

**Family Care / Medicaid Long-Term Care
Long Term Care Coordination Agreement
Clackamas and Washington Counties**

Medicaid-funded long term care (LTC) services are legislatively excluded from Coordinated Care Organization (CCO) budgets and will continue to be paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services. In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-directed care, CCOs and the LTC system will need to coordinate care and share accountability for individuals receiving Medicaid-funded long term care services.

This is a non-binding agreement between FamilyCare (FC), a CCO within Clackamas and Washington Counties, and the local Aging and People with Disabilities offices (APD) for Clackamas and Washington Counties. The mutual goal of the proposed agreement is to improve person-directed care, align care and service delivery and provide the right amount of care at the right time for beneficiaries across the LTC system.

Based on the good faith description of the roles and responsibilities of the entities participating in the proposed agreement to coordinate care and share accountability for Medicaid funded long term care, **FamilyCare and Aging and People with Disabilities for Clackamas and Washington Counties** agree to participate in the following activities:

1. Prioritization of high needs members in LTC

FC and APD will establish a standard definition of high needs members and criteria for assessing individuals by November 1, 2012. FC and APD will collaborate to establish this process, to promote: sharing of information regarding risk criteria for health system and long-term care system and education regarding critical risk factors for each system of care.

The partners will share initial information about potentially high risk members by March 15, 2013. By June 15, 2013, the parties will revisit whether these agreements have been effective in identifying high risk members and make adjustments to the definition and processes as needed.

FC and APD will establish a process for using information available, including data provided by OHA/DHS central office, to identify a list of individuals each has in common.

FC and APD shall share key information pertinent to each entity's risk assessment:

- APD LTC staff will share key information, listed below, for its highest needs individuals served by FC, such as those identified as having the most needs for assistance with activities of daily living - (service priority levels 1-3). APD staff will also share this information for members who are known to have other complex conditions, high Emergency Department (ED) usage, or other complicating circumstances on an ad hoc or individual basis. Key LTC client information that APD will share with FC includes:
 - Case manager contact information
 - Service Priority Level

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- LTC provider contact information
- Member's LTC goals/preferences
- Service Plan, including Contract RN involvement
- Risks
- Natural Supports
- Last assessment date
- Monitoring frequency

FC agrees to share key information from individual risk assessments for individuals defined as high needs, as well as relevant information from community health assessments with designated APD staff. Key information that FC will share with APD includes:

- Key risk factors;
- Treatment and care plan; and
- Interdisciplinary Team lead members.

Methods of information sharing:

- Information will be shared according to a schedule established by APD and FC.
- Information will be shared electronically if available, by fax or secure email to the designated contact person or back-up.
- As FC and State data systems are improved to provide more consumer information, new data sources will be incorporated into information sharing.
- FC and APD will periodically review the data sharing content and process to ensure the information shared is useful and the process is timely and efficient.
- An updated contact list for designated staff to be liaison for problem-solving, information sharing and other key communication will be shared between FC and APD programs at least quarterly.

In recognizing the importance of continual dialogue and learning, FC and APD programs will do the following to enable a Plan Do Study Act (PDSA) cycle:

- By March 15, 2013, develop a mutually agreed upon list of high risk members;
- By June 15, 2013, parties will meet to review and assess whether the parties have successfully identified and prioritized high risk members; identify the strengths of the work to date, any challenges or barriers to achieving the Triple Aim and any unexpected opportunities. The parties will document any insights and will update and amend this Agreement as necessary; and determine measures and timeframes for future accountability and evaluation efforts, in coordination with OHA/DHS metrics and accountability efforts.

2. Development of individualized care plans

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By June 30, 2013, FC and APD will share individual care plans for members who are also receiving Medicaid long-term care services and who have an individual care plan with FC provider. The above information will be shared at least semi-annually, more frequently according to individual need or as new care plans are developed.

By June 30, 2013, APD will share key client information with FC for individuals for whom FC has developed an individual care plan, including information documented in the long term care client assessment and planning system (CAPS). APD will share this information with FC on a monthly basis or as new care plans are developed. Key LTC client information will include:

- APD LTC case manager contact information
- LTC provider contact information
- Service Priority level
- Member's LTC goals/preferences
- Service Plan, including Contract RN involvement
- Risks
- Natural Supports
- Last assessment date
- Monitoring frequency

Additionally, the member care plans shall include key LTC client information identified above.

3. Transitional care practices

APD has primary responsibility for supporting individuals receiving Medicaid LTC services and transitions across LTC care settings, from hospital or nursing facility to home or residence of choice.

By September 1, 2012, FC and APD will begin developing a process for supporting individuals who transition across care settings. At a minimum, the following principles will be addressed:

- FC and affiliated providers will develop a consistent system to enable APD LTC case managers and LTC Transition/Diversion Specialists to support transition planning, including advanced notification of hospital discharges and collaboration during discharge planning process to ensure care transitions that are appropriate, safe and person-directed.
- FC will work with nursing facilities, or other LTC provider, to support effective care and transition planning, including notification of admissions, hospitalizations, and other relevant status changes; and collaboration to ensure proactive and person-directed care planning and an appropriate and safe transition.

