Memorandum of Understanding
Long Term Care Coordination between PacificSource Community Solutions, Inc. and Department of Human Services Aging & People with Disabilities Program Districts 10 & 11

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-centered care, CCO's 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 PacificSource Community Solutions, Inc. & Aging and People with Disabilities Districts 10 & 11. The mutual goal of the proposed agreement is to improve person-centered care, align care and service delivery and provide the right amount of care, in the right place at the right time for beneficiaries across the LTC system; based on the roles and responsibilities of each entity, recognizing the purpose is to ensure coordination between two systems to provide quality care, produce the best health and functional outcomes for individuals to prevent escalation of costs for both systems.

DHS APD District 10 serves the following geographical area: Deschutes County (Bend, Redmond & La Pine), Jefferson County (Madras), and Crook County (Prineville); DHS APD District 11 serves members residing in zip codes 97731, 97733, 97737 and 97739. Each entity agrees to participate in an annual MOU and attend a monthly collaboration meeting for shared accountability of activity agreements. The following agreement is effective July 1, 2015 – June 30, 2016.

PSCS & DHS APD Districts 10 & 11~ Long Term Care MOU

Domain 1: Prioritization of High Needs Members			
Objective	**Activities**	**Shared Accountability**	**Deliverables & Outcomes**
Aligned definition of high needs members.	Identify high needs users considering these primary identification factors: • APD SPL Levels 1-13 • ER and Hospital Utilization • PSCS Risk Score • Complex Conditions • Claims Data • Mental Health • Behavioral Health • Chemical Dependency • Complicating Circumstances • Member self-referral	APD: LTSS Innovator Agents (LTSS IA), Case Managers (CM), Transition Coordinators (TC), and Supervisory Team PSCS: Member Support Specialists (MSS) & Care Team *LTSS IA will conduct a Quarterly report and share with MOU team for evaluation and process review*	Identification of high needs members by APD and PSCS using agreed upon primary identification factors. Aligned definition for care coordination will potentially reduce avoidable ED visits and hospital readmissions while increasing care coordination for identified high needs members.
Monthly information sharing.	APD will share LTC CCO report monthly with PSCS PSCS agrees to process LTC CCO report and create Complex Patient Report per County service area and share with APD	APD: LTSS IA PSCS: MSS and Care Team	APD and PSCS will utilize the complex patient reports to prioritize high needs members and inform agenda discussions for Integrated Care Management (ICM) meetings and related care coordination activities. APD and PSCS develop prioritized lists of members who have high health care needs
Identify Candidates for Individualized Care Plans (ICPs).	APD and PSCS will utilize reports to identify candidates for ICMs and other members who would benefit from care coordination, ICPs and case management	APD: LTSS IA, supervisory team and field staff PSCS: MSS and Care Team *LTSS IA & PSCS MSS team will track ICM process and report to the MOU team semi-annually regarding member impact/outcomes.*	Enhance coordination between PSCS and APD via ICM meetings and related activities. PSCS & APD identify candidates for ICMs and other members who would benefit from care coordination and case management from among prioritized list of high needs members.

Domain 2: Development of Individualized Care Plans			
Objective	**Activities**	**Shared Accountability**	**Deliverables & Outcomes**
Individualized Care Plans (ICPs) are informed by ICM meetings.	APD & PSCS share data (e.g., CAPS assessment) to inform each other, increase care coordination, and improve the efficient use of resources for each member. APD & PSCS use member data to identify service gaps, develop ICPs, and to improve integrated care management.	APD: CMs and TCs PSCS: MSS and Care Team *LTSS IA & PSCS MSS team will track ICM process and report to the MOU team semi-annually regarding ICP impact and outcomes of each participant.*	PSCS & APD share Individualized Care Plans (ICPs) for selected members via ICM meetings and related activities with a goal of improving health outcomes, member health literacy and ensure that plans reflect member or family/caregiver preferences and goals to ensure engagement and member satisfaction with care. Increased flow of information and alignment of care for identified members. Coordinated APD and PSCS follow-up on ICPs developed via ICM meetings and related activities.

Domain 3: Transitional Care Practices			
Objective	**Activities**	**Shared Accountability**	**Deliverables & Outcomes**
Increased coordination and communication to ensure timely and comprehensive patient centered transition.	APD and PSCS identify opportunities to improve transitions via collaboration, including education on LTC service choice and placement options, with; providers, hospital discharge planners, nursing facility case managers, and PSCS Member Support and APD Transition teams at monthly collaboration meeting. APD and PSCS commit to open communications regarding transitions in care for identified members. PSCS and APD will continue to explore strategies to enhance information sharing between hospitals, APD, PSCS, LTC facilities and others involved in care transitions.	APD: LTSS IA, CMs, TCs and Supervisory Team PSCS: MSS and Care Team *MOU team will monitor transitions to assist and establish relevant communication pathways and discuss identified opportunities at the monthly collaboration meeting.*	APD & PSCS mutual understanding and documentation of processes of transitional care to increase coordination. To work collaboratively to enhance existing systems and ensure that members receive comprehensive transitional care, including follow-up when entering and leaving an acute care facility or a long term care setting. Increased coordination to expedite appropriate transitions in care. Mutual goal of increasing communication timeliness for pre-screening admissions for effective transitions to reduce potential cost shifting and assure continuity of care for high risk members.

