UMPQUA HEALTH

CORPORATE POLICY & PROCEDURE

	Policy Name: Intensive Care Coordination Services (ICC)
Department: Clinical Engagement	Policy Number: CE16
Version: 6	Creation Date: 9/19/2017
Revised Date: 4/17/19, 7/26/19, 9/25/19, 12/5/19	Review Date: 8/10/18

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network

Signature: F Douglas Carr, MD.

Approved By: F. Douglas Carr, MD, Chief Medical Officer Date: 12/23/19

POLICY STATEMENT

Umpqua Health Alliance (UHA) is committed to supporting our members with Intensive Care Coordination by utilizing all available resources to improve their physical health and mental well-being consistent with OAR 410-141-3870 (fka 410-141-3170).

PURPOSE

To assist members identified with the need for intensive care coordination (ICC) by establishing a connection between the Case Manager (CM) Coordinator and the member/family as defined in the UHA CCO Contract and OAR 410-141-3870 (fka 410-141-3170).

RESPONSIBILITY

Clinical Engagement

DEFINITIONS

Care Coordination: A series of actions contributing to a patient-centered, high-value high-quality system. Care coordination is defined as the organized coordination of member's health care services and support activities between two or more participants deemed responsible for the member's health outcomes and the role of care coordinator. Organizing the delivery of care and resources involves a team-based approach focused on the needs and strengths of the individual member. The care coordinator ensure that participants involved in in a member's care facilitate the appropriate delivery of health care services and supports. Successful care coordination requires the exchange of information among participants responsible for meeting the needs of the member, explicit assignments for the functions of specific staff members, and addresses interrelated medical, social cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes. Successful care coordination is achieved when the health care team, including the member and family/caregiver, supported by the integration of all necessary information and resources, choose and implements the most appropriate course of action at any point in the continuum of care to achieve optimal outcomes for the members.

Care Coordinator: A single, consistent individual who is familiar with a member's history, strengths, needs and support system; follow a member through transitions in levels of care, providers, involved systems and legal status; takes a system wide view to ensure services are unduplicated and consistent with identified strengths and needs; and who fulfills care coordination standards as identified in the CCO Contract.

Case Management Services: Services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.

FKA: Formerly known as.

Health Information Technology (HIT): The technology that serves as the foundation for health system transformation and administration of the services provided by UHA under their contract with Oregon Health Authority (OHA) and which enables care coordination among providers and contains costs through the sharing of medical information useful in diagnosis and treatment decision making, facilitates patient registries, enables unified quality reporting and empowers members to participate in their overall wellness and health.

Home and Community Based Services (HCBS): Home and Community based services provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illness.

I/DD: Intellectual Disability as defined in OAR 411-320-0020(21) and/or Developmental Disability as defined in OAR 411-320-0020(11).

Intensive Care Coordination Plan (ICCP): A collaborative, comprehensive, integrated and interdisciplinary–focused written documentation that includes details of the supports, desired outcomes, activities and resources required for an individual receiving ICC services to achieve and maintain personal goals, health and safety. It identifies explicit assignments for the functions of specific care team members, and needs in order to achieve optimal health and wellness outcomes.

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Prioritized Populations: Individuals who 1) Are older adults; individuals, who are hard of hearing, deaf, blind, or have other disabilities; 2) Have complex or high health care needs, or multiple or chronic conditions, or severe persistent mental illness (SPMI), or are receiving Medicaid-funded long-term care services and supports (LTCSS); 3) Are children ages 0-5 at risk of maltreatment, children showing early signs of social/emotional or behavioral problems or have a social emotional disturbances (SED) diagnosis; 4) Are in medication assisted treatment for substance use disorder (SUD); 5) Are pregnant women, parents with dependent children, guardians of children, and grandparents of depend grandchildren; 6) Are children with neonatal abstinence syndrome, children in Child Welfare; 7) Are IV drug users, have SUD in need of withdrawal management; 8) Have HIV/AIDs or have tuberculosis; 9) Are veterans and their families; and 10) Are at risk of first episode psychosis, and individuals within the intellectual and developmental disability (IDD) populations.

Special Health Care Needs: Individuals who are aged, blind, deaf, hard of hearing, disabled or who have complex medical needs, high healthcare needs, multiple chronic conditions, mental health issues or SUD and either have functional disabilities, or live with health or social conditions that place them at risk of developing functional disabilities (serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care).

