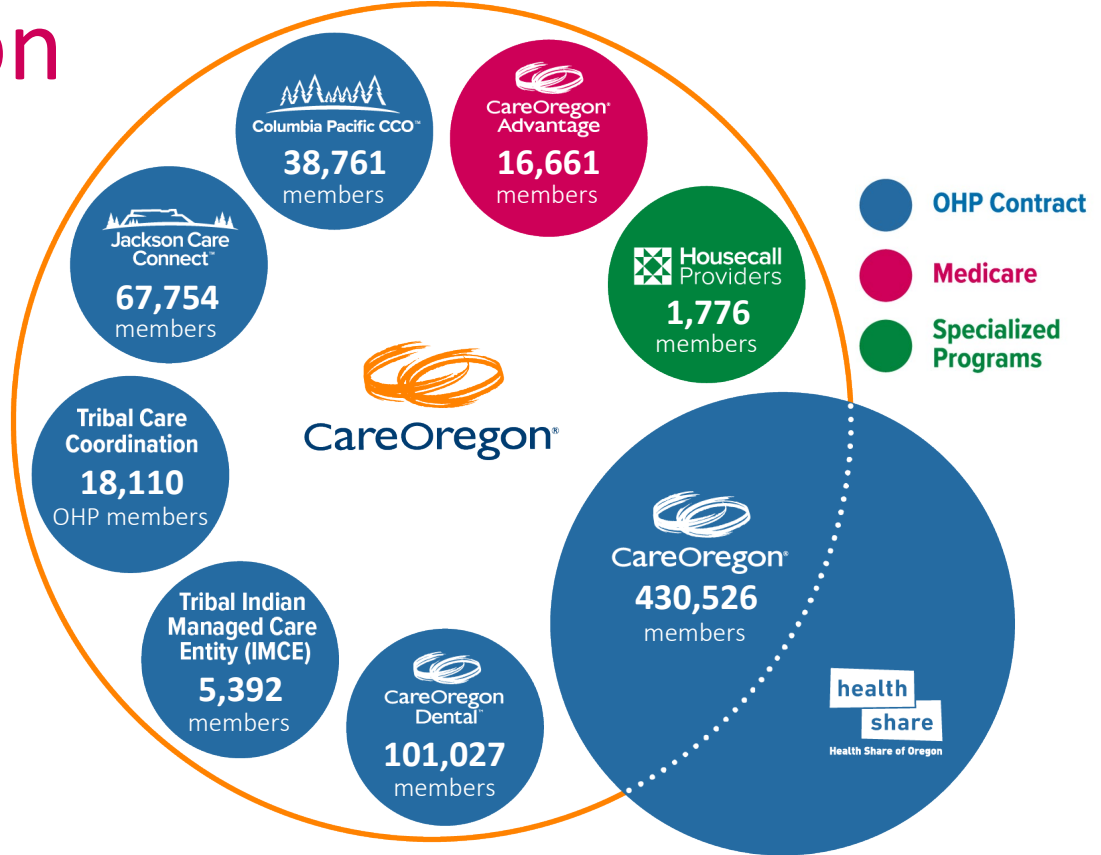


Special Needs Plan Model of Care Training 2023

Provider module

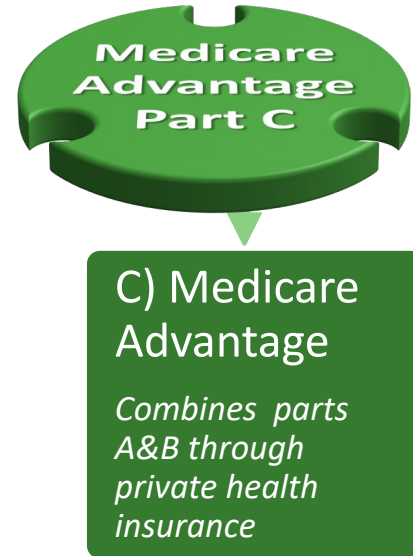
The CareOregon family

CareOregon is a mission-driven, community based non-profit organization. For almost 30 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, an Indian Managed Care Entity, a dental care organization, and in-home medical care, palliative care and hospice 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.



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 ~16,500 D-SNP members.



Population health partnerships

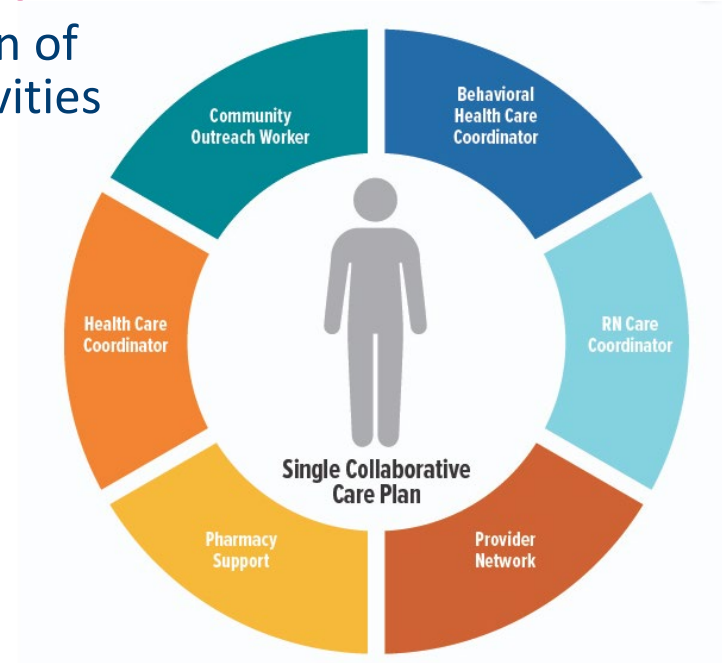
We work collaboratively with partners to promote well-being, resilience and hope, and to reduce barriers for our most vulnerable members.



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
- Panel Coordinators
- Community Partners
- Pharmacists
- Navigators



Care coordination

Regional Care Team		Region/Clinic System	Phone Number
M e t r o	Steel	Washington County Clinics OHSU Clinics HouseCall Providers	503-416-3727
	Abernethy	Clackamas County Clinics Adventist Clinics	503-416-3729
	St John's	Multnomah County Clinics West of 205	503-416-3726
	Burnside	Outside In	503-416-3657
	Sellwood	Maternal Child Health Pediatric Clinic Foster Care Youth	503-416-3768
	Tilikum	Multnomah County Clinics East of 205	503-416-1770
C C O	Jackson Care	Jackson County	503-416-3742
	CPCCO	Columbia County Clatsop County Tillamook County	503-416-3743
	Unassigned	No PCP Assignment	503-416-3731



Supporting Regional Leadership			Direct Member Support/ RCT		
Health System & Community	Delivery System	Population Health Management	Telephonic	Hospital	Clinic/Home
CBO Support / Partnership Bldg	Cost & Utilization	Population Segmentation	HCC ENCC RN Triage Coord	TCO Specialist	HRS TCO RN Housing CM
SDOH / Comm. Equity	Clinical / Comm. Partnership	Identified sub pop. work	RCP, RCT, SNF, BH referrals	Transitions post discharge	Social Determinant PCP align
Sys Lvl Involvement	Inform Strategies	Quality	Community Partners referrals	PCP collaboration	Pharm Med Rec
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?



