Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: CM-002	**TITLE:** Care Coordination
DEPARTMENT: Care Management	**APPROVED BY:** Chief Medical Officer & President/CEO
EFFECTIVE DATE: 11/14/2017	**LAST REVISION DATE:** 6/29/2020
REVIEW DATES:	
APPLIES TO: Yamhill Community Care, Contracted Partners, Providers, and Subcontractors	

DEFINITIONS:

Word or Acronym	Definition
Community Health Worker (CHW)	Individual who has expertise or experience in public health; works in urban or rural community in association with a local health care system; to the extent practicable, shares ethnicity, language, socioeconomic status and life experience with the residents of the community served; assists member to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness; provides health education and information that is culturally appropriate to the members being served; assist member is receiving the care they need; may give peer counseling and guidance on health behaviors and may provide direct services such as first aid or blood pressure screening.
Community Integration Manager (CIM)	A Multi-tenant platform designed to perform core health plan administrative functions including provider reimbursement, utilization management, member enrollment and customer service.
Coordinated Care Organization (CCO)	A corporation, governmental agency, public corporation, or other legal entity this is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.
Dual Special Needs Plan (D-SNP or DSN Plan)	Medicare Advantage plan that limits enrollment to Medicare beneficiaries who meet certain eligibility criteria, these plans serve people who have both Medicare and Medicaid benefits.
Exceptional Health Care Needs (EHCN)	Members identified as aged, blind or disabled who have complex medical needs.
Full Benefit Dual Eligible (FBDE)	For the purpose of Medicare Part D coverage, Medicare clients who are also eligible for Medicaid.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Federal law with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.
Institution for Mental Diseases (IMD)	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient 7 psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.
Intensive Care Coordination (ICC)/Exceptional Needs Care Coordination (ENCC)	Specialized case management for members identified as aged, blind or disabled who have complex medical needs including: I. Early identification of members eligible for ENCC services. II. Assistance to ensure timely access to providers and capitated services; III. Coordination with providers to ensure consideration is given to unique needs in treatment planning; IV. Assistance to providers with coordination of capitated services and discharge planning; and V. Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems.
Long Term Services and Supports (LTSS)	Medicaid services and supports provided under a CMS approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services and Settings and Person-Centered Service Planning (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.
Managed Care Entity (MCE)	Entity that enters into a contract to provide services in a managed care delivery system including but not limited to managed care organizations, prepaid health plans, and primary care case managers.
Medicare Advantage (MA)	Type of Medicare health plan offered by a private company that contracts with Medicare. Medicare pays the premiums for participants in Medicare Advantage plans.
Patient Centered Primary Care Home (PCPCH)	Health care clinic that has been recognized for their commitment to patient-centered care. In a Patient-Centered Primary Care Home, the patient the most important part of the care. The Patient-Centered Primary Care Home Program recognizes clinics as primary care homes and makes sure they meet the standards of care. The program is part of the Oregon Health Authority and one of the many efforts to help improve the health of all Oregonians and the care they receive.
Participating Provider	A licensed practitioner or provider that is participating in an YCC delegates provider network.

Practitioner/Provider	A person who is licensed pursuant to Oregon state law to engage in the provision of health care services within the scope of their license or certification. An individual, facility, institution, corporate entity, or other organization which supplies or provides for the supply of services, goods or supplies to covered individuals pursuant to a contract, including but not limited to a provider enrollment agreement.
Provider Network (Delivery System)	Participating providers affiliated with the CCO who are authorized to provide services to its members.
Special Health Care Needs (SHCN)	Members who have health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and either I. Have functional disabilities, II. Live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care), social needs are addressed. Any additional resources are requested via Community Health Workers (CHWs). CHWs often times will reach out directly to members and families in need.
Traditional Health Worker (THW)	Umbrella term for frontline public health workers who work in a community or clinic under the direction of a licensed health provider. The 5 types of Traditional Health Workers: Birth Doula, Personal Health Navigator, Peer Support Specialists, Peer Wellness Specialist and Community Health Workers.
Specialty Providers (Specialist)	Any Provider not acting as a primary care provider who has clinical training in a specified area. Medical specialist are doctors who have completed advanced education and clinical training in a specific area of medicine.

