





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

March 11th, 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.*

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.

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
- **Stretch Break & Fun Activity**
- **Overview of Mobile Crisis and Stabilization Services** and review InCK requirements, current options and strategies being explored.
  Interactive Group Activity
- Provide an **overview of proposed process for exploring integration and sharing of information required as part of the InCK Model**, spotlight on selected **Community Information Exchange (CIE)**
- Heads up on **June Partnership Council** meeting

Welcome

Oregon Pediatric Improvement Partnership

- **Akira Bernier**– Research Associate & Practice Facilitator

Oregon Health Authority:

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

Page 2 of Pre-Reading

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.

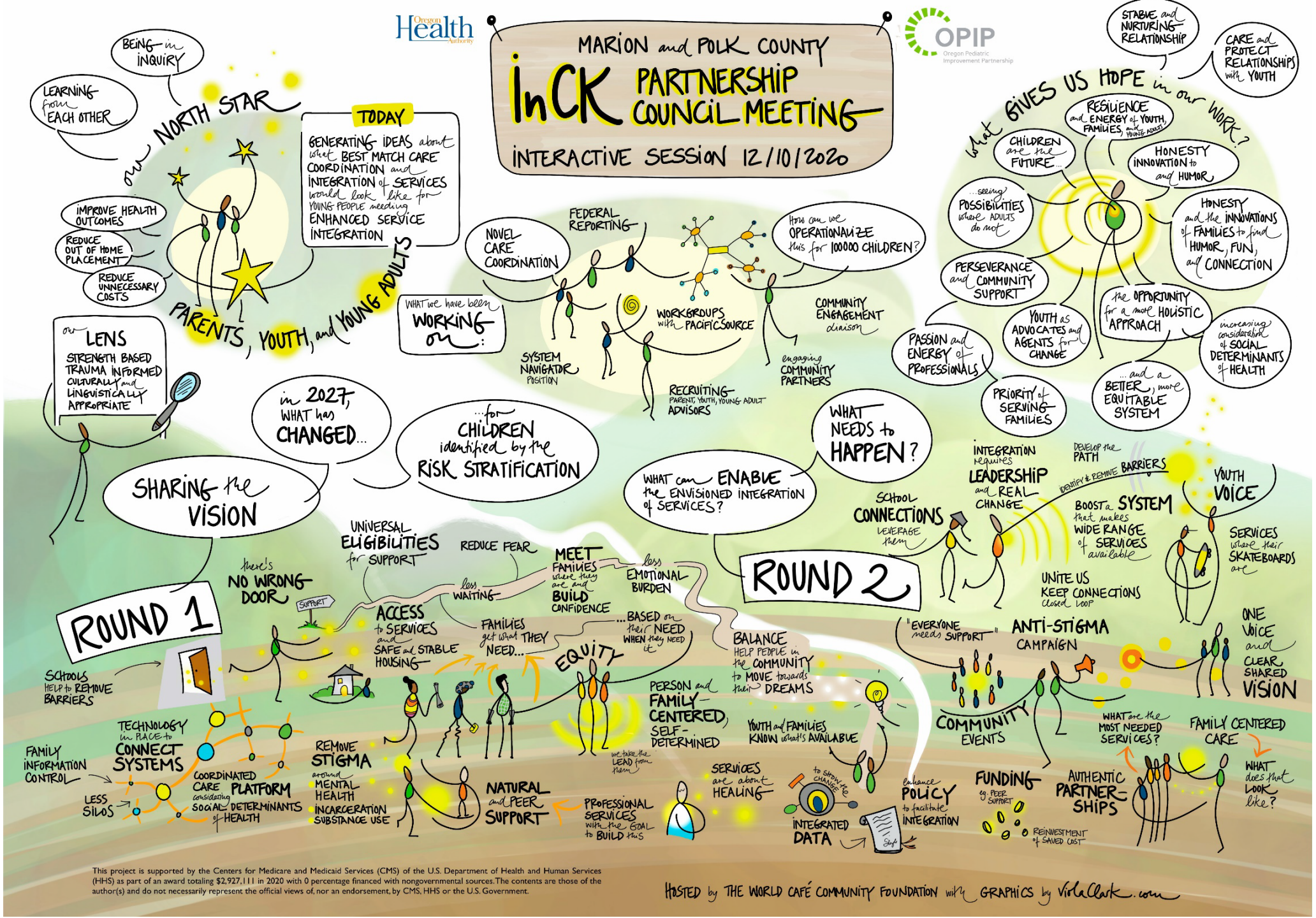
Regional Activities & Supports Funded by Project

- 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.

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 with 100 percent funded by CMS/HHS. 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

Page 3 of Pre-Reading



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
- **Stretch Break & Fun Activity**
- **Overview of Mobile Crisis and Stabilization Services** and review InCK requirements, current options and strategies being explored.
  Interactive Group Activity
- Provide an **overview of proposed process for exploring integration and sharing of information required as part of the InCK Model**, spotlight on selected **Community Information Exchange (CIE)**
- Heads up on **June Partnership Council** meeting

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 <u>subsets of children</u>** 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.

Oregon's Service Integration Needs Assessment: Cross-Sector System-Level Health Complexity Data: Preliminary Findings for Marion and Polk County

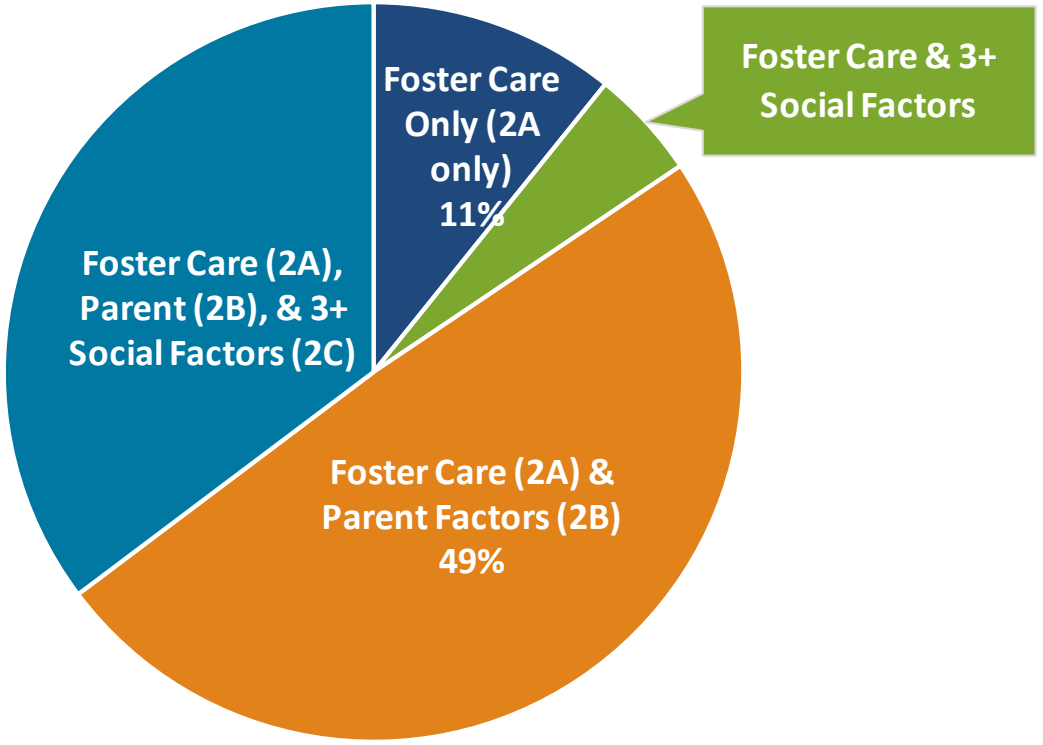
Level 2 Service Integration Level 2 (SIL 2)

	Point 1: Exhibited need for two core child services		Point 2: Functional symptom of impairment	Total Children with Combined Indicators Current Available
	Child had 1+ core service…	*…and exhibited need for additional services* **SOCIAL COMPLEXITY**	*MEDICAL COMPLEXITY*	**HEALTH COMPLEXITY**
2A	Child had physical or behavioral health service *(Data Not available yet)*	• 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, OR • Non-Complex Chronic	**5.02%, N=2,933**
2B		Social Complexity that includes • Parent substance abuse, &/or • Parent mental health, &/or • Parental incarceration	Medical Complexity • Complex Chronic, OR • Non-Complex Chronic	**CC:4.53%, N=2,651** **NC:8.83%, N=5,166**
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:0.65%, N=380**
			Children Birth to Five: • Non-Complex Chronic	***NC: 0.39%, N=64***
2D		***Chronic absenteeism, or risk for absenteeism, from Oregon Department of Education data (New variable under construction)***	Medical Complexity • Complex Chronic, OR • Non-Complex Chronic	***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 Marion and Polk County as of May 2020. 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 Marion and Polk

Within Foster Care + Medical Complexity (SIL 2A)
Population
(% of population with overlapping factors)
N= 2,933



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 Marion and Polk counties as of May 2020. Total population in Marion & Polk as of May 2020 was 58,478. 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 Marion & Polk Data

Ambulatory Care: Avoidable ED Visits

Complexity Factor	Rate per 1,000
Overall CCO Member Level File	*6.1*
Overall Child Health Complexity Population	4.8
Social	
3 or more indicators	5.5
1-2 indicators	4.5
None in System-Level Data	3.5
Medical	
Complex Chronic	7.2
Non-complex Chronic	5.6
No Medical Complexity	4.1
Health	
Complex Chronic, 3+ Social Factors	7.6
Complex Chronic, 1-2 Social Factors	6.8
Complex Chronic, 0 Social Factors	6.5
Non-Complex Chronic, 3+ Social Factors	6.1
Non-Complex Chronic, 1-2 Social Factors	5.3
Non-Complex Chronic, 0 Social Factors	4.6
Healthy, 3 + Social Factors	4.7
Healthy, 1-2 Social Factors	4.0
Healthy, 0 Social Factors	3.2

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 Marion and Polk counties as of May 2020. Total population in Marion & Polk as of May 2020 was 58,478. See https://www.oregon.gov/oha/HPA/dsi-tc/Documents/DataDictionary-Social-Indicators.pdf

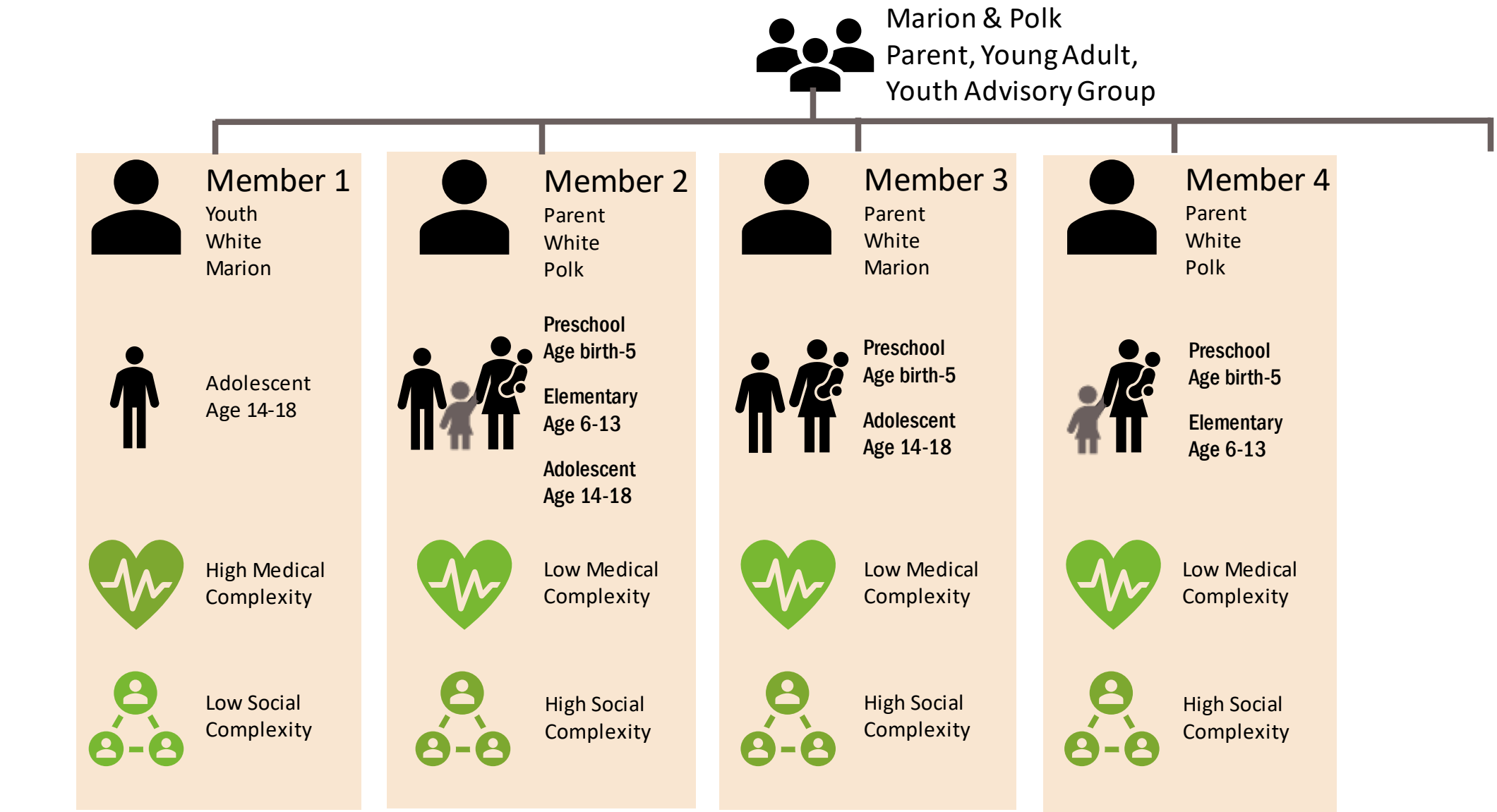
Parent, Youth & Young Adult Advisory Group (PYYAG)

