PLAN OPERATIONS

Advantage Dental
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Policy and Procedure			
Policy Name:	**Case Management and Care Coordination**	Policy ID:	**PLANCG-07**
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PURPOSE

To establish the Dental Care Organization's (DCO) case management and care coordination program, in which enrollees can receive additional support in accessing dental and health care services in an effective, coordinated manner.

POLICY

The DCO's Care Coordination Department oversees its case management and care coordination program. Care coordination involves the timely coordination of dental and health care services to meet an enrollee's specific needs in a cost-effective manner that ensures continuity and quality of care, and promotes positive outcomes. Care Coordinators serve as a patient advocates, while at the same time assuring appropriate use of resources. Care coordination and case management are a collaborative process between the enrollee, the DCO and providers, and requires the cooperation of all parties to achieve success. The DCO's Care Coordination Department ensures a consistent and confidential flow of information among the variety of health care services and access points to arrive at positive treatment outcomes for enrollees. The DCO is committed to the use of individual care plans to the extent feasible to address the supportive, therapeutic, and cultural and linguistic oral health of each enrollee, particularly those with intensive care coordination health needs.

The Care Coordination Department will facilitate requests for enrollee care coordination from any person or entity making such request, including, but not limited to the Member Services Department, through the grievance system, from dental providers and other healthcare providers, from care facilities, CCOs, the Oregon Health Authority, or any other Managed Care Entity.

The DCO is committed to providing care coordination services for all of its enrollees, including care coordination across the spectrum of health care services and at alternative access sites (ex. home settings, hospitals, and alternative care facilities). This includes coordinating the services the DCO furnishes its enrollees with the services the enrollee receives from any other Managed Care Entity, and for Full Benefit Dual Eligible (FBDE) enrollees, from Medicare providers and, where applicable, Medicare Advantage or Dual-eligible Special Needs (DSN) plans, to avoid duplication of services. The DCO's Care Coordination Department consults with the DCO's Vice President of Clinical Services, or their designee who is a licensed dentist, on all care coordination cases that are clinical in nature.

The DCO ensures that in coordinating care, the enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable and consistent with State laws and federal regulations governing privacy and confidentiality of health records.

In terms of access, the DCO provides culturally and linguistically appropriate services and supports, in locations as geographically close as possible, to where the enrollee resides or seeks services. The DCO offers coordination of access to providers (including physical health, behavioral health, mental health and substance use disorders, and oral health) within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations.

1. The DCO is committed to care coordination and integration activities including, but not limited to:
    a. Enhanced communication and coordination between Coordinated Care Organizations (CCOs), the Oregon Health Authority (OHA), mental health and Substance Use Disorders (SUD) providers and dental providers;
    b. Implementation of integrated prevention, Early Intervention and wellness activities;
    c. Development of infrastructure support for sharing information, coordinating care and monitoring results;
    d. Use of screening tools, treatment standards and guidelines that support integration;
    e. Support of a shared culture of integration across service delivery systems.

2. Typical examples of oral health care coordination include but are not limited to:
    a. A dental hygienist notifying a medical provider when discussions with the enrollee indicate they are symptomatic of diabetes.
    b. A dentist's discussion and/or discussion plus hand-off of the enrollee to a tobacco cessation counselor.
    c. A referral to an oral surgeon when an oral health exam identifies possible disease of the mouth, including cancerous lesions.
    d. A Care Coordinator ensuring that the primary care dentist is informed of the outcome of their patient's hospital surgery so that the dentist can support the patient's recovery.

