Memorandum of Understanding

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, 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 Western Oregon Advanced Health (CCO) and the Aging and People with Disabilities District 7 (AAA or DHS-APD district office). 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 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, Western Oregon Advanced Health (WOAH) and the Aging and People with Disabilities District 7 (APD District 7) agree to participate in the following activities:

1. Prioritization of high needs members in LTC		
CCO Expectation	AAA/APD Expectation	CCO/AAA/APD agreements:
• 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. ○ CCO will factor in relevant referral, risk assessment and screening information from local AAA/APD offices and LTC providers. ○ CCOs will define how it will communicate and coordinate with AAA/APD when assessing members receiving Medicaid-funded LTC services.	• AAA/APD will provide CCOs with access to information needed to identify members with high health care needs. • 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.	CCO and APD District 7 will share key information pertinent to each entity's risk assessment: • APD District 7 staff will also share, on a case by case basis, information about individuals that are known to have other complex conditions including information about: ○ Hospitalizations ○ Changes in condition ○ Destabilizing long term care plans ○ Eligibility clients who are in crisis ○ Eligibility clients who have been brought to APD DISTRICT 7's attention by law enforcement ○ Clients with substance abuse or mental health issues if those issues involve a hospital or nursing facility. • WOAH will share, on a case by case basis, the following: ○ Additional care or support services provided to identified high need LTC members. High need members may include clients with multiple chronic illnesses resulting in multiple ER visits or hospital observation/admission ○ Information about identified high needs members who

1. Prioritization of high needs members in LTC		
		may transition from hospital to LTC o Individualized care plans for identified high needs members. WOAH and APD District 7will use information available, including data provided by OHA/DHS central office, to identify a list of individuals each has in common. • APD District 7 will share key information about individuals receiving long term care services on a spreadsheet titled "CCO Report" that will be delivered via secure email to the WOAH designated contact, as listed below, by the tenth calendar day of each month. • As WOAH expands its data capabilities, WOAH and APD District 7 will work towards the inclusion of APD data on individuals receiving long term care services into WOAH electronic health record. Designated contact staff: • WOAH Case Management team: o Yvette Grabow, ygrabow@docshp.com, 541-269-4559 o Lovena Flaherty, RN, BSN, lovena.flaherty@docshp.com, 541-269-3200 • APD District 7, Curry County: o APD Diversion/Transition team: ▪ Gayle Christiana, gayle.m.christiana@state.or.us, 541-756-2017 ▪ Karen Wright, karen.m.wright@state.or.us, 541-756-2017 ▪ Carl Fair, carl.n.fair@state.or.us, 541-756-2017 ▪ Brad Olds, brad.q.olds@state.or.us, 541-469-9299, ext. 233 (Curry County) o APD Diversion/Transition support staff ▪ Dena McDonald, dena.l.mcdonald@state.or.us, 541-756-2017

1. Prioritization of high needs members in LTC
Shared Accountability
WOAH and APD District 7 will hold each other accountable in the following ways: • Information will be shared at bi-monthly care team meetings. Individual cases are brought forward at the meetings both reactively and proactively to respond to or prevent health or placement issues. • APD will attend weekly complex case staffing meetings at Bay Area Hospital • WOAH case management will attend daily check-ins with hospitalists at Bay Area Hospital and report information on shared individuals to APD • WOAH, APD and Coos County Mental Health will meet to staff cases monthly and report information on shared individuals to WOAH. • Information may be shared outside of scheduled meetings on an as needed basis through telephone or secure email between designated contact staff.

2. Development of individualized care plans		
CCO Expectation	AAA/APD Expectation	MOU activities
• CCOs' individualized person-centered care plans will include information about the supportive and therapeutic needs of each member, including LTC services and supports needs. o Plans will reflect member or family/caregiver preferences and goals captured in AAA/APD service plans as appropriate. o Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from AAA/APD and with LTC providers.	• 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.	WOAH agrees to share individual care plans for members also served by the District 7 office. The above information will be shared as needed or as new care plans are developed. WOAH will share APD contact information with each individual's care coordinator and/or primary care home for purposes of care coordination. APD District 7 will share key information with WOAH for individuals that WOAH has developed an individual care plan, including information documented in the long term care client assessment and planning system (CAPS). APD District 7 will share this information with WOAH as needed or as new care plans are developed. Key client information will include: • Member choice of living situation and preferences and most cost effective option to meet member care needs • APD case manager contact information • LTC provider contact information The result of sharing information is a coordinated, individualized care plan which identifies member/consumer needs and assigns tasks to ensure the needs are met. Care plan resulting from this process will be agreed upon by the member or their representative.

2. Development of individualized care plans
Shared Accountability
WOAH and APD District 7 will hold each other accountable in the following ways: • Parties will connect at least weekly by telephone and at multidisciplinary care teams to update each other on progress and outcomes of the care plan.

3. Transitional care practices		
CCO Expectation	AAA/APD Expectation	MOU activities
• CCO will demonstrate how it will coordinate and communicate with AAA/APD to incent 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.	• AAA/APD will demonstrate how it will coordinate and communicate with CCO to incent 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.	APD District 7 agrees to collaborate with WOAH to ensure that wrap-around services are utilized based on availability. • APD Diversion/Transition staff will coordinate with WOAH regarding post-placement needs supporting the member's health needs, care preferences, goals and most cost effective option to meet member care needs. • Diversion/Transition team will coordinate with post-placement (in-home care or LTC facility) and other supports including family, guardian and non-CCO partners regarding member health needs, care preferences and goals and most cost effective option to meet member care needs. WOAH agrees to collaborate with APD to ensure: • Member care needs are met with the most cost-effective and appropriate options • WOAH case management will be available, when deemed necessary, for continued communication with member, PCP and APD to ensure continuity of care. WOAH and APD District 7 agree to coordinate all transitions into or out of the CCO service area for members receiving long term care services to ensure continuity of services between the old and new LTC and medical providers and CCOs.

