

**Yamhill County Care Organization/Medicaid Long-Term Care
Long Term Care Coordination Agreement
Clackamas 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 Yamhill County Care Organization and Aging and People with Disabilities offices (APD) for Clackamas 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, Yamhill County Care Organization and Aging and People with Disabilities for Clackamas Counties agree to participate in the following activities:

1. Prioritization of high needs members in LTC

YCCO and APD will establish a standard definition of high needs members and criteria for assessing individuals by December 1, 2012. YCCO 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 31, 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.

YCCO 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.

YCCO and APD will 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 YCCO, 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 that 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 YCCO includes:

- Case manager contact information
- Service Priority Level
- LTC provider contact information
- Member's LTC goals/preferences
- Service Plan, including Contract RN involvement
- Risks
- Natural Supports

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- Last assessment date
- Monitoring frequency

YCCO 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 YCCO 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 YCCO.
- Information will be shared electronically if available, by fax or secure email to the designated contact person or back-up.
- As YCCO and State data systems are improved to provide more consumer information, new data sources will be incorporated into information sharing.
- YCCO 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 YCCO and APD programs at least quarterly.

YCCO and APD programs will do the following:

- By March 15, 2013, develop a mutually agreed upon list of high risk members;
- By July 15, 2013, YCCO and APD will meet to review and assess whether they have successfully identified and prioritized high risk members; determine the strengths of the work to date; identify any challenges or barriers to achieving the Triple Aim and any unexpected opportunities. YCCO and APD 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

By April 1, 2013, YCCO 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 YCCO 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 April 1, 2013, APD will share key client information with YCCO for individuals for whom YCCO 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 YCCO 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

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- Member's LTC goals/preferences
- Service Plan, including Contract RN involvement
- Risks
- Natural Supports
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Additionally, the member care plans will 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 March 31, 2013, YCCO and APD will begin developing a process for supporting individuals who transition across care settings. At a minimum, the following principles will be addressed:

- YCCO 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.
- YCCO 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.
- YCCO 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.
- YCCO 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 April 2013, YCCO and APD will identify the roles, responsibilities and scope for YCCO 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 YCCO 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

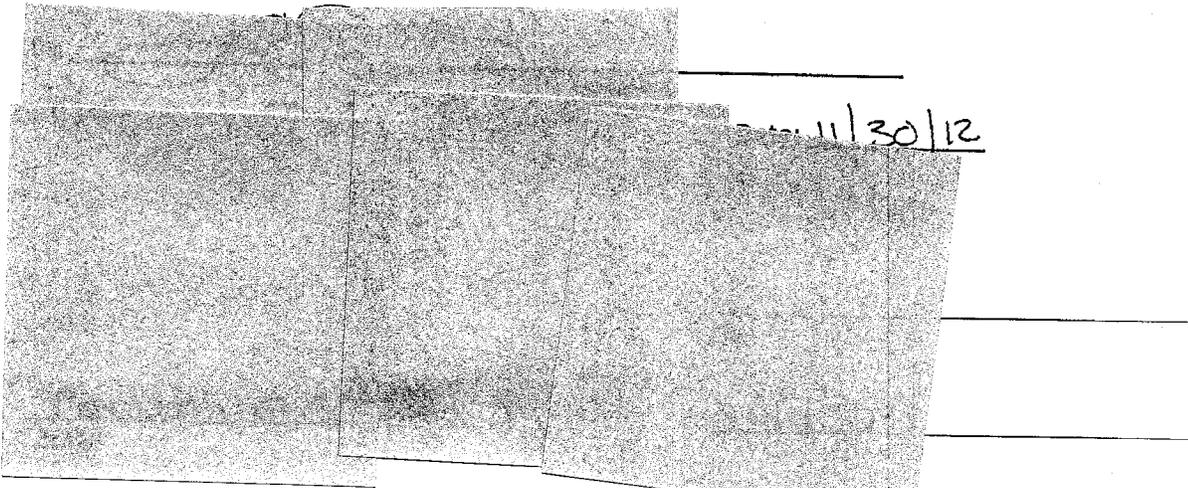
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By April 2013, YCCO will ensure that the care team leader will confer with all providers responsible for a members care, including LTC providers and APD LTC case managers and LTC Transition/Diversion Specialists.

By March 15, 2013, YCCO 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.

Signatures and Contacts

Yamhill County Care Organization



Department of Human Services, Aging and People with Disabilities, Central Office

By: Patricia E. Baxter Patricia E. Baxter; Signed as to form

Title: Chief Operating Officer, APD Date: 12/12/12

The designated contact person for APD, Clackamas County:

First name _____ Last name _____

Email _____ Phone _____

Reviewed: _____
By: Genevieve M. Sundet Date: November 30, 2013
Aging and People with Disabilities Program Manager