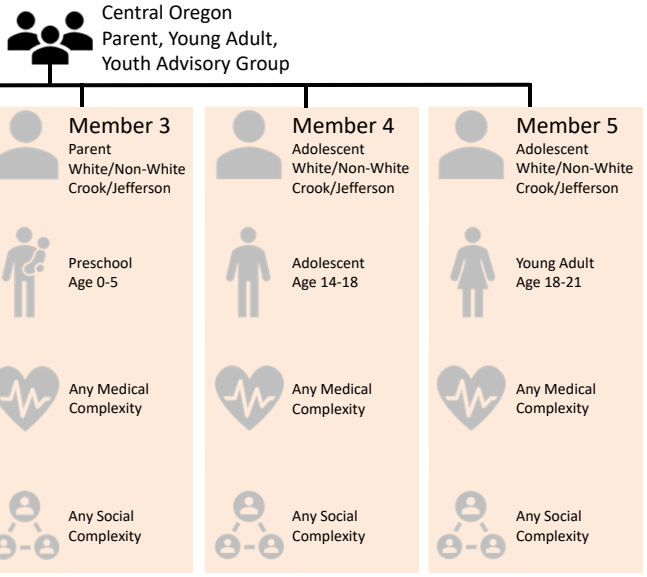




"Seeing it all mapped out, you don't realize how much you've done, how far you've gone. It really puts into perspective what you've learned."

- Parent, Family 1

Oregon's Integrated Care for Kids Model: **Parent, Young Adult, Youth Advisory Group**



Please reach out to Cara Lind or Dustin Stilwell for more information about how to help with member recruitment:

Cara: lindc@ohsu.edu
Dustin: stilweld@ohsu.edu

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Spotlight of Three Key Components

- Work Sessions with PacificSource Community Solutions and Current Areas of Focus
- Systems Navigator Position: Hiring and Onboarding
- Clinical Provider Engagement
- PCPCH Assessments & PCPCH Learning Curriculum

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Partnership with PacificSource Community Solutions

- Critical & essential partner in each component of the InCK Model.
- InCK Population: Publicly insured (Medicaid/CHIP) birth to 21 in the five county region.
- PacificSource Community Solutions (PCS) contracted as the Coordinated Care Organization (CCO) for approximately 93% of the InCK population.
- OHA providing subaward to PCS to support infrastructure & staffing to ensure that key processes and systems in place for the **Implementation Period**
- PCS organizational home for the **Systems Navigators**
  - One in each region

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Partnership with PacificSource Community Solutions

- Across all components of the InCK Model **PCS** plays a critical & essential role
- Two examples:
  - **Service Integration Level 1** activities related to access to preventive care, screening and assessments related to housing instability and food instability
  - **Risk Stratification and Service Integration**:
    - Backbone of the InCK Model is leveraging system-level data for the "Need Assessments" to determine the **Service Integration Levels.**
    - Per contractual requirement and agreements, OHA is providing the **Needs Assessments** and related**,** proposed **Service Integration Levels (SIL)** to PCS
    - PSCS will then be working with and identifying clinical partners and other entities with established data use agreements the SIL flags to inform next step Care Coordination activities.

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PCS, OPIP, OHA Work Sessions Anchored to Core Elements of InCK

- Pages 12-13 of Pre-Reading Materials
- Nine topic-specific workgroups involving involve key leaders and staff within PCS, OPIP, and **OHA.**
- Monthly check-ins with the Directors of CCOs in each Region: Marion and Polk & Central Oregon
- Monthly meeting with PCS leadership, OPIP, & **OHA** leadership.