POLICY:

Yamhill Community Care (YCC) delegates all or part of this function or process. Through the oversight, YCC will ensure compliance with all applicable federal, state, contractual rules and regulations and requirements.

YCC and delegates ensure primary care and coordination of healthcare services for all members. This is done by YCC, delegates and participating providers implementing methods of coordination with physical, oral and behavioral care in various ways which can include having written policies, procedures and systems in place to monitor services.

YCC and delegates provide members integrated person-centered care and services, assuring that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations member when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan.

YCC works with providers, and for FBDE members, works with affiliated MA and DSN plan or Medicare providers, to develop partnerships that allow of access to, and coordination with social and support services, including culturally specific community-based organizations, community-based behavioral health services, DHS Medicaid-funded long term care and home and community based services, DHS Office of Developmental Disability Services, Type B area

agencies on aging (AAAs) or State Aging and People with Disabilities (APD) district offices in the services area, community-based developmental disability providers and organizations and mental health crisis management services.

YCC utilizes data to understand the disparities in members health based on their race, ethnicity, location, age, sex and other member specific data and works to address these disparities to improve the health of our members by achieving improvements in overall quality of care and population health.

YCC member's privacy will be protected throughout the care coordination process per the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 164, Subpart A and E. YCC will provide coordination and transition that is medically appropriate, trauma-informed linguistically and culturally appropriate manner in accordance to state and federal rules including but not limited to Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and National Culturally and Linguistically Appropriate Services (CLAS) standards as established by the US Department of Health and Human Services.

PROCEDURE:

All members shall have an ongoing source of primary care appropriate to his or her needs and a practitioner or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. Members are provided information on how to contact their primary care provider which is located on their YCC ID Card, welcome letter and customer service can provide contact information.

- Primary care teams are responsible for transitioning members out of hospital settings into the most appropriate, independent and integrated care setting, including home and community based as well as hospice and other palliative care settings.
- Primary Care Providers shall arrange, coordinate, and monitor other medical and mental health or dental care for members who require services from agencies providing health care services under the CCO capitation, except for the following:
    - Members are not required approval from a PCP in order to gain access to mental health and substance use disorder assessment and evaluation services. Members may refer themselves to outpatient mental health services.

YCC will ensure that members have care appropriate to their needs in conjunction with or addition to the following:

1. Delegates and providers shall have and maintain a formal referral system.
2. Children especially those in custody of DHS, who need, or who are being considered for, psychotropic medications, receive medications that are for medically accepted indications.
    - YCC and partners will prioritize service coordination and the provision of other behavioral health services and supports for these children.
3. Provider Network shall consist of consultation and referral providers, including alternative care settings for all services covered by the plan.
4. Provider Network shall have referral services and services received in alternative care settings reflected in member's clinical record.
5. Delegates and providers shall coordinate services for members transitioning between levels of care, including appropriate discharge planning for short term and long-term hospital and institutional stays Traditional Healthcare Workers/Certified Healthcare Workers are utilized when appropriate.
6. Results of identification and assessment of enrollee needs are shared with other health care providers from which the enrollee may be receiving services, so that these activities are not duplicated; such as information sharing between physical health providers and mental health providers with respect to prescribed medications.
7. Member may obtain all covered services either directly or upon referral from the date of enrollment through the date of disenrollment, except when the member is enrolled in

Medicare HMO or Medicare Advantage FCHP or PCO.

