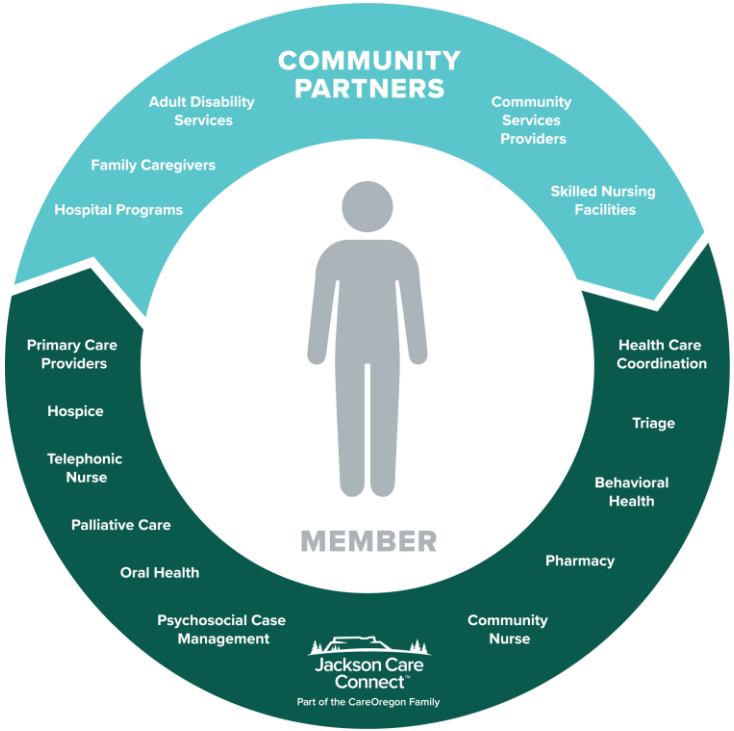
Care Coordination and Intensive Care Coordination Services

Regional Care Team (RCT) Overview

Learning objectives and agenda

- Regional Care Team Introduction and overview of the team
  - Who we are
  - Who we serve
  - What we do
  - How we can help
  - How you can reach us



What is a Regional Care Team (RCT)?

- Jackson Care Connect's Regional Care Teams (RCTs) offer providers a community of resources with a single point of contact for you and your patients. RCTs work closely with providers and members to smooth the way to better care and better outcomes.
- Members will have a consistent care team that will collaborate across disciplines to develop and implement a member-centric care plan through telephonic, electronic or community-based interventions to resolve identified needs and promote healthy outcomes.
- Each RCT is made up of care coordinators with a variety of backgrounds and experience, including:
  - Nursing
  - Behavioral health
  - Substance use disorders
  - Pharmacy
  - Health system navigation
  - Local community resources
  - And others
- With care coordination through RCTs, we will deliver the right care, at the right time, in the right place, with the right team.

RCT: Who are we?

- Triage coordinator
- Health care coordinator
- Health resilience specialist
- RN care coordinator
- Behavioral health coordinator
- Clinical pharmacist
- Intensive care coordinator

Health care coordinator

- Often, the first point of contact for RCT
- Accepts referrals to the RCT from network partners
- Care coordination activities:
  - Assist in finding new or alternative providers
  - Assist in DME questions
  - Provide information on authorizations and appeals
  - Support in finding and accessing community resources
  - Health plan navigation
  - Health-related services support
  - General questions

RN care coordinator

- Offers phone and in-person care coordination support for members and providers:
  - Supports care coordinators in clinics
  - Identifies gaps in care and works with providers and families, implementing care plans that address gaps
  - Coordinates interagency/interdepartmental ICT meetings, create action-oriented care plans
- Creates communication pathways between members, providers, Jackson Care Connect and social service agencies
- Provides transitional support for hospital admits and discharges
- Provides both phone and community-based supports
- Provides RN clinical lens to other cases RCT members are working on

Behavioral health care coordinator

- Works by phone with:
  - Members
  - Providers
  - Family
  - Community partners
- Assists with navigating multiple systems:
  - Helps identify behavioral health supports and programs
  - Assists with transitions between providers, programs, and levels of care
  - Works closely with county programs (e.g., ICC, wraparound)
  - Collaborates with RN on team when medical issues are also present

