Special Needs Plan
Model of Care Training
2022

Provider Module
For more than 25 years, CareOregon has offered health services and community benefit programs to Oregon Health Plan members. Today, we support the needs of over 500,000 Oregonians through three coordinated care organizations, a Medicare Advantage plan, a Tribal Care Coordination program, a dental care organization, and in-home medical care with Housecall Providers. CareOregon members have access to integrated physical, dental and mental health care, and substance use treatment. We believe that good health requires more than clinics and hospitals, so we also connect members to housing, fresh food, education and transportation services. CareOregon is a mission-driven, community non-profit with offices in Portland, Medford and Seaside, Oregon.
Medicare Dual Special Needs Plans (D-SNPs)

• CareOregon became a Medicare Advantage Plan in 2006.
• CareOregon Advantage Plus is approved by CMS as a D-SNP (dual eligible SNP) that serves a subset of Medicare patients who have both Medicare and Medicaid coverage.
• We became a D-SNP plan to serve a vulnerable dually eligible population. Thousands of our OHP members qualify for Medicare due to age and/or disability.
• CareOregon currently serves ~14,500 D-SNP members.
Population Health Partnerships
We work collaboratively with partners to promote well-being, resilience and hope, and to reduce barriers for our most vulnerable members
Regional Care Team (RCT)

Our purpose is to provide organized coordination of Member’s health care services and support activities to improve a member’s health outcomes.

- Team Based Approach
- Focus on the needs and strengths of the individual
- Address interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes.
- Include member (whenever possible), Providers, Community Partners and other individuals involved in member’s care- YOU!
- Meet and exceed regulatory requirements
Who we are

- Triage Coordinators
- Health Care Coordinators
- Behavioral Health Care Coordinators
- Health Resilience Specialists
- Nurse Care Coordinators
- Intensive Care Coordinators
- Community Partners
- Pharmacists
- Navigators
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- **Population Health Partnerships**
- **Care Coordination**
- **Supporting Regional Leadership**
- **Direct Member Support/RCT**
- **Population Data, Health Equity, Trauma Informed**
What is the Model of Care (MOC)?

...and why do providers need to be trained on it?

- The MOC is a CMS requirement that provides the *structure for CareOregon Advantage’s care coordination processes and systems for delivering care to our Dual Special Needs Population (D-SNPs).*
- CareOregon must ensure that contracted providers are aware of resources available for these members.
- CareOregon must ensure that contracted providers have access to care plans, practice guidelines, and referral processes for members who would benefit from care coordination.
Our D-SNP Population

• Top three age distribution categories are 65-74 (36%), 75-89 (23%), and 55-64 (18%)
• 82% in Tri-County area
• 51% Caucasian; 15% Asian and Pacific Islander; 4% African American; 5% Hispanic
• 42% Depression, 6% Bipolar Disorder, 11% SUD
• 31% with diabetes mellitus
• 13% with COPD
As a health plan, how can we help our members address their social determinants of health barriers?

- Employment assistance
- Food access
- Transportation
- Rental assistance
- Social support
The presence of disability is a unique factor in the health of our SNP members. For several years we have seen an increase in those members qualifying for Medicare due to age as opposed to disability. However, our most recent data indicates a slight change in that observed trend.
Medical Conditions of D-SNP members

Medical Condition

- COPD: 13%
- Frailty: 25%
- Diabetes: 31%
- SUD: 11%
- Depression: 42%
- Asthma: 27%
- CHF: 15%
- Bipolar: 6%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
How we understand our population: Health Risk Assessment Tool (HRAT)

• We attempt to identify and build our Model of Care around the HRA, a detailed questionnaire. The HRA is designed to identify risk factors and triggers for care coordination services.

• Health risk assessments (HRAT):
  > HRATs are completed via in-home assessment, mail, portal, face to face or telephone interview.
  > Each new and existing enrollee receives a mailed HRAT to complete and submit.
  > New members receive a Welcome Call within 90 days of enrollment.
Individualized Plan of Care

• HRAT data is combined with chart review data to produce an individual care plan (ICP) for the member.

• The individual care plan can be mailed to the member and providers as requested or sent through member & provider portals. Members are encouraged to meet and discuss this plan with their primary care provider (PCP).

• High-risk members are referred to RCTs for intervention and ongoing care coordination.
Interdisciplinary Care Teams

- CareOregon multidisciplinary teams, including Regional Care Team staff, Medical Directors, Pharmacists, nurses, social workers, respiratory therapists and peer specialists, meet to discuss complicated cases and members with change in health status.

- Participation may include community providers.
Continuum of Services

Screening
- Welcome and Wellness
  - HRAT

Outreach & Navigation
- Outreach
  - Regulatory
  - Clinical
  - Rapid Response
- Social Health Navigation

Care Coordination
- Incoming/Intake
  - Referrals
  - Care Coordination
- Assessment
  - Care Plan
  - ICT

Intensive Services
- Regional Care Team
  - Behavioral Health ICC
  - Physical Health ICC
  - Social Health
  - Advanced Illness Care
  - High Risk Pharmacy
  - Identified Vulnerable Populations

Activity/Team
- Population
  - New and Annual Adult Members
  - Special Populations and Previously Screened Members
  - All Members
Thank you for completing this training. Just one last step:

Please ensure that you sign and return the MOC Training Attestation in your contracting packet.

Thank you!
Contact us

Care Coordination

ccreferral@careoregon.org
Questions?

Contact Melodie Farmer
PHP Quality Manager
Population Health Partnerships
farmerm@careoregon.org
503.416.4631
Thank you