

# Regional Care Team (RCT) Overview



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CareTeam Manager,  
Metro

# RCT: Who are we, what do we do?

- A multidisciplinary team
  - Nurses
  - Social Worker/Behavioral Health Specialists
  - Health Care Coordinators
- Provide care coordination for CareOregon members & providers
  - Coordinates interagency/interdepartmental ICT meetings, creating action oriented care plans
- Address other needs such as appropriate Community and Social Service resources and supports

# Health Care Coordinator

- First point of contact for RCT
- Care Coordination activities
  - Assist in finding new/alternative providers
  - Assist in DME questions
  - Authorizations and appeals
  - Support in finding & accessing community resources
  - General questions

# RN Care Coordinator

- Care Coordination support for member and/or provider:
  - Supports care coordinators in clinics
  - Identifies gaps in care and works with providers and families to implement care plan to address gaps
  - Coordinates interagency/interdepartmental ICT meetings, creating action oriented care plans
- Creates communication pathways between member, providers, CareOregon, and social service agencies
- Provides clinical lens to other cases RCT members are working on.

# Transitional Care RN Care Coordinator

- Care Coordination support for member and/or provider post hospitalization:
  - Follows transitional care protocols
    - 4 pillars
      - Follow up with member
      - PCP appointment
      - Med reconciliation
      - Red Flags
- Provides clinical lens to other cases RCT members are working on.
- Provides community based support
- Currently telephonic d/t COVID restrictions

# Behavioral Health Care Coordinator

- Works telephonically:
  - Member
  - Providers
  - Family
  - Entire Care Team including DHS, DD, Juvenile, Schools, etc.
- Assists navigating multiple systems
  - Support in identifying BH supports/programs
  - Assist with transitions between BH programs
  - Works closely with County programs (ICC/ Wraparound)
  - Collaborates with RN on team when medical issues are also present

# Health Resilience Specialist

- Embedded in PCP clinics- in person support :
  - Member
  - Providers
  - Family
- Assists navigating multiple systems
  - Support in identifying BH supports/programs
  - Provides in person support in clinic and community setting.
  - Supports connection back to PCP and specialty medical support.
  - Collaborates with RN on team when medical issues are also present
  - Currently telephonic – d/t COVID restrictions

## MCHD Regional Care Teams

- Tilikum RCT (503-416-1770)
  - East County, Rockwood, MidCounty
  - Supervisor, Julie Baer [baerj@careoregon.org](mailto:baerj@careoregon.org)
- St. Johns RCT (503-416-3726)
  - North Portland, NE Clinic, SE Clinic
  - Supervisor, Addam Stell [stella@careoregon.org](mailto:stella@careoregon.org)



# Referral Process

- Email:
  - <https://www.careoregon.org/docs/default-source/providers/form-referral-form.pdf>
  - [ccreferral@careoregon.org](mailto:ccreferral@careoregon.org)
- Phone call:
  - 503-416-3731 ask to be connected to RCT
  - Tilikum RCT (Mult Co east of 205)
  - St. Johns RCT (Mult CO west of 205)
- Response
  - w/ in 1 business day – reply to let you know which RCT is taking
  - w/in 3 business days – case should be assigned and actively be

Care Coordination Referral Form

health share  
Health Member Program

CareOregon

Please fill out both pages with as much information as possible.  
If you do not hear from us within one (1) business day,  
please call 503-416-3731.

**Referrer information**

Date of referral: \_\_\_\_\_

Referred by: \_\_\_\_\_ Contact phone #: \_\_\_\_\_  
(Person completing this form preferred) (Direct number preferred)

Relation to member: \_\_\_\_\_ Agency/role (if applicable): \_\_\_\_\_

If referrer is not the member, is the member aware of this referral?  Yes  No

Member name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Member ID: \_\_\_\_\_

**Request for care coordination assistance for:** (Please check all that apply)

<input type="checkbox"/> Request for Case Consultation/ ICT Meeting	<input type="checkbox"/> Multiple ED or IP admission
<input type="checkbox"/> Provider access	<input type="checkbox"/> Community-based resource support
<input type="checkbox"/> Complex medical condition(s)	<input type="checkbox"/> Substance use support
<input type="checkbox"/> Behavioral health support	<input type="checkbox"/> Other (Describe): _____
<input type="checkbox"/> Self-management coaching and support	_____
<input type="checkbox"/> Transition of care support	_____

Please provide details below regarding the reason for referral/issues of concern:

\_\_\_\_\_

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  - ccreferral@careoregon.org
- Phone call:
  - 503-416-3731 ask to be connected to RCT
  - Tilikum RCT (Mult Co east of 205)
  - St. Johns RCT (Mult CO west of 205)
  - Abernethy RCT (Clackamas CO)
  - Steel RCT (Washington CO)
  - Burnside RCT (Central City Concern clinics)
- Response
  - w/ in 1 business day – reply to let you know which RCT is taking the case
  - w/in 3 business days – case should be assigned and actively being worked

**Care Coordination Referral Form**

 

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# Transitions Process

# Questions/Issues or Concerns?

Emily Adler

503-593-7480 (cell)

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