- 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.**

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 for **one spot**
- Once all members are onboarded and CMMI approves Carry Forward request:
  - Community café informed session of the PYAYG

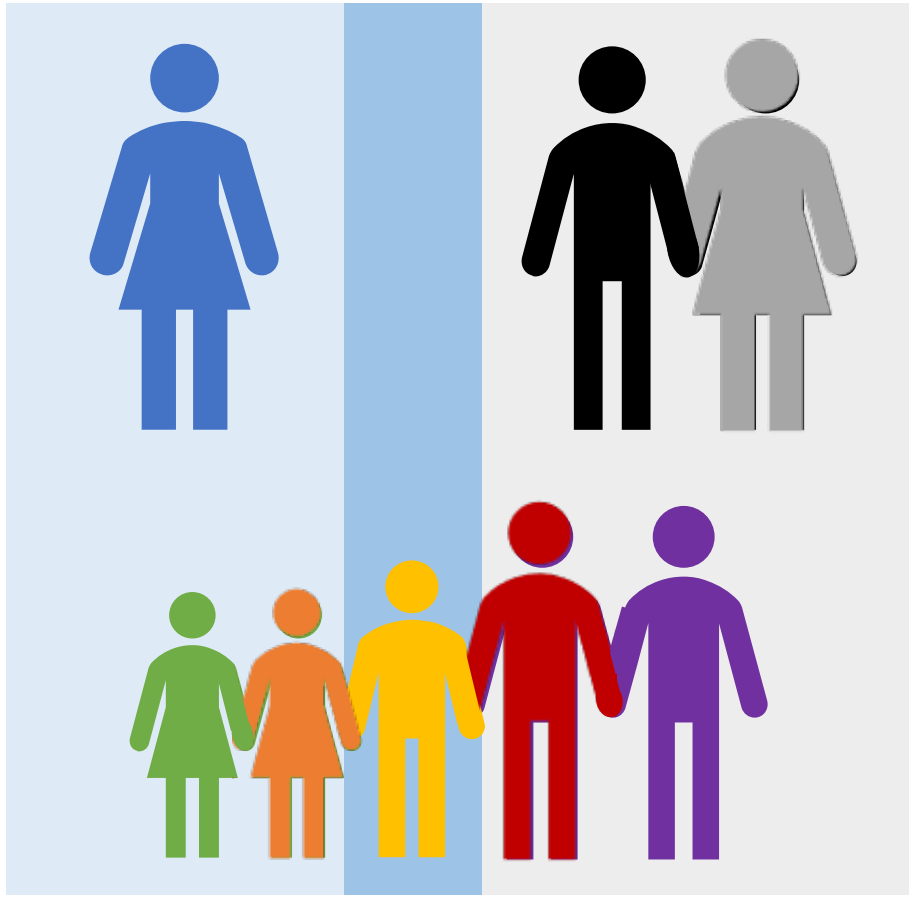
Oregon's Integrated Care for Kids Model:
Parent, Young Adult, Youth Advisory Group



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

Family 1

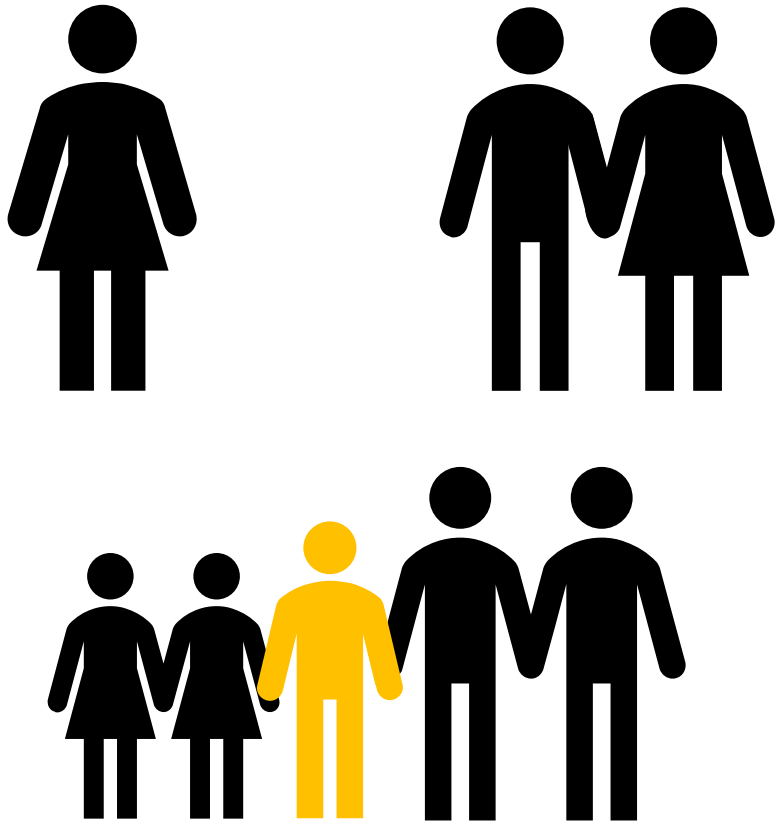
- Parent 1
- Parent 2
- Step-Parent 1
- Youth (17 years old)
- Step-brother (20 years old)
- Step-brother (17 years old)
- Sister (13 years old)
- Sister (12 years old)

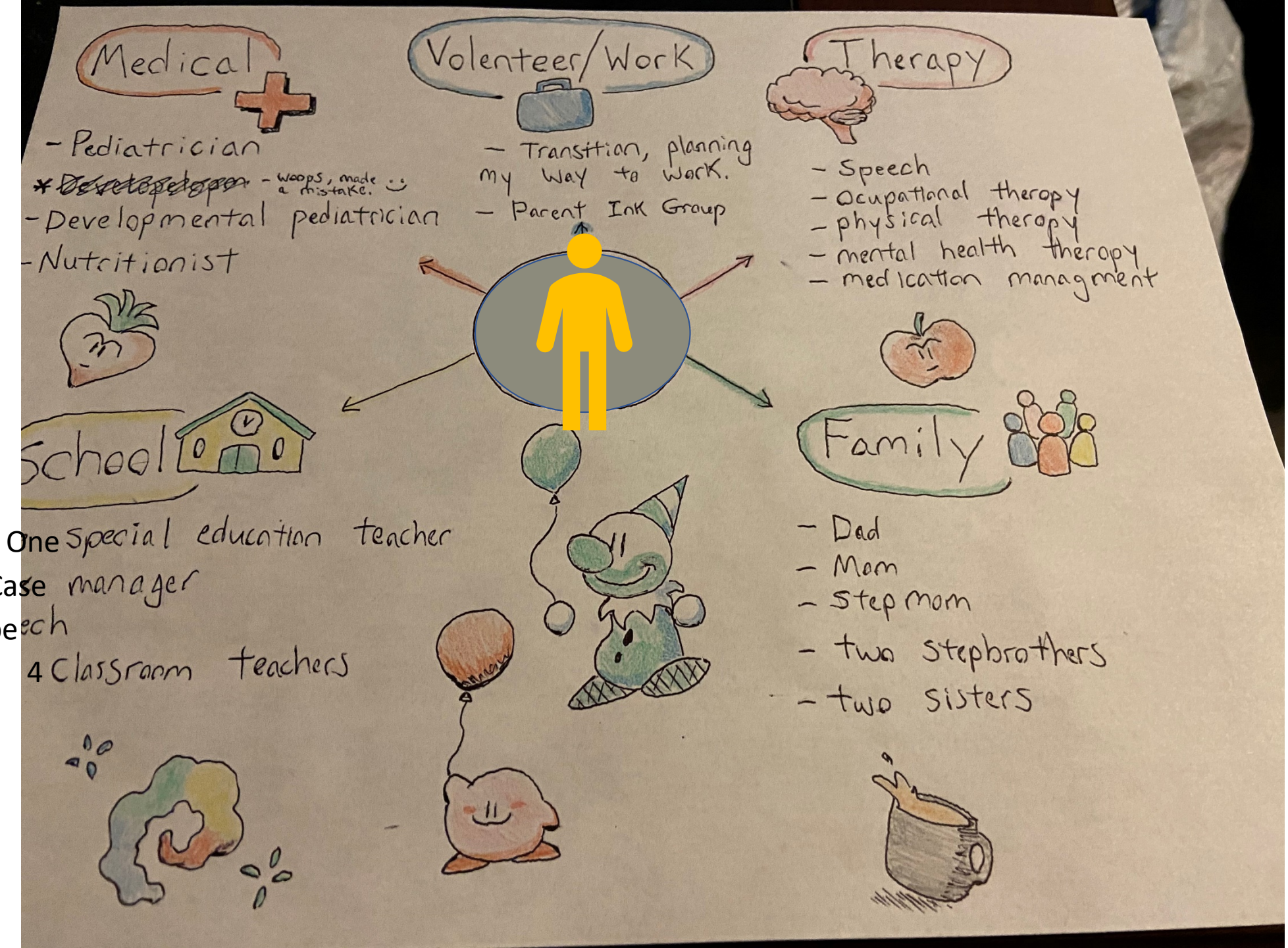


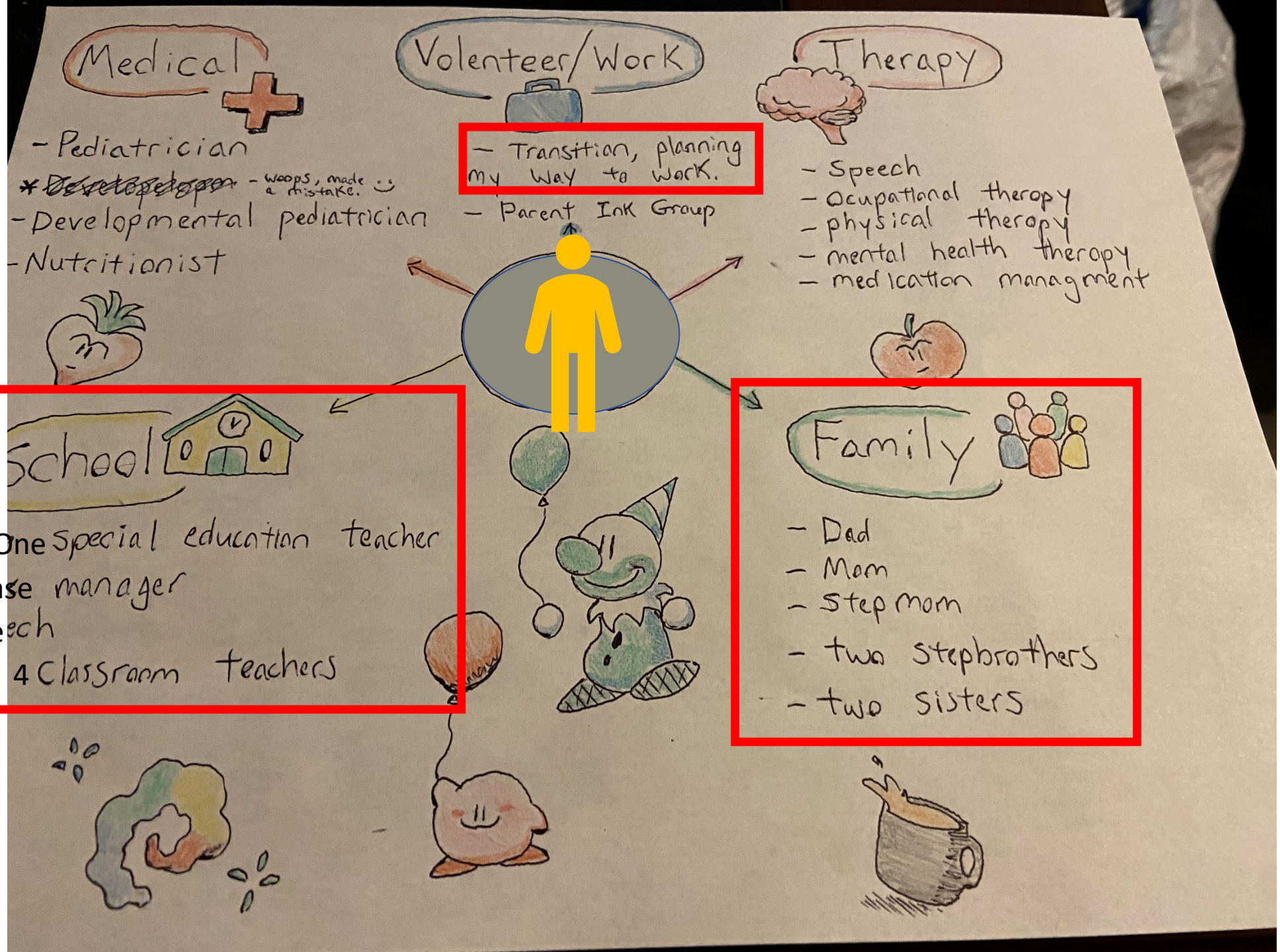
Oregon's Integrated Care for Kids Model:
Parent, Young Adult, Youth Advisory Group

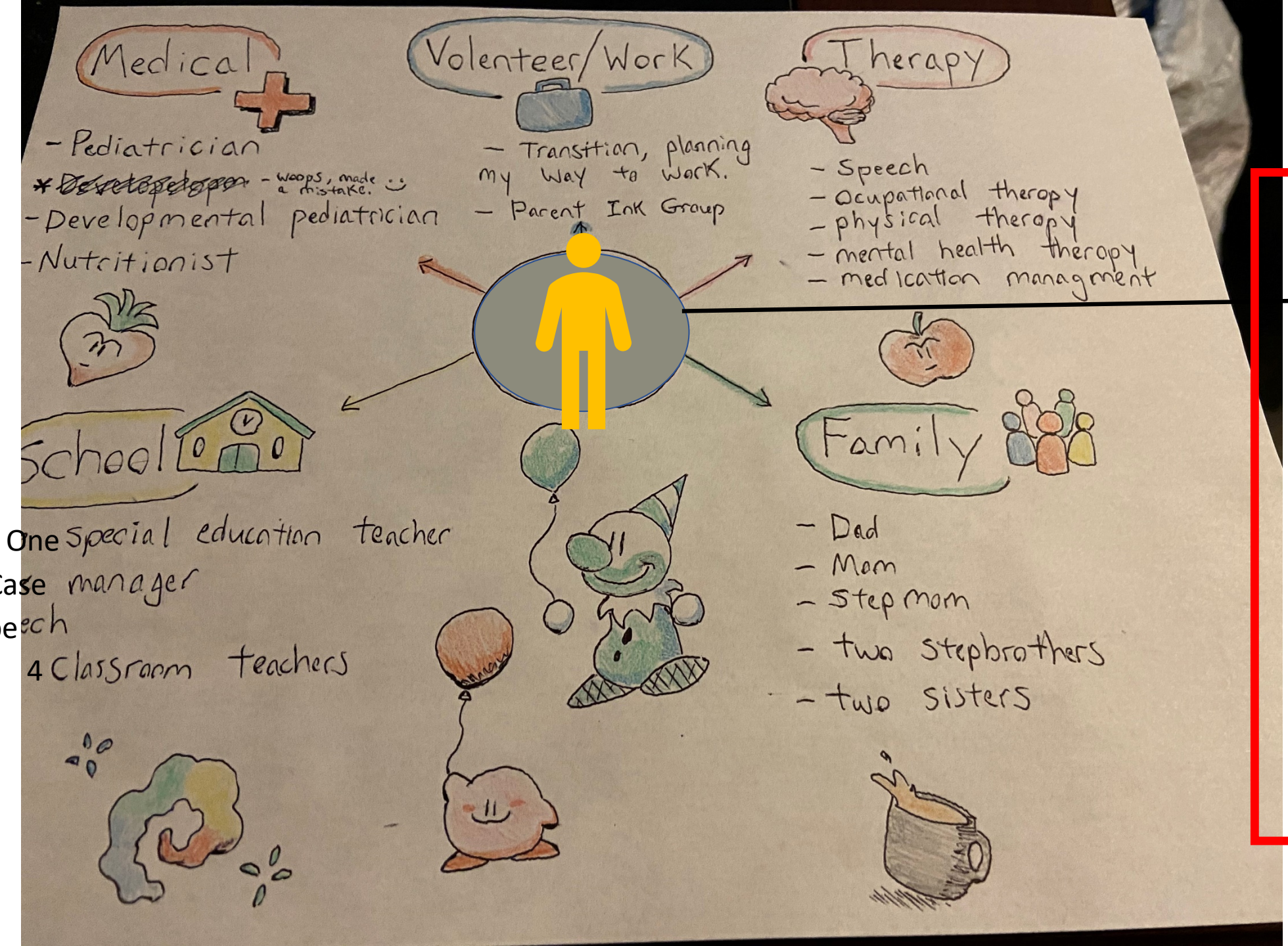
Family 1

- **Parent 1**
- **Parent 2**
- **Step-parent 1**
- **Youth (17 years old)**
- **Step-brother (20 years old)**
- **Step-brother (17 years old)**
- **Sister (13 years old)**
- **Sister (12 years old)**



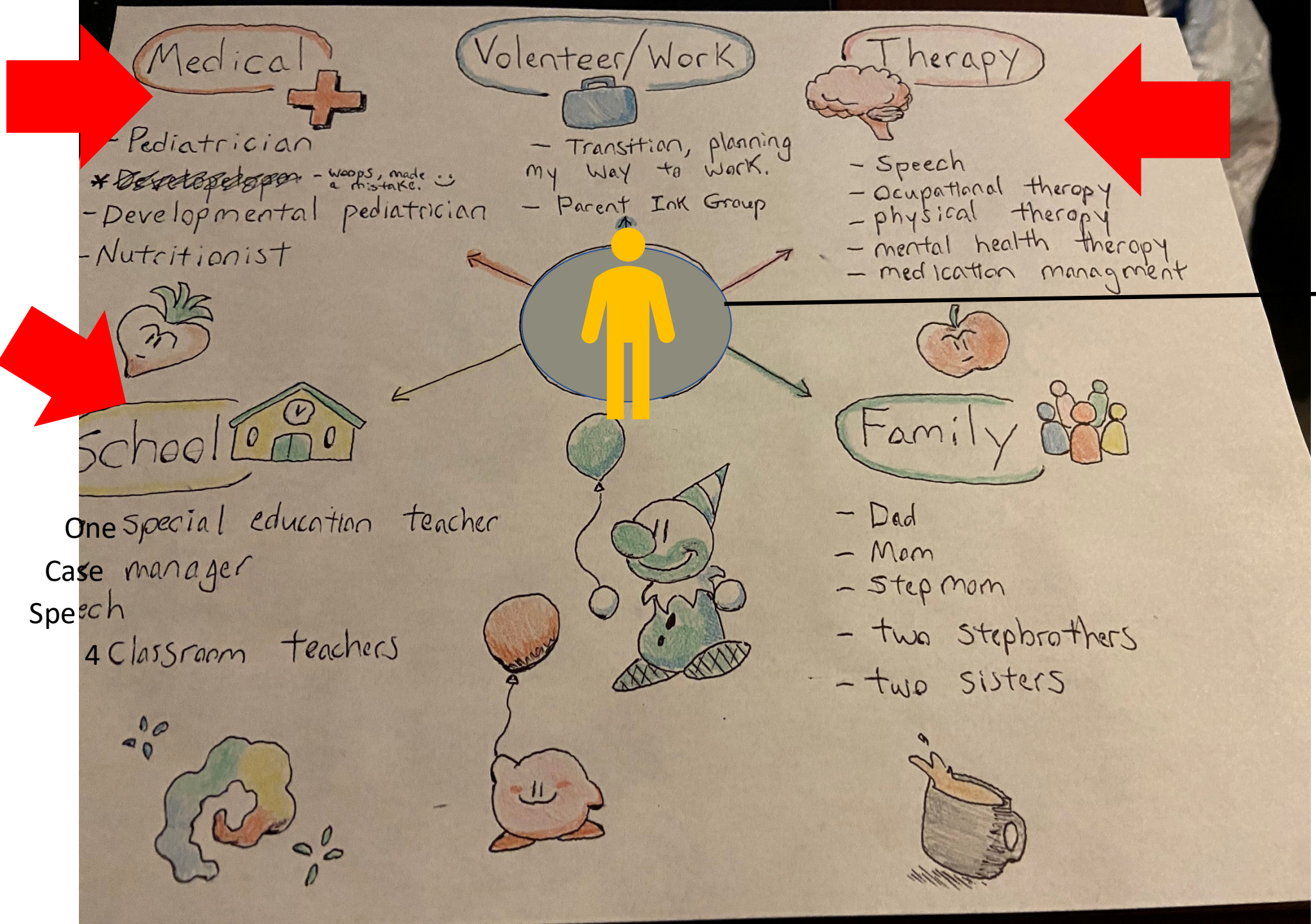

Medical
- Pediatrician
* Developedopon - woops, made a mistake.
- Developmental pediatrician
- Nutritionist
Volenteer/Work
- Transition, planning my way to work.
- Parent Ink Group
Therapy
- Speech
- Ocupational therapy
- physical therapy
- mental health therapy
- medication managment
School
One Special education teacher
Case manager
Speech
4 Classroom teachers
Family
- Dad
- Mom
- Step mom
- two Stepbrothers
- two sisters


Medical
- Pediatrician
* ~~Developedopon~~ - woops, made a mistake. ☺
- Developmental pediatrician
- Nutritionist
Volenteer/Work
- Transition, planning my way to work.
- Parent Ink Group
Therapy
- Speech
- Ocupational therapy
- physical therapy
- mental health therapy
- medication managment
School
One Special education teacher
Case manager
Speech
4 Classroom teachers
Family
- Dad
- Mom
- Step mom
- two Stepbrothers
- two sisters



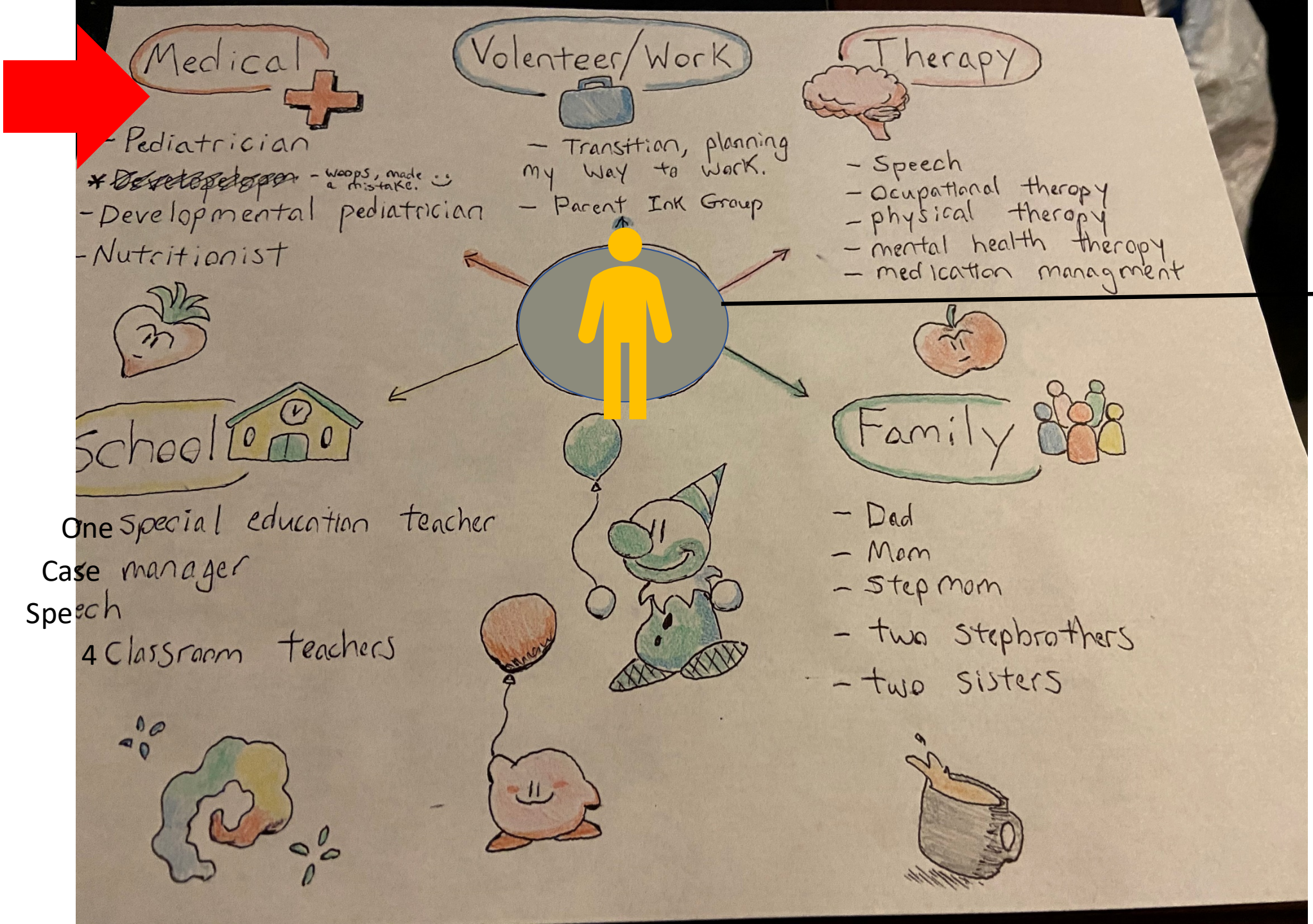
Care Coordination (provided by mom)

- Mom does majority of scheduling appointments, interacting with providers and keeping up-to-date on needs for entire family, including youth
- The youth's 13 yo sister has an IEP and 12 yo sister has a 504



Care Coordination (provided by mom)

- Mom does majority of scheduling appointments, interacting with providers and keeping up-to-date on needs for entire family, including youth
- The youth's 13 yo sister has an IEP and 12 yo sister has a 504



Care Coordination (provided by mom)

- Mom does majority of scheduling appointments, interacting with providers and keeping up-to-date on needs for entire family, including youth
- The youth's 13 yo sister has an IEP and 12 yo sister has a 504