8. Denying or review of denied referral requests is done by a health care professional.
9. YCC or delegates will ensure when members that are hospitalized in an inpatient or outpatient setting for covered services have notation in their appropriate PCP's clinical record with admit, discharge, length of stay and applicable chart notes and reports. This information can then be shared as appropriate for transition planning and follow-up.
10. When member's care is being transferred from one health plan to another or for member transferring from fee-for-service to YCC. YCC and delegates shall make every reasonable effort within the laws governing confidentiality to coordinate the transfer of the client into the care of a participating provider.
11. YCC and delegates shall coordinate the services it furnishes to members with the services they may receive from another Prepaid Health Plan (FCHP, PCO, DCO, CDO, MHO, CCO) in accordance with OAR 410-141-0120. PCPs shall ensure that in the process of coordinating care, the member's privacy is protected in accordance with the privacy requirements of 45 CFR parts 160 and 164 subparts A and E to the extent that they are applicable.
12. YCC and/or delegate shall ensure that members receiving services from extended or long-term psychiatric care programs will receive follow-up services as medically appropriate to ensure discharge within five working days of receiving notification of discharge readiness.
13. YCC and/or delegates shall coordinate with community providers, community emergency service agencies, and community social support providers to promote an appropriate response to members experiencing a mental health crisis as well as non-crisis care
14. YCC and/or delegate shall use a multi-disciplinary team service planning and case management approach for members requiring services from more than one public agency, to avoid service duplication and assure timely access to a range and intensity of service options that provide individualized, medically appropriate care in the least restrictive setting.

YCC and delegates coordinate physical health, behavioral health, intellectual and developmental disability and ancillary services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities:

- With services that members receive from other CCOs or MCEs;
- With services members receive in Fee For Service Medicaid; and
- With services members receive from community and social support providers.

Non-Discrimination, ADA, and CLAS

YCC ensures that participating providers have the tools and skills necessary to communicate and provide services in a linguistically and culturally appropriate manner in accordance to state and federal rules including but not limited to Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and National Culturally and Linguistically Appropriate Services (CLAS) standards as established by the US Department of Health and Human Services. YCC assists in the facilitation of information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities). YCC requires providers and their employees undergo appropriate education in cultural competence and trauma-informed care in accordance with the Health Equity Plan Training and Education.

PCPCH

PCPCHs are focal points of coordinated and integrated care so members have a consistent and stable relationship with a care team responsible for comprehensive care management. YCC encourages providers to communicate and coordinate care with the PCPCH in a timely manner, using electronic health information technology where available. YCC and/or

delegates has established hospital and specialty service agreements that include the role of the PCPCH and specify processes for requesting hospital admission or specialty services, performance expectations for communication, and medical record sharing for specialty treatment sat the time of hospital admission discharge for after-hospital follow up appointments.

Transitions of Care
YCC ensures members are transitioned out of hospital settings into the most appropriate independent and integrated community settings. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings, and the State Hospital. YCC coordinates appropriate referrals to ICC services to ensure that the member's rights are met and that there is post-discharge support.

When a member's care is being transferred from one MCE to another or for OHP clients transferring from fee-for-service to YCC, YCC shall make every reasonable effort within the laws governing confidentiality to coordinate (including but not limited to ORS 414.679) transfer of the OHP client into the care of an YCC participating provider.

YCC has systems to assure and monitor transitions in care so that members receive comprehensive transitional care and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care, and ensure providers and subcontractors receive information on the process for members accessing care coordination.

For members who are discharged to post hospital extended care at the time of admission to a skilled nursing facility (SNF), YCC shall notify the appropriate department office and begin appropriate discharge planning. YCC shall pay for the full 20-day post-hospital extended care benefit when appropriate, if the member was enrolled with YCC during the hospitalization preceding the nursing facility placement:

- YCC shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC);
- For members who are discharged to Medicare Skilled Care, YCC shall notify the appropriate department office when YCC learns of the admission. Goals of discharge planning coordination include reducing duplication of assessment and care planning activities and services by multiple entities involved in the member's care;
- YCC shall coordinate transitions to Medicaid-funded long-term care, services, and supports, after the PHEC is exhausted, by communicating with local department offices when members are being discharged from an inpatient hospital stay or transferred between different long-term care settings.
- YCC shall ensure that the member and treatment team participate in discharge planning activities and support warm handoffs between levels or episodes of care.