3. The DCO shall provide all of the elements of oral health care coordination on behalf of its enrollees, and, in doing so, shall:
    a. Support the appropriate flow of relevant information to manage enrollee care and, in the absence of full health information technology capabilities, implement a standardized approach to effectively plan, communicate, and implement transition and care planning and follow-up.
    b. Work with providers, and for FBDE (Full Benefit Dual Eligible) enrollees, work with the enrollee’s Medicare Advantage (MA) or Dual Special Needs (DSN) Plans or Medicare providers, to develop the partnerships necessary to allow for access to, and coordination with, social and support services, including culturally specific community-based organizations, community-based mental health services, DHS Medicaid-funded Long Term Services and Supports (LTSS) providers and case managers, including Home and Community Based Services, under the State’s 1915(i) or 1915(k) State Plan Amendments or the 1915(c) HCBS Waiver, DHS Office of Developmental Disability Services, community based developmental disability providers and organizations, and mental health crisis management services.
    c. Develop culturally and linguistically appropriate tools that providers may use to assist in educating enrollees about roles and responsibilities in communication and care coordination.
    d. Coordinate with DHS Medicaid-funded long-term care providers and Type B Area Agency on Aging (AAAs) or State Aging and People with Disabilities (APD) district offices in its service area for enrollees receiving DHS Medicaid-Funded LTSS; Coordinate with residential behavioral health service providers, including providers

outside of its service area, for enrollees receiving both Medicaid-funded and non-Medicaid-funded residential addictions and mental health services.

e. Use evidence-based practices and innovative strategies to ensure coordinated and integrated person-centered care for all enrollees, including those with severe and persistent mental illness, Special Health Care Needs, or other chronic conditions, who receive home and community-based services under Section 1915(i), the States Plan Amendment, or any LTSS through DHS.
f. Encourage and work with its providers to develop the tools and skills necessary to communicate in a culturally and linguistically appropriate fashion and to integrate the use of Health Information Exchange (HIE) and event notification.
g. Provide enrollees with adequate and appropriate access to dental providers for oral health services.
h. Provide enrollees with adequate, timely and appropriate access to specialty and outpatient hospital/ASC services. The DCO's service agreements with specialty and outpatient hospital/ASC providers will:
    i. address the coordinating role of patient-centered oral health care;
    ii. specify processes for requesting outpatient hospital/ASC admission or specialty services; and
    iii. establish performance expectations for communication and dental/dental records sharing for specialty treatments: (a) at the time of outpatient hospital/ASC admission or (b) at the time of hospital/ASC discharge for the purpose of facilitating after-outpatient hospital/ASC follow up appointments and care.
i. Maintain documentation demonstrating that enrollees have been informed of the various components of the delivery system, and received as applicable:
    i. Access to a consistent and stable relationship with an oral health care team that is responsible for comprehensive care management and transitions;
    ii. Assistance in having their supportive and therapeutic needs addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible;
    iii. Assistance in navigating the health care delivery system; and
    iv. Health risk screenings, as appropriate.

PROCEDURES

1. **Intensive Care Coordination for Enrollees with Special Health Care Needs**

Care coordination can exist as a single referral or may be more expansive in scope, especially in circumstances where the enrollee has been identified and/or assessed as having Special Health Care Needs. Through its Care Coordination Department, the DCO provides case management and care coordination services in circumstances where enrollees with Special Health Care Needs require enhanced oversight of services and/or care, which may or may not include integration of care with other care providers beyond oral health care. For enrollees with Special Health Care Needs or receiving Long Term Services and Supports (LTSS) determined through an assessment to need a course of treatment or regular care monitoring, the DCO allows direct access to a specialist as appropriate for the enrollees' condition and identified needs. The DCO provides intensive care coordination or case management services to enrollees who are aged, blind, disabled or who have complex medical needs, consistent with ORS 414.712, including enrollees with mental illness and enrollees with severe and persistent mental illness receiving home and community based services under the State's 1915(i) State Plan Amendment.

Not all enrollees with Special Health Care Needs require care coordination or case management services. In some situations, case management or care coordination of an enrollee that had not

been previously identified as exhibiting Special Health Care Needs may be required. The DCO prioritizes working with enrollees who have high health care needs such as multiple chronic conditions and mental illness or Substance Use Disorders. The DCO actively engages such enrollees in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.

2. Care Plans

The DCO's care coordination efforts include a care management assessment and the development of a care plan. The care plan may include access to a comprehensive directory of network providers, referral providers, community providers and alternative care settings necessary for the delivery of covered services to enrollees. In the event the DCO's network does not offer providers that can meet the needs of enrollees, it will refer its enrollees to a qualified non-participating provider.