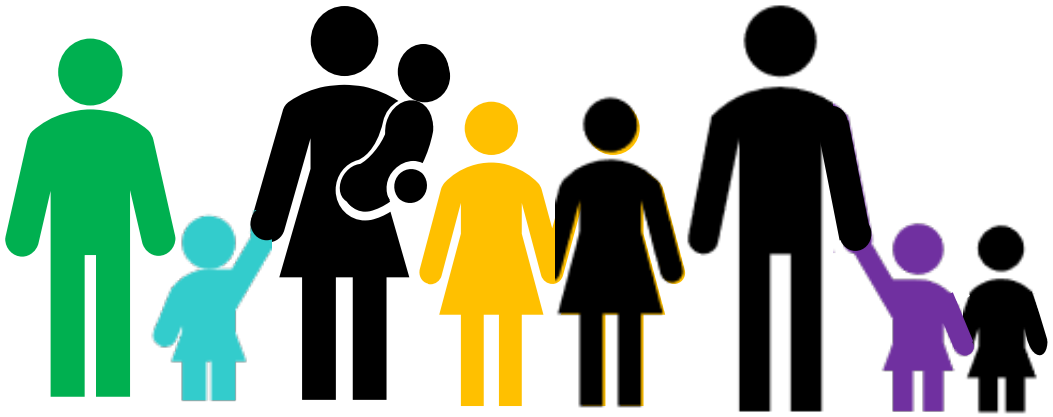
Oregon's Integrated Care for Kids Model:
Parent, Young Adult, Youth Advisory Group

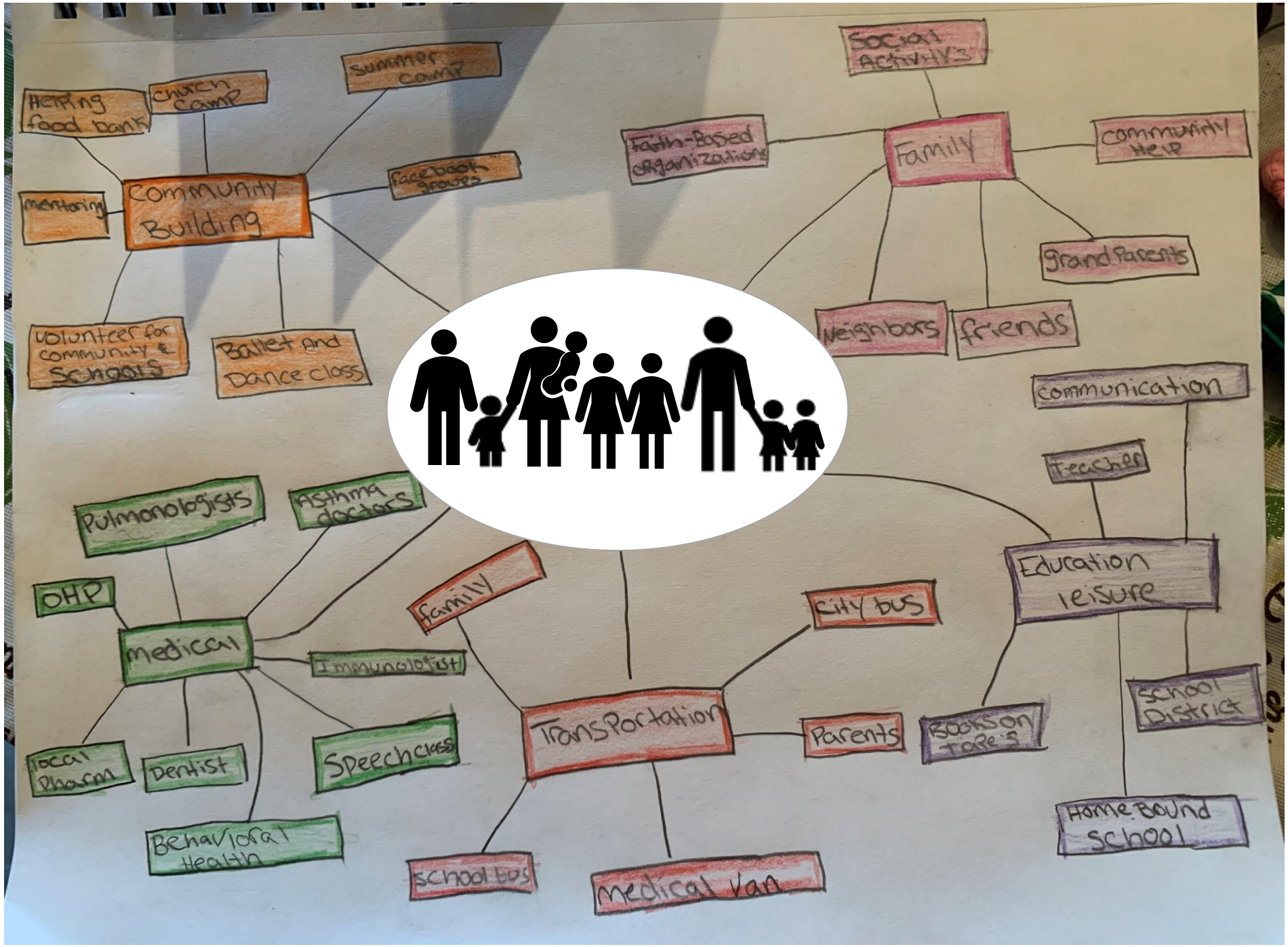
Family 2

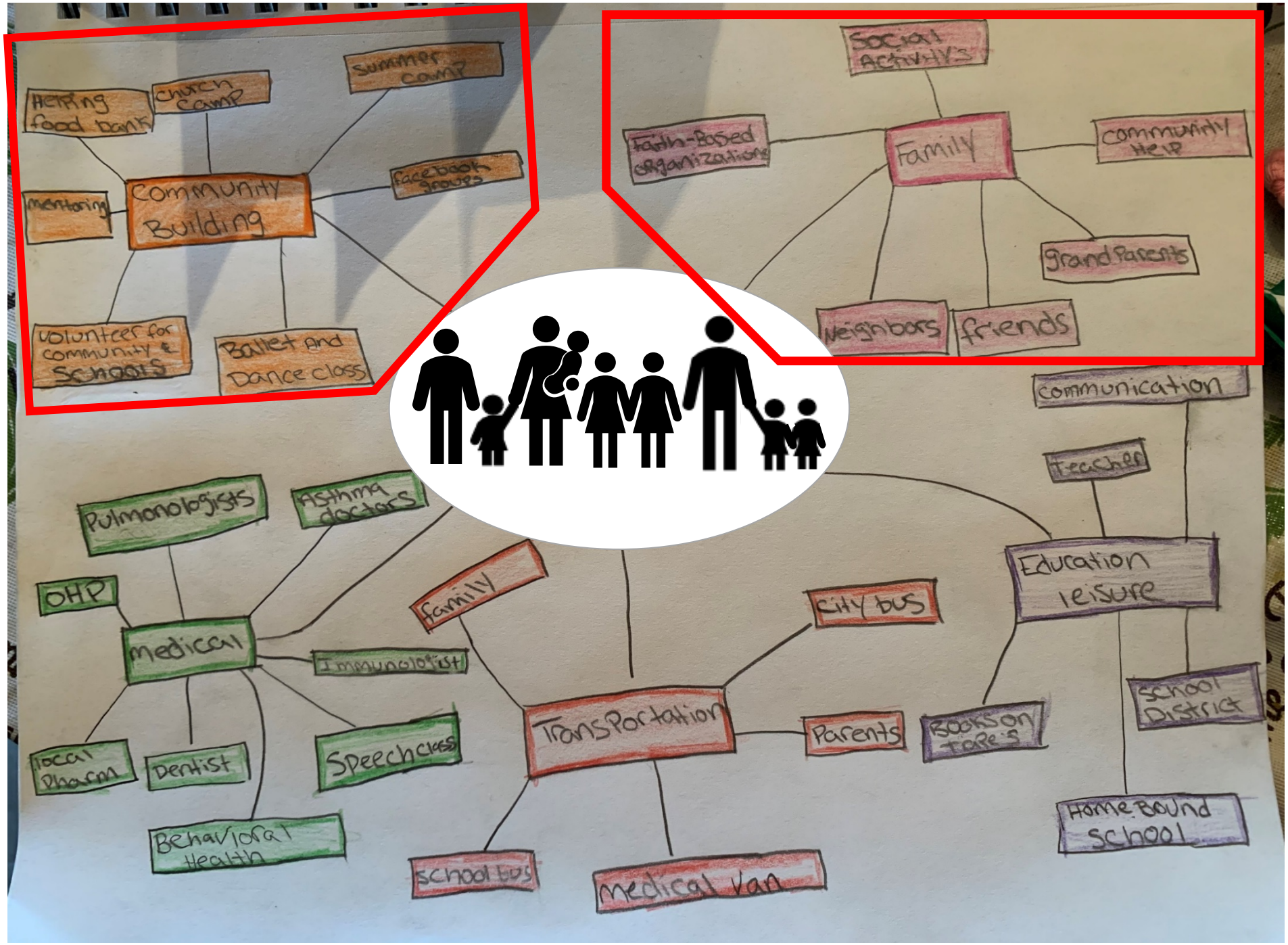
- **Parent 1**
- **Parent 2**
- **Son (15 years old)**
- **Daughter (12 years old)**
- **Daughter (10 years old)**
- **Daughter (6 years old)**
- **Daughter (4 years old)**
- **Daughter (infant)**
- **Daughter**