Coordination with Social and Support Services
YCC shall work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs:

- YCC and/or delegates have procedures for coordinating member health services with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of YCC services with long-term care services and crisis management services;
- YCC has a Memorandum of Understanding (MOU) or contract with the local type B Area Agency on Aging or the local office of the Department's APD, detailing their system coordination agreements regarding members receiving Medicaid-funded LTCSS;
- YCC has establish agreements with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area,

maintaining a comprehensive and coordinated behavioral health delivery system and to ensure member access to behavioral health services, some of which are not provided under the global budget.

YCC shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs, and CMHPs, to promote an appropriate response to members experiencing a behavioral health crisis and to prevent inappropriate use of the emergency department or jails.

Inpatient Psychiatric Services

YCC may cover and reimburse inpatient psychiatric services, not including substance use disorder treatment at an Institution for Mental Diseases (IMD). The state may make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services for an alternative service or setting, incorporating all the following requirements as defined in 42 CFR 438.6(e):

- For members aged 21-64;
- As inpatient psychiatric services for a short-term stay of no more than 15 days during the period of the monthly capitation payment;
- The provision of inpatient psychiatric services in an IMD shall meet the requirements for in lieu of services as defined in 42 CFR 438.6(e)(2)(i) through (iii):
  - The alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan;
  - YCC must offer the option to access the state plan services and may not require a member to use the IMD as an alternative service or setting;
  - The approved in lieu of services are authorized and identified in the YCC contract and may be offered to members at YCC's option.

Extended or Long-Term Psychiatric Care

YCC shall ensure that members receiving services from extended or long-term psychiatric care programs, such as secure residential facilities, shall receive follow-up services as medically appropriate to facilitate discharge as soon as reasonably possible. YCC shall coordinate the care of members that enter the Oregon State Hospital and develop agreements with community mental health programs regarding the management of adults who were members upon entering the state hospital and are transitioning from the Oregon State Hospital.

Oregon State Hospital & State Institutions

YCC and partners coordinate with the Oregon State Hospital, other state institutions, an other behavioral health hospital settings to:

- Member transition facilitation into the most appropriate, independent, and integrated community-based settings.
- Appropriate referral coordination to intensive care coordination (ICC) services to ensure that the member's rights are met and there is post-discharge support.

Medicaid-Funded Long-Term Care Nursing or Community-Based Care Facilities

If the member is living in a Medicaid-funded long-term care nursing facility or community-based care facility or other residential facility, YCC shall communicate with the member and the department Medicaid funded long-term care provider or facility about integrated and coordinated care services.

Out of Network or Out of State Care

YCC shall coordinate a member's care even when services or placements are outside the service area. Temporary placements by the Authority, Department, or health services placements for services including residential placements may be located out of the service area; YCC shall coordinate care while in placement and discharge planning for return to the county of origin or jurisdiction. For out of area placements, an out of area exception shall be made for the member to retain the YCC enrollment, while the member's placement is a

temporary residential placement elsewhere. For program placements in Child Welfare, BRS, OYA, and PTRS, OAR 410-141-3800 program specific rules will be followed.

Except as provided in OAR 410-141-3800 (placements in Child Welfare, BRS, OYA, and PTRS) YCC shall coordinate patient care, including care required by temporary residential placement outside the YCC service area or out-of-state care in instances where medically necessary specialty care is not available in Oregon:
YCC enrollment shall be maintained in the county of origin with the expectation of YCC to coordinate care with the out of area placement and local providers;
YCC shall coordinate the discharge planning when the member returns to the county of origin.
If a member loses Medicaid coverage while in an episode of care, the care coordinator will continue to manage the member's care until Medicaid coverage resumes.

