

## **OHA/DHS Guidance**

### **Shared Accountability for Long Term Care (LTC) –Memorandum of Understanding (MOU)**

#### **Appendices to this document:**

- Appendix A: Designated MOU contacts
- Appendix B: APD/AAA service delivery system map
- Appendix C: Overview of the APD/AAA service delivery system
- Appendix D: Sample MOU template
- Appendix E: Glossary of terms

#### **Shared Accountability**

CCOs will be responsible for delivering high quality, person-centered health care to its members, including members receiving Medicaid-funded LTC services such as services in residential care facilities, nursing homes, or in home services and supports.

Medicaid-funded LTC services are legislatively excluded from CCO budgets and will continue to be paid for directly by the Department of Human Services (DHS). Local LTC offices authorize, manage and monitor these LTC services. In some regions of the state, these responsibilities are carried out by DHS/ Aging and People with Disabilities (APD) field offices, and in other regions, DHS has contracted with Type B Area Agencies on Aging (AAAs).

In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will be responsible for coordinating care and sharing accountability for outcomes for the individuals served by CCOs and the local LTC office. OHA/DHS has worked closely with stakeholders to develop four strategies for shared accountability, including:

- Requirements to coordinate;
- MOU outlining how the CCO and LTC local office will coordinate and communicate;
- Reporting of key metrics (see Monitoring/Evaluation section); and
- Shared financial accountability, including incentives or penalties related to performance on key metrics.

The purpose is to ensure that coordination between the two systems is occurring and to align incentives between the two systems to provide quality care, to produce the best health and functional outcomes for individuals and to prevent escalation of costs for both systems.

Strategies to share accountability between CCOs and the LTC system for consumer health outcomes focus on intensive care coordination for high risk individuals and transitions of care. One of the accountability strategies is the completion of a MOU between the CCO and the local Aging and People with Disabilities (APD)/Area Agency on Aging (AAA) office. The MOU is to serve as the starting point for developing and establishing working relationships and processes between these entities. The goal is a strong partnership that supports and promotes the goals of the triple aim (better care, better health, lower costs), that prevents and avoids cost shifting between systems and that holds both systems accountable for outcomes.

### **Purpose/Scope of this Guidance:**

This guidance outlines specific expectations for CCOs and LTC offices related to five domains required to be addressed in the resulting MOU, as well as the process and timeline for review/approval of MOUs, and expectations around monitoring and evaluation. In addition, the guidance provides information around eight optional domains for consideration for MOUs.

This guidance builds off the Coordinated Care Organization (CCO) criteria requirements of HB 3650 and is described in the CCO implementation proposal and in the OHA proposal for Medicare/Medicaid Alignment Demonstration<sup>1</sup>. The information in this document is specific to the MOU requirement relating to the shared accountability for LTC.

This guidance covers<sup>2</sup> MOUs between CCOs and:

- Type B Area Agency on Aging (AAA)
- State of Oregon Aging and People with Disabilities (APD)

This guidance does not cover:

- MOUs or contracts that CCOs are required to have with local mental health authorities, community mental health programs, community developmental disability programs or support service brokerages. More information will be provided on these topics in the near future.
- The three-way contract required for the Medicare/Medicaid Alignment demonstration between the Center for Medicaid Services (CMS), the State, and the CCO.

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<sup>1</sup> The Strategic Framework for Coordination and Alignment between CCOs and Long Term Care and can be viewed at: <http://www.oregon.gov/OHA/OHPB/meetings/2012/2012-0214-cco-strategic-framework.pdf>

<sup>2</sup> See Appendix B for description of AAA and APD service delivery systems

- MOUs or contracts that CCOs may choose to enter into in order to provide transformational services envisioned beyond the expectations outlined in this document.

This document is intended to provide guidance and technical support for the completion of an MOU with an emphasis on local flexibility, innovation and reasonable time frames for initial and ongoing improvements.

### **DHS/OHA Review/Approval Process:**

DHS/OHA will review MOUs to ensure that each of the five required domains are sufficiently addressed. In addition, DHS/APD central office will sign all MOUs with APD LTC local offices, and will countersign MOUs with Type B AAAs.