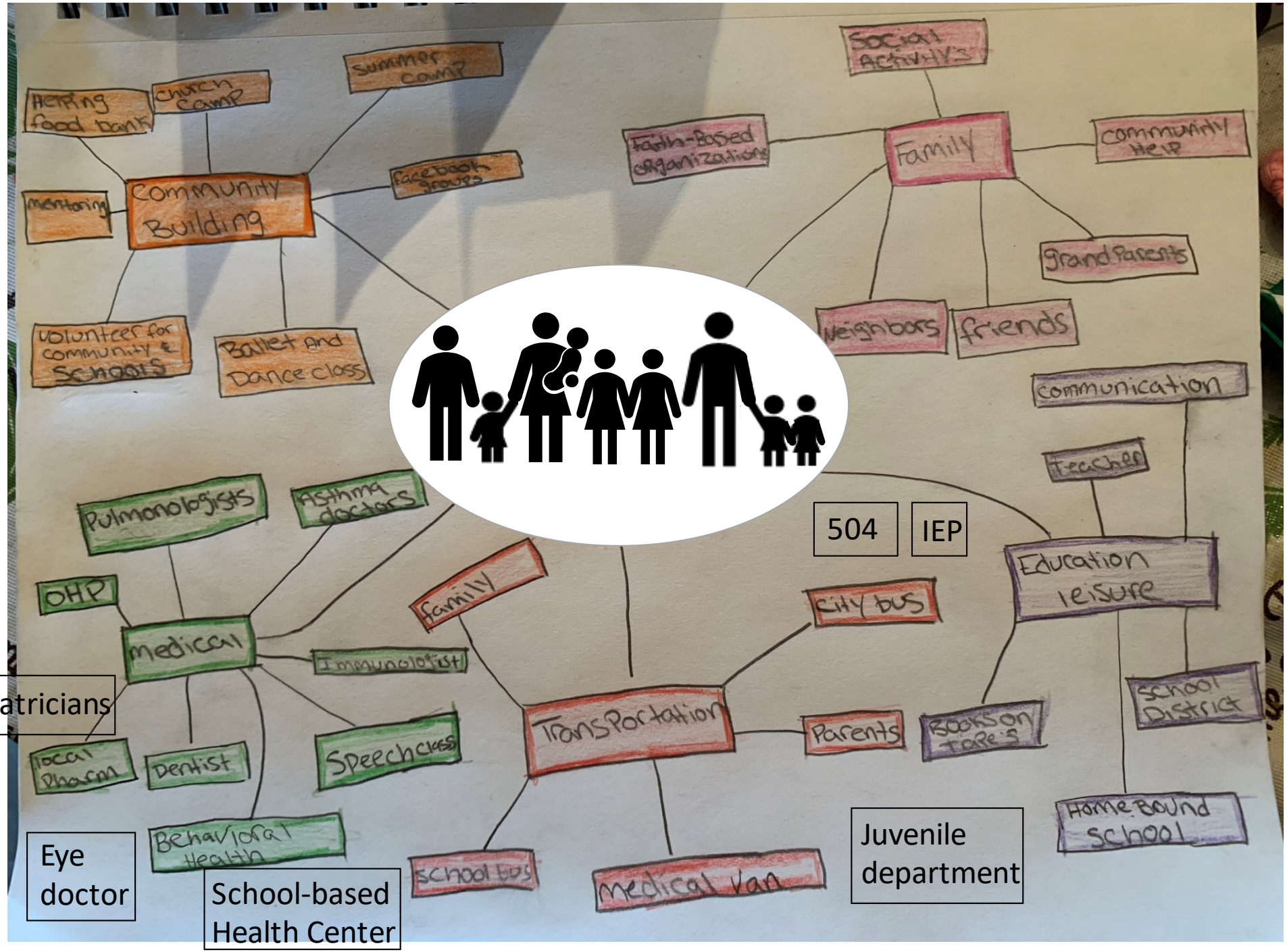
Family 2

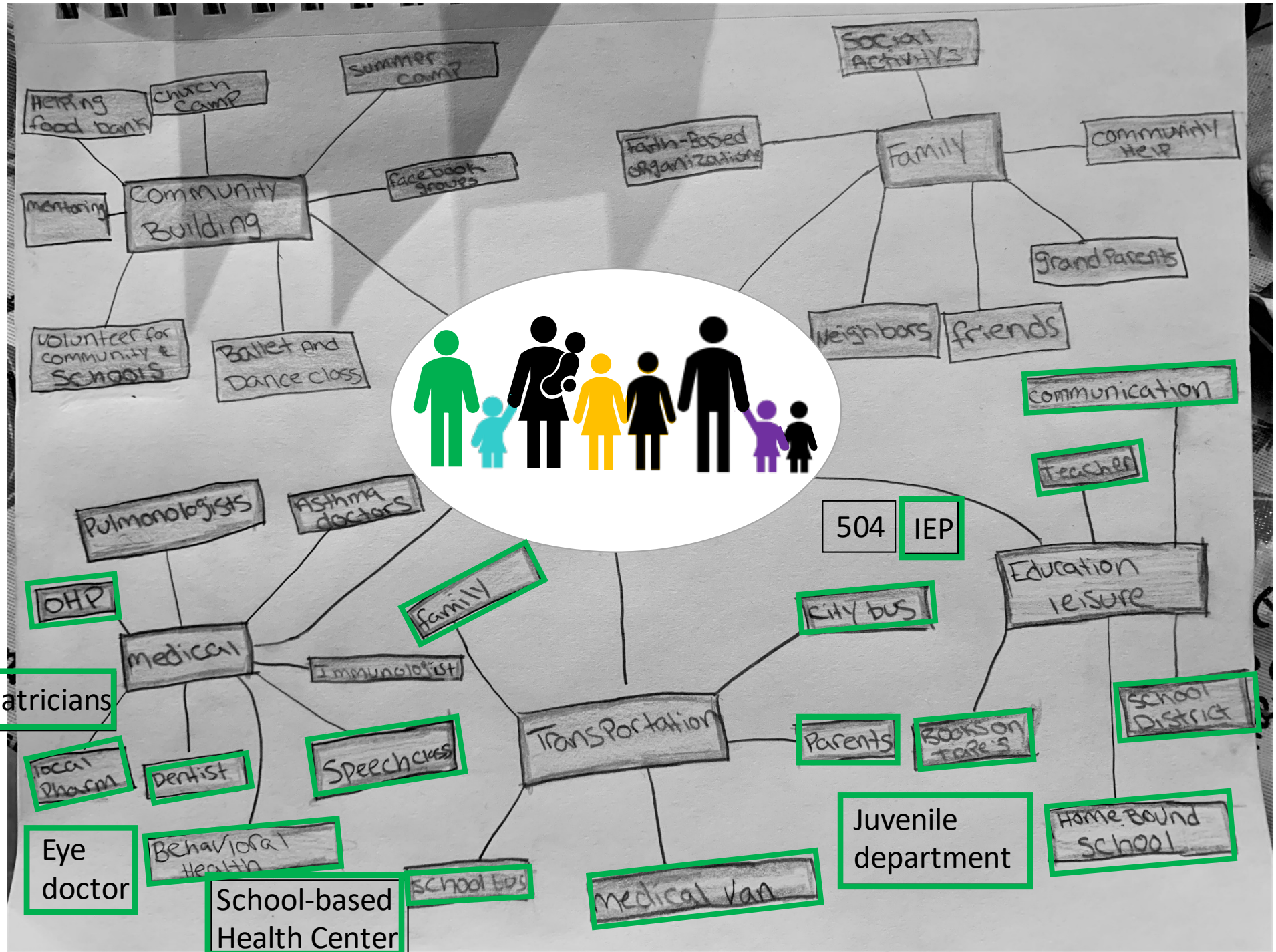
- **Parent 1**
- **Parent 2**
- **Son (15 years old)**
- **Daughter (12 years old)**
- **Daughter (10 years old)**
- **Daughter (6 years old)**
- **Daughter (4 years old)**
- **Daughter (infant)**
- **Daughter**

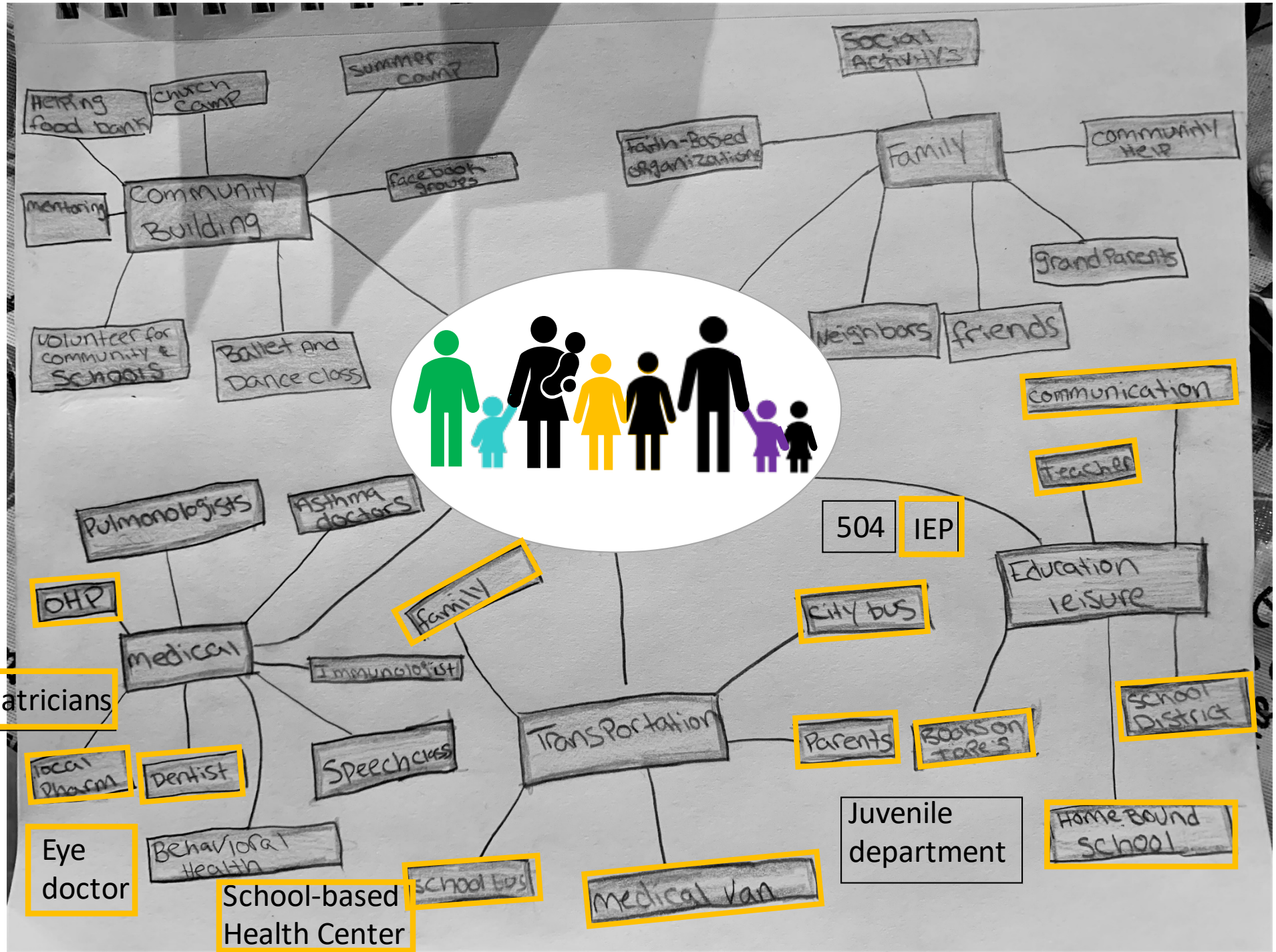


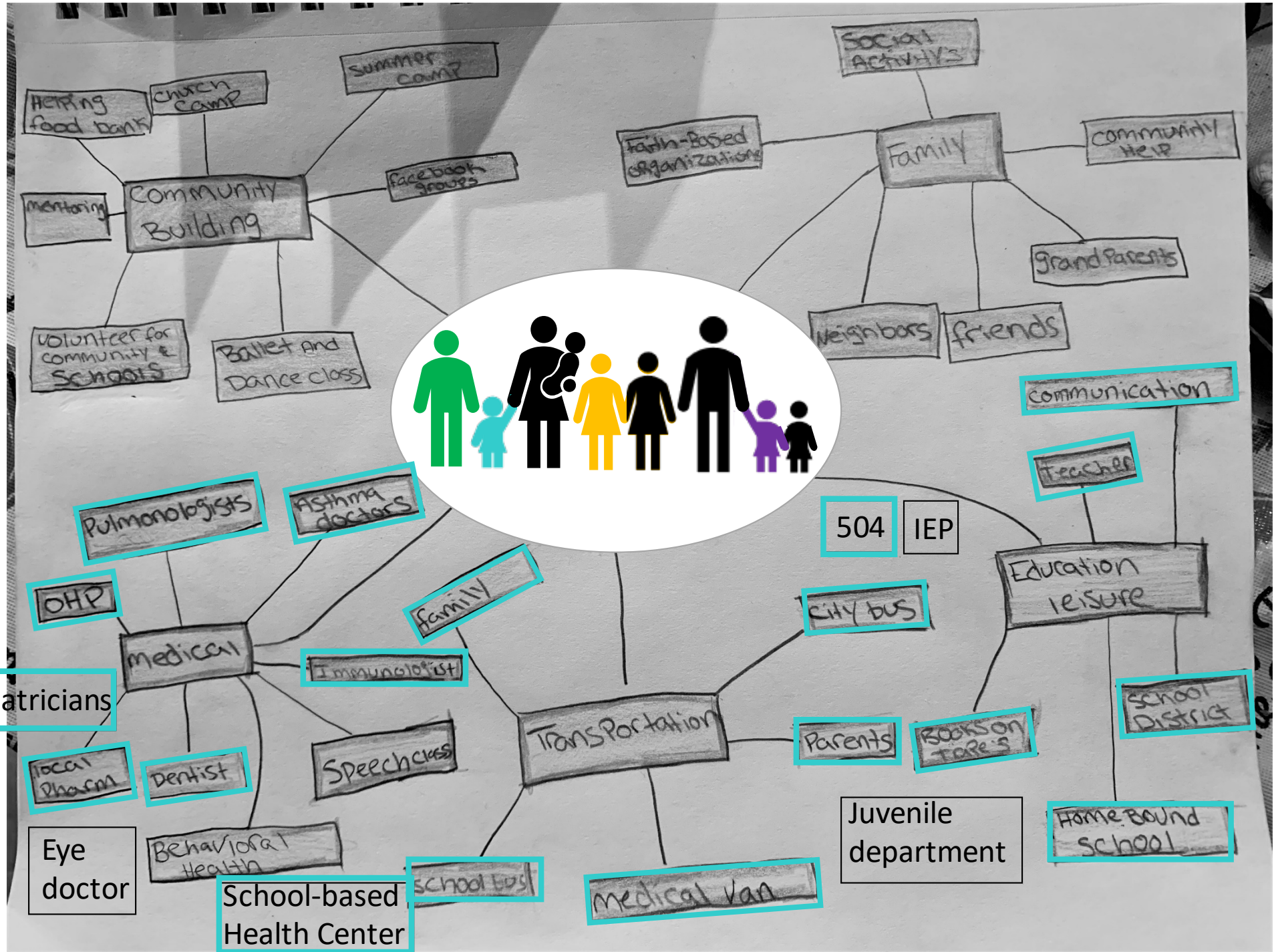

Social Activity's
Faith-Based organizations
Family
community Help
Grandparents
Neighbors
friends
communication
Teacher
Education leisure
School District
Home Bound School
Books on Tapes
Parents
City bus
Transportation
school bus
medical van
Family
Pulmonologists
Asthma doctors
OHP
medical
Immunologist
local Pharm
Dentist
Speech class
Behavioral health
Helping food bank
church camp
Summer camp
facebook groups
mentoring
Community Building
volunteer for community & schools
Ballet and Dance class

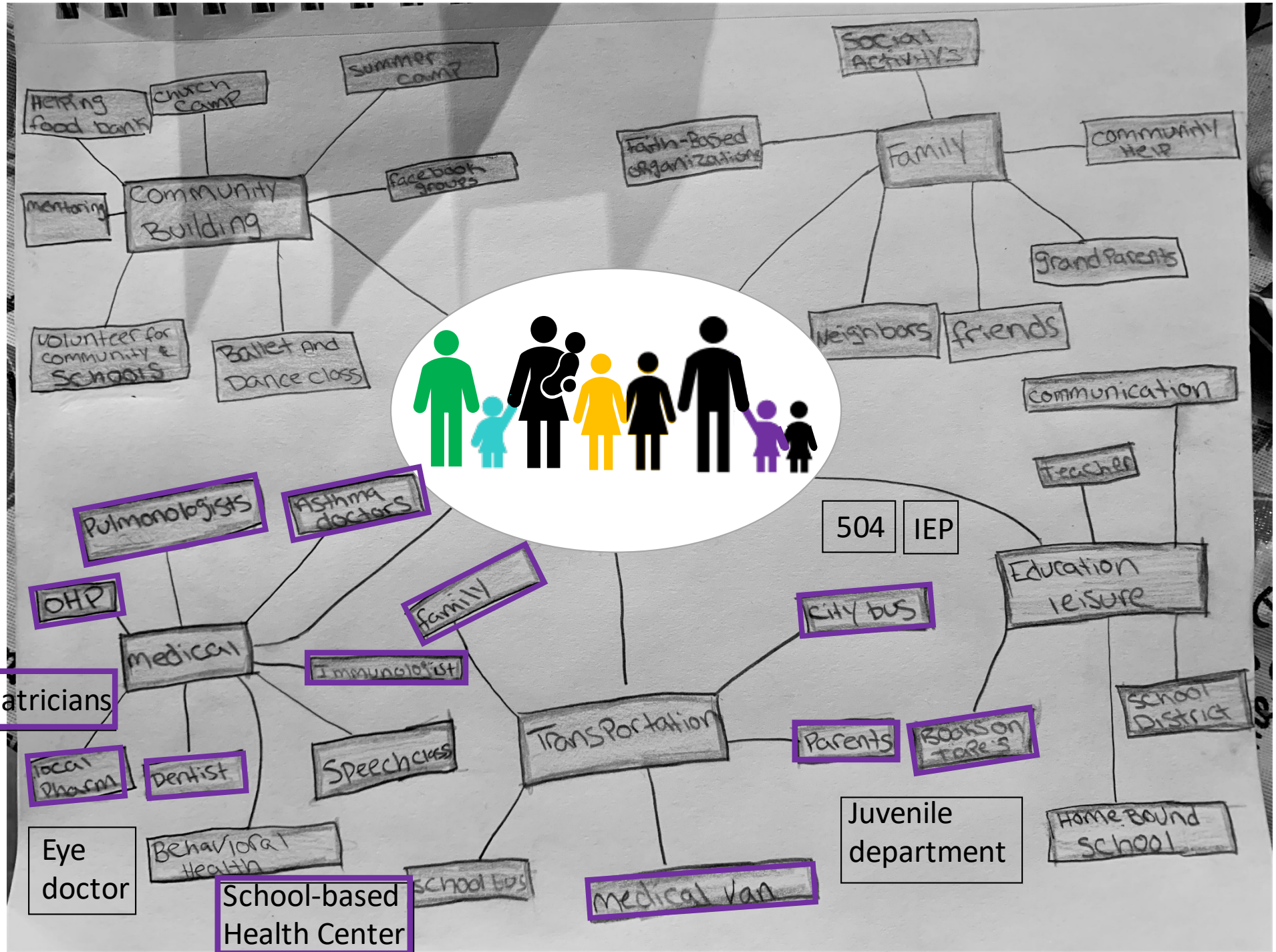

Community Building
Helping food bank
church camp
summer camp
mentoring
facebook groups
volunteer for community & schools
Ballet and Dance class
Family
Social Activities
Faith-Based organizations
community Help
Grandparents
Neighbors
friends
communication
Teacher
Education leisure
School District
Home Bound School
Pulmonologists
Asthma doctors
OHP
medical
Immunologist
local Pharm
Dentist
Speech class
Behavioral health
family
Transportation
city bus
Parents
Books on Tapes
school bus
medical van

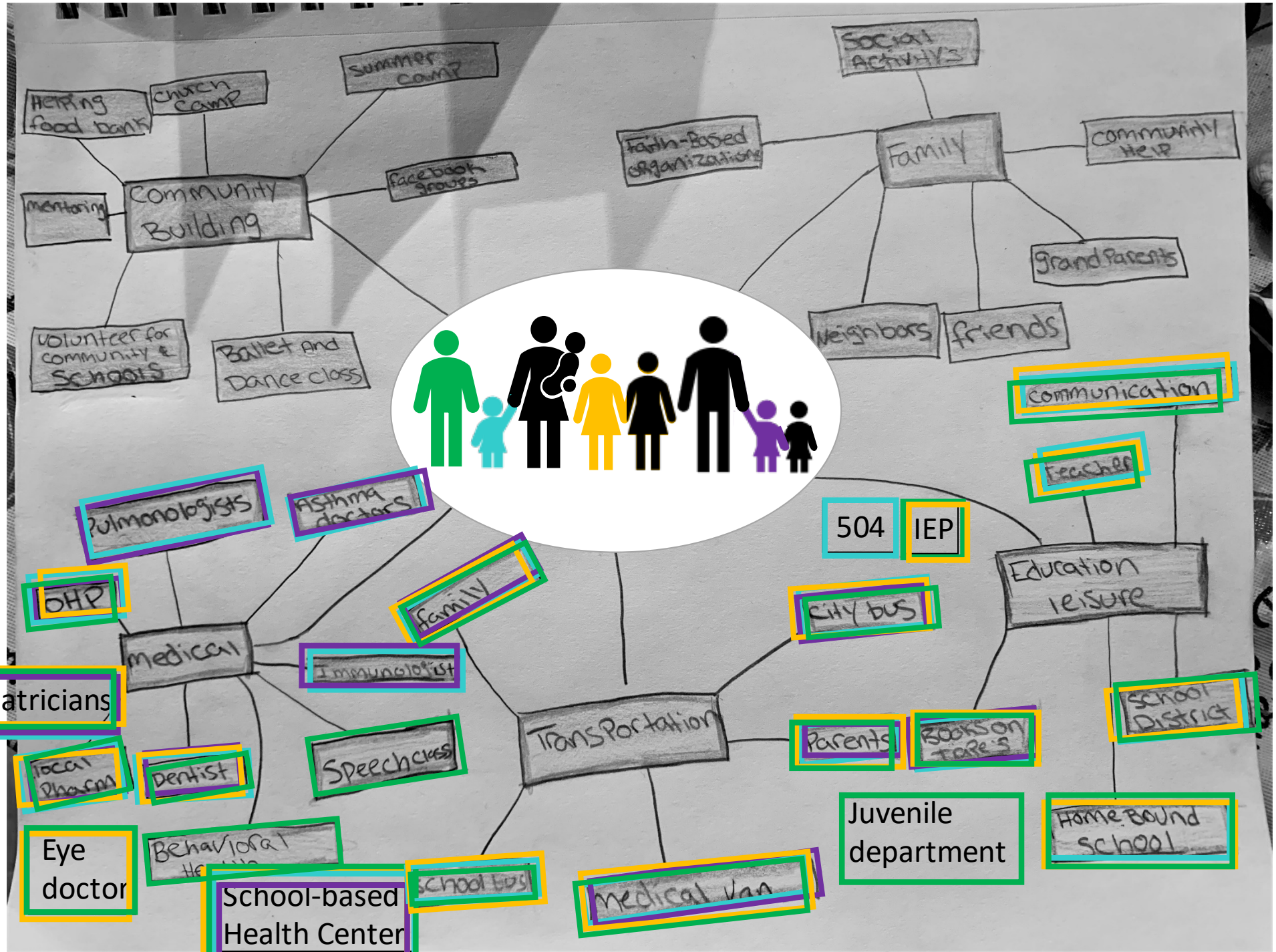

Social Activities
Summer camp
Church camp
Helping food bank
Community Building
Facebook groups
Mentoring
Faith-Based organizations
Family
Community Help
Grandparents
Volunteer for community & schools
Ballet and Dance class
Neighbors
friends
communication
Teacher
504
IEP
Education leisure
Pulmonologists
Asthma doctors
OHP
medical
Immunologist
family
City bus
Pediatricians
Transportation
Parents
Books on Tapes
School District
Local Pharm
Dentist
Speech class
Behavioral Health
Eye doctor
School-based Health Center
school bus
medical van
Juvenile department
Home Bound School


Community Building
Helping food bank
church camp
summer camp
facebook groups
mentoring
Volunteer for community & schools
Ballet and Dance class
Family
Social activity's
Faith-based organizations
community help
Grandparents
Neighbors
friends
Communication
Teacher
504
IEP
Education leisure
School District
Home Bound School
Juvenile department
Books on tapes
Parents
City bus
Transportation
Family
Medical van
School bus
Pulmonologists
Asthma doctors
OHP
medical
Immunologist
Pediatricians
local Pharm
dentist
Speech class
Behavioral Health
Eye doctor
School-based Health Center


Helping food bank
church camp
summer camp
Community Building
mentoring
facebook groups
volunteer for community & schools
Ballet and Dance class
Social activity's
faith-based organizations
Family
community help
Grand Parents
Neighbors
friends
communication
Teacher
504
IEP
Education leisure
Pulmonologists
Asthma doctors
OHP
medical
Family
Immunologist
Pediatricians
City bus
Transportation
Parents
Books on tapes
School District
local Pharm
Dentist
Speech class
Eye doctor
Behavioral Health
School-based Health Center
school bus
medical van
Juvenile department
Home Bound School


Helping food bank
church camp
summer camp
Community Building
mentoring
facebook groups
volunteer for community & schools
Ballet and Dance class
Social activity's
faith-based organizations
Family
community Help
Grand Parents
Neighbors
friends
communication
Teacher
504
IEP
Education leisure
School District
Home Bound School
Pulmonologists
Asthma doctors
OHP
medical
Immunologist
Pediatricians
local Pharm
Dentist
Speech class
Behavioral Health
Eye doctor
family
Transportation
city bus
Parents
Books on Tape's
Juvenile department
school bus
School-based Health Center
medical Van

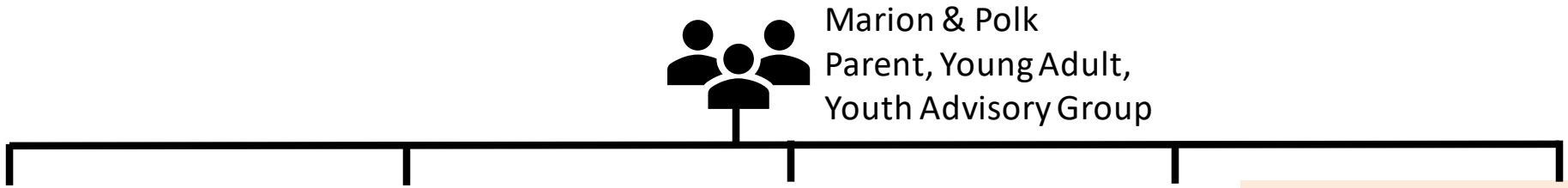

Helping food bank
church camp
summer camp
Community Building
mentoring
facebook groups
volunteer for community & schools
Ballet and Dance class
Social activity's
faith-based organizations
Family
community help
grand Parents
neighbors
friends
communication
Teacher
504
IEP
Education leisure
Pulmonologists
Asthma doctors
OHP
medical
family
Immunologist
Pediatricians
City bus
School District
Transportation
Parents
Books on Tape's
local Pharm
dentist
Speech class
Eye doctor
Behavioral Health
School-based Health Center
school bus
medical van
Juvenile department
Home Bound School


Helping food bank
church camp
summer camp
Community Building
mentoring
facebook groups
volunteer for community & schools
Ballet and Dance class
Social activity's
faith-based organizations
Family
community help
grand Parents
Neighbors
friends
communication
Teacher
504
IEP
Education leisure
Pulmonologists
Asthma doctors
OHP
medical
family
Immunologist
Pediatricians
city bus
TransPortation
Parents
Books on tape's
School District
local Pharmacy
dentist
Speech class
Eye doctor
Behavioral
School-based Health Center
school bus
medical van
Juvenile department
Home Bound school

“What I do know is that if [my child] were trying to independently navigate this as an adult or even with a support person (who wouldn’t get the information unless shared by the person with the disability), it would be devastating and lead to negative outcomes.

[My child] would likely not have his much needed medication and would not follow appropriate healthcare guidelines for wellness or preventative measures.” - Mom of youth participant

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



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

Kiara: kyoder@earlylearninghub.org
Cara: lindc@ohsu.edu

Member 5
Adolescent
Northern Marion Co

Young Adult
Age 18-21 OR
Other Ages with
Factors Below

Any medical complexity

Social complexity aligned with foster care, parental factors in 2B

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
- **Stretch Break & Fun Activity**
- **Overview of Mobile Crisis and Stabilization Services** and review InCK requirements, current options and strategies being explored.
  Interactive Group Activity
- Provide an **overview of proposed process for exploring integration and sharing of information required as part of the InCK Model**.
- Heads up on **June Partnership Council** meeting

Spotlight of Four Areas of Work

- Work Sessions with PacificSource Community Solutions and Current Areas of Focus
- Systems Navigator and Community Engagement Liaison Update
- Clinical Provider Engagement
- PCPCH Assessments & PCPCH Learning Curriculum

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

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

- Pages 11-12 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.

Page 12 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)*

Spotlight of Four Key Components

- Work Sessions with PacificSource Community Solutions and Current Areas of Focus
- Systems Navigator and Community Engagement Liaison Update
- Clinical Provider Engagement
- PCPCH Assessments & PCPCH Learning Curriculum

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**

Quarterly InCK Population File

Oregon Health Authority

Oregon Department of Human Services

PacificSource HEALTH PLANS

CCO InCK Data Repository for Population Management

The image part with relationship ID rId31 was not found in the file.

Refreshed warehouse of InCK Population Data from CCO/HIE/CIE/System Navigator

System Navigator & Community Engagement Liaison

The image part with relationship ID rId28 was not found in the file.

- System Navigator: Based in **Pacific Source Community Solutions of Marion and Polk** because they are covered entity subject to privacy laws as defined under HIPAA and have business associate agreement (as defined by HIPAA) with:
  - Oregon Health Authority
  - Core services providers (physical and behavioral health, schools, housing, food, early care and education, Title V, child welfare and mobile crisis)
  - Access Health Information Exchange and Community Information Exchange (CIE: UniteUs) used as part of the InCK Model.
- **Marion and Polk Community Engagement Liaison (Kiara Yoder)**
  - Support asset mapping
  - Front-Line provider engagement

The image part with relationship ID rId3 was not found in the file.

Overview of System Navigator Position

Support Data Tracking of Core Services

The image part with relationship ID rId30 was not found in the file.

Set up the **processes and information infrastructure** by which referrals are made, completed, and tracked across the different Core Services

Develop and Maintain Asset Map of Core Services

The image part with relationship ID rId29 was not found in the file.

Leverage existing community resource lists to **develop an extensive mapping of assets**

Maintain resources **and support** other Care Coordinators in **use of resource for best match services**

Support Existing Care Coordinators

The image part with relationship ID rId27 was not found in the file.

