Effective Care Coordination to Improve Systems: Community Based Care

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Learning Objectives

• Understanding a model for collaborative care coordination following community based prevention services

• Developing care coordination as part of the system of care and connecting community services to comprehensive care
Oregon Background

• Divided into 15 regional Coordinated Care Organizations
• Dental is mostly subdelegated to 6 managed care dental plans
• High degree of collaboration between plans for community based services
  • Models differ regionally
    • Dental plan operated community based programs
    • Dental plan collaboration to fund and operate community based programs
    • FQHC and other provider partnerships
    • Local community based programs and organizations with independent EPDH
Community Services in 3 Phases

Partner Engagement

- School relationships, permission slip return rates, classroom strategies

Service Delivery

- Clinical teams that provide preventive services and risk assessment

Care Coordination

- Follow up care coordination
Using risk assessment to drive care coordination

Use risk assessment to define care coordination strategies

• Need mechanisms to risk stratify as part of community care delivery and data collection

• Clinicians need ability to refer for care coordination if an individual falls outside risk stratification criteria
  • Example: BSS 1 with significant restorative needs but doesn’t meet criteria for BSS 2 (pain, infection)
Plan for All Risk Categories

- Care coordination or follow up communication for all risk categories
- Know your goals of care coordination
- Set your methods and strategies accordingly
- Document your plan
  - Letter sent home for lower risk categories
  - More detailed and intensive as risk increases
  - Create a pathway for higher levels of care coordination when risk categories are broad
Who Does Care Coordination

Capacity to carry out care coordination should be identified and included in planning with all partners

- List left with school nurse
- Organization who is also providing the onsite services (FQHC, local provider partner...)
- The individual(s) who provided the onsite service
- Separate contract for the care coordination components
Contacting the Family

- Leverage all sources of possible contact information
- Phone calls and follow up letters
- Payer partner care coordination teams
- Existing provider relationships
- Documented escalation process when unable to reach
  - Community specific
    - Could be Head Start team, school nurse, patient advocate, case worker, other school staff
Access to Care: Engage as part of community planning

- Variable, depending on the community but critical
- Service location/organization
- Medicaid managed care plan
- Local providers
  - FQHCs, community clinics, voucher systems with local private practices, local dental society
  - Leveraging community relationships is critical
How are we doing?
Tracking effectiveness

- Reporting metrics should also include care coordination and risk stratification measures
- Care coordination complete
- Care coordination closed
- Payer partners claims data
- Set goals for improvement
Understand your community event

• Be intentional about your care coordination strategy as part of event planning

• Head Start and School Based Sealant Programs

• Specific events with target populations, often centered around a community partner

• Services in WIC

• Community Health Fair
Building Care Coordination in the System of Community Care

- Letters of Agreements or Contracts
- Agree to core principles and minimum level intervention and process
- Document workflows
- Transparent reporting
  - Closing and completing referrals
- Convene partners and stakeholders consistently
Future Opportunities

- Risk assessment is not captured via claims using currently available CDT risk codes
  - Inconsistent and competes with appropriate risk coding submitted by providers in non-community patient care settings
- Considering adult programs
- Interdisciplinary care coordination
Questions?

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