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Page 13 of Pre-Reading

PCS, OPIP, OHA Work Sessions Anchored to Core Elements of InCK

1. Coordination & Engagement with Health Care Providers
2. Care Coordination
3. Systems Navigator
4. System Level Data and Risk Stratification
5. Health Information Exchange (HIE)
6. Housing & Food Insecurity, Community Information Exchange (CIE)
7. Mobile Crisis
8. Alternative Payment Methodology (APM)
9. *Tribal Engagement (Under development, not yet started)*

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Spotlight of Four Key Components

- Work Sessions with PacificSource Community Solutions and Current Areas of Focus
- Systems Navigator Position: Hiring and Onboarding
- Clinical Provider Engagement, PCPCH Assessments & Learning Curriculum

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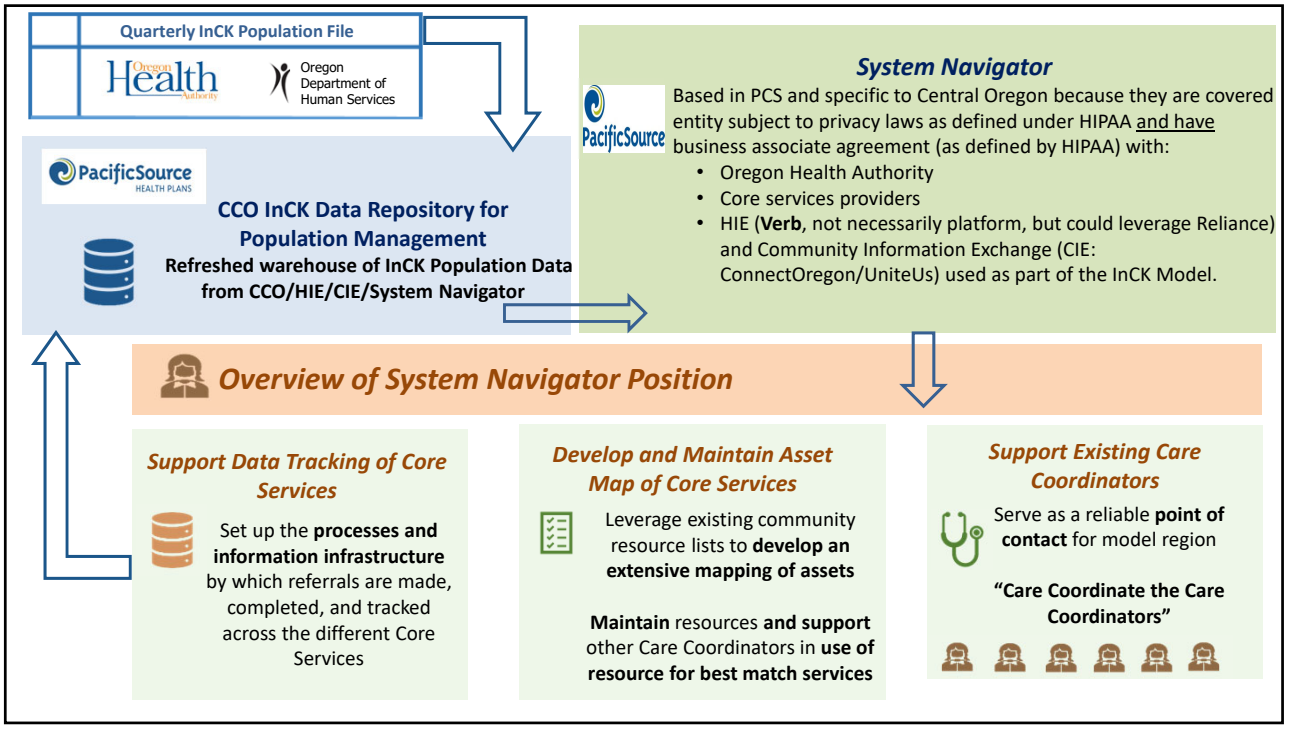
Systems Navigator Position

- Critical component of the InCK Model
- Required position to be funded by InCK Model Funding
- Funding for position is within OPIP's budget, but goes to a local organization
- **Focus of our July and September Partnership Council meetings where we received input and guidance**
- **After September meeting, moved forward for it to be housed in PCS given your feedback and input**



Systems Navigator Update

- Status of Systems Navigator position in Central Oregon
- Working with PCS to develop an onboarding plan with goal to:
  - Create a Streamlined Onboarding Plan for Both Pacific Source & OPIP
  - Bring Individual up to Speed on Role as Soon as Possible
  - Begin working on Asset Mapping and other important components of the Systems Navigator
- SN will attend Partnership Council Meetings
- SN will lead a number of the engagement efforts and asset mapping process of priority for the next quarter.