Health resilience specialist

- Some are embedded in PCP clinics
- Provides phone and in-person support to:
  - Members
  - Providers
  - Family
- Assists with navigating multiple systems:
  - Helps identify behavioral health supports and programs
  - Provides in-person support in clinic and community settings
  - Supports connections back to PCP and specialty medical support
  - Collaborates with RN when medical issues are also present

Intensive care coordinator

- Provides phone and community-based care coordination for the most vulnerable adult and youth members, including members with complex behavioral concerns, severe and persistent mental illness, and substance use disorders
- Has knowledge of adult and youth systems of care
- Focuses on supporting members as they transition in and out of intensive community and facility-based psychiatric treatment settings

Who we serve?

All Jackson Care Connect members have access to care coordination and intensive care coordination services. Some populations may be prioritized for care coordination including members identified as aged, blind, or disabled or for members with:

- Special health care needs
- Complex medical needs
- Multiple chronic conditions
- Behavioral health issues/concerns
- Severe and persistent mental illness (SPMI)
- High-risk pregnancy

- DHS Medicaid-funded long-term care services and supports (LTCSS)
- Treatment being provided outside of the CCO catchment area
- Treatment provided in long-term care settings including the Oregon State Hospital

Who we serve: Priority populations - Youth

Children and youth have access to care coordination and intensive care coordination services. Some populations that may be prioritized include youth in the following situations:

- Children 0-5 at risk of maltreatment
- Children showing early signs of social, emotional or behavioral problems
- Children and adolescents in the care or custody of DHS Child Welfare or OYA
- Children and youth placed in a correctional facility solely for the purpose of stabilizing a behavioral health condition
- Children with serious emotional disturbances
- Children with neonatal abstinence syndrome
- Children and youth known to be receiving or to have received care in an emergency department
- Children and youth with an admission to acute inpatient psychiatric care and/or sub-acute care, or upon discharge from such care
- Children placed in LTC at SCIP and SAIP
- Children at risk of placement disruption, school failure, criminal involvement, becoming homeless or other undesirable outcomes due to a behavioral health disorder

RCT: What do we do?

- A multidisciplinary care coordination team
  - Provide care coordination for Jackson Care Connect members, working closely with providers and community partners
  - Coordinate interdisciplinary care team (ICT) meetings, create action-oriented care plans
  - Care coordination can provide consistency through multiple systems: hold the story, share the story
- Support members who fall through the cracks and provide access to services

Care coordinators and intensive care coordinators (ICC)

- Care coordinators and intensive care coordinators:
  - Are responsible for coordinating the provision of all covered services and some non-covered services for members.
  - Use evidence-based and innovative strategies within the services' delivery system to ensure consideration is given to members' needs in treatment planning, and to ensure comprehensive, coordinated and integrated person-centered care for members.
  - Assist members in navigating the health care delivery system and connect members with services, providers and other appropriate settings such as:

- Primary care providers and specialty providers
- Oral health providers
- Behavioral health providers
- Oregon Youth Authority
- Oregon State Hospital
- DHS Medicaid-funded long-term care and community-based services
- DHS office of Developmental Disability Services
- DHS Child Welfare
- Substance use disorder treatment
- Crisis management services
- Wellness and prevention resources and preventative screenings
- Services and/or resources that address social determinants of health
- Community and social support services
- Traditional health workers or other peer-delivered services
- NEMT services

Care coordination and ICC services are provided as appropriate and may be on an ongoing basis until the **earliest** of the following dates:

- The desired outcome has been achieved for a length of time sufficient to predict stability
    - This is why we reach out to your teams
- The member is unwilling and or not ready to engage in care coordination efforts
- The member ceases to be engaged and/or opts out
- The member loses OHP coverage or changes health plans
- The member dies

How do I make a care coordination referral?

- Online: Submit a completed Care Coordination Referral form and we'll route it to your assigned RCT.
- Email: Send us a completed form to ccreferral@careoregon.org.
- Call your RCT Directly at 503-416-3742 or Customer Service at 503-416-4100 and we'll connect you to your team.

Questions, issues or concerns?

Contact our care coordination team
503-416-3742

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