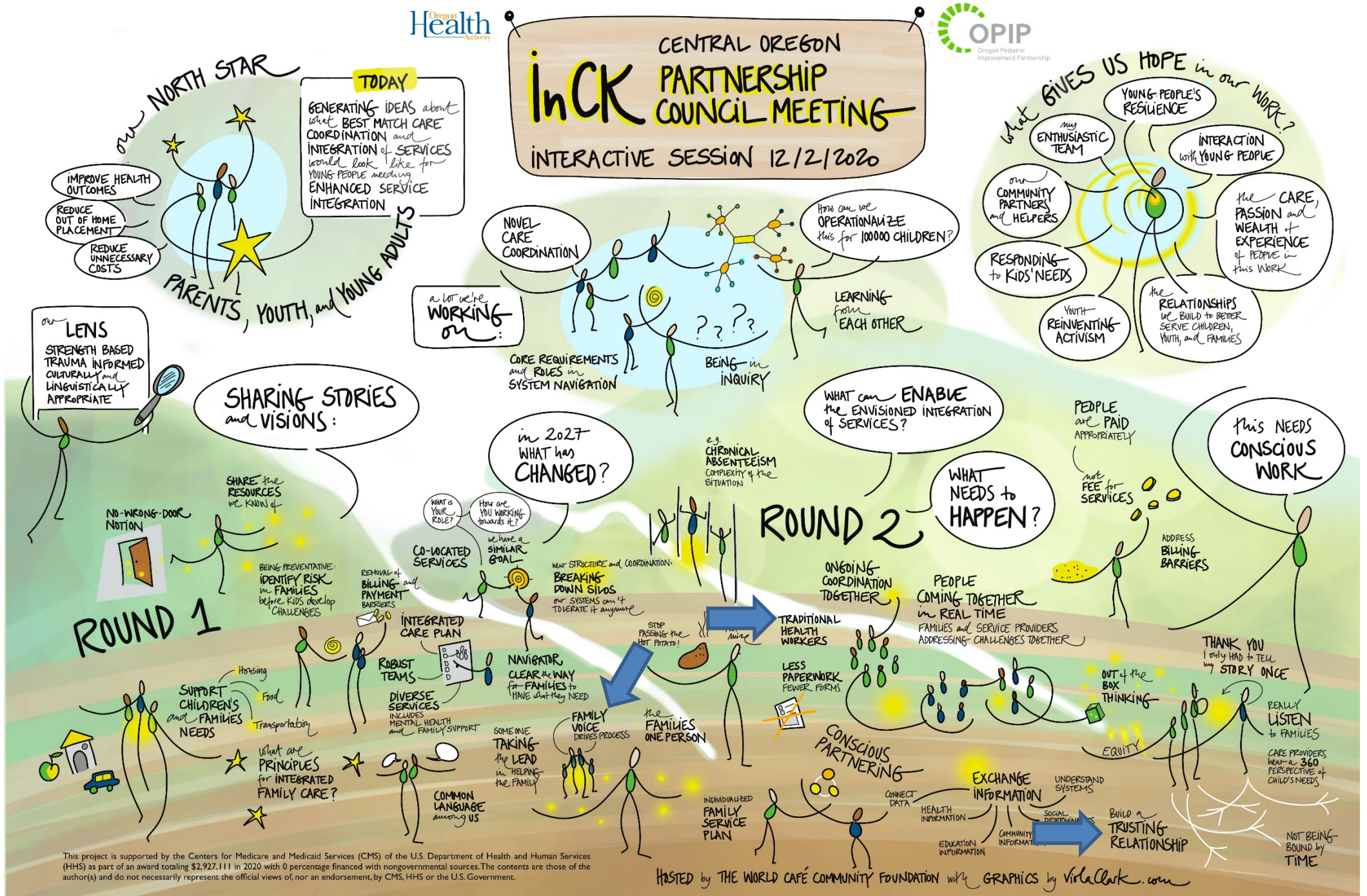
# *Oregon's Integrated Care for Kids (InCK):*

## *OPIP's Sharing of* Learnings to Date with PCS about the Needs and Opportunities for THW Supports and Opportunities for Health Complex Children

## 12/7/2021

# OPIP Efforts & Learning That Led to Interest in InCK: Need Continues After InCK

- Health outcomes of the child tied with health outcomes of the parent/adult
- Parent report of isolation and needing to be the "care coordinator"
  - Difficulty in doing that when the parent has a number of factors they are trying to address
- Few efforts or investments in THW models focused on
  - Children
  - Parents with the **social complexity factors** (Health care a mandatory reporting environment)
  - **Medically complex children (primary care is not their central home)**
- Oregon InCK Risk Stratification – Majority of which still possible with Health Complexity Data
  - Includes parental social complexity factors for which addressing and supporting the parent could improve outcomes of children and reduce risk for out of home placement
- Right care at the right time by the right person
  - Often not in medical world, especially for these factors
  - Peer to peer support and connection
  - Unique lens of medically complex children
  - Unique lens of dyadic support – for parent individual, as a parent of a child and then addressing the child needs
  - Unique lens of FAMILY – many with multiple health complex children and socially complex parent


Oregon Health Authority
OPIP
Oregon Pediatric Improvement Partnership
CENTRAL OREGON
InCK PARTNERSHIP COUNCIL MEETING
INTERACTIVE SESSION 12/2/2020
our NORTH STAR
PARENTS, YOUTH, and YOUNG ADULTS
IMPROVE HEALTH OUTCOMES
REDUCE OUT OF HOME PLACEMENT
REDUCE UNNECESSARY COSTS
TODAY
GENERATING IDEAS about what BEST MATCH CARE COORDINATION and INTEGRATION of SERVICES would look like for YOUNG PEOPLE needing ENHANCED SERVICE INTEGRATION
what GIVES US HOPE in our WORK?
YOUNG PEOPLE'S RESILIENCE
my ENTHUSIASTIC TEAM
INTERACTION with YOUNG PEOPLE
our COMMUNITY PARTNERS and HELPERS
the CARE, PASSION and WEALTH of EXPERIENCE of PEOPLE in this WORK
RESPONDING to KIDS' NEEDS
YOUTH REINVENTING ACTIVISM
the RELATIONSHIPS we BUILD to BETTER SERVE CHILDREN, YOUTH, and FAMILIES
a lot we're WORKING on:
NOVEL CARE COORDINATION
How can we OPERATIONALIZE this for 100000 CHILDREN?
LEARNING from EACH OTHER
CORE REQUIREMENTS and ROLES in SYSTEM NAVIGATION
BEING in INQUIRY
our LENS
STRENGTH BASED
TRAUMA INFORMED
CULTURALLY and LINGUISTICALLY APPROPRIATE
SHARING STORIES and VISIONS:
in 2027 WHAT has CHANGED?