PROCEDURES

Screening Members for ICC Eligibility

1. UHA will conduct an Intensive Care Coordination (ICC) assessment of other members, including children age 18 and under, upon referral or after an initial-health risk screening as set forth below. All referrals for ICC assessments shall be responded to by the CCO within in one (1) business day of receipt of the referral and the ICC assessment shall be completed within 30 days after receipt of referral or completion of an initial health-risk screening.
    a. A health risk screening conducted under and in accordance with OAR 410-141-3868 indicates a member has special healthcare needs or other needs or conditions that may indicate a need for ICC services.
2. UHA will have policies and procedures in place that enable early identification of members who have ICC needs. UHA will have an established process for responding to all requests for ICC assessments or services which will include, without limitation, the requirement to respond to all requests or referrals for ICC assessments or services within one (1) business day. Associated policies are:
    a. CE15 - Specialty Health Care Services;
    b. CE18 - Integrated Care Coordination;
    c. CE26 - Behavioral Health Screening Care Coordination Intensive Care

Coordination and Reporting; and

d. MS8 - Health Risk Assessment.

3. ICC assessments will identify the physical, behavioral, oral, and social needs of a member.
4. The member, member's representative, provider, including Home and Community Based Service (HCBS) provider, other medical professional serving the member, or the member's Oregon Health Plan (OHP) long term services and supports (LTSS) CM may refer or self-refer the member for a health risk screening, conducted under and in accordance with OAR 410-141-3865, for intensive care coordination (ICC) services.
    a. UHA identifies member(s) needing ICC through the health risk assessments;
        i. Health risk assessments surveys are mailed out to all new members.
            1. The initial health risk screening will include questions that indicate risk and need for sooner assessment of special/intensive health care needs OAR 410-141-3870(4) (fka 410-141-3170(5)).
            2. All members of prioritized populations will be automatically assessed for ICC services within 10 calendar days of completion of the health risk screening, or sooner if required by their health condition. Children who are members of a prioritized population shall be provided behavioral health services according to presenting needs.
    b. Members eligible for ICC (prioritized population) will be assigned a Case Management (CM) Coordinator or Behavioral Health (BH) Coordinator.
        i. CM Coordinator or BH Coordinator assignments will be made within three (3) business days of determining a member is eligible for ICC services.
        ii. If a member is in a condition-specific program at the time they are determined eligible for ICC services, or enters a condition specific program while receiving ICC services, then UHA will appoint the CM Coordinator of the condition-specific program as the CM Coordinator or BH Coordinator for the member while the member is in the condition-specific program. After a member transitions from the condition-specific program, UHA will reassess the member within seven (7) days of the transition and assign a new CM Coordinator or BH Care Coordinator with three (3) business days of the completion of the ICC reassessment.
            1. UHA will notify members of their ICC status by at least two (2) means of communication within five (5) business days

following the completion of the ICC assessment.

2. Notification will include details about the ICC program and the name and contact information of their assigned CM Coordinator.

iii. Completed health risk assessments are sent to Case Management Department.

iv. Case Management designee will reach out to the member by phone or mail to offer ICC services to the prioritized population within five (5) business days following the completed screening. Notifications will include details of the ICC program and the name and contact information of the CM Coordinator or BH Coordinator.

v. Case Management Specialist will create a referral in Community Integration Manager (CIM) and assign a CM Coordinator or BH Coordinator, the designee will make three initial attempts to reach the member, by phone or mail.

vi. Case Management Specialist will also enter member into Collective Medical group for monitoring. CM Coordinator's will follow up with alerts from Collective Medical within 30 days.

c. Referrals:

i. Referrals from providers, members, or other professional providers will be processed and referred to CM Coordinator for follow up with the member within one business day of receiving referral for ICC.

ii. CM Coordinator or BH Coordinator will make three reasonable attempts to reach the member within one business day and schedule a face-to-face meeting with the member.

iii. The CM Coordinator or BH Coordinator will see member at the member's earliest convenience, but no later than 30 days.

iv. If member cannot be reached or located, the CM Coordinator or BH Coordinator will create a referral in CIM and reach out to the member by phone or mailing every three months in an attempt to get the member engaged in ICC services.

v. CM Coordinator or BH Coordinator will inform the requesting provider of failed attempts to engage the member and create a care plan to monitor the patient.

d. Claims data analytics:

i. UHA will review and monitor members of the prioritized populations using business intelligence data system.

ii. Members will be identified through gap lists, over and underutilization

of services and Emergency Department visits.

iii. Case Management designee will offer ICC service through phone calls and mailings every three months.

iv. Case Management designee will add member to Collective Medical group for monitoring and assign a CM Coordinator in Collective Medical.

v. CM Coordinator will make three attempts to engage member in ICC services.

vi. If CM Coordinator or BH Coordinator is not able to reach or engage the member, Case Management designee will continue to monitor and check in with the member every three (3) months.

5. For members engaged in services, the member will have an assessment completed within 30 days or at the member's earliest convenience. The completed assessment will generate an individualized care plan with interventions, goals, with outcomes and target dates. The individual care plan will be shared with pertinent members of the treatment team with member's permission.
    a. Care plans will be faxed or emailed to designated staff in provider's office.
    b. The CM Coordinator will evaluate care plans by setting target dates and reminders in the operating system, target dates will be set based upon the member's individual needs.
    c. CM Coordinator will update care plan at least annually, per member request or as condition changes.
        i. All members engaged in ICC services will be monitored for changes in condition through Collective Medical Group;
        ii. Referrals from providers; and
        iii. Member's request.
    d. Care plans will be audited by supervisor annually.
        i. Auditor will ensure care plans are appropriate for condition;
        ii. Address member's identified needs; and
        iii. Shared with pertinent treatment team members.
6. General assessments are completed through a face-to-face meeting with the member, member representative or members designated healthcare partner.
    a. Completed general assessments will create a care plan and be completed at the member's earliest convenience or within 30 days.
    b. The care plan is reviewed with the member, member's family or member's designee and shared with the providers based on member's choice.
7. UHA receives referrals for healthcare screening or assessment for members receiving long-term care or long-term services and supports from Department of Human

Services (DHS) and refers to intensive care management for health assessment within 30 days, or as quickly as the member's health condition requires.

8. UHA periodically informs participating providers, as described in the UHA Provider Handbook, of the availability of ICC services, provide training for patient centered primary care homes (PCPCH) and other primary care providers' staff on ICC services and other support services available for members.
9. UHA makes ICC services available to coordinate the provision of these services to members who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other healthcare settings.
10. UHA shall implement procedures to share the results of its identification and assessment, including assessing the cultural and linguistic needs, of any member appropriate for intensive care coordination services, with participating providers serving the member so that those activities are not duplicated.
11. UHA has a referral process, which is described in the UHA Member Handbook, for direct access to network specialists, for identifying, assessing and producing a treatment plan for each member identified as having a special healthcare need. UHA produces a treatment plan or service plan for members with special health care needs, including members receiving LTSS that are determined through a health assessment to need a course of treatment or regular care monitoring. Each treatment plan shall be:
    a. Developed by the member's designated provider, including any community-based support services and the member's participation;
    b. Include consultation with any specialist caring for the member; including DHS long-term care or long-term services and supports providers in development of plans;
    c. Approved by the UHA in a timely manner if UHA approval is required;
    d. Follow rules outlined in OAR 410-141-3835 (fka 410-141-3225) service authorization; and
    e. In accordance with any applicable quality assurance and utilization review standards.
12. UHA CM Coordinator or BH Coordinator will share treatment or service plans and results of any identification and assessment of that member's needs to prevent duplication of those activities with the State, including DHS offices for member's receiving long-term care or LTSS, or others serving the member to meet 42 CFR § 438.208 to prevent duplication of those activities as noted:
    a. Include the results of any identification and assessment of member's risk or needs assessments, for members receiving Medicaid-funded long-term care or long-term services and supports; or with Medicare Advantage (MA) plans serving dually eligible members;

b. Make a best effort to conduct an initial health risk screening of each member's needs, within 90 days of the effective date of enrollment for all new members as quickly as the member's health condition requires, or within 30 days after the member has been referred, or the member is receiving Medicaid long term care or long term services and supports, or is a member of a priority population for ICC as described in OAR 410-141-3870(4) (fka 410-141-3170(5)).
    a. UHA shall document all attempts to reach the member by telephone and mail, including subsequent attempts, to demonstrate compliance.
c. Have mechanisms to ensure review of member's potential need for Medicaid long-term services and supports and ensure members identified as potentially eligible for Medicaid long-term services and supports are referred to DHS.

13. UHA will assess members for ICC eligibility (prioritized population), revise care plans if necessary and ensure care coordination after notice of any of the following events:
    a. New hospital visit (ER or admission);
    b. New pregnancy diagnosis;
    c. New chronic disease diagnosis (includes behavioral health);
    d. New behavioral health diagnosis;
    e. Opioid drug use;
    f. IV drug use;
    g. Suicide attempt, ideation or planning;
    h. New I/DD diagnosis;
    i. Events placing the member at risk for adverse child experiences, such as DHS involvement or new reports of abuse or neglect to Child Welfare Services or Adult Protective Services;
    j. Recent homelessness;
    k. Two (2) or more billable primary Z code diagnoses with one (1) month;
    l. Two (2) or more caregiver placement within the past six (6) months;
    m. An exclusionary practice, such as being asked not to return to day care, for children aged 0-6, or suspension, expulsion, seclusion, or in-school suspension, for school-aged children;
    n. Discovery of new or ongoing behavioral health needs;
    o. Discharge from a residential setting or long-term care back to the community;
    p. Severe high level of self-reported or detected alcohol or benzodiazepine usage while enrolled in a program of medication assisted treatment;

q. Two or more readmissions to an acute care psychiatric hospital in a six (6) month period;
r. Two (2) or more readmissions to an emergency department for psychiatric reason in six (6) month period; and
s. Exit from condition specific program.

14. Members shall be reassessed for ICC, services and care plans, or, if applicable, ICC plans shall be revised, at minimum, annually (see SOP-CE16/CE18-03 - Intensive Case Management Care Plans).
15. Reassessment for ICC, services and care plans, or, if applicable, ICC plans shall be revised if necessary, must be performed upon member request.
16. For those members receiving ICC services and upon the occurrence of any of the triggering events listed above in section 13, (a-s), ICC Care Coordinators shall, if in the ICC Care Coordinator's professional opinion, it is necessary to reassess the members for ICC services, update the member's ICC plan, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3868 and 410-141-3870. Contact will be made with the member by the ICC Care Coordinator within three (3) calendar days of receipt of notice of a reassessment triggering event
17. For those members not receiving ICC services, and upon the occurrence of any of the reassessment triggering events listed above in section 13 (a-s), UHA will conduct a new health risk screening and, as applicable, reassess members for ICC eligibility, revise care plans, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3865. Contact shall be made with the member by the ICC Care Coordinator within seven (7) days of receipt of notice of reassessment triggering event.

Availability of ICC services

1. ICC services are available during normal business hours, Monday through Friday.
2. Information on ICC services are available when necessary to a member's representative during normal business hours, Monday through Friday.
3. If a member is unable to receive services outside of normal business hours, UHA provides a 24/7 nurse hotline and mobile crisis unit for its members.

Case Management Coordinators Staffing and Services Performed

1. Meet face-to-face with the member, or make multiple documented attempts to do so, for the initial and exiting appointments. Thereafter, ICC CM Coordinators or BH Coordinator will have face-to-face contract with the member individually at least once every three (3) months and make other kinds of contract (face to face

when possible) three (3) times a month or more frequently if indicated. If an ICC Care Coordinator is unable to comply with the member contact efforts taken to overcome the barriers, to the member contact requirements:

   a. Attempt to contact the members no more than three (3) calendar days after receiving notification of a reassessment trigger. If an ICC Care Coordinators is unable to make contact with the member within three (3) calendar days of a reassessment trigger, the ICC Care Coordinator must document in the member's case file all efforts made to contact the member. ICC Care Coordinator must continue brief contact with members have experienced a reassessment trigger as long as deemed necessary by the care team before they revert back to the routine contact requirement.

2. Contact the member's Primary Care Provider (PCP) within one (1) month of ICC assignment, no less than once a month thereafter, or more often if required by the member's circumstances, to ensure integration of care.
3. Facilitate communication between and among behavioral and physical health services providers regarding member progress and health status, test results, lab reports, medications, and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services, or errors. This communication shall provide an interdisciplinary, integrative and holistic care update, including a description of clinical interventions being utilized and member's progress towards goals.
4. UHA will ensure a member's DHS area Agency on Aging (AAA)/ Aging and People with Disabilities (APD), Office of Developmental Disability Services, long term care or LTSS CMs have a direct method to contact the members intensive care coordination team.
5. UHA will ensure that the number of members who are assigned to each ICC Care Coordinator does not exceed each ICC Care Coordinator's capacity to meet all the intensive care coordination needs of such assigned members.
6. Convene and facilitate interdisciplinary team meetings monthly, or more frequently, based on need. Interdisciplinary team meetings must include the member unless the member declines or the member's participation is determined to be significantly detrimental to the member's health in accordance with OAR 410-141-3865(7)(d). The CM Coordinator or BH Coordinator is responsible for arranging for the PCP or PCP staff to bring material to the meeting. The meetings shall provide a forum to:
   a. Describe the clinical interventions recommended to the treatment team;
   b. Create a space for the member to provide feedback on their care, self-reported progress towards their ICC plan goals and their strengths

exhibited in between current and prior meeting.

c. Identify coordination gaps and strategies to improve care coordination with the member's service providers;
d. Develop strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring; and
e. Align with the member's individual ICC plan.

7. Convening a post-transition meeting of the interdisciplinary team within 14 days of a transition between levels, settings or episodes of care.
8. If a member is enrolled in other programs, including condition-specific programs, where there is a CM Coordinator, the ICC CM Coordinator or BH Coordinator remains responsible for the overall care of the members, while the program-specific case manager will be responsible for supporting specific needs based on their specialty within the interdisciplinary team.
9. UHA will implement processes for documenting all of the ICC services provided and attempted to be provided to members and for creating and implementing ICC plans for members requiring ICC services. UHA will produce ICC plan for each member requiring ICC services. Each ICC plan will:
    a. Be developed in a person-centered process with providers caring for the member, including any community-based support services and LTCSS providers and the member's participation;
    b. Include consultations with any specialist care for the member and DHS long-term services and supports providers and CM Coordinators;
    c. Be approved by UHA in a timely manner if prior authorization is required;
    d. In alignment with rules outlines in OAR 410-141-3838 service authorization; and
    e. In accordance with any applicable quality assurance and utilization review standards.
10. UHA will periodically inform all participating providers of the availability if ICC and other support services available for members. UHA will also periodically provide training of PCPCHs and other PCP staff.
11. UHA staff providing or managing ICC care coordination services shall be required to:
    a. Be available for training, regional OHP meetings, and case conference involving OHP clients (or their representatives) in the CCO's service areas who are identified as being of a prioritized population;
    b. If a member is unable to receive services during normal business hours, UHA will provide alternative availability options for the members;
    c. Be trained for, and exhibit skills in, person-centered care planning and

trauma informed care, and communication with and sensitivity to the special health care needs of priority populations. UHA will have a written position description for its staff responsible for managing ICC services and for staff who provide ICC services:

i. UHA will have written policies that outline how the level of staffing dedicated to ICC is determined.
ii. The ICC policies must include without limitation, care coordination staffing standards such that the complexity, scope and intensity of the needs of members receiving ICC services can be met.

12. UHA will make ICC services available during normal business hours, Monday through Friday. Information on ICC services shall be made available when necessary to a member's representative during normal business hours, Monday through Friday. If a member is unable to receive services outside of normal business hours, UHA will provide alternative availability options for member.
13. UHA has a process to provide members with special health care needs who are receiving ICC services with direct access to a specialist (e.g., a standing referral or an approved number of visits), as appropriate for the member's condition and identified needs.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Clinical Engagement	Intensive Case Management Care Plans	SOP-CE16/CE18-03	4/23/19	1
Clinical Engagement	Interdisciplinary Team	SOP–CE16/CE18-04	6/28/19	1
Clinical Engagement	New Beginning Program	SOP-CE16/CE18-05	7/22/19	1
Clinical Engagement	New Day Program	SOP-CE16/CE18- 07	7/25/19	1
Clinical Engagement	Special Health Care Needs	SOP-CE15/CE16/CE18-09	7/26/19	1