YCC shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside YCC's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. YCC shall pay the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295. Authorization of services shall reflect rules outlined in OAR 410-141-3835 MCE Service Authorization.

Identification of Members for Case Management or Additional Services
All members may be identified for additional services including intensive care coordination by the following:
State enrollment files,
Health risk screening and assessment for each member's needs are completed:

- Within 90 days of the effective date of enrollment for all new members, or
- Within 30 days when the member is referred or is receiving Medicaid Long Term Care or Long-Term Service and Support, or
- As quickly as the member's health condition requires. Screenings are documented as well as subsequent attempts if the initial attempt to contact the member is unsuccessful.
- Annually, upon a change in responsibility, or change in health status indicating a need for an updated assessment

Assessments
Health Risk Assessments (HRA) provide questions regarding the members general health, including diagnosis' the member has had, number of emergency room visits, flu vaccinations, smoking, depression, mental health provider needs, eye exams and dental exams. The member is also asked their primary language and to rate their general health.

Once received the HRA is reviewed by a Care Management Team (RN Care Coordinator, LCSW, CSC or Pharmacist) based on HRA answers identify gaps in care, chronic conditions, safety concerns, and access to care and appropriateness for ENCC program. Additional assessments may be completed when member is speaking with care management to determine member needs.

HRA CIM Documentation
HRAs are then forwarded securely to the YCC Community Health Worker Hub with a notation on members who are flagged ENCC and those requiring community resource assistance. The CHWs attach them to the member file in CIM and create a flag that indicates the HRA is attached a secure CIM link to the members primary care provider (PCP) is also sent for HRA notification for additional follow up as necessary and encouraged to integrate the HRA and if appropriate resulting care plans into the member medical record.

Non-ENCC HRA Follow Up

CHW staff review the HRA information for assistance with community resources, identification of social determinant needs, locating providers or obtaining services or supports. CHWs also provide members with dental, behavioral, transportation and traditional health worker contacts for services and supports as needed. All CHW cases with notations, attachments etc. are tracked in CIM.

HRA Sharing
In an effort to eliminate duplicate efforts, YCC documents HRA screenings in the CIM system. In the event CIM is not a utilized system by the provider additional efforts will take place to share the HRA results, all privacy requirements are followed in efforts to share the HRA with:

- The state or other MCEs serving the member;
- Members receiving Medicaid-funded LTSS and, if approved by the member, their case manager and LTCSS provider, if approved by the member; and
- Medicate Advantage plans serving dual eligible members.

A member may decline care coordination and ICC. YCC shall explicitly notify members that participation is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.

Care Plans
YCC's care coordinators shall develop, and YCC shall require their provider network to use, individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs, including members with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving Medicaid-funded LTCSS.
Care Plan Requirements:

- Incorporation of information from treatment plans from providers involved in the member's care, and, if appropriate and with consent of the member, information provided by community partners. Contain a list of care team members, including contact information and role, compiled in cooperation with the member.
- Make provision for authorization of services in accordance with OAR 410-141-3835 MCE Service Authorization.
- Be developed within 30 days and updated annually for all members not in ICC or a specialized program. For members enrolled in ICC or a specialized program, care plans must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner if care plan needs change.
- Be revised at least every 3 months for members receiving ICC services and every 12 months for other members.

Care plans shall reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals. Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered:

- To ensure engagement and satisfaction with care plans, members shall participate in the creation of care plans.
- Members must be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan.
- Care coordinators shall actively engage members and caregivers and shall ensure that they understand their role as outlined in the care plan and that they feel equipped to fulfill their responsibilities.
- If a member's participation would be significantly detrimental to the member's care or health, a member may be excluded from the development of a care plan and denied access to a copy of the plan. YCC will document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts have been made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue the exclusion must

be documented as above.

