# Coordinated Care Organization (CCO) best practices for care coordination for children, youth, and young adults

This document is intended to:

- Provide an overview of CCO care coordination expectations and objectives,
- Share best practices that care coordination teams have found helpful to support children, youth, or young adults (referred to as "youth" in this document),
- Give CCOs background on the challenges of helping with youth and steps they may need to take for successful care,
- Identify ways CCO designated care coordination staff and other representatives should support youth and their families based on common themes that arise for youth with complex needs and,
- Identify ways CCO representatives and CCO designated care coordination staff should collaborate with Oregon Department of Human Services (ODHS) Child Welfare to support youth in (and at risk of) temporary lodging (TL). For further detail about this, please also refer to the document on Temporary Lodging Prevention for CCOs.

## CCO Care Coordination

Coordinated Care Organizations (CCOs) must ensure all services accessed by members are coordinated according to the needs of members, following the requirements in OAR 410-141-3860, OAR 410-141-3865 and in 410-141-3870.[1]

Care coordination is intended to continuously improve member health outcomes, ensure a member's ability to live well with and manage any chronic conditions or disabilities, improve member satisfaction, reduce health inequities and reduce barriers to accessing health care.

In all aspects of its systems and practice, CCO care coordination must be person- and family-centered, trauma-informed and responsive, culturally, linguistically and developmentally responsive and appropriate, accessible to all members, delivered with a whole-person approach that encourages member self-determination and autonomy, and designed to account for the unique contextual needs of various member populations in relation to their families and communities, such as children, youth, young adults, and older adults, so that every member's needs are identified and addressed in a way that is appropriate for their situation, and focused on prevention, safety, early identification, intervention, and ongoing management.

CCOs must develop and continuously improve the infrastructure needed to support, enable, and uphold their care coordination responsibilities, and work to identify and address system barriers. This infrastructure includes the technology, systems, processes, relationships, and agreements needed for timely need identification, information sharing, access to care, and care planning..

[1] Primary responsibility for Care Coordination is determined based on the payor of the physical health benefit (see OAR 410-141-3860(3)), so when this document outlines CCO responsibilities, it is primarily speaking to members with a CCOA or CCOB plan type. However, the recommendations for considering and addressing behavioral health needs are also relevant for members with a CCOE or CCOG plan type, even though Medicaid FFS is primarily responsible for their overall Care Coordination.

Most CCOs subcontract some of their care coordination responsibilities to one or more downstream entities. CCOs are ultimately responsible for their members' care, including the performance of their subcontractors with care coordination responsibilities outlined in this document.
CCOs must develop a Care Profile for all members that collects relevant information about their needs, preferences, care team, including role and contact information, and an overview of the supports, services, activities, and resources deployed to address their needs.[2]

CCOs must develop a Care Plan when indicated by the member's needs as initially assessed, in response to a change in health related circumstances, or when requested by the member, their representative or guardian, or an involved provider or entity. [3]

CCOs must ensure services are coordinated accordingly, including:

- Proactive community supports and collaboration between providers;
- Convening urgent care coordination meetings as needed;
- Evaluate potential utilization of flexible funding to support the youth's unique needs; and
- Wraparound supports when appropriate.

### CCO role in care coordination for youth with complex needs

CCOs are responsible for the delivery of appropriate and coordinated health care services and supports to their Oregon Health Plan members. Youth with complex needs are often at higher risk for school suspension or expulsion, involvement with Child Welfare, juvenile justice involvement, and out of home placements in intensive treatment supports.

CCO ownership of care coordination is essential for collaboration across child-serving systems, as CCO clinical leadership must have well-established connections and working relationships with system partners (including local ODHS and Developmental Disability offices, juvenile justice representatives, behavioral health providers, schools, hospitals and clinics, etc.) to lead prompt response to youths' needs.

For youth in Child Welfare custody, CCO care coordination is essential to provide robust support to meet the youth's behavioral, dental, physical, developmental, and social health needs with the goal of being proactive whenever possible.[4]

## CCO Care Coordination Meetings for youth members

Youth with complex health needs, including those involved with Child Welfare, are a prioritized population with Special Health Care Needs, as defined in OAR 410-141-3500 (77). When these members have an ongoing special condition that requires a course of treatment or regular care monitoring, CCOs have additional care coordination responsibilities, including convening Interdisciplinary Team Meetings.[5]

Designated care coordination staff should convene these care coordination meetings at a time when the majority of the team members can participate, particularly the youth and family/guardian, at least twice per month or more frequently if needed (noting that in some cases members may decline to participate or it may be determined inappropriate to include the member if it would be detrimental to

[2] OAR 410-141-3870(4)
[3] OAR 410-141-3870(5)
[4] For further information on TL, please review the Temporary Lodging Prevention for CCOs Fact Sheet.
[5] OAR 410-141-3870(7)

their well-being).[6] Beyond the context of these meetings, the examples below represent questions CCOs should proactively ask and answer as they coordinate services for youth with complex needs.

### Care coordinators should bring information from the Care Profile to the initial care coordination meeting, along with the following:

- **Current care:** Who is the member's primary care and other providers? Is care established with those providers? If establishment with providers and delivery of services have not occurred, what is the plan to do so? Are there resources in place to address any urgent or emergent needs, and if not, what escalation is needed to ensure prompt and appropriate care?
- **Utilization history:** Emergency department visits, hospitalizations, higher levels of behavioral health care, specialty care, and previous CCO involvement if not currently engaged. Do any past recommendations or referrals need to be followed up on? What is the current recommended and authorized level of care?