Spotlight of Four Key Components

- Work Sessions with PacificSource Community Solutions and Current Areas of Focus
- Systems Navigator Position: Hiring and Onboarding
- Clinical Provider Engagement
- PCPCH Assessments & Learning Curriculum

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Engaging Front Line Providers

- At September 2020 Partnership Council meeting we outlined our plan and strategy for engaging front-line clinical providers
- Incorporated feedback received to our outreach and engagement strategy
- Worked with PCS **to use currently available health complexity data** (InCK Service Integration Needs assessments leverage and build off that) to identify top providers:
  1. Primary Care
  2. Behavioral Health
  3. Specialty Providers, including entities contracted with specific Care Coordination/Case Management for which PCS has data
- PCS provided this data overall, but also by county to ensure considerations for regional variations
- Based on and informed by this data, **OPIP have begun outreach to Patient Centered Primary Care Homes (PCPCH)**
  - Once OHA provides PCS with the **InCK Needs Assessment data related to SIL2/SIL3** will begin outreach with behavioral health and specialty providers

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Engaging PCPCHs in InCK

- **Page 14-15 of your Pre-Reading materials.**
- **PCPCHs play a critical role in operationalizing components of InCK** model **for Service Integration Levels 1 and 2 and 3**
  - Need to understand current processes/workflows relative to InCK through baseline assessments and engagement.
  - Opportunity to also hear from sites about opportunities, barriers, and hopes for InCK.
- OPIP developed a three-part engagement process with partner PCPCH sites.
- Includes general overview information and targets information gathering on the following:
  1. Current Screenings Used that Focus on **Social Determinants of Health** (SDoH) and Connection to Services, Electronic Health Record and Data Management, Areas PCPCH hopes are addressed in InCK
  2. **Practice Characteristics**, Opportunities and Barriers
  3. **Care Coordination** Processes and Internal Supports Available to Patients, **Collaboration with other systems** (PCS, DHS, Home Visiting, etc.), Current pain points and areas the practice hopes are addressed, Supports practices needed to be successful

Central Oregon PCPCH Engagement: Phase 1 Sites Identified by PCS Data of Where InCK Health Complex Population is Attributed

Central Oregon: Phase 1 PCPCH Partner Engagement	
Patient Centered Primary Care Homes	**Engagement Status**
COPA	InCK 101 Engagement Call (1/15), Scheduling Practice-Level Overview.
Mosaic	InCK 101 Engagement Call (12/17) with practice champions: Ellie Millan, Lindsey Overstreet and Betsy Mitchell. InCK Practice Overview call on 2/19. Now scheduling the multiple meetings needed for the practice baseline questions
La Pine Community Health Center	InCK 101 Engagement Call (12/1) with Erin Gage-Fitzpatrick, InCK Practice Overview Scheduled for 3/2.
Summit Medical Group	InCK 101 Engagement Call (12/8) with Justin Sivill, Cindie Sagner and Debbie Foster, will be reaching back out to begin next step

Spotlight of Four Key Components

- Work Sessions with PacificSource Community Solutions and Current Areas of Focus
- Systems Navigator Position: Hiring and Onboarding
- Clinical Provider Engagement
- PCPCH Assessments & Learning Curriculum

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Learning Curriculum for PCPCH

- Monthly learning sessions on key topic areas, starting Spring 2021
  - Curriculum will include evidence-informed, feasible and meaningful tools and strategies to support implementation starting in 2022
  - Among others, topic areas will include:
    - ✓Background on InCK, specific to PCPCH role
    - ✓Social determinants of health screening and closed loop referrals to community supports
    - ✓Care coordination for children identified by the risk flags
    - ✓Behavioral health supports and multi-generational approach
    - ✓Coordinated use of EHRs and health/community information exchange

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Learning Curriculum for PCPCH

- Between learning sessions will be weekly meetings to provide:
  - Open Q&A sessions
  - Meetings with Systems Navigators
  - Opportunities to share with other practices and meet other core service partners
  - Targeted technical assistance
- Curriculum will aim to thoughtfully incorporate:
  - Family voice and strengths
  - Trauma-focused lens
  - Health equity lens

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Rapid Fire Question and Feedback:

Zoom Break Out Groups

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Today's Agenda

- **Welcome, 2021 Refresher on INCK Model & Visuals from Community Café Informed Sessions**
- **Update on Oregon's Service Integration Needs Assessment** and overview of the baseline **Parent, Youth and Young Adult Advisory Care Maps** for persons identified by Needs Assessment.
- Provide an update and **overview of extensive and broad work being done to operationalize components of the InCK model starting in 2022.** **Small Group Feedback**
- **Overview of Mobile Crisis and Stabilization Services** and review InCK requirements, current options and strategies being explored. **Interactive Group Activity**
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- Provide an **overview of proposed process for exploring integration and sharing of information required as part of the InCK Model**. **Small Group Feedback**
- Heads up on **June Partnership Council** meeting

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Integrated Care for Kids and Mobile Crisis Response

Ryan Daven, PacificSource
Laura Sisulak, Oregon Health Authority
Angela Leet, Oregon Department of Human Services

Aim for this session

- Understand InCK and CCO 2.0 requirements for Mobile Crisis Response Services
- Share current state of our work together
- Share our next steps, opportunities for input
- Leave some time for questions and input

Defining our Work Together: InCK and PacificSource

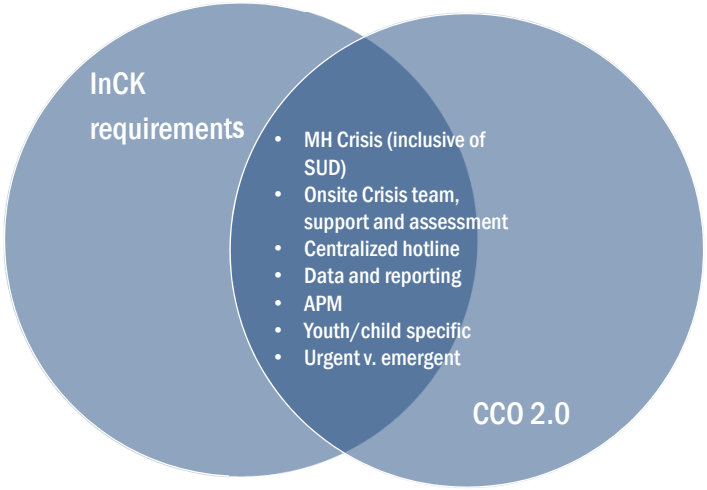
- Identify and ensure we meet all of our "Must Have's"
- Identify and build upon existing strengths and services in the community (inventory) and identify gaps, barriers, inequities.
- Partner with the community organizations doing this work
- Leverage current and growing statewide planning and resources
- Ensure alignment with CCO 2.0 requirements and PacificSource work
- Identify priorities for improvement and align resources

InCK Requirements for Mobile Crisis/Stabilization

A system for responding to the initiation of crisis/stabilization services, including:

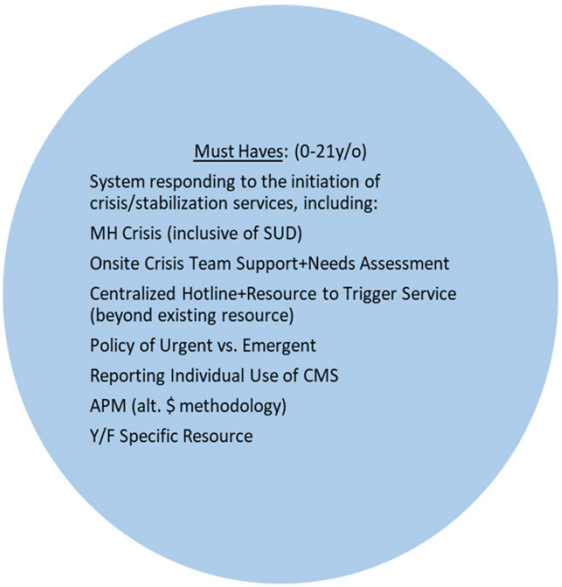
- **Address behavioral health crises, including substance use, minimally**
- **Ability to send staff to a child's residence to stabilize the crisis situation and perform a needs assessment**
- **A central hotline (24/7) that is widely advertised in the target population and can be called to trigger service initiation.**
- **Policies clarifying what types of crises are appropriate for the crisis hotline and which are best addressed by calling 9-1-1.**
- **As a Core Service, required to report patient level data**
- **Alternative Payment Model(s) to support mobile crisis response services**

Our Must Have's



PacificSource Foundation:

- **CCO 2.0: Ex. M Section 10: A-E**
  - Twenty-four-hour access to stabilization services
  - Services which address Behavioral Health Emergencies
  - Presence of a Robust Crisis Service Array
  - Diversion Programs and other less restrictive levels of care
  - Quality Improvement Plan
- **Shared Why:**
  - Increased well-being post-crisis
  - Trauma informed crisis resolution and systems navigation
  - Reducing treatment of Behavioral Health in medical settings
  - Greater access to those with lived experience
- **Accurate, Comprehensive Inventory by County**



Anticipatory, Transformational Strategy

- **Staged Approach:**
  - Partnering with key stakeholders: CMHPs, COAs, LE, DHS, etc.
  - Thoughtful thorough analysis of data
  - Short Term and Long-Term strategies responsive to regional priorities and demographics
  - Development of systemic assurance attuned to how InCK priorities intersect
  - System re-design and innovation

Guiding Questions:
Does this happen now? What are the impacts of inaction currently?
How will we unite the right people? How do we surround the opportunity?
How will we change the system?
Where can we find a point of leverage?
How will we get early warning of the problem?
How will we know if we're succeeding?
How will we avoid doing harm?

Long Term Vision and the Nice to Haves/Time:

Contractor shall establish a written Quality Improvement plan for the crisis management system to address the requirements identified in OAR 410-141-3140 and provide the Quality Improvement plan to OHA upon request.

Ideal State:

- Assurance that our regional Crisis Management Systems accommodate members far beyond existing services: (i.e., prioritization of diversion, stabilization, community connection)
- Quality Assurance and Quality Improvement Plans sufficient to support continuous systems improvement
- Utilization of Evidence-Based, outcome-oriented (ST/LT) supports for holistic well-being of youth
- Seamless prevention/intervention/postvention coordination across community based, cross-sector service array
- Universal Suicide Prevention/Intervention Training

Milestones:

- Data Informed (qualitative/quantitative) Environmental Scan
- Ensure standardized data recording/submission practices
- Formulate Regional Acute Care Steering/Advisory Councils
- Develop Policy Practice which adequately differentiates urgent and emergent
- Develop Data Informed Quality Improvement Plan
- Value-based
- Community centered
- Methodologies promoting cross-system, community focused approach to CMS

Mobile Response and Crisis Response Inventory….

Current Crisis Supports/Programs (i.e. mobile crisis, diversion, walk-in/drop-off centers, respite, crisis stabilization)
County Crisis Services - Crisis services are a 24-hour program that responds by phone or face-to-face. Services may include assessment, intervention planning, information and referral services. In addition, provide brief crisis stabilization through individual or group treatment. ▪ Mobile, ▪ Diversion ▪ Walk-in ▪ Respite ▪ Crisis stabilization Stabilization Center – offering a menu of crisis services (link below) – Children? https:// Co-Responder Program- (adults only?) A Master's level mental health clinician is embedded within Police Department's Community Response team. Clinician and officer respond together to mental health related calls for service. Peer Support services are available as well for follow-up and engagement.

- **Feedback and input welcome:**
  - **Angela.Leet@dhsoha.state.or.us**
  - **Ryan.Daven@pacificsource.com**
- **Next steps as a workgroup:**
  - **Partner with local stakeholders to identify and build upon existing strengths and services in the community**
  - **Thoughtful, thorough analysis of data from rural/frontier/urban perspectives**
  - **Leverage current and growing statewide planning and resources.**
  - **Identify priorities for improvement and align resources**

Statewide Crisis and Mobile Response Efforts

National and State Implementation of 9-8-8 – National Suicide Prevention Hotline

Congress passed a bipartisan bill to establish 988 as a three-digit hotline number in May of 2020

- The legislation stipulates a July 2022 nationwide implementation date
- Oregon received a state planning grant in 2020 to help the state put together the resources, training, technical assistance and infrastructure needed (grant from Vibrant Emotional Health which currently administers the current National Suicide Prevention Line)
- OHA is working with healthcare providers, local governments, emergency services and other groups to create a plan that will establish an infrastructure to support 988 much like the standards currently in place for 911
- Infrastructure to include crisis and mobile response for all ages, all behavioral health related crisis needs and warm hand off to community services and supports

2021 Legislative Session Crisis and Mobile Response Related Bills

- **House Bill 2417 -** Mobile crisis intervention teams
- **House Bill 2086 -** Statewide crisis system (relates to 988 implementation)
- **House Concurrent Resolution 5 –** Intent to develop statewide strategy for crisis response

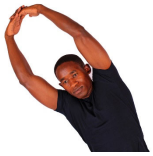
Questions and Feedback

PROVIDE FEEDBACK FOR INVENTORY

CONTACT US ABOUT THE DETAILS OR TO CONTRIBUTE

QUESTIONS

Break



- Optional activity
  - To participate, open up a new browser on your computer or phone.
  - Go to www.menti.com
  - You'll be prompted to enter a code: **75 56 93 3**

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Oregon Health Authority

Oregon InCK Model: System-, Practice- and Community-level Data

OPIP

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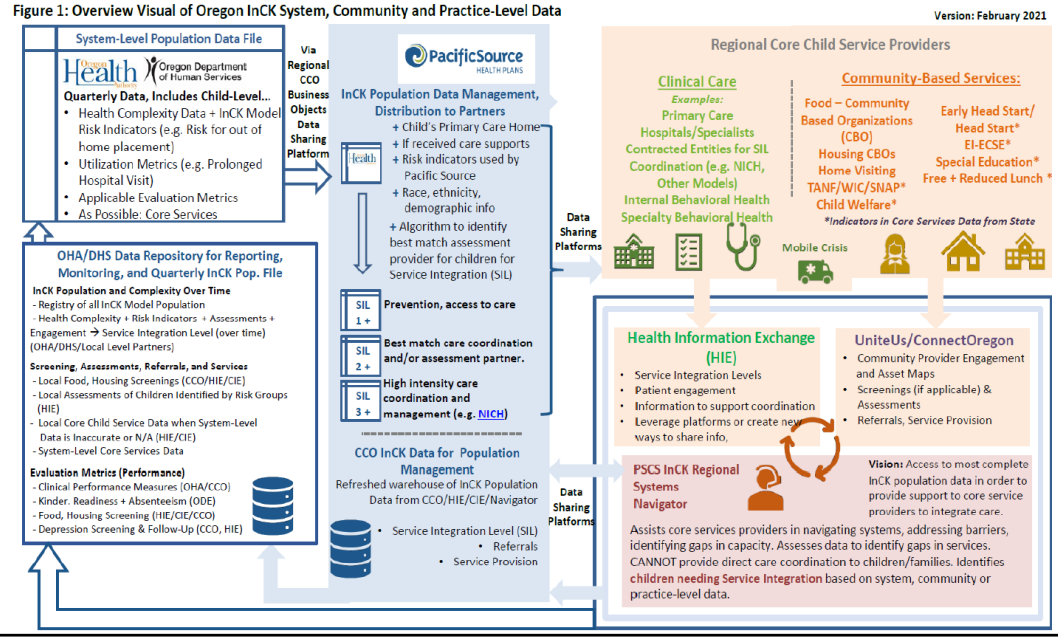
Page 17 of Pre-Reading