Shared Accountability
WOAH and APD District 7 will hold each other accountable in the following ways: • APD will attend weekly complex case staffing meetings at Bay Area Hospital • WOAH case management will attend daily check-ins with hospitalists at Bay Area Hospital and report information on shared individuals to APD • Both parties will work with hospital discharge team on hospital initiatives to reduce readmissions. • Both parties will share information about upcoming and in-progress transitions of WOAH members receiving or needing long term supports and services at bi-monthly care team meetings.

4. Member engagement and preferences		
CCO Expectation	AAA/APD Expectation	MOU activities
• 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.	• 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.	APD service delivery model is based on member care preference and individual choice. APD District 7 LTC case managers and diversion/transition specialists will: • Actively engage member and their supports in LTC service planning • APD case managers will choice counsel potential LTC member regarding LTC service criteria and options • APD District 7 will collaborate with member, their supports and WOAH for LTC planning purposes. WOAH case management will collaborate with: • Member, PCP/PCPCH, APD and LTC provider when appropriate and as needed • WOAH case management will understand goals and preferences of member through h communication with APD or with member as needed.
Shared Accountability		
WOAH and APD District 7 will hold each other accountable in the following ways: • Members are informed of care team meetings and both parties seek out member needs and preferences prior to the team meetings. • Member care team may go together to visit member at their home as needed. • Member care team will attend case staffings at facilities with member and the facility care team as needed.		

5. Establishing member care teams		
CCO Expectation	AAA/APD Expectation	MOU activities

• CCO will support the flow of information to AAA/APD.
• 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.
• To support care teams, CCO will
  o Work with AAA/APD to ensure that it identifies members receiving LTC services.
  o Include LTC providers and AAA/APD case managers as part of the team based care approach.
• Adapt team-based care approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services.
	• 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.
	• AAA/APD will ensure that CCO 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.
	• AAA/APD will have knowledge of and actively participate in CCO team based care processes when appropriate.
	• DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams.
		APD Diversion/Transition team is the key contact for WOAH engagement. Contact information can be found in Domain 1 above.
		• Diversion/Transition team responds to all WOAH requests for information by triaging requests and directing them to the appropriate LTC case manager as needed.
		• Diversion/transition coordinators will assist WOAH and LTC case managers with complex cases
		• LTC case managers will coordinate with WOAH regarding identified LTC member service planning
		• APD diversion/transition team or case managers will participate in interdisciplinary care team meetings or other person-centered care coordination meetings as needed.
		
		WOAH case management team members agree to
		• Collaborate with APD District 7 diversion/transition team, LTC providers and PCPCH/PCP as needed
		• Attend ICT meetings with APD, hospital and mental health agency to discuss, plan or update member care plans
		• Collaborate with all necessary parties to ensure patient-centered continuity of care is provided to the member.

Shared Accountability		
WOAH and APD District 7 will hold each other accountable in the following ways: • WOAH and APD Interdisciplinary care team meetings will be held bi-monthly. Individual cases are brought forward at the meetings both reactively and proactively to respond to or prevent health or placement issues. • APD will attend weekly complex case staffing meetings at Bay Area Hospital • WOAH case management will attend daily check-ins with hospitalists at Bay Area Hospital and report information on shared individuals to APD • WOAH, APD and Coos County Mental Health will meet to staff cases monthly and report information on shared individuals to WOAH.		

Optional Domain for MOU CCO/LTC

E. Governance Structure		
CCO Expectation	AAA/APD Expectation	MOU activities
• 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.	• AAA/APD will participate at the community level in the board / Advisory panel for LTC perspective as needed. • 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). • DHS/APD will articulate how APD will include CCO participation in their policy development structures.	APD District 7 LTC manager will represent LTC programs on the WOAH Community Advisory Councils in Coos and Curry Counties • APD District 7 LTC will encourage interested LTSS consumers to serve on the Community Advisory Councils
Shared Accountability		
WOAH and APD District 7 will hold each other accountable in the following ways: • WOAH will notify APD District 7 of Community Advisory Council meeting schedules and provide agendas and meeting documents as necessary. • APD District 7 manager or a representative will attend monthly meetings of the WOAH Coos County Community Advisory Council and the WOAH Curry County Community Advisory Council.		

Signatures and Contacts

For Western Oregon Advanced Health CCO

The designated contact person is:

Phil	Greenhill
First name	Last name
pgreenhill@docshp.com	541-219-7400, ext. 115
Email	Phone
Authorizing Signature	4/30/2015 Date

For APD District 7

The designated contact person is:

Michael	Marchant
First name	Last name
michael.m.marchant@state.or.us	541-756-2017
Email	Phone
Authorizing Signature	5/1/15 Date

For DHS, Aging and People with Disabilities Division, Central Office

The designated contact person is:

DONALD A.	ERICKSON
First name	Last name
donald.a.erickson@state.or.us	503-884-8774
Email	Phone
[signature]	6/11/15
Authorizing Signature	Date