### During the initial staffing, discuss these elements of the youth's situation:

- **Youth preferences:** What does the youth want for themselves, and what do they find helpful? What goals do they have? Youth can be placed in services with only parent/guardian consent in Oregon, but they should still be involved in discussions and provided with personalized supports where possible.
- **Equity issues:** Does the youth need and/or want a culturally specific provider? What is their preferred language? What are their pronouns? If the youth identifies as gender non-conforming/LGBTQ2SIA+, are there unmet health needs around that? Does the youth's cultural and ethnic background create other considerations in providing/developing a plan of care? Does the youth's family of origin have specific values and/or faith practices that are important to consider when delivering care? CCO representatives should be prepared to discuss culturally specific and appropriate supports available, provide linkages to these supports, including interpretation during care, during care coordination and any other meetings, and translation of any documentation.
- **Medications/continuity of care:** Ensure the youth has adequate supply of all medications, and that they have a current prescriber to renew prescriptions as appropriate (psychiatric and physical health). If they are new to the CCO, are there continuity of care authorizations that need to be secured? OHA staff can help connect to current/previous providers if needed.
- **Behavioral health:** Is there a current, established provider, and an appropriate level of care (or referral) in place? If providers are on the call, ask them about current recommendations, make sure the Mental Health Assessment and/or ASAM[7] is up to date, and discuss whether the youth needs a higher level of care.
  All youth in, or at risk, of TL should be screened to determine the appropriate level of behavioral health care (e.g., Intensive In Home Behavioral Health Treatment (IIBHT)). If they are not in the correct level of care, the CCO should connect youth to those services urgently.
- **Respite:** Is the youth eligible for respite care? Care coordinators should provide access to respite care when appropriate and available. Consider alternative respite care options (e.g., relief nurseries, home care).
- **Crisis/safety plan:** Is there a current, updated plan? Verify what crisis response is in place, and that all team members know how to access it. Make sure any in-home providers know where the youth will be if their placement changes, and that the provider knows who to contact to schedule therapy and do proactive check ins.

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[6] OAR 410-141-3870(7)(a)

[7] American Society of Addiction Medicine criteria for levels of care in substance use disorder treatment https://www.asam.org/asam-criteria/implementation-tools/criteria-intake-assessment-form#:~:text=The%20ASAM%20Criteria%20defines%20the,Biomedical%20conditions%20and%20complications

If the youth is in TL, this requires extra communication as multiple staff are involved, and what hotel they are staying in can change from day to day.

- **Non-traditional supports:** Can peer supports, faith-based organizations, or other providers not funded by the CCO (e.g., grant-funded mentoring) support the youth and family?
- **BHRNs (Behavioral Health Resource Networks):** For youth with substance use issues, ensure the team is aware of youth-focused providers and how to access their supports. Support the team in connecting to this resource if there are challenges.

### After the initial staffing and ongoing, CCO designated care coordination staff should consider:

- **Higher level of care (behavioral health):** If the staffing indicates this possibility, make sure the appropriate assessments and referrals to providers have taken place. If prior authorization is needed, ensure the request has been submitted, processed, and completed. This requires frequent and active follow-ups*. If the requested and approved service is unavailable (or will be delayed), the CCO must develop an alternative plan to meet the clinical needs of their member, such as in-home services, 24-hour crisis supports, respite, or more frequent medication management appointments.*
- **Wraparound or other types of care coordination assessment**: If not already connected, is Wraparound appropriate for the youth's needs? Assessment of the members' needs and the method of care coordination that would best meet them should be done.
- **Health-related services/flexible funds**: Can these supports stabilize placement? If family members are CCO members, do they need or want support in those areas? Consider all aspects of health as well as social determinants of health. Assess if there are needs such funds can support (e.g., weighted blanket, alarms, activities/camps) and ensure providers know the process to access these funds. Facilitate access to any appropriate services to meet the youth and family's needs.
- **Developmental screening/assessment needs**: Partner as appropriate with the local Community Developmental Disabilities Program around intellectual/developmental disabilities screening, referral, and service coordination. Remember that youth may still need behavioral health supports in addition to these services and provide coordination.
- **Crisis planning:** Assess if the current plan works as intended and resolve any access issues. Do family members and/or Child Welfare staff have the correct contact information for after-hours assistance? Ensure that providers know where the youth is physically located!
- **Active and persistent communication:** Youth with complex needs require active and persistent communication due to the number of providers and systems involved. It requires additional effort to ensure parties are on the same page.
- **Internal case escalation:** Navigate internal CCO systems to engage appropriate parties based on needs (such as pharmacy, non-emergent medical transportation, utilization management). Include Provider Relations if there are provider denials for services, to explore contracting solutions to potential barriers.
    - Ensure that all care coordination staff are knowledgeable about the expectations of EPSDT and explore options based on clinical recommendations.
    - Explore out-of-network options, particularly for marginalized populations.
    - Convene care conferences or internal consultation opportunities if recommendations are unclear or there are challenges with access to appropriate care.
- **Emergency department support:** If the youth ends up in the emergency department, proactively engage with hospital social work staff regarding assessment. If the emergency department looks to release the youth, ensure appropriate safety planning has occurred if the youth was there for suicidal risk. Once the youth is discharged from the emergency department, followup with the family/youth/guardian is recommended to ensure continuity of care according to the needs which brought youth to the emergency department.

- **Referrals and care pathways:** Follow up with team members frequently to ensure follow-through on any referrals. Check in with prospective providers to see if they need more information. Educate providers as necessary regarding the continuum of care and referral pathways.

## Questions?

If CCO staff have complex care coordination concerns related to behavioral health and youth in TL with behavioral health needs, or need help connecting with a member's caseworker, contact OHA's Complex Clinical Care Coordinator (Summer Hunker summer.hunker@oha.oregon.gov or 503-756-8540).

CCOs may also reach out to the Quality Assurance team related to CCO expectations, HSDQualityASsurance@odhsoha.oregon.gov.