The DCO arranges for dental care management for all enrollees through the enrollee's primary care dental home. The DCO has adopted a standardized caries risk assessment tool and urges all Primary Care Dentists (PCDs) to complete initial caries risk assessments and ongoing reevaluation during recall and periodic dental visits. When the DCO determines that an enrollee requires an enhanced level of care, such as having Special Health Care Needs, the enrollee is referred to the DCO's Care Coordination Department. The Care Coordination Department will work with the providers involved to develop a care plan for the enrollee, with the enrollee's participation. This includes the enrollee's PCD and any specialist caring for the enrollee. Case management and care coordination services are provided in a consistent and confidential manner to ensure that the enrollee receives the necessary care under a care plan, and that the encounter between provider and enrollee results in a positive health experience. Each care plan is individual to the enrollee and generally requires the following elements:

a. Assessment of individual needs through the collection of health data, either through health records, input from contacts, enrollee interviews and/or communications with an enrollee's support system, including family, friends or other care providers.
b. Development of an individualized plan through identification of needed services and treatment that address the enrollee's supportive and therapeutic needs.
c. Monitoring services and treatments in real time to confirm consensus among providers with the goal of identifying and correcting any gaps in treatment.
d. Facilitation, implementation and coordination of providers' services to ensure seamless integration of care.
e. Assess enrollee satisfaction and compliance with services, providing a benefit value snapshot to quality of life.
f. Documentation of activities, services and outcomes.
g. Report outcomes, on-going condition of care to the legally responsible parties.
h. Care plans shall reflect the enrollee's preferences and goals, and if applicable, family or caregiver preference and goals to ensure engagement and satisfaction and ensure authorization of services.

3. Initial Outreach and Health Risk Screenings

Upon initial enrollment with the DCO, the DCO's Member Outreach Department conducts initial outreach calls and oral health risk screenings to determine each new enrollee's needs. The oral health risk screenings are to be completed as quickly as the enrollee's health condition requires, but within ninety (90) days from the date the DCO is notified of their eligibility, or within thirty (30) days if the enrollee has been referred or if the DCO has indication that the enrollee is receiving Medicaid Long Term Care or Long Term Services and Supports, or is an enrollee of a priority population for Intensive Care Coordination (ICC) as described in OAR 410-141-3870.

The DCO maintains documentation on the oral health risk screening process used for compliance. If the oral health risk screening requires additional information from the enrollee, the Member Outreach Department shall document all attempts to reach the enrollee by phone and mail, including subsequent attempts, to demonstrate compliance. Enrollees are identified for health risk screenings from the enrollment files received from applicable CCOs and the OHA. All outreach attempts and call results are documented in the DCO's system. Oral health risk screenings are securely shared as appropriate with the enrollee's Primary Care Dentist, key specialists, applicable CCO, OHA, or other Managed Care Entity serving the enrollee to avoid duplication of activities.

4. Assessment and Interventions

The DCO's Case Management Department is responsible for the care coordination and monitoring of an enrollee's dental needs. When the DCO learns that an enrollee may require an enhanced level of care, the DCO's Care Coordination Department will begin the assessment. An assessment is conducted to identify potential medical, mental health, chemical dependency, oral health and social service needs and enrollees with Special Health Care Needs. As part of this process, the Care Coordination Department will provide the enrollee (orally and in writing) with information (including contact information) on the designated person or entity responsible for coordinating the services accessed by the enrollee. The letter to the enrollee will be mailed to the address on file for the member within 3 business days of the date the enrollee enters the case management system.

Additionally, the Care Coordination Department will work with OHA, CCOs and providers, as applicable, to prioritize timely access to care for certain Prioritized Populations as defined under OAR 410-141-3515. Access to care shall be coordinated and provided to certain enrollees as follows:

a. Pregnant women will be provided with an immediate assessment and intake.
b. Enrollees with Special Health Care Needs may be allowed direct access to a specialist as appropriate based on their condition and identified needs. The DCO's VP of Clinical Services makes the final determination on such direct access accommodations. This applies to the following enrollees: (i) older adults, (ii) enrollees who are blind, deaf, hard of hearing, or have other disabilities, (iii) enrollees who have complex dental health needs, high health care needs, multiple chronic conditions, and/or behavioral health issues, including SUD, (iii) enrollees who are receiving Medicaid Funded Long-term Services and Supports or Home and Community Based Services, or receiving Long Term Services and Supports determined through an assessment to need a course of treatment or regular care monitoring.
c. Enrollees with ongoing or chronic conditions, or who require Long-Term care and Long-Term Services and Supports shall have services authorized in a manner that reflects the enrollee's ongoing need for such services and supports and does not create a burden to enrollees needing medications or services to appropriately care for chronic conditions.

5. Coordination of Care for Full Benefit Dual Eligible Enrollees

For FBDE enrollees, the DCO will develop the partnerships necessary to allow for access to and coordination with, social and support services as appropriate, including culturally specific community based organizations, community-based mental health services, DHS Medicaid-funded Long Term Care Supports and Services and Home and Community Based Services, Type B Area Agencies on Aging or State APD offices in its service area, DHS Office of Developmental Disability Services, Community based developmental disability Providers and organizations and mental health crisis management services. As appropriate these partnerships will be formalized through Service Agreements and/or Business Associate Agreements.

6. **Identification of Enrollees with Special Health Care Needs**
   Enrollees with Special Health Care Needs are identified through CCO health assessments, PCDs, specialist referrals, care coordination points, and/or upon contact from the enrollee's family or representative. Identification of enrollees with Special Health Care Needs can occur through enrollee contact with the Member Services Department or through dental provider contact during the care coordination or utilization management processes. Upon identification, the DCO's Care Coordination Department works with the family or enrollee representative to ensure appropriate specialist referrals.

7. **Referral of Enrollees with Special Health Care Needs and General Care Coordination Cases**
   All complex and special needs cases will be referred to the Case Management Department for case management and care coordination. Complex cases are defined as those cases where the dental condition is compromised by a medical condition, and either the care needs to be coordinated between medical and dental providers, or between the PCD and a specialty dental provider. Special needs cases are described as those enrollees with Special Health Care Needs.

8. **Referral for Care Coordination between Service Providers**
   a. PCDs initiate a request for case management/care coordination by completing the request form online through the Provider Portal and by attaching all necessary information (x-rays, chart notes, treatment plans). All types of requests for care coordination cases (including participating specialists, out of network providers, special needs requests, and hospital) are to be submitted in this format.
   b. PCDs will ensure that the request is documented in the enrollee's dental record, along with appropriate entries in enrollee's chart notes identifying the dental procedure to be performed and the clinical basis for the procedure.
   c. PCD will maintain a comprehensive medication list, which includes all prescription medications the enrollee is taking and their medication allergies, including medications prescribed by the enrollee's PCP or specialists.
   d. Case management and care coordination cases are to be processed within 24 hours to 7 days after PCD has requested the services dependent on the urgency of the referral.

9. **Referral for Care Coordination for Behavioral Concerns**
   a. PCDs initiate a request for case management/care coordination by completing the request form online using the secure provider portal and by attaching all necessary information (x-rays, chart notes, treatment plans). All types of requests for care coordination cases (including behavioral issues, suspected acts of fraud, waste or abuse, and threats or acts of violence) are to be submitted in this format.
   b. PCDs will ensure that the request is documented in the enrollee's dental record, along with appropriate entries in enrollee's chart notes identifying the behavioral concern.
   c. Case management and care coordination cases are to be processed within 24 to 7 days after PCD has requested the services from the DCO, dependent on the urgency of the referral.

10. **Care Coordination's Administrative Procedures**
    The Care Coordination Department is responsible for maintaining official documentation for all case management or care coordination requests. In cases where extensive treatment is required over multiple visits, the Care Coordination Department will ensure the DCO receives provider progress reports for additional visits beyond initial approval.

The Care Coordination Department may conduct the following activities for complex and special needs cases:

a. In conjunction with the VP of Clinical Services, PCD, primary care medical provider, and mental health provider, as applicable, develop a dental treatment care plan.
b. In conjunction with the VP of Clinical Services, PCD, primary care medical provider, and mental health provider, as applicable, assist with coordinating delivery of dental care with the most appropriate general or specialty dentist.
c. Assist with coordinating communication between medical providers and dental providers to ensure that dental treatments do not interfere with medical treatments.
d. Monitor and reevaluate the progress of the dental treatment care plan to ensure effectiveness.
e. In conjunction with the VP of Clinical Services, PCD, primary care medical provider, and mental health provider, as applicable, modify the dental treatment care plan, as indicated by updated information.
f. Report any issues affecting access, availability, and coordination of care to the VP of Clinical Services for referral to the Quality Assurance and Performance Improvement Committee.

11. Monitoring

The Care Coordination Department regularly monitors care coordination and case management files for completeness using the Care Coordination File Checklist (attached to this policy). In addition, provider compliance is assessed through regular review of the referral process, chart audits, complaints, and feedback from those routinely engaged with the DCO in the care coordination process.

The DCO's Peer Review and Credentialing Committee will review care coordination and continuity of care issues, case management and care plan content; suggesting areas for improvement, revisions to the coordination process, alternative care settings to consider for improving dental health outcomes, and specifically addresses individual cases in light of dental outcomes.

Periodically, the DCO's Operations Department, working in collaboration with the VP of Clinical Services, shall audit findings of care plans, to determine whether the care plan(s) are dentally/medically appropriate and consistent with OHA/CMS guidelines and meet the requirements set forth on the Care Coordination File Checklist. Care plan auditing shall occur no less than twice a year. During the audit, the Operations Department and VP of Clinical Services shall meet with the Department Manager and update care plan protocols, as necessary, to ensure on-going quality of care.

REFERENCES

OAR 410-141-3515; OAR 410-141-3860; OAR 410-141-3865; OAR 410-141-3870; OAR 410-120-0000.

DEFINITIONS

"Care Coordination" is a series of actions contributing to a patient-centered, high-value, high-quality care system. Care Coordination is defined as the organized coordination of an Enrollee's health care services and support activities between two or more participants deemed responsible for the Enrollee's health outcomes and minimally includes the Enrollee (and their family/caregiver as appropriate) and a single consistent individual in 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 Enrollee. The Care

Coordinator ensures that participants involved in an Enrollee'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 Enrollee, explicit assignments for the functions of specific staff members, and addresses interrelated dental, 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 Enrollee and Family/caregiver, supported by the integration of all necessary information and resources, chooses and implements the most appropriate course of action at any point in the continuum of care to achieve optimal outcomes for Enrollees.

"Care Plan" means the documented tracking and monitoring of coordination of care for enrollees that may, but not exclusively, require multiple providers due to the extensive Special Health Care Needs or have conditions that warrant on-going care on the part of the enrollee.

"Case Management Services" means services provided to ensure that DCO enrollees 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.

"Special Health Care Needs" means individuals who have high health needs, multiple chronic conditions, mental illness or Substance Use Disorders and either 1) have functional disabilities, or 2) 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), or 3) are an enrollee of the Prioritized Populations as defined under OAR 410-141-3515. The DCO acknowledges that enrollees may, but not necessarily, be non-ambulatory or they may be ambulatory but have a severe developmental disability or mental impairment that manifests itself in behavior management issues that preclude provision of dental care in an office setting.

FORMS AND OTHER RELATED DOCUMENTS
Care Coordination File Checklist; Care Plan Form

Revision History

Date:	Description
12/17/2018	Adoption and approval.
04/23/2019	Updates based on annual review.
12/05/2019	Conversion to revised policy and procedure format and naming convention.
12/30/2020	Updates based on annual review. Elements from Case Management policy incorporated herein. Case Management policy retired.