Care Coordinator Principles:
Care coordinators will perform care coordination in accordance with the following principles:
Care coordinators will:

- Use trauma informed care, culturally responsive and linguistically appropriate care, motivational interviewing and other patient-centered tools to actively engage members in managing their health and well-being;
- Set agreed-upon goals for the member with continued CCO network support for self-management goals;
- Promote utilization of preventive, early identification and intervention, and chronic disease management services;
- Focus on prevention, and when prevention is not possible, manage exacerbations and unanticipated events impacting progress toward the desired outcomes of treatment;
- Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the individual;
- Promote medication management, intensive community-based services and supports and, for ICC members, peer-delivered services and supports; and
- Have contact with the active program-specific care team at least twice per month, or sooner if clinically necessary for the member's care.

Care coordinators shall promote continuity of care and recovery management through:

- Shall continue through episodes of care, regardless of location of individual;
- Monitoring of conditions and ongoing recovery and stabilization;
- Adoption of condition management and a whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual, including avoidance and minimization of acute events and chronic condition exacerbations;
- Engaging members, and their family and caregivers as appropriate

Exceptional Needs/Intensive Care Coordination
These services are available to members identified as aged, blind, or disabled, who have complex medical needs, multiple chronic conditions, behavioral health issues, and for members with severe and persistent behavioral health issues receiving home and community-based services. YCC will make trauma informed, culturally and linguistically appropriate ICC/ENCC services available to all referred members who qualify for such services.

YCC will provide intensive care coordination services without limiting the foregoing, YCC will:

- Without requiring a referral, automatically screening all members of prioritized members for ICC services. YCC shall make trauma informed, culturally and linguistically appropriate ICC/ENCC services available to all members of prioritized populations who qualify.
- Provide trauma informed, culturally and linguistically appropriate ICC/ENCC services and behavioral health services to children and adolescent members according to presenting needs.
- Provide trauma informed, culturally and linguistically appropriate ICC/ENCC services to members receiving Medicaid funded home or community-based setting for long term care services and supports under the State's 1915(i) or 1915(k) State Plan Amendments or the 1915(c) HCBS Waiver.
- Screen all member not identified above when referred by:
    - The member themselves,
    - The member's representative,
    - A provider, including without limitation an HCBS Provider, and
    - Any medical personnel service as a member's Medicaid LTSS case manager.
- Screen members who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting for ICC services.
- Provide ICC services to members who are children and adolescents in the custody of

DHS and those children and adolescents otherwise identified by the YCC contract Exhibit B, Part 4 and Exhibit M.
- Respond to requests for ICC screening services with an initial response by the next business day following the request.
- Periodically inform all participating providers of the availability of ICC services providing training to PCPCHs and other PCP staff regarding the ICC screenings and services and other support services available to members.
- Ensure that a member's DHS Area Agency on Aging/Aging and People with Disabilities, Office of Developmental Disability Services, long term care, or long-term services and supports care manager, have a direct method to contact the member's ICC Care Coordination Team.
- Ensure that the member's ICC Care Coordinator's name and telephone number are available to agency staff and members or member representative when ICC services are provided to the member.
- Ensure that the number of members who are assigned to each care coordinator does not exceed care coordinator's capacity to meet all the ICC needs of such assigned members.

Services can be requested by the member, member's representative, provider, other medical personnel serving the member, or the member's Authority case manager.
- All requests receive an initial response made by the next working day following the request.

ENCC/ICC staff facilitates care coordination and continuity of care by:
- Sharing pertinent information with all appropriate providers,
- Collaboration of providers to ensure treatment plan alignment,
- Reporting identified gaps in care,
- Assisting providers and ENCC members with transitions of care,
- Providing members with educational materials to cover their specific healthcare needs,
- Working with the members community case workers to ensure all resources and services are provided to members in a timely manner,
- Review of provider treatment plans and development of interventions to support the member's care plan and goals, and
- Documentation of all interventions in the electronic charting system so that it readily available to the health care team.

YCC will ensure the following:
ENCC/ICC services are made available to coordinate the provision of the services to members who exhibit inappropriate, disruptive, or threatening behavioral in the provider's office or clinic or other health care setting.
HRA results are shared with participating providers serving the member so activities are not duplicated.

Transition Planning by Care Coordinators
YCC facilitates transition planning for members. Care coordinators must take the following steps to facilitate transitions and ensure applicable services continue after discharge:
- The member's care coordinator must participate and play an active role in discharge planning from a specialized facility.
- For discharges from the State Hospital and residential care, the care coordinator shall have contact with the member no less than 2 times per month prior to discharge and 2 times within the week of discharge. Care coordinators must attempt to engage in a face-to-face warm handoff to relevant care providers during transition of care and discharge planning. The care coordinator shall also engage with the member, face to face, within 2 days post discharge.
- For discharges from an acute care admission, care coordinator shall have contact with the member within 1 business day of admission, 2 times a week while the member is in

acute care, and no less than 2 times a week within the week of discharge, on a face-to-face basis if possible.

- Prior to discharge, YCC or delegate will conduct a transition meeting to facilitate development of a transition plan. This meeting must be held prior to the member's return to the Contractor Service Area, 30 days prior to discharge, or as soon as possible if YCC is notified of impending discharge or transition with fewer than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue.
- YCC will oversee management of all members who have had a lapse in Medicaid coverage, and work to establish services that may be needed but currently are not available in their region.
- YCC will supervise care coordinators to ensure they are providing appropriate services and supports to members and provide full oversight and supervision to the assigned care coordinators. The individual tasked with such responsibility will be a licensed master's-level mental health professional. This supervisory responsibility is not delegated or subcontracted outside of YCC, and YCC holds care coordinators responsible for ensuring integrated coordination of care.

COMPLIANCE & OVERSIGHT:

1. YCC will routinely verify that delegates have policies and procedures that meet state, federal and CCO contract requirements for care coordination.
2. Referral and care coordination data will be routinely requested by YCC of all delegates for review by appropriate YCC staff and/or committees.
3. YCC will verify that network providers are informed about the availability of ENCC/ICC services, provide training for patient centered primary care homes and other primary care provider's staff on ICC/ENCC services and other support services available for members.
4. YCC communicates its integration and coordination policies via the YCC Provider Handbook to participating providers, regularly monitor providers' compliance via the appropriate delegate, and takes any corrective action necessary to ensure compliance. YCC documents all monitoring and corrective action activities.
5. Treatment plan audits will take place routinely using the Care Coordination File Review Tool to ensure the following:
    a. Development by the member's designated provider with member participation,
    b. Inclusion of consultation with specialist caring for the member,
    c. Approval in a timely manner, and
    d. Any applicable utilization or quality assurance standards are met.

REFERENCES:

42 CFR 438.208
45 CFR parts 160 and 164 subparts A and E
OAR 410-141-0120, 410-141-3170; 410-141-3860; 410-141-3865
Health Insurance Portability & Accountability Act of 1996
OHA CCO Contract
Health Risk Assessment
Care Coordination File Review Tool

RELATED POLICIES & DOCUMENTS:

DO-001 Delegation Oversight Policy and Procedure
CM-001 Special & Exceptional Healthcare Needs
SVC-001 Availability of Services
SVC-003 Systems of Care and Wraparound
SVC-005 Behavioral Health Services

LOG OF REVISION

DATE	REVISION	BY WHOM
03/22/2019	Policy updated with additional CCO contract and OAR requirements for clarity in YCC policy and procedure.	JRoe, QA Specialist
07/25/2019	Policy definitions and additional clarity provided to current content. Branding format changes completed.	JRoe QA Specialist
10/30/2019	Definition Updates, Addition of HRA process and guidelines. ENCC/ICC clarifications and updates due to rule changes.	JRoe, QA Specialist
01/09/2020	Children & psychotropic meds with service coordination.	JRoe, QA Specialist
6/29/2020	Added additional contract language for compliance with EQR.	SEide, St. QA & Compliance Mgr