### **Time Line\* - CCO/LTC MOU**

- Mid-April – MOU guidance posted online as final
- April – Areas with CCO applicants are identified via their Letters of Intent. Local CCO-AAA/APD Offices begin process of MOU development internally with technical assistance from DHS/OHA.
- April/May – CCO and AAA/APD offices define process for completing MOU and meet as needed to complete process.
- June 15 –MOUs due to APD/OHA for review.
- June 30 – APD/OHA review completed.
- July 1 – MOU finalized (or by the time the CCO contract is signed)
- Aug 1 - MOU operational (or by the time CCOs’ contracts are effective)
- Ongoing- Monitoring and evaluation

\*MOU operational dates listed are for the initial CCO application wave, and will be adjusted for later rolling CCO application waves.

### **Monitoring and Evaluation**

OHA and DHS are developing processes and metrics to support the shared accountability framework discussed above. Within the MOU, the CCO and the LTC office are asked to describe how they will hold each other mutually accountable for agreed upon activities. Listed below are four mechanisms that CCOs and LTC offices may find useful to assure mutual accountability. These mechanisms could be phased in over time, and CCOs/LTC offices may want to update their MOUs to coordinate with the metrics and processes under development by OHA and DHS.

1. Review and assess whether MOU agreements have been carried out, identify strengths of the MOU, challenges or barriers to meeting MOU agreements,

unexpected opportunities, informal/anecdotal outcomes, and revise MOU to adjust for this new information;

2. Identify relevant process and/or outcomes metrics related to specific CCO/LTC office joint efforts or goals;
3. Monitor processes: track the extent to which CCOs and LTC offices are interacting around the five required domains (e.g., for how many/what % of CCO members in LTC did AAA provide risk assessments; how many joint care conferences were attended; etc.); and
4. Measure outcomes for the CCO members in LTC to assess whether coordination and joint efforts are having actual impacts on individuals served by both systems with a focus on health equity.

In addition to building mutual accountability into the MOU, DHS/OHA intends to monitor MOUs in a number of ways:

1. CCO metrics developed and monitored by OHA in conjunction with DHS, including analysis of each metric by members receiving Medicaid-funded LTC – see below;
2. LTC system metrics developed and monitored by DHS in conjunction with OHA (under development);
3. Troubleshooting, informal check-ins with DHS/OHA; and
4. Post implementation evaluation to assess how shared accountability is working, whether MOUs are useful, and what structures and relationships have developed including identify challenges, barriers, best practices, lessons learned.

Finally, CCOs will be held accountable to a set of metrics<sup>3</sup>, including the following, which will be assessed for each CCO's members receiving Medicaid-funded LTC:

- Member/patient Experience of care (CAHPS tool or similar)
- Health and Functional Status among CCO enrollees
- Rate of tobacco use among CCO enrollees
- Obesity rate among CCO enrollees
- Outpatient and ED utilization
- Potentially avoidable ED visits
- Ambulatory care sensitive hospital admissions (PQIs)
- Medication reconciliation post discharge
- All-cause readmissions
- Alcohol misuse – screening, brief intervention, and referral for treatment

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<sup>3</sup> See RFA table C-1 for the full list of CCO accountability metrics:  
<https://cco.health.oregon.gov/RFA/Pages/Download-the-RFA.aspx>

- Initiation & engagement in alcohol and drug treatment
- Follow-up after hospitalization for mental illness
- Screening for clinical depression and follow-up
- Timely transmission of transition record
- Care plan for members with Medicaid-funded long-term care benefits

### **Process for creating a MOU:**

The MOU will be created jointly by CCO and the LTC office serving that area. It should reflect the capabilities and resources of the local entities and may be different from MOUs created by other organizations around the state.

A discussion about shared goals may assist in creating agreements that are strong and relevant. Shared goals include:

- Creating a better experience for the individual;
- Preventing/avoiding cost shifting;
- Providing better care and services;
- Reducing disparities based on race, ethnicity, limited language proficiency;
- Creating better health outcomes;
- Lowering costs; and
- Pursuing innovative and transformational approaches to care.

A suggested beginning point for discussion is to get an understanding of each entity's current capabilities, processes, language and terminology, and any limitations in each of the required domain areas. Having a shared understanding of the services, philosophy, and operational capabilities of both the CCO and LTC system should aid in the development of the MOU.

Also, Health System Transformation efforts place emphasis on wellness and prevention and include new roles and approaches that should be considered during your discussions. These include flexible services such as new non-traditional health care workers (community health workers, peer wellness specialists and health care navigators), as well as flexible service approaches (see glossary for definition). Discussion and shared understanding about these approaches and resources should inform collaboration and planning to reach shared goals.

Other considerations:

- Who is the lead contact in each organization for day to day operation of MOU?
- What is the process for assessing whether the MOU meets our goals?
- What is the process for revising/amending the MOU?
- What are the methods for resolving disputes/problem solving?

The minimum domains that must be addressed in the LTC/CCO MOU are:

1. Prioritization of high needs members
2. Development of individualized care plans
3. Transitional care practices
4. Member engagement and preferences
5. Establishing member care teams

Each required domain contains sets of expectations for the CCO and AAA/APD office that must be addressed in the MOU. The sample questions and guidance are intended to be helpful in working out the MOU details and are for assistance and illustrative purposes only. The questions are not required to be asked or formally submitted as part of the MOU process as CCOs and LTC offices will likely develop questions and answers unique to their local environment.

Listed after the required domains are additional, voluntary, domains that are relevant to alignment and coordination, but are not required being included in the MOU. They are:

- A. Use of best practices
- B. Use of health information technology
- C. Member access and provider responsibilities
- D. Outcome and quality measures
- E. Governance structure
- F. Learning collaboratives
- G. Role of primary care home
- H. Safeguards for members

Please note: DHS/OHA Central Office is identifying ways it can support the MOUs developed by local offices including methods for sharing client information. More information about Central Office supports will be forthcoming.

## REQUIRED DOMAINS - MOU Worksheet: Questions and Guidance

### 1. Prioritization of high needs members in LTC

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"> <li>• CCOs will define universal screening process that assesses individuals for critical risk factors that trigger intensive care coordination for high needs members receiving Medicaid funded LTC services.                             <ul style="list-style-type: none"> <li>o CCO will factor in relevant referral, risk assessment and screening information from local AAA/APD offices and LTC providers.</li> <li>o CCOs will define how it will communicate and coordinate with AAA/APD when assessing members receiving Medicaid-funded LTC services.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will provide CCOs with access to information needed to identify members with high health care needs.</li> <li>• AAA/APD will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid AAA/APD offices into CCOs' individualized care plans for members with intensive care coordination needs.</li> </ul>
<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations</li> </ul>	

#### Questions for Discussion

1. How does each entity define and screen for risk/high needs?
2. Are there common definition elements (safety, preservation of living situation, costs, cultural and linguistic barriers, etc?) that create natural focus areas and a shared definition?
3. What should be the process for prioritizing high risk members? How will the process assure that individuals who are traditionally underserved be included amongst the highest priority group for intensive care coordination? (Examples include those at risk of inpatient psychiatric hospitalization, those receiving intensive mental health services or those that have transitioned from the Oregon State Hospital.)
4. How can relevant information from both entities be included in this process? Are there opportunities to develop common referral or tracking tools?
5. How will we efficiently and effectively share information, initially and down the road?

Guidance:

CCO and APD/AAAs offices build processes and information sharing agreements regarding their joint approach for high needs members in LTC.

APD/AAA data sharing possibilities: Provide CCO with risk related information collected by APD such as, risk elements on the CAPS, exceptions requests, eviction requests.

**2. Development of individualized care plans**

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"> <li>• CCOs’ individualized person-centered care plans will include information about the supportive and therapeutic needs of each member, including LTC services and supports needs.               <ul style="list-style-type: none"> <li>o Plans will reflect member or family/caregiver preferences and goals captured in AAA/APD service plans as appropriate.</li> <li>o Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from AAA/APD and with LTC providers.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid AAA/APD offices into CCOs’ individualized care plans for members with intensive care coordination needs.</li> </ul>
<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations</li> </ul>	

Questions for Discussion

1. How does each entity currently develop individualized care plans?
2. What shared information would be most helpful to each entity in creating individualized care plans?
3. Can the desired information be easily shared?
4. What is a reasonable starting point and where do we want to get to and by when?
5. How will both entities incorporate the use of non-traditional workers when identifying needs, preferences and goals and developing service plans?

Guidance:

Initial MOUs should reflect the prioritized information that is reasonable to collect

and share in the development of individualized care plans. The plan for sharing information should be consistent with the goals of improving health, improving beneficiary care and lowering costs. This area should improve over time as systems for sharing information are refined and knowledge is gained through experience.

### 3. Transitional care practices

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"> <li>• CCO will demonstrate how it will coordinate and communicate with AAA/APD to incentivize and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive comprehensive transitional care, as required by HB 3650.</li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will demonstrate how it will coordinate and communicate with CCO to incentivize and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive comprehensive transitional care, as required by HB 3650.</li> </ul>
<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations</li> </ul>	

#### Questions for Discussion

1. What does an ideal care transition involve from a consumer perspective? From each entity’s perspective? From a cultural perspective?
2. What tools, checks or safeguards does each system use to ensure comprehensive transition care planning? Can these tools be shared?
3. What is a reasonable time frame for communication when care transitions are occurring or care transition planning is needed?
4. What critical information should be shared to facilitate care transitions?
5. What practices can we adopt including flexible services and approaches that best use our talents and resources?

#### Guidance:

Ensuring communications and coordination between CCOs and AAA/APD is particularly critical during transitions, at the same time that limited resources require a close examination of areas where there is a potential for duplication of effort. Discussion should include understanding of roles and responsibilities during the critical period after an acute care episode, as well as transitions to Medicaid funded LTC.

#### 4. Member engagement and preferences

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"> <li>• CCO will actively engage members in the design and, where applicable, implementation of their treatment and care plans, in coordination with AAA/APD where relevant to LTC service planning.</li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will actively engage individuals in the design, and where applicable, implementation of their LTC service plan, in coordination with CCO where relevant to health care treatment and care planning.</li> </ul>
<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations</li> </ul>	

#### Questions for Discussion:

1. How are individuals currently engaged in their care?
2. How are individual preferences currently captured?
3. How can the CCO and AAA/APD share information on individual preferences?
4. How can client specific supports for individual engagement and preferences be coordinated between the AAA/APD and CCO?
5. What are concerns and perceived barriers to full member engagement?

#### Guidance:

MOU should establish how client preference information known to each entity will be shared and incorporated into care planning. For example, LTC typically captures information regarding the individual’s choice of living situation while CCOs will likely have information related to an individual’s health goals. Both entities should identify resources to support member engagement such as the non-traditional workforce.

#### 5. Establishing member care teams

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"> <li>• CCO will support the flow of information to AAA/APD.</li> <li>• The CCO-appointed lead provider or care team will confer with all providers responsible for a member’s care, including LTC providers and AAA/APD.</li> <li>• To support care teams, CCO will:</li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will define roles, responsibilities and process for assignment of and participation in the CCO care team, including coordination with CCO lead care coordinator, for members needing routine and intensive care coordination.</li> <li>• AAA/APD will ensure that CCO</li> </ul>

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"> <li>o Work with AAA/APD to ensure that it identifies members receiving LTC services.</li> <li>o Include LTC providers and AAA/APD case managers as part of the team based care approach.</li> <li>o Adapt team-based care approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services.</li> </ul>	<p>providers/care teams are notified of which CCO members are receiving LTC, the relevant local AAA/APD office contact, and contact for relevant LTC provider.</p> <ul style="list-style-type: none"> <li>• AAA/APD will have knowledge of and actively participate in CCO team based care processes when appropriate.</li> <li>• DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams.</li> </ul>
<ul style="list-style-type: none"> <li>• MOU will address how CCO and APD/AAA will hold themselves mutually accountable to meeting these expectations</li> </ul>	

Questions for Discussion

1. How do we want to design our care teams?
2. Are there established bridges between LTC and CCO staff and providers and is there a way to leverage those bridges in the design of a care team?
3. What can we do now? Later?
4. What can we accomplish through technology, cyber/video conferencing, phone conferences, face-to-face?
5. What are the roles and responsibilities for members of the care team?
6. Do we need to create protocols/ground rules for participation, etc?

Guidance:

CCO and APD/AAAs build agreements regarding their team approach for high risk members. Teams can be utilized more broadly if mutually desired. Items to consider include, membership of care team, inclusion of individual, how team meets/shares information and frequency of meeting/sharing information.

**OPTIONAL DOMAINS for inclusion in the CCO/LTC MOU:**

Below are additional domains of coordination and alignment found in the Strategic Framework for Coordination and Alignment between CCOs and Long Term Care<sup>4</sup>. These elements are included for consideration because of the potential for improved coordination and alignment of LTC and CCO activities, but are not required to be addressed in the final MOU.

**A. Use of Best Practices**

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"><li>• CCO will describe capacity and plans for ensuring that best practices are applied to individuals in LTC settings, including best practices related to care coordination and care transitions.</li></ul>	<ul style="list-style-type: none"><li>• AAA/APD will support CCO efforts to implement best practices approaches, and will share best and promising practices including care coordination; care transitions and evidence based healthy aging programs related to serving individuals in LTC settings with CCOs.</li></ul>

Questions for Discussion

1. What best and promising practices does each entity currently train/use that can be applied to interactions between the CCO/LTC systems? Are flexible services included in the consideration of best practices?
2. Does either entity have a quality improvement program or initiatives related to care coordination or care transitions?
3. To what extent does each entity have knowledge of best practices around care coordination, care transitions and evidence based healthy aging programs?
4. Other than learning collaboratives (see pg. 16, section F.) what ongoing methods can we create to identify and implement evolving best and evidence-based practices?
5. How will we hold ourselves accountable?

Guidance:

Plan to describe or offer best practices re: care coordination / transitions/ health aging that you think will work for your shared clients. Discuss tools on care

<sup>4</sup> <http://www.oregon.gov/OHA/OHPB/meetings/2012/2012-0214-cco-strategic-framework.pdf>

coordination/transitions/healthy aging provided by DHS central office. Identify resources you have to support best practices.

## B. Use of Health Information

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"> <li>As part of the HIT improvement plan, CCO will identify a strategy to partner with the LTC system to improve upon any existing efforts to share information electronically.</li> </ul>	<ul style="list-style-type: none"> <li>AAA/APD will partner with CCO in developing electronic information sharing strategy.</li> <li>DHS/APD will develop mechanisms to improve the sharing of relevant DHS Information with CCOs.</li> </ul>

Questions for Discussion:

1. What do we need to share and understand about our respective information systems?
2. What opportunities exist for electronic sharing of information?
3. What are the challenges to electronic information sharing and are there “low tech” solutions?
4. Who should be involved from our organizations in developing a plan for electronic data sharing?
5. How will we hold ourselves accountable?

Guidance:

Discuss existing electronic systems in place and information that is collected. Initial agreements could detail what is reasonable now and include plans for improving systems and information sharing.

## C. Member Access and Provider Responsibilities

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"> <li>Tools developed for members should be accessible to individuals receiving LTC services and supports and/or their family or representative.</li> </ul>	<ul style="list-style-type: none"> <li>AAA/APD will provide education materials to Medicaid clients, contracted providers, family caregivers and client-employed providers on member access to services through the CCO.</li> </ul>

Questions for Discussion:

1. Are needed materials and learning opportunities currently available to consumers?
2. What are the important factors (health literacy, culturally appropriate transmission of information) in making information accessible to individuals receiving long term care? How can we ensure that we incorporate these factors into outreach, education materials, or any other form of communication?
3. Consumers expect information and guidance to be available about the public programs, health benefits and services that they may qualify for. Can we collaborate in new ways to meet this expectation?
4. Would cross training between entities be beneficial in assisting consumers to understand beneficiary materials?
5. How will we hold ourselves accountable?

Guidance:

Sharing current standards and practices to better understand the differences and similarities in how each entity communicates with members may assist with identifying strategies for greater consistency and a more efficient process to assure member’s access to information and services.

**D. Outcome and Quality Measures**

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"><li>• CCO will demonstrate an acceptable level of performance related to shared accountability for individuals receiving LTC services and supports.</li></ul>	<ul style="list-style-type: none"><li>• AAA/APD will demonstrate an acceptable level of performance related to shared accountability for individuals served by the CCO and receiving LTC services and supports.</li></ul>

Questions for Discussion:

1. What does each entity feel is an initial acceptable level of assistance that they can provide to each other to meet key performance expectations?
2. What can both entities agree on to do in the first year of operations?
3. How might performance expectations be raised over time? What are the key or compelling transformative changes that you would like to see for important populations or sub-populations in your community (e.g. increased tenure in HCBS for people with Mental Illness)?

4. How will each side document, share and report out on progress and achievements in performance expectations?
5. How will we hold ourselves accountable?

**Guidance:**

When developing the MOU, entities may choose to develop a method for reporting on activities to document their goals and performance toward goals. Entities may also wish to set a timeframe for re-visiting performance expectations.