WHAT can ENABLE the ENVISIONED INTEGRATION of SERVICES?
WHAT NEEDS to HAPPEN?
ROUND 1
ROUND 2
SHARE the RESOURCES we KNOW of
NO-WRONG-DOOR NOTION
BEING PREVENTATIVE: IDENTIFY RISK in FAMILIES before KIDS develop CHALLENGES
REMOVAL of BILLING and PAYMENT BARRIERS
CO-LOCATED SERVICES
WHAT is YOUR ROLE?
How are YOU WORKING towards it?
we have a SIMILAR GOAL
INTEGRATED CARE PLAN
ROBUST TEAMS
DIVERSE SERVICES
INCLUDES MENTAL HEALTH and FAMILY SUPPORT
NAVIGATOR CLEARS the WAY for FAMILIES to HAVE what they NEED
NEW STRUCTURE and COORDINATION: BREAKING DOWN SILOS
our SYSTEMS can't TOLERATE it anymore
e.g. CHRONICAL ABSENTEEISM
COMPLEXITY of the SITUATION
STOP PASSING the HOT POTATO!
TRADITIONAL HEALTH WORKERS
LESS PAPERWORK
FEWER FORMS
ONGOING COORDINATION TOGETHER
PEOPLE COMING TOGETHER in REAL TIME
FAMILIES and SERVICE PROVIDERS ADDRESSING CHALLENGES TOGETHER
PEOPLE are PAID APPROPRIATELY
not FEE for SERVICES
ADDRESS BILLING BARRIERS
this NEEDS CONSCIOUS WORK
THANK YOU I only HAD to TELL my STORY ONCE
REALLY LISTEN to FAMILIES
CARE PROVIDERS hear a 360 PERSPECTIVE of CHILD'S NEEDS
NOT BEING BOUND by TIME
OUT of the BOX THINKING
EQUITY
SUPPORT CHILDREN'S and FAMILIES NEEDS
Housing
Food
Transportation
what are PRINCIPLES for INTEGRATED FAMILY CARE?
COMMON LANGUAGE among US
SOMEONE TAKING the LEAD in HELPING the FAMILY
FAMILY VOICE DRIVES PROCESS
the FAMILIES ONE PERSON
CONSCIOUS PARTNERING
INDIVIDUALIZED FAMILY SERVICE PLAN
EXCHANGE INFORMATION
CONNECT DATA
HEALTH INFORMATION
EDUCATION INFORMATION
COMMUNITY INFORMATION
SOCIAL DETERMINANTS
UNDERSTAND SYSTEMS
BUILD a TRUSTING RELATIONSHIP
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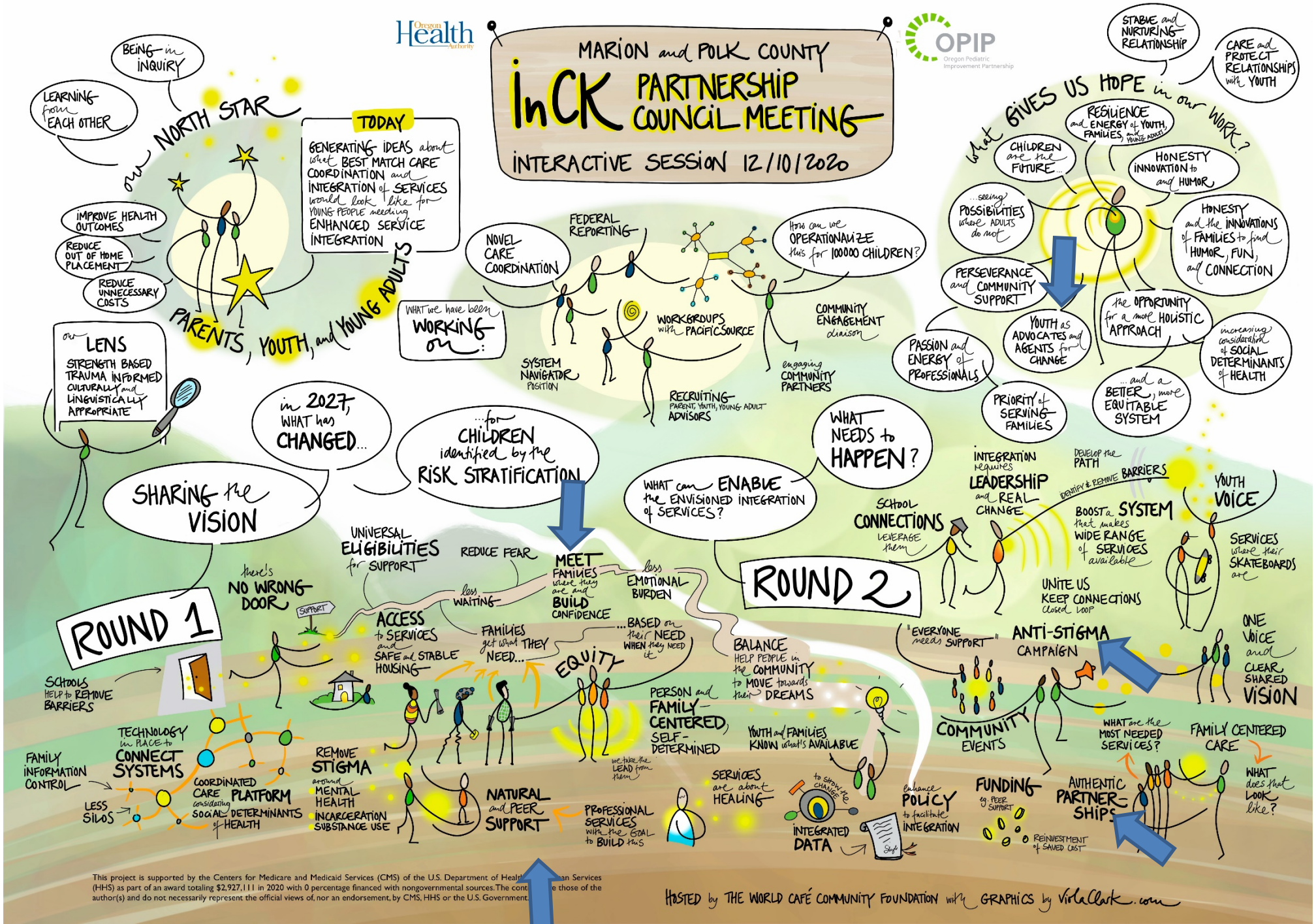
MARION and POLK COUNTY
InCK PARTNERSHIP COUNCIL MEETING
INTERACTIVE SESSION 12/10/2020
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TODAY
GENERATING IDEAS about what BEST MATCH CARE COORDINATION and INTEGRATION of SERVICES would look like for YOUNG PEOPLE needing ENHANCED SERVICE INTEGRATION
our LENS
STRENGTH BASED TRAUMA INFORMED CULTURALLY and LINGUISTICALLY APPROPRIATE
WHAT we have been WORKING on:
NOVEL CARE COORDINATION
FEDERAL REPORTING
WORKGROUPS with PACIFICSOURCE
SYSTEM NAVIGATOR POSITION
RECRUITING PARENT, YOUTH, YOUNG ADULT ADVISORS
COMMUNITY ENGAGEMENT liaison
engaging COMMUNITY PARTNERS
How can we OPERATIONALIZE this for 100000 CHILDREN?
STABLE and NURTURING RELATIONSHIP
CARE and PROTECT RELATIONSHIPS with YOUTH
what GIVES US HOPE in our WORK?
RESILIENCE and ENERGY of YOUTH, FAMILIES, and YOUNG ADULTS
CHILDREN are the FUTURE...
HONESTY INNOVATION to and HUMOR
...seeing POSSIBILITIES where ADULTS do not
HONESTY and the INNOVATIONS of FAMILIES to find HUMOR, FUN, and CONNECTION
PERSEVERANCE and COMMUNITY SUPPORT
YOUTH as ADVOCATES and AGENTS for CHANGE
the OPPORTUNITY for a more HOLISTIC APPROACH
increasing consideration of SOCIAL DETERMINANTS of HEALTH
PASSION and ENERGY of PROFESSIONALS
PRIORITY of SERVING FAMILIES
...and a BETTER, more EQUITABLE SYSTEM
in 2027, WHAT has CHANGED...
...for CHILDREN identified by the RISK STRATIFICATION
WHAT NEEDS to HAPPEN?
WHAT can ENABLE the ENVISIONED INTEGRATION of SERVICES?
SHARING the VISION
ROUND 1
ROUND 2
there's NO WRONG DOOR
SUPPORT
UNIVERSAL ELIGIBILITIES for SUPPORT
REDUCE FEAR
less WAITING
MEET FAMILIES where they are and BUILD CONFIDENCE
less EMOTIONAL BURDEN
ACCESS to SERVICES and SAFE and STABLE HOUSING
FAMILIES get what THEY NEED...
...BASED on their NEED WHEN they NEED it
EQUITY
we take the LEAD from them
PERSON and FAMILY-CENTERED, SELF-DETERMINED
BALANCE HELP PEOPLE in the COMMUNITY to MOVE towards their DREAMS
SCHOOLS HELP to REMOVE BARRIERS
TECHNOLOGY in PLACE to CONNECT SYSTEMS
FAMILY INFORMATION CONTROL
LESS SILOS
COORDINATED CARE PLATFORM considering SOCIAL DETERMINANTS of HEALTH
REMOVE STIGMA around MENTAL HEALTH INCARCERATION SUBSTANCE USE
NATURAL and PEER SUPPORT
PROFESSIONAL SERVICES with the GOAL to BUILD this
SERVICES are about HEALING
YOUTH and FAMILIES KNOW what's AVAILABLE
to SUPPORT the CHANGE
INTEGRATED DATA
Enhance POLICY to facilitate INTEGRATION
FUNDING eg. PEER SUPPORT
REINVESTMENT of SAVED COST
SCHOOL CONNECTIONS LEVERAGE them
INTEGRATION requires LEADERSHIP and REAL CHANGE
DEVELOP the PATH
IDENTIFY & REMOVE BARRIERS
BOOST a SYSTEM that makes WIDE RANGE of SERVICES available
YOUTH VOICE
SERVICES where their SKATEBOARDS are
UNITE US KEEP CONNECTIONS closed LOOP
"EVERYONE needs SUPPORT"
ANTI-STIGMA CAMPAIGN
ONE VOICE and CLEAR SHARED VISION
COMMUNITY EVENTS
WHAT are the MOST NEEDED SERVICES?
FAMILY CENTERED CARE
WHAT does that LOOK like?
AUTHENTIC PARTNERSHIPS
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# Needs Identified in InCK for THW Supports

- **Within the starting partners:**
  - **PCPCH**
  - **PCS Care Management**
  - **Wraparound**
  - SN (*Dependent on InCK, but PYYAYG and partners noted need for centralized case manager across systems)*
- **Broadly, THW Supports Needed**
  - **Type of Need Assessment support**
    - ✓ **Medical complexity**
    - ✓ **Type of Social Complexity**
  - **Where the Medically Complex Go and How They get home (Hospital, Specialty)**
  - **DHS Given Overlap Child Welfare Involved**
  - **Culturally and Linguistically Matched**
  - **Specific to Health Complexity: Parents with social complexity and medical complexity**
  - **Specific to Dyadic Behavioral Supports (Parent SUD, MH, Incarceration, Child Welfare Involved)**
  - **Housing Navigator**
  - **Support to engage on ACCESS**
  - **Community Supports – Where do we People Park Their Cars**

# Needs Identified & Unclear Solutions, but Barriers We Know

- Best care at best time
  - Needs assessment flags going to clinical and PCS partners – not clear how that works if we leverage and work with community partners
- Barrier to Access and how to ensure Access if the THW is based in traditional settings
- Barrier to Trust - reporting factors associated with mandatory reporters
- Barriers to trained & “ready to go” workforce
- Retention of Peer to Peer Supports – but priority in that type of THW

# Parent, Youth, and Young Adult Advisory Feedback

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

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

*"There is a lot of paperwork for every entity we deal with. I've filled out 50-70 page intake forms."*

*"We only have one car, in order to attend appts, we would have to pack all the kids in the car at 6am and take my husband to work then come back and get ready for school and appointments."*

# ***Identified Barriers to Engagement & Retention***

- Child-specific coordination that doesn't take into account the family unit and competing demands within the family .
- Parents only subject matter experts in content and resources. Having to train everyone and every new person whom may provide care.
- Medicalized models of coordination, when the most important and valuable models of care coordination often community based and peer to peer based.
- Competing demands in getting services and barriers to fidelity of services (Transportation, Access, Availability , CLAS relevant services.

# Patient Centered Primary Care Home Feedback

*"We don't feel that we will be able to meaningfully connect families to the right services and provide the "at the elbow" supports needed unless a traditional health worker is part of our team."*

*"Particularly for health complex children, just referring families and not supporting them in the referral process or finding the right match to community-based and social services is insufficient. We also struggle to "close the loop" with many of these referrals, thus are not able to proactively assist families who are unable to navigate the systems without assistance."*

*"We need more at the elbow support and advocacy on behalf of health complex children, who consistently and persistently have inequitable access and inequitable supports.- PCPCH."*

# Knowing What We Need, Understanding PCS Commitment Broadly Regardless of the Status of InCK

Priorities to Consider, each with a Lens of Culturally and Linguistically Matched or Prioritized THW Services:

- Children with **medical complexity**
  - Hospital and specialty based supports (No one is on first)
- Children with **social complexity**
  - **Housing Navigators** given the SDOH Metric (not necessarily within PCPCH)
  - Youth centered models – adolescent IL transition and adolescent SUD treatment
  - Family-centered CHW programs
  - Ensuring parent SUD/MH that is paired with child attachment focused services
- Children with **health complexity** and risk for high costs
  - **Peer-to-peer** family supports anchored to medical and social complexity factors
- Children with **child welfare involvement**
  - **Peer-to-peer** supports to engage and connect parents with the foundational supports around substance abuse, mental health, past incarceration, etc.

# Promising Practices & Models To Consider

## Children with Medical Complexity

- **Asthma Program : Healthy Homes** – Heavily replicated CHW model to address asthma (disproportionate rates in BIPOC children). Unique aspect to this services was the CHW's developed a service line *embedded in an existing home visiting program* as a cost-saving method in addition to decreasing burden on service-using families.

## Children with Health Complexity

- **Adolescent Continuing Care Units** - adolescent inpatient care therapeutic program. Peer Mentors are *full-time, empowered members* of the multi-disciplinary team in both treatment and education, tasked with support and advocacy in development of person-centered treatment plans.

- **Sixteenth Street Community Health Center Childhood Lead Outreach Project** - During home visits, CHW/nurse teams tested blood, conducted environmental assessments, gave hazard supports, & provided prevention education. Findings included lowered lead levels of children, in addition to *secondary reductions in other prevalent problems* such preventable injuries and community violence.

# Promising Practices & Models To Consider

## Children with Child Welfare Involvement

- **Parent to Parent Program at Children's Village** – All staff identified as Peer Specialists. Program offers emotional support, groups, peer connection, and parent training to families, but unique aspect is focus on *youth/family resiliency building* (targeted sibling support, inclusive recreation and social opportunities from trained teen mentors).

## Children with Social Complexity

- **University of New Mexico Community Health Worker Model** – CHWs in primary care and MCO's are in a *larger CHW network* called LEADS, directly connected to CHW's embedded in social service agencies. CHW's in medical setting personally direct referrals and connection to address social need factors through the integrated network, facilitating trusted hand-offs.

- **Migrant and Seasonal Agricultural Health Services** – CHWs are part of a mobile outreach team to remove barriers to care for MSAW *families*. Mobile units were located *onsite* at local farms and housing communities *after school and work hours* to provide basic primary care services; CHW's provide translation services and culturally-informed connection to needed services.