Serve as a reliable **point of contact** for model region

“Care Coordinate the Care Coordinators”

The image part with relationship ID rId26 was not found in the file.

Systems Navigator Update

- Status of Systems Navigator position in Marion and Polk
- 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.

PacificSource OPIP Oregon Health Authority

Updated from Marion and Polk Community Engagement Liaison

- In Partnership with OPIP, Kiara has co-facilitated all PCPCH engagement
- Leading Parent and Youth Engagement in Marion County and Polk County
- Participated in SDOH Workgroup to ensure alignment between potential future CCO incentive measure and alignment with InCK
- Serving as connection to Marion and Polk CHIP
- Participating in relevant PCS Workgroup to help ensure alignment with community level priorities

OPIP Oregon Health Authority

Spotlight of Four Key Components

- Work Sessions with PacificSource Community Solutions and Current Areas of Focus
- Systems Navigator and Community Engagement Liaison Update
- Clinical Provider Engagement
- PCPCH Assessments & PCPCH Learning Curriculum

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

Engaging PCPCHs in InCK

- **Pages 13-14 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

Marion and Polk County PCPCH Engagement: Phase 1 Sites Identified by PCS Data of Where InCK Health Complex Population is Attributed

Marion and Polk: Phase 1 PCPCH Partner Engagement
Childhood Health Associates of Salem
Salem Pediatrics
Woodburn Pediatrics
Yakima – Lancaster and Pacific Pediatric Sites

Spotlight of Four Key Components

- Work Sessions with PacificSource Community Solutions and Current Areas of Focus
- Systems Navigator and Community Engagement Liaison Update
- Clinical Provider Engagement
- PCPCH Assessments & PCPCH Learning Curriculum

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

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

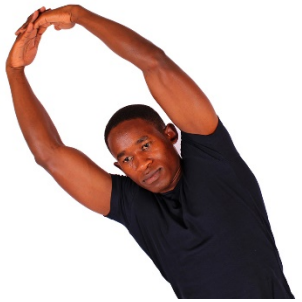
Rapid Fire Question and Feedback:

Zoom Break Out Groups

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
- **Stretch Break & Fun Activity**
- **Overview of Mobile Crisis and Stabilization Services** and review InCK requirements, current options and strategies being explored.
  Interactive Group Activity
- Provide an **overview of proposed process for exploring integration and sharing of information required as part of the InCK Model**, spotlight on selected **Community Information Exchange (CIE)**
- Heads up on **June Partnership Council** meeting

Break



- Optional activity
  - To participate, open up a new browser on your computer or phone.
  - Go to www.menti.com
  - Enter a code to join: 5311 1843
  - You'll be prompted to enter a nickname.

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
- **Stretch Break & Fun Activity**
- **Overview of Mobile Crisis and Stabilization Services** and review InCK requirements, current options and strategies being explored.
  Interactive Group Activity
- Provide an **overview of proposed process for exploring integration and sharing of information required as part of the InCK Model**.
- Heads up on **June Partnership Council** meeting

Integrated Care for Kids and Mobile Response and Crisis Services

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

Aim for this session

- Understand InCK and CCO 2.0 requirements for Mobile Response and Crisis 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

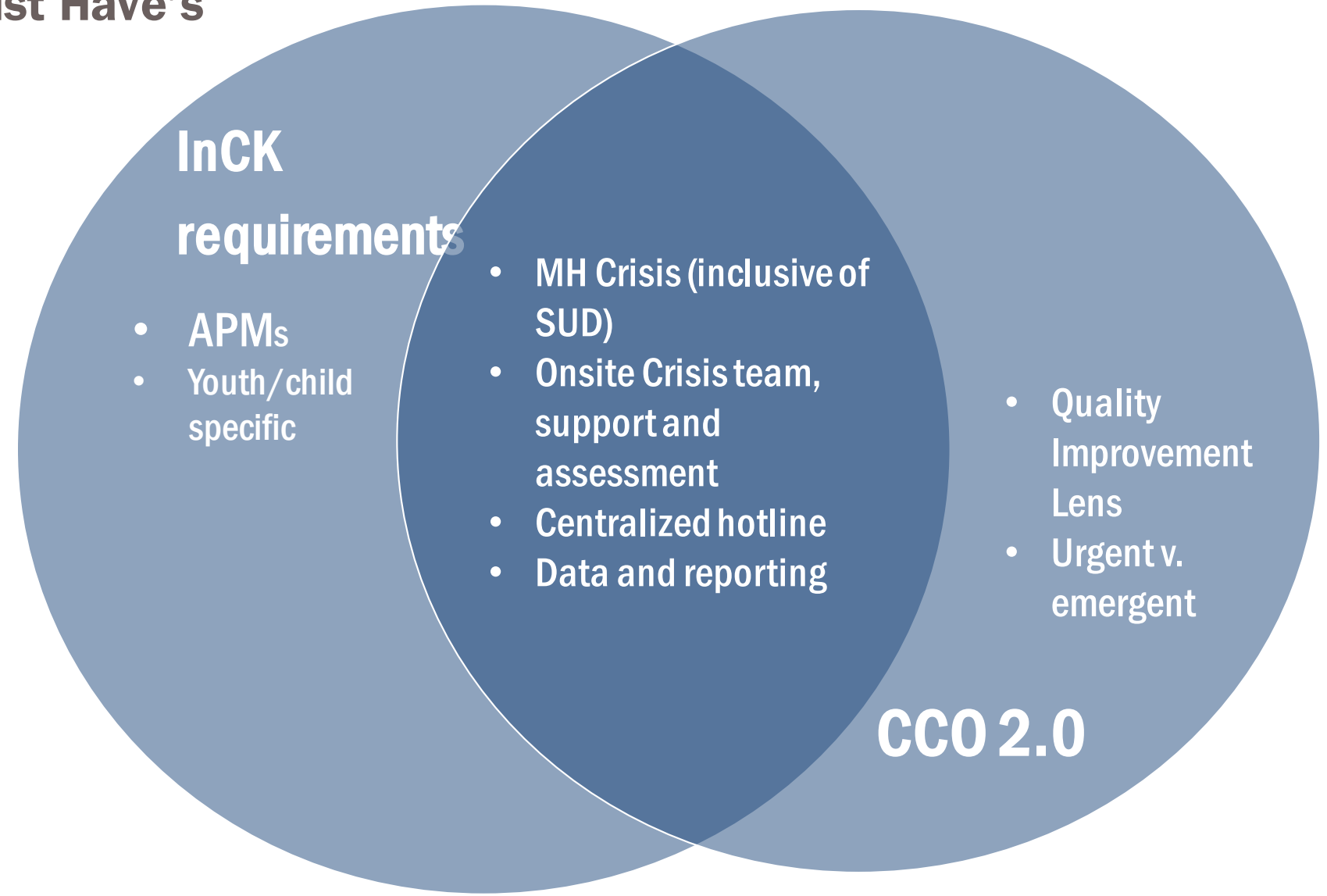
- Identify and ensure we meet all of our “Must Have’s”
- Identify and build upon existing strengths and services in the community (inventory) and identify gaps, barriers, inequities.
- Partner with the community organizations doing this work
- Leverage current and growing statewide planning and resources
- 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

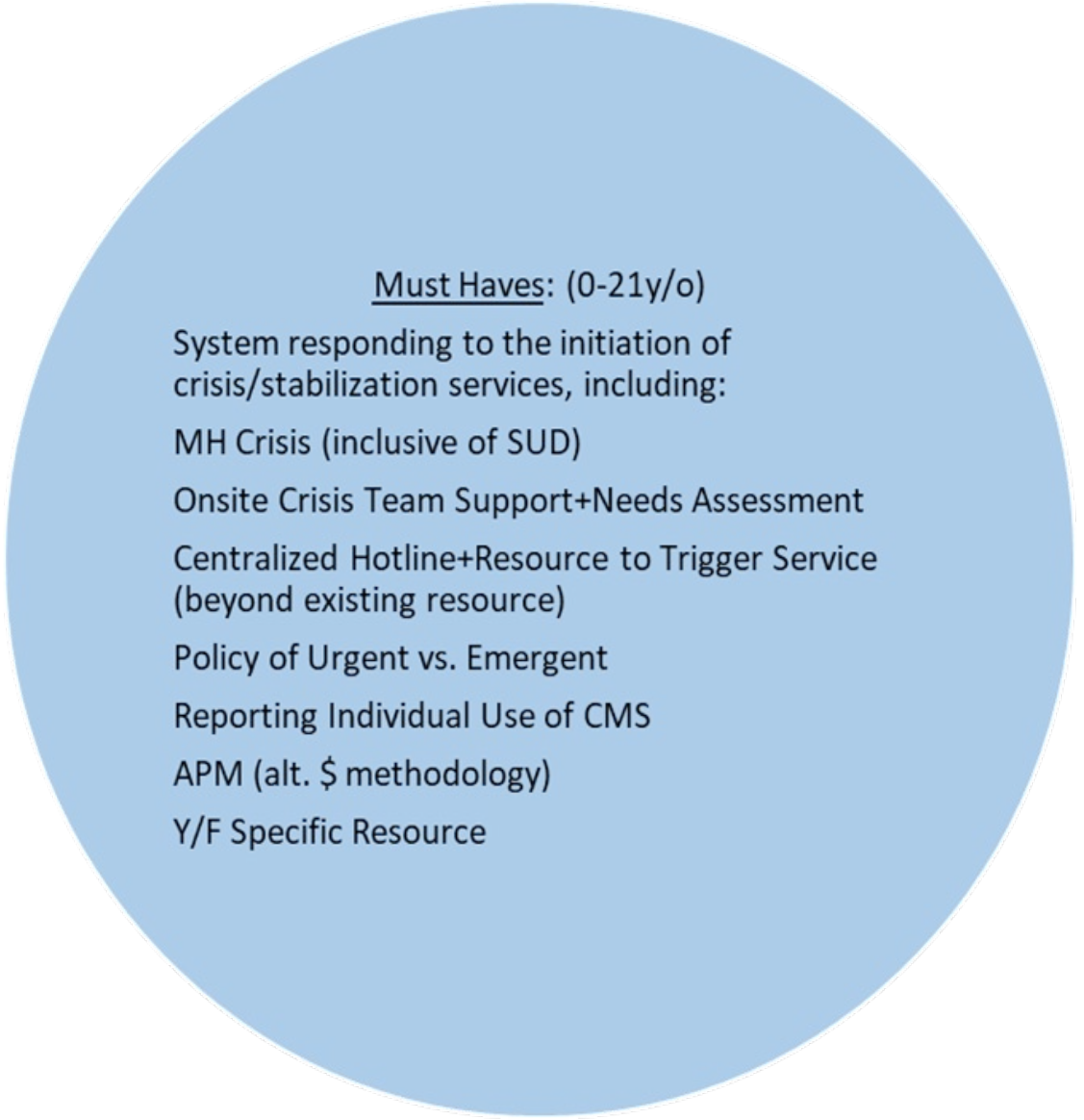


PacificSource Foundation:

- **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

Crisis and Mobile Response Inventory

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

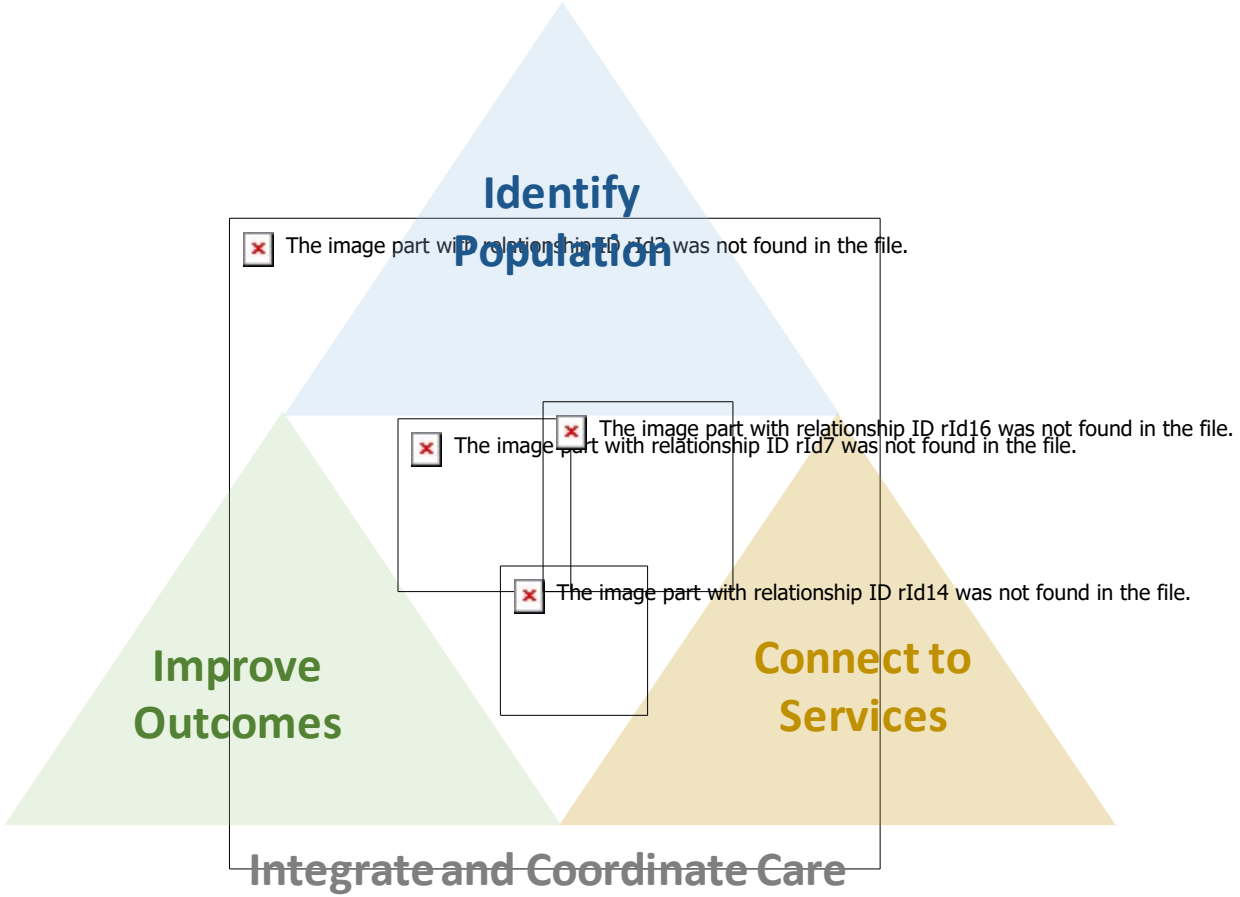
CONTACT US ABOUT THE DETAILS OR TO CONTRIBUTE