**E. Governance Structure**

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<p>CCO will clearly articulate:</p> <ul style="list-style-type: none"> <li>• How CCO governance structure will reflect the needs of members receiving LTC services and supports through representation on the governing board or community advisory council.</li> </ul>	<ul style="list-style-type: none"> <li>• AAA/APD will participate at the community level in the board / Advisory panel for LTC perspective as needed.</li> <li>• AAA will articulate how the membership of the local governing boards, Advisory Councils, or governing structures will reflect the needs of clients served by the regional CCO(s).</li> <li>• DHS/APD will articulate how APD will include CCO participation in their policy development structures.</li> </ul>

**Questions for Discussion:**

1. What types of governance structures might benefit from each entity’s involvement? How?
2. What roles and responsibilities could both entities play in each other’s governance structures to support better consumer representation and consideration of LTC consumer needs?
3. How can AAA/APD expertise in LTC consumer needs be helpful and /or included in CCO structures?
4. How can CCO medical expertise be helpful and included in AAA/APD governance structures?
5. How do population and service data in your service area influence governance structure membership?
6. How will we hold ourselves accountable?

Guidance:

In developing MOU , APD/AAA management may consider being available/willing to participate in CCO boards or any CCO LTC advisory panels and similarly, CCO representatives may consider being available/willing to participate the AAA advisory council, at least when health issues are being discussed or as an on-going member.

**F. Learning Collaboratives**

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"> <li>Each CCO participates in the learning collaborative described in ORS 442.210</li> </ul>	<ul style="list-style-type: none"> <li>AAA/APD will participate in learning collaborative on relevant topics such as care coordination, LTC, best practices.</li> </ul>

Questions for Discussion:

1. How can we create and support a learning environment between our organizations?
2. What does a learning collaborative mean to each entity?
3. What resources and people are available to support the learning collaborative?
4. What learning collaborative topics are the top priorities for local action?
5. How will we hold ourselves accountable?

Guidance:

There will be a statewide learning collaborative established by OHA that APD and the AAAs are expected to participate in. Local offices may wish to have their own collaboratives or on-going joint efforts and action to focus on best practices. See the glossary, Appendix E., for a definition of learning collaborative.

**G. Role of Person Centered Primary Care Home (PCPCH)**

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"> <li>CCO will partner with the local AAA/APD office to develop a method for coordinating services with PCPCH providers for members receiving LTC services.</li> </ul>	<ul style="list-style-type: none"> <li>AAA/APD will develop methods and protocols for supporting and coordinating with PCPCH providers.</li> <li>AAA/APD will support coordination between LTC providers and PCPCH providers.</li> </ul>

Questions for Discussion:

1. Does the CCO have, or it is forming a PCPCH?
2. What types of coordination, above and beyond what you have considered in the other domains, will be necessary for coordination with a PCPCH?
3. How will we hold ourselves accountable?

Guidance:

In a changing care environment involving the growing use of PCPCH providers how will each entity support clients and each other with effective communication, coordination, and education of this model.

**H. Safeguards for Members**

<b>CCO Expectations:</b>	<b>APD/AAA Expectations:</b>
<ul style="list-style-type: none"><li>• CCO will coordinate safeguards, including access to peer wellness specialists, personal health navigators, and community health workers where appropriate and develop processes ensuring these services are coordinated with LTC services to maximize efficiencies.</li><li>• CCO will describe how planned or established mechanisms for managing member complaints and grievances will be linked to, coordinated with, and inform team-based care practices for members in LTC.</li></ul>	<ul style="list-style-type: none"><li>• AAA/APD will ensure that choice counseling materials and processes reflect member rights, responsibilities, and understanding of benefits.</li><li>• AAA/APD will ensure that staff understand and communicate safeguards, including use of peer wellness specialists, personal health navigators, and community health workers and ensure that these services are coordinated with LTC services to maximize efficiencies.</li><li>• AAA/APD will coordinate with CCOs to manage member complaints and grievances for CCO members.</li></ul>

Questions for Discussion:

1. What are the safeguards in each system?
2. How will the CCO and AAA/APD work together to ensure that members have access to safeguards?
3. How will each entity ensure and coordinate a no wrong door policy for member complaints and grievances?
4. How will non-traditional worker activities be aligned and coordinated with LTC services to support active member involvement in care?
5. How will we hold ourselves accountable?

Guidance:

The MOU should detail what is shared by each entity regarding the other. Agreements developed should take a “no wrong door” approach to addressing individual’s questions/issues and seek to find solutions at the lowest level appropriate.