Transportation



Housing Resources



Employment assistance

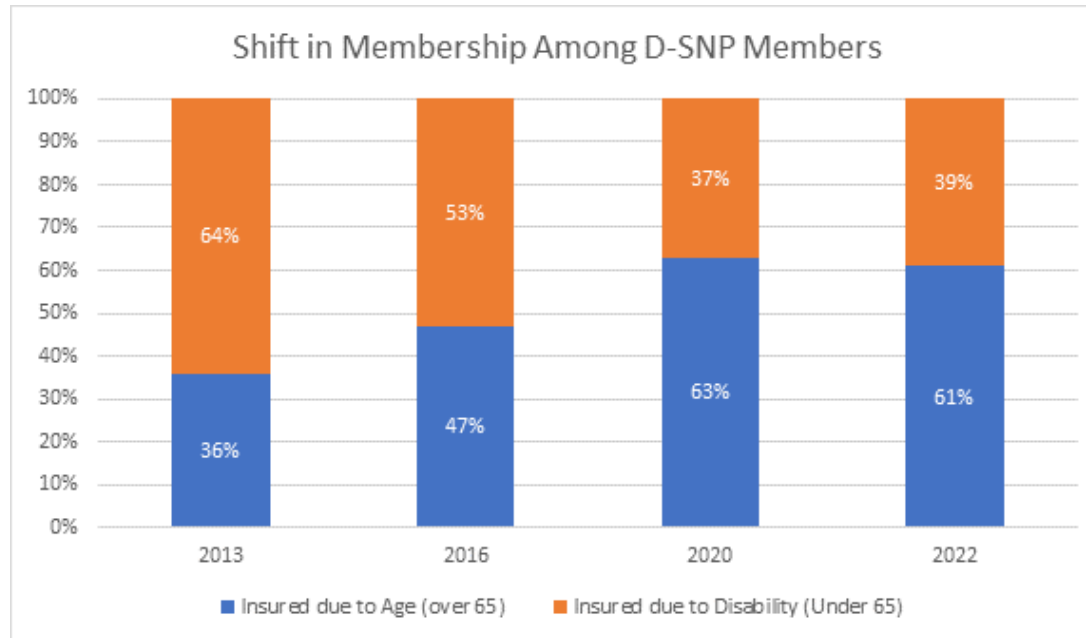


Food access

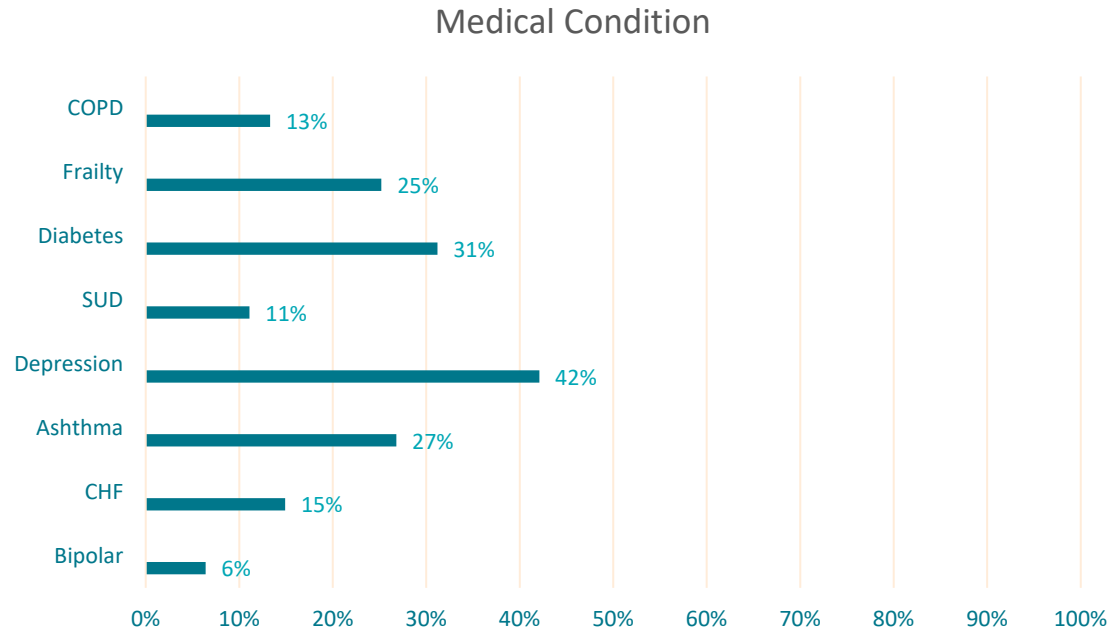


Social support

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



How we understand our population: Health Risk Assessment Tool (HRAT)

- We attempt to identify and build our Model of Care around the HRAT, 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.

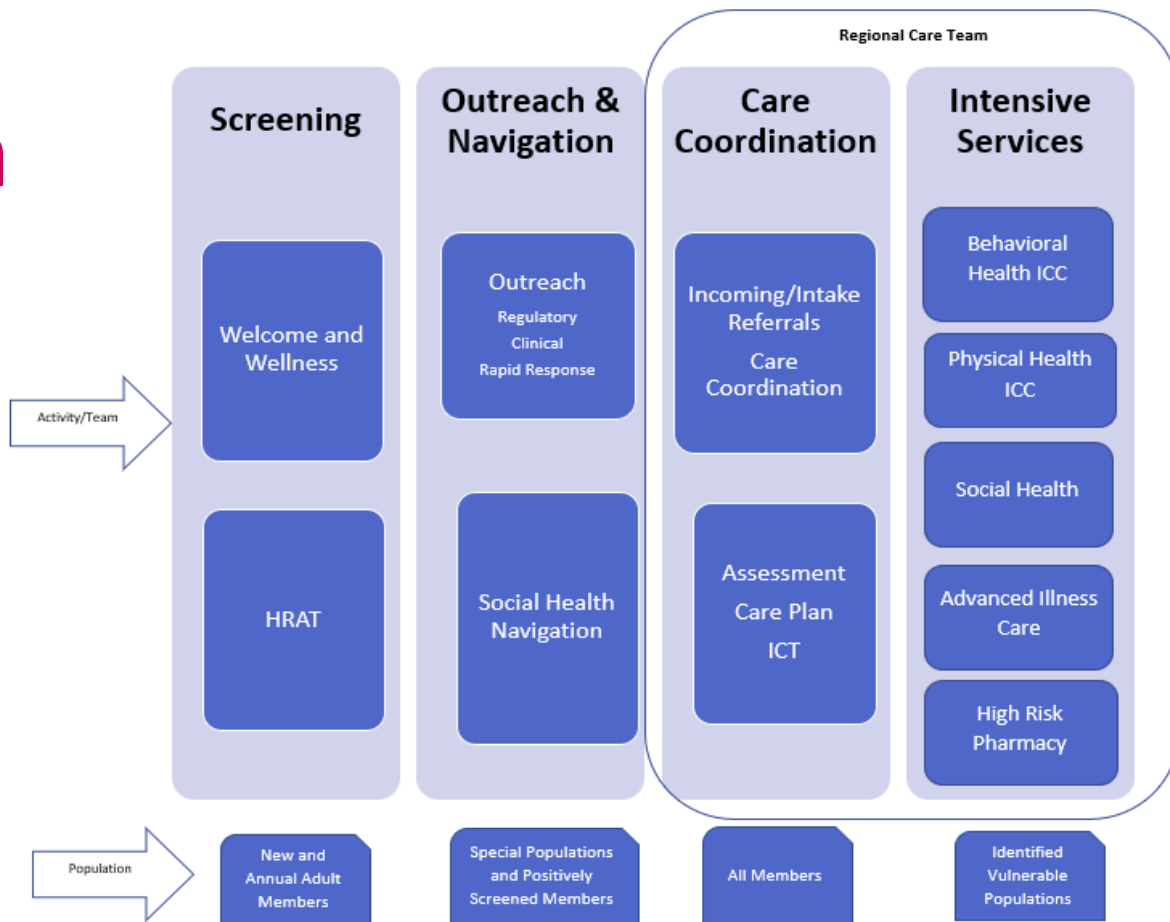
Individualized plan of care

- 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



Thank you for completing this training. Just one last step:

Please ensure that you sign and complete the MOC Training Attestation form.
[Click here to access the form.](#)

Thank you!

Contact us

Care Coordination referrals:
cereferral@careoregon.org

Other questions:
Andrew Missel
PHP Quality Manager, Population Health Partnerships
missela@careoregon.org

Thank you