Figure 1: Overview Visual of Oregon InCK System, Community and Practice-Level Data



Critical Role of Health Information Exchange (HIE) in InCK: A Verb and Noun

- Core component of the InCK Model is leveraging cross-sector data to support:
  - Early identification of children with risk indicators
  - Inform care coordination
  - Support care integration across core service providers, potential care conferences
  - Measurement of quality in alignment with InCK required metrics
- Each one of these uses is a "work stream" that involves:
  - ❖Various entities being connected
  - ❖Varied information that is being shared
  - ❖Assurance that sharing aligned with data use agreements
- Use of the System-Level Needs Assessment data yielding the Service Integration Levels needs to begin in 2022

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Importance of HIE to Meet the InCK State, Community and Practice-Level Strategy

- Data from **OHA** to **PCS**
- Data from **PCS** to **CLINICAL partners** and contracted providers that serve the INCK Population for **SIL 2 and SIL3 Populations for the SIL Checklist**
  - **Requires OHA risk indicator data**
  - **Includes physical, behavioral and other care coordination entities**
- Data from SIL2 and SIL 3 **CLINICAL partners and contracted providers back to PCS** that serve the INCK Population
  - ✓ SIL Level, Adjudication based on provider experience, parent/youth and/or young adult engagement
  - ✓ Clinical Metrics & SDOH Metrics
- Data from **CLINICAL partners and contracted providers** back to PCS that serve the INCK Population, with strong emphasis on the **SIL 1** populations
  - ✓ Clinical Metrics & SDOH Metrics
- **PCS back to OHA** on the required data elements that relate to InCK

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Current Areas of Focus Related HIE to Support Service Integration Levels

- Using currently available child health complexity data that PCS has (released August 2020), identified potential clinical providers
- Developing "use cases" and scenarios for how to share information in a way that is feasible, valid and meets data use and data sharing requirements
- Developing a detailed HIE roadmap, by provider, of current infrastructure and opportunities
  - Current EHR and EHR structure and supports (Includes information from PCPCH engagement)
  - Use of current tools and information provided by PCS
  - Use of tools such as Collective Medical (not limited to CMT)
  - Use or planned use of ConnectOregon
- Based on this information, will develop proposed scenarios for how the information can and to whom it will be shared.
  - Tailored to the site and sites capacity
  - Anchored to the SIL2 and SIL3
  - Meeting data sharing and data use requirements.
  - Meet CMMI grant requirements

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Figure 1: Overview Visual of Oregon InCK System, Community and Practice-Level Data

Version: February 2021

System-Level Population Data File

Oregon Health Authority | Oregon Department of Human Services

Quarterly Data, Includes Child-Level…

- Health Complexity Data + InCK Model Risk Indicators (e.g. Risk for out of home placement)
- Utilization Metrics (e.g. Prolonged Hospital Visit)
- Applicable Evaluation Metrics
- As Possible: Core Services

Via Regional CCO Business Objects Data Sharing Platform

OHA/DHS Data Repository for Reporting, Monitoring, and Quarterly InCK Pop. File

InCK Population and Complexity Over Time
- Registry of all InCK Model Population
- Health Complexity + Risk Indicators + Assessments + Engagement → Service Integration Level (over time) (OHA/DHS/Local Level Partners)

Screening, Assessments, Referrals, and Services
- Local Food, Housing Screenings (CCO/HIE/CIE)
- Local Assessments of Children Identified by Risk Groups (HIE)
- Local Core Child Service Data when System-Level Data is Inaccurate or N/A (HIE/CIE)
- System-Level Core Services Data

Evaluation Metrics (Performance)
- Clinical Performance Measures (OHA/CCO)
- Kinder. Readiness + Absenteeism (ODE)
- Food, Housing Screening (HIE/CIE/CCO)
- Depression Screening & Follow-Up (CCO, HIE)

PacificSource Health Plans

InCK Population Data Management, Distribution to Partners
+ Child's Primary Care Home
+ If received care supports
+ Risk indicators used by Pacific Source
+ Race, ethnicity, demographic info
+ Algorithm to identify best match assessment provider for children for Service Integration (SIL)

SIL 1+ Prevention, access to care

SIL 2+ Best match care coordination and/or assessment partner.

SIL 3+ High intensity care coordination and management (e.g. NICH)

CCO InCK Data for Population Management
Refreshed warehouse of InCK Population Data from CCO/HIE/CIE/Navigator
- Service Integration Level (SIL)
- Referrals
- Service Provision

Data Sharing Platforms

Regional Core Child Service Providers

Clinical Care
Examples:
Primary Care
Hospitals/Specialists
Contracted Entities for SIL Coordination (e.g. NICH, Other Models)
Internal Behavioral Health
Specialty Behavioral Health

Community-Based Services:
Food – Community Based Organizations (CBO)
Housing CBOs
Home Visiting
TANF/WIC/SNAP*
Child Welfare*
Early Head Start/ Head Start*
EI-ECSE*
Special Education*
Free + Reduced Lunch *

*Indicators in Core Services Data from State

Mobile Crisis

Health Information Exchange (HIE)
- Service Integ
- Patient engag
- Information t
- Leverage platforms or create ne ways to share info,

UniteUs/ConnectOregon
- Community Provider Engagement and Asset Maps
- Screenings (if applicable) & Assessments
- Referrals, Service Provision

PSCS InCK Regional Systems Navigator

Vision: Access to most complete InCK population data in order to provide support to core service providers to integrate care.

Assists core services providers in navigating systems, addressing barriers, identifying gaps in capacity. Assesses data to identify gaps in services. CANNOT provide direct care coordination to children/families. Identifies children needing Service Integration based on system, community or practice-level data.

VERSION 3.0 6/8/2020

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

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

Goals

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

Population of Children to Receive InCK Model

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

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

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

Active Monitoring
Preventive care

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

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

Enhanced assessments and screenings
Best Match Care Coordination

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

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

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

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

Regional Activities & Supports Funded by Project

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

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

This program 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 an award totaling $16 million. The contents are those of the author(s) and do not necessarily represent

Critical Role of Community Information Exchange (CIE) in InCK

- **Page 18 of Pre-Reading**
- Core component of the InCK Model is identifying children with housing insecurity and food insecurity needs and developing mechanisms to connect them to services
- Health related services provided by Community Based Organizations are critical to support children's health
- **ConnectOregon** has been selected as the CIE for the InCK Model
  - Aligned with broader PCS strategies
  - Builds off pilots & learnings from COHIE (Required component of Central Oregon PC Charter)
- Starting in Fall 2021, PCS signed a contract with **Unite Us/Connect Oregon** in Central Oregon to support better connection to community-based organizations.
- At a future Partnership Council meeting, staff from Unite Us/Connect Oregon will present how:
  - How clinical and community-based providers of the InCK Population will be engaged to consider use of Unite Us/Connect Oregon

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Rapid Fire Question and Feedback:

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Priority Next Steps

- PCS Work sessions
- Further recruitment of PYYAYG
- Operationalizing key components of the model that "go live" in 2022
  - ✓System-Level Needs Assessments, Indicators from OHA to PCS
  - ✓InCK clinical provider engagement informed by data
  - ✓Service Integration Levels
  - ✓Developing proposed curriculum and supports that relate to best match care coordination models
  - ✓InCK clinical provider engagement
  - ✓HIE steps to support required components of the model
  - ✓CIE steps to support required components of the model
  - ✓Finalizing OR InCK Team proposal for performance metrics related to Kindergarten Readiness, Housing and Food Instability Screening, Depression Screening and Follow-Up
- Next meeting is **June 1st 1-3 PM**

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

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