QUESTIONS

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
- **Stretch Break & Fun Activity**
- **Overview of Mobile Crisis and Stabilization Services** and review InCK requirements, current options and strategies being explored.
  Interactive Group Activity
- Provide an **overview of proposed process for exploring integration and sharing of information required as part of the InCK Model**.
- Heads up on **June Partnership Council** meeting

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

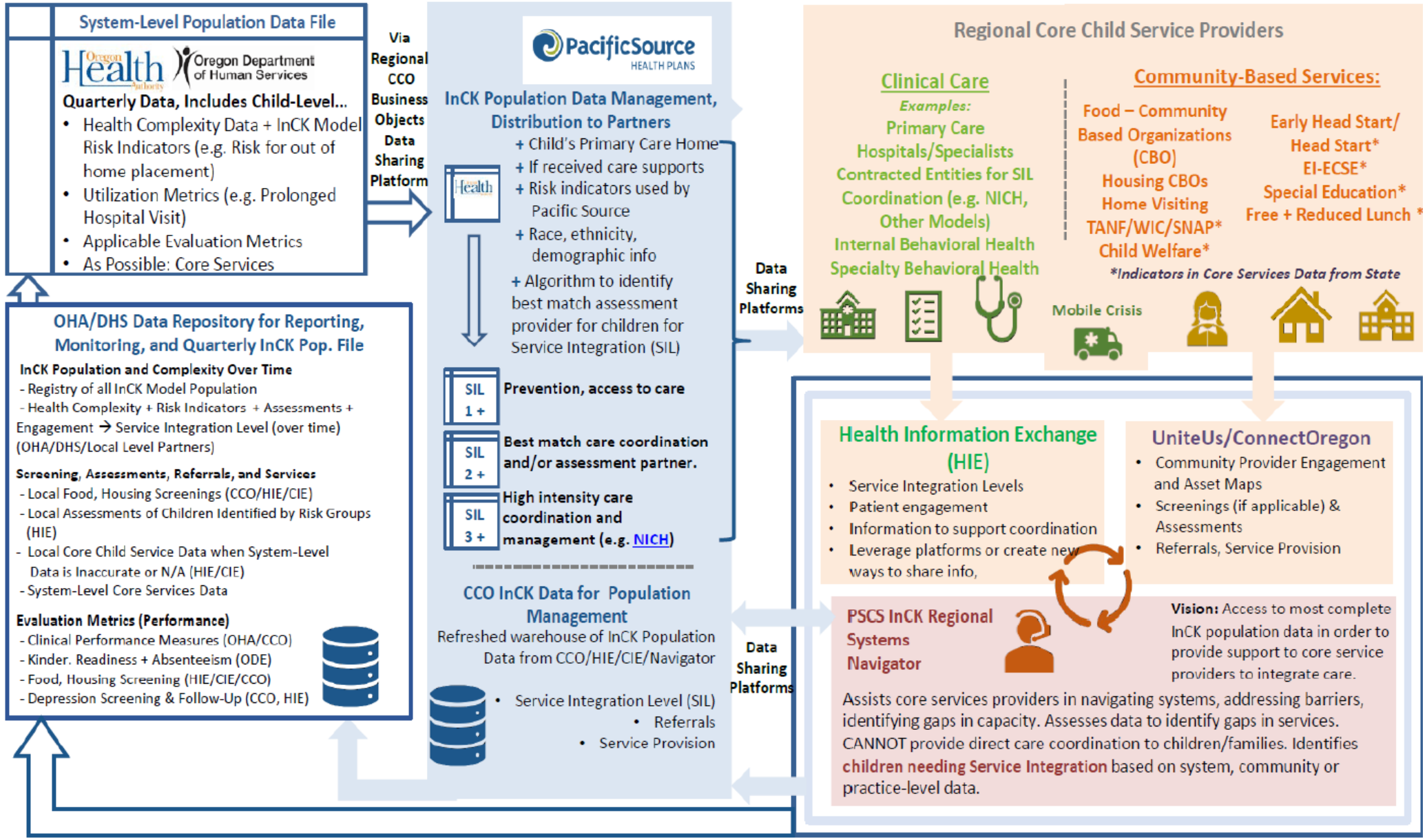


Oregon Health Authority

OPIP

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

Version: February 2021



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

Current Areas of Focus Related HIE to Support Service Integration Levels

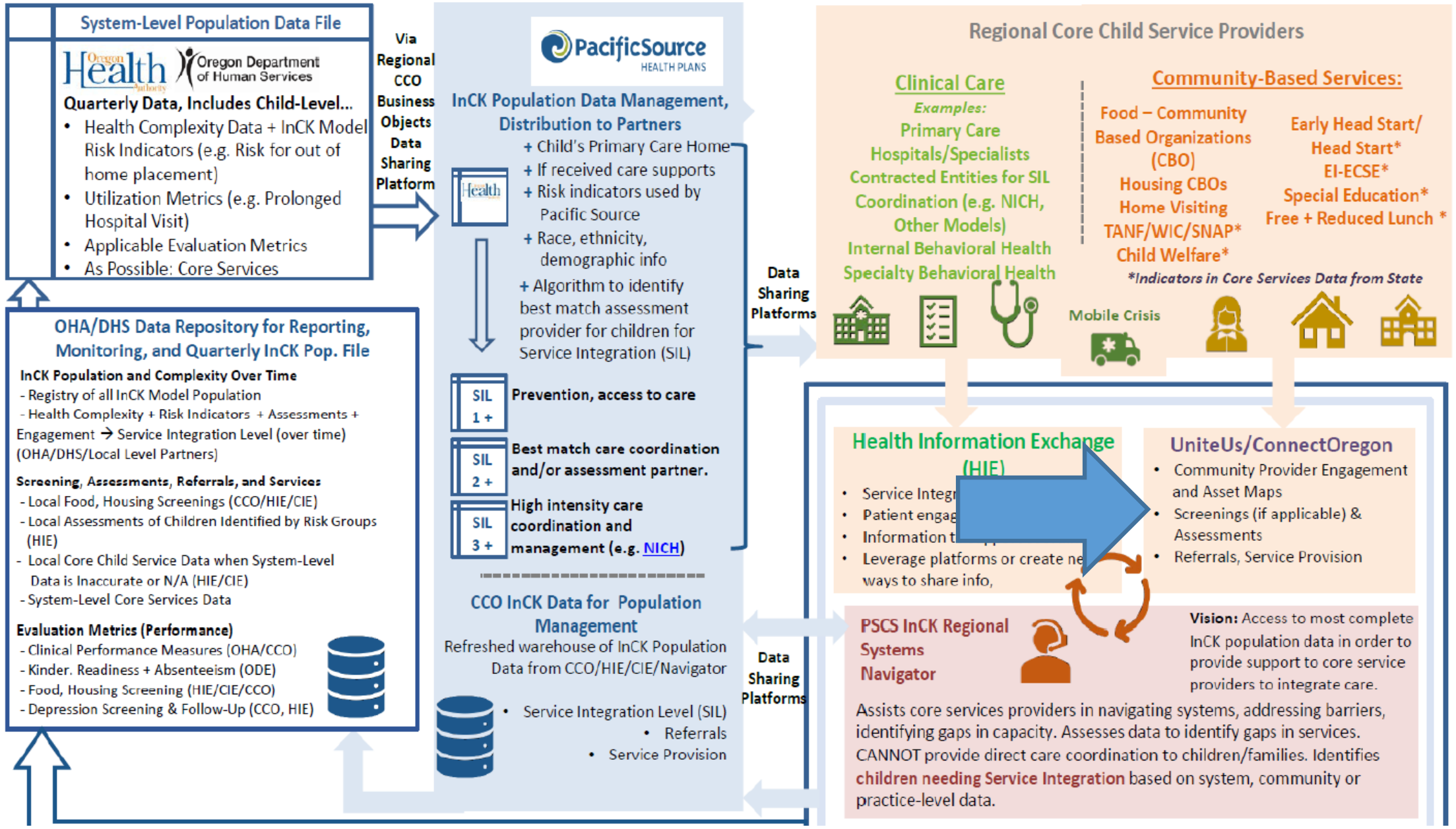
- Using currently available child health complexity data that PCS has (released August 2020), identified potential clinical providers
- Developing "use cases" and scenarios for how to share information in a way that is feasible, valid and meets data use and data sharing requirements
- Developing a detailed 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

Oregon Health Authority

OPIP

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

Version: February 2021



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 in InCK

- **Page 15 of Pre-Reading**
- **Core component of the InCK Model:** Identify children with housing and/or food insecurity needs *and* develop mechanisms to connect them to services
- **Community Information Exchange**
  - Type of Health Information Technology
  - Enables health and social care providers to collaborate on addressing patient and community SDOH needs
- **Connect Oregon**
  - Powered by the Unite Us Platform
  - Statewide network
    - Most major health systems and CCOs
  - The Community Information Exchange to be leveraged in InCK Model implementation
    - **Screen** for SDOH needs
    - Facilitate **closed loop referrals** to community-based services
    - **Track** a patient's care journey
    - Use longitudinal data to identify potential **community resource needs and investments**

CONNECT OREGON

UNITE US

Critical Role of Community Information Exchange in InCK

- **PacificSource's investment in Connect Oregon**
  - Vision: *Our staff and provider partners are empowered to identify and connect members to the community resources they need.*
  - Unlimited, no cost web-based licenses for all contracted providers and community-based organizations
  - Includes no cost training and onboarding from the regional Unite Us team
  - Wave 1 rollout in the Marion-Polk CCO region
    - Targeted outreach and engagement with InCK core service providers
    - Partnership with the Willamette Health Council to help build a diverse network
- *Need to learn more?*
  - Introduction and demo sessions for health care providers
    - First Tuesday of each month at 12:00pm
    - Third Thursday of each month at 7:00am
    - Register here: https://uniteus.com/oregon-events/
  - Contact us for a 1:1 meeting
    - Abigail Warren, Account Manager, abigail.warren@uniteus.com

CONNECT OREGON

To help protect your privacy, PowerPoir utomatic download

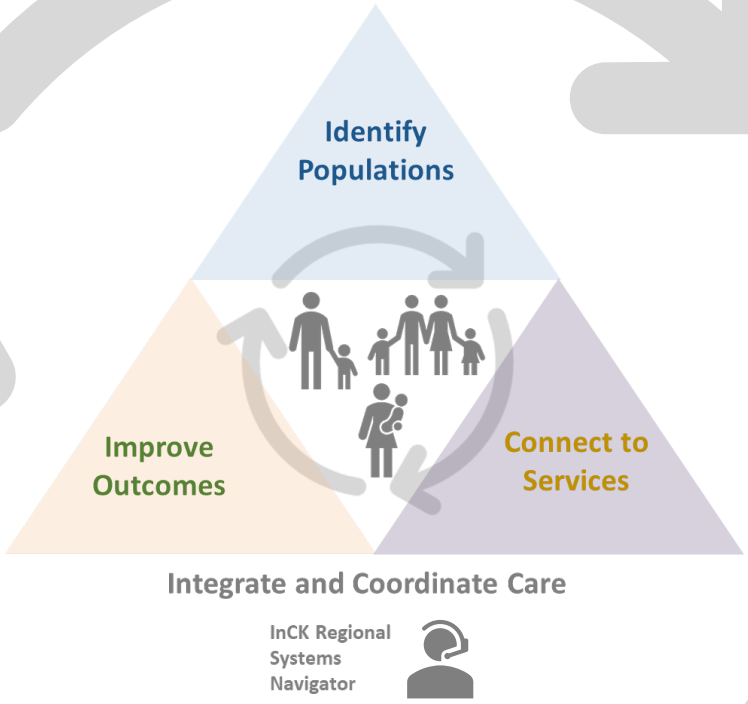
UNITE US

Identification of Populations:

- Publicly insured children birth to age 21
- InCK Model regions: Marion, Polk, Deschutes, Jefferson and Crook counties
- **All children (SIL 1) receive screening for housing and food insecurity**

Improve Outcomes:

- Children/families get the services/resources they need when and where they need them
- The upstream SDOH factors that ultimately impact health are addressed
- Longitudinal data to identify potential community resource needs and investments



Connection to Services

Connect Oregon:

- Statewide network of health and social care providers
- SDOH screening and closed loop referrals

CONNECT OREGON

UNITE US

Questions?
Feedback?

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 10th 1-3 PM**

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