Domain 4: Member Engagement & Preference			
Objective	**Activities**	**Shared Accountability**	**Deliverables & Outcomes**
Member preferences are accurately reflected in Individualized Care Plans (ICPs).	PSCS shares results of ICM interview and follow-up. APD shares results of actively engaging members via choice counseling in the design and implementation of their LTC service plan.	APD: CMs PSCS: MSS and Care Team *Member feedback is compiled at semi-annual ICM review*	ICPs include increased member input informed by member preferences. Improvement of members' experience of care across CCO and LTC systems. Members receive assistance navigating the health care delivery system in accessing community and social support services designed to provide choice, independence and dignity.

Domain 5: Establishing Member Care Teams			
Objective	**Activities**	**Shared Accountability**	**Deliverables & Outcomes**
Establish Integrated Care Management (ICM) teams to work jointly on Individualized Care Plans (ICPs) for identified members during ICM meetings and related activities.	APD and PSCS coordinate involvement of appropriate providers and partners. APD and PSCS explore existence of additional community resources to enhance members care.	APD: LTSS IA, CMs and Supervisory Team PSCS: MSS and Care Team	Establishing member care teams for identified prioritized members that will support the flow of information and assist in developing innovative approaches to members' complex and unique needs.
Maintain schedule for regular CCO APD LTC ICM meetings for identified members.	APD & PSCS conduct monthly ICM meetings and related care coordination activities.	APD: LTSS IA, CMs and Supervisory Team PSCS: MSS/Care Team	APD & PSCS conduct monthly ICM meetings and related activities including appropriate providers and partners, resulting in regular discussion of LTC members identified as candidates for ICPs and the development of ICPs.
Maintain ICM process document.	APD and PSCS identify member candidates for ICPs to be developed via ICM meetings and related activities to form meeting agenda. APD and PSCS develop ICPs including action plans and follow-up activities. APD and PSCS maintain ICM process document which defines performance metrics, information sharing and meeting timelines.	APD: LTSS IA, CMs and Supervisory Team PSCS: MSS and Care Team *LTSS IA & PSCS MSS team will track ICM process and report to the MOU team semi-annually regarding ICP impact and outcomes of each participant.*	ICMs are purposed to prioritize high needs members in creating comprehensive member-centered ICPs resulting in engaged providers and members. ICMs primary goal is a reduction in readmission rates, increase provider cross discipline engagement, increase member engagement and compliance as well as health literacy.

Optional Domain A: Use of Best Practices		
Objective	**Activities**	**Deliverables & Outcomes**
Ensure consideration of best practices in the development of ICPs and the conduct of ICM activities.	PSCS and APD identify and consider best practices via literature searches, discussion with other APD and CCO organizations, and participation in related education and industry conferences.	APD and PSCS concerted efforts to identify, share, and consider best practice approaches involving care coordination, transitions and evidence based health aging programs related to serving individuals in LTC setting.

Optional Domain B: Use of Health Information		
Objective	**Activities**	**Deliverables & Outcomes**
Develop mechanisms to improve sharing of information electronically.	APD and PSCS explore development of electronic templates, EHR documentation, and information sharing to support the development of ICPs, electronic documentation and communication of relevant information.	APD and PSCS develop electronic templates, EHR records, and information sharing protocols APD will support PSCS in developing electronic information sharing by developing mechanisms to improve the sharing of relevant DHS information with PSCS.
Explore possibility of health information exchange.	APD and PSCS explore strategies to connect the processes with Health Information Exchange platforms in planning and/or under development.	APD and PSCS identify potential content and requirements involved in connecting to and accessing Health Information Exchange platforms

Optional Domain F: Learning Collaborative		
Objective	**Activities**	**Deliverables & Outcomes**
Provide education and resources to support process improvement and enhance collaborations	APD & PSCS will participate in learning collaboratives on relevant topics concerning LTC such as care coordination, best practices, APD programs, community resources, processes, PSCS policies, etc.	APD and PSCS familiarized with each other's systems, business models, policies, and practices Enhanced care coordination and integrated care management through participation in identified learning collaborative

Optional Domain H: Member Safeguards		
Objective	**Activities**	**Deliverables & Outcomes**
Ensure ICPs are informed by member input and preferences, ICM process is responsive to provisions for member protection and rights.	Review and strengthen the influence of ICP development, where appropriate, of member preferences, issues identified via grievance, appeals and findings via other sources of member oriented activities	Increased member oriented development of ICPs via the ICM process

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