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- FC will work with its affiliated providers and delivery system partners to integrate APD LTC staff into hospital care transitions teams to identify and follow individuals who would benefit from community-based care transitions supports.
- FC will work with its affiliated providers and delivery system partners to use of an evidence-based model for care transitions of members and will set up process and outcome measures that ensure coordination of care across health and LTC systems.

4. Member engagement and preferences

By March 15, 2013, FC and APD will identify the roles, responsibilities and scope for FC care coordinators and APD LTC case managers to:

- Actively engage individuals in their health and LTC service plans,
- Coordinate care/service planning processes,
- Communicate regularly with the FC member and members of the care team regarding the coordinated care/service plan
- Respond to urgent situations or when care plan becomes unstable; and
- Update the care/service plan to reflect changes in the members' needs or preferences.

5. Establishing member care teams

By March 15, 2013, FC will ensure that the care team leader will confer with all providers responsible for a members care, including LTC providers and APD LTC case managers and LTC Transition/Diversion Specialists.

By March 15, 2013, FC will work with APD programs to identify all high needs members receiving LTC services and APD programs shall provide relevant information regarding the members' LTC services.

By June 30, 2013, FC and APD programs shall include APD LTC case managers as part of the team based care approach and shall require providers to confer with APD case managers.

6. Use of best practice

By June 30, 2013, APD will incorporate information from the CCO into the care planning of the individual. Information will include best practice approaches, and other health-related, evidence-based practices that support the individual in a LTC setting.

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7. Use of health information

Per ORS 414.679, FC and APD will begin sharing health and LTC service information about shared clients effective August 1, 2012 and establish processes to facilitate cross-system communication and protocols for using information to coordinate care across settings and systems.

FC and APD will pilot access to electronic health records for key LTC staff and develop strategy and agreement for access and security by December 31, 2013

8. Member Access and Provider Responsibilities

By February 2013, FC and APD will establish a process to include Medicaid LTC program in their comprehensive communication approach with Medicaid LTC beneficiaries to ensure maximum impact to engage beneficiaries in their health care. Specific aspects may include:

- Links to FC web-site and calendar of wellness events on the ADRCofOregon.gov and on APD's Aging & Disability Services web-site;
- FC printed and translated materials regarding member access to CCO services available to APD LTC program to share with members and family caregivers.

FC will engage the FC Community Advisory Council to monitor and measure patient engagement and activation. FC to communicate with APD LTC offices regarding feedback sessions/focus groups to solicit member feedback.

9. Outcome and quality measures

As guidance is made available by OHA/DHS, FC and APD LTC program will coordinate to establish shared accountability performance measures.

10. Governance Structure

FC Community Advisory Council (CAC):

- A charter will be established no later than August 1, 2012 that outlines the roles and responsibilities of consumers and community representatives serving on the CAC, ensuring that a majority of the CAC representation is made up of consumers and that older adults and people with disabilities are represented. Community representatives will include at least one Medicaid LTC agency employee and one LTC provider representative.
- FC will coordinate with APD LTC program to conduct recruitment for LTC Medicaid consumer participation on the CAC.

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FC Clinical Advisory Panel:

- FC will include representatives from APD Medicaid LTC programs on the Clinical Advisory Panel to represent the clinical and health needs of Medicaid LTC beneficiaries

11. Learning Collaborative

FC and APD LTC program will coordinate regarding opportunities to increase staff and community partner education in the areas of health literacy, motivational interviewing, person- directed planning and practices to promote member engagement.

FC and APD LTC program will develop a schedule of training and educational opportunities for each other's systems of care or service delivery and ensure attendance of inter-disciplinary staff from health and LTC programs. Topics may include:

- LTC assessment and planning processes,
- Elder abuse reporting and prevention,
- Primary health homes,
- Health literacy, and
- Other topics to be determined.

12. Role of person centered primary care home (PCPCH)

By January 2014, FC will coordinate with APD to pursue co-location or other coordination opportunities with LTC staff to facilitate an integrated approach to care for individuals needing long-term services and supports.

13. Safeguards for members

By August 1, 2012, FC and APD Medicaid LTC program will share contact information and protocols for reporting and responding to member complaints and grievances pertaining to their coverage in either system.

Signatures and Contacts

Family Care

By _____

Title: _____

Date: _____

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Signatures and Contacts

Family Care

By _____
Title: _____ Date: 12/17/2012

The designated contact person is:

First name _____ Last name _____
Email _____ Phone _____

Department of Human Services, Aging and People with Disabilities

By: Patricia Beatty
Title: Chief Operating Officer Date: 5/6/13

The designated contact person for APD, Washington County:

Jessica _____ Sottg _____
First name Last name
jessica.m.sohes2@state.or.us 503-469-2098
Email Phone

The designated contact person for APD, Clackamas County:

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Genevieve

First name

Sundt

Last name

genevieve.m.sundt@state.or.us

Email:

971-673-6079

Phone: