## CCO-LTSS Partnerships MOU Template:

**MOU Period: Jan. 1, 2022____thru Dec. 31, 2022_____**

*Submit your CCO's CCO-LTSS MOU by January 15th to CCO.MCODeliverableReports@state.or.us.*

**CCO Name _____Advanced Health_____ OHA Contract #__161754-6_____**

**Partner AAA/APD District (s) Names/Locations _____APD District 7_____**

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**If more than one AAA/APD office in your CCO Geographic Region Please Circle or X Whichever Applies:** Single Combined MOU_x__ Multiple MOUs___

### CCO – LTSS MOU Governance Structure & Accountability:

| CCO Lead(s): | APD/AAA Lead(s): |
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| **CCO will clearly articulate:**<br>How CCO governance structure will reflect the needs of members receiving Medicaid funded Long-Term Services and Supports (LTSS), for example through representation on the governing board, community advisory council or clinical advisory panel.<br>How Affiliated MA or DSNP plan participates in the MOU work for FBDE. | **AAA/APD will clearly articulate:**<br>How AAA/APD governance Lead(s) for participation at the community level in the board / Advisory panel for LTSS perspective/Care Coordination<br><br>AAA/APD will articulate how the membership of the local governing boards, Advisory Councils, or governing structures will reflect the needs of members served by the regional CCO(s). |

**CCO-LTSS APD/AAA MOU(s): See MOU Worksheets for additional detail on MOU expectations in each domain**

| MOU Service Area: | | | | |
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| **Shared Accountability Goals with APD/AAA or ODDS: Domain Addressed** | **CCO Agreed to Processes & Activities** | **LTSS Agency Agreed to Processes & Activities** | **Process Monitoring & Measurement: Specific Identified Local Identified Measures of Success** | **Annual Report on Specific Statewide Measures of Success (provide data points*) — monthly & annual [REQUIRED data points at minimum}** |
| **DOMAIN 1: Prioritization of high needs members** | | | | |
| DOMAIN 1 Goals: Prioritization of high needs members | Advanced Health's customer service department screens all new members with an initial Health Risk Screening for identification of LTSS members in need of Intensive Care Coordination (ICC) services when they come on the plan, and annually thereafter. Follow up when their condition changes (ER admission or hospitalization), may be outreach from Customer Service, APD case workers, and/or member's primary care team Case Manager.<br><br>After customer service receives an health risk screening indicating a high needs member seeking | APD utilizes risk assessment data, service priority levels (updated at least annually), and case manager concerns (ex: ED utilization, hospitalization, at-risk of losing housing) to identify high-risk members who may benefit from ICC. APD case managers share their LTSS member concerns at the hospital complex case meeting, monthly CCO/APD meeting, call the AH Customer service and/or email the Intensive Care coordination referral email inbox with a completed ICC referral screen. | Advanced Health leveraged existing professional relationships with APD case managers and administrators to quickly form an administrator level monthly collaborative meeting. This monthly meeting gave us the ability to build stronger relationships, discuss MOU requirements, design new processes, share staff contact information, problem solve inter-agency issues and advocate for collaboration with our mental health and AAA partners. | Submitted annual report on specific statewide measures of success |

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| | service and/or self-identifies from a prioritized population (such as having a disability, chronic condition and/or receiving LTSS services), an intensive care coordination referral screen is completed by a customer service representative and emailed to ICCreferrals@advancedhealth.com. ICC team responds to the email request within 1 business day.<br><br>Advanced Health uses the Activate Care software care coordination tool to organize and track the required ICC administrative tasks such as assessing any member from a prioritized population for ICC services within 10 calendar days by an ICC Nurse and/or Traditional Health Worker.<br><br>Activate Care also includes a triggering event assessment for care coordinators to complete after receiving either a notification from Collective Medical of hospitalization (via ADT feed into Activate Care) and/or any other | Furthermore, APD also emails the most recent LTSS list for Advanced Health/APD consumers once a month to the ICC Director.<br><br>Internal discussion is currently underway at the CCO to determine the best approach to systematically review the 800+ identified CCO/APD consumers for potential referral to intensive care coordination.<br><br>As of 2022, APD now has access to Activate Care and is working towards uploading summary of SPL assessment to the ICC members' care plans. | A second monthly meeting began in Jan 2021 and overseen by the ICC Director to identify prioritization of members and discuss shared LTSS members between CCO care coordinators and LTSS case managers. An excel spreadsheet was created to track our shared LTSS membership which includes case note discussion, service level planning, risk assessment and care plans. This data helps us to prioritize high needs members for follow up care. The tracking sheet contains the assigned CCO coordinator, LTSS case manager and status of the member. Every month the team discusses each member with the presence of mental health and AAA agencies. Of note, Pacific Source dual eligible members can also be discussed at this meeting, if needed, since they are being monitored by an ICC Nurse. | |

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| | known reported triggering event. Care coordinators have been instructed to contact the member no more than 3 calendar days after receiving notification of a reassessment trigger.<br><br>Members are instructed to contact Advanced Health customer service to be reassessed for ICC services upon the member's request and follow the standard process described above by completing another ICC referral screen for review by the ICC Director and/or ICC program manager. If members are in intensive care coordination for more than a year, Activate Care reminds the care coordinators to complete an annual PRAPARE social needs assessment at a minimum.<br><br>Hospitalized members are eligible for the Transition of Care ICC program, and APD planning. LTSS members are discussed weekly at Bay Area Hospital's complex care coordination meeting between | | It should be noted here that as of 2022, APD case managers now have electronic access to Activate Care, are able to review ICC care plans, add goals and assign tasks, upload risk assessments, service plan level (SPL) assessments and review CCO outreach notes of ICC members. APD case managers are also able to communicate through Activate Care via messages to other persons with approved access to member's record including other care team members and the member themselves. This is a major milestone in our development and given our team the ability to cross collaborate electronically, allowing quicker collaboration when priority needs arise.<br><br>The CCO tracks all referrals to ICC via an excel tracking sheet. In addition to this, the CCO is also automatically tracking any referral activity with our | |

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| | hospital nursing case managers, ICC nurse and/or TOC nurse and APD case managers to discuss current LTSS member needs, problem solve solutions and discharge planning needs for our prioritized members.<br><br>Members who have higher emergency room visits and/or consistent hospital readmissions are prioritized for outreach and tagged into an "ICC" Collective Medical group for monitoring. | | electronic care planning tool, Activate Care. The ICC Director reviews a monthly Activate Care data extract of any referral activity between the CCO and APD and adds the necessary information to this tool. | |
| **DOMAIN 2: Interdisciplinary care teams** | | | | |
| DOMAIN 2 Goals: Interdisciplinary care teams | IDT meetings occur five times a month; once a week at the hospital (complex care) and monthly between CCO and APD staff. Each meeting includes LTSS supervisors and case managers; CCO nurses, traditional health workers and a licensed mental health practitioner.<br><br>In addition to this, APD and CCO administrators meet once a month for process development, | The APD CM lead worker acts as the point of contact for the CCO care coordinator. APD case managers routinely contact CCO nurses and traditional health workers to problem solve cases outside of standard meetings. LTC supervisors are also present at the IDT meeting for support, guidance and direction to staff. | Advanced Health maintains and tracks the CCO/APD monthly meeting schedule with the use of Microsoft Outlook. The CCO also utilizes Microsoft Teams to host the monthly virtual meeting, provide chat functioning and recording of staff attendance. CCO established this standard monthly meeting in Jan 2021. CCO and APD agreed that these meetings are held once a | |

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| | continued relationship building, and problem solve interagency issues.<br><br>Integrated care plans are developed using a person-centered process and created in Activate Care, with input from the member either through the standard enrollment and intake intensive care coordination process as described in our policy and procedures, and/or from additional prioritized information acquired at an IDT discussion. LTSS members are notified of their ICC enrollment within 5 days of their initial assessment by a phone call from their assigned coordinator. An enrollment letter is also mailed to the member with the care team contact information and summarized purpose of the ICC program.<br><br>ICC Members or their authorized representatives can obtain access to Activate Care to view and participate in additional development of their care plan. | APD routinely updates the CCO on their case manager staff roster and assignment to LTSS members for improved communication and in preparation for our monthly IDT meeting and for sharing of Activate Care records.<br><br>Members are given the opportunity to participate in ad-hoc meetings between APD and CCO staff, as appropriate, outside of the regularly scheduled weekly meetings, due to lack of time and other LTSS members being discussed.<br><br>According to APD, it should be noted that LTSS members with a SPL 1 to 3 are the highest need members with significant cognition and/or mobility issues are most likely not even able to meet for care coordination meetings. | month on the last Wednesday for 1 hour to staff cases. The ICC Director tracks the outcomes of the monthly IDT meetings and emails an encrypted excel list of each LTSS member, their assigned CCO/LTSS staff and current health status of the member to the APD administrator team for APD staff distribution and review. APD and CCO administrators periodically email each other an updated list of their respective staff rosters. Any LTSS staff changes are then updated and reflected in the monthly calendar invite and access to Activate Care.<br><br>Our local hospital maintains the weekly IDT meeting schedule and patient list. Each hospital IDT meeting includes participation from hospital nursing case managers, discharge planners, hospital physician, LTSS case managers and CCO nurses. Each week the hospital emails an encrypted | |

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| | ICC staff are responsible for coordinating assistance with resources and supports to address SDOH.<br><br>As of 2022, APD case managers presently have access to Activate Care and able to monitor progress and upload assessments.<br><br>During the IDT meeting, some of the guiding standard questions applied to all cases include:<br><br>What is the primary healthcare goal(s) and progress in care coordination?<br>-What APD services is the individual receiving?<br>-Any noticeable and significant changes in physical and/or behavioral health symptoms?<br>-Is the individual managing their activities of daily living?<br>-Any potential safety concerns in the home?<br>-Any acute/high-risk medical conditions or concerning medications? | | email of their caseload to the CCO and APD staff.<br><br>The weekly hospital IDT meeting includes addressing the needs of the members to ensure a successful transition from one patient setting and/or level of care to another. Discharge planning, follow-up scheduling, medications, DME, NEMT transport, home environment, and barriers to care or treatment plan, are a few aspects of the transitional care discussion during and after the weekly hospital IDT meeting. One of the primary goals of these transitional meetings is to reduce avoidable hospitalizations and to reduce length of stay. | |

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| | -Is there lack of access to care and/or durable medical equipment?<br>-Is there a risk for readmission to the emergency department?<br>-Is there a risk for harming themselves or others?<br>-Is the individual struggling with their treatment plan?<br>- Is there any health equity, language and/or cultural considerations?<br>- Is there a POLST/Advanced Directive/ End of Life Care Planning needed?<br>-Could HRS flex fund spending used to assist member with SDOH and/or non-covered DME needs? | | | |
| **DOMAIN 3: Development and sharing of individualized care plans** | | | | |
| DOMAIN 3 Goals: Development and sharing of individualized care plans | Advanced Health uses a stepwise process, according to ICC administrative rules, in the development of an individualized care plan. An initial referral screen is completed either by the LTSS member themselves and/or their representative which indicates current medical, behavioral and/or social needs and their motivation for participation in their own care. Once the member is matched with | As of the beginning of 2022, LTSS staff have access to the LTSS members care plans in Activate Care and are currently working towards uploading their assessment information to the Activate Care shared care plan.<br><br>APD shares assessment, care plan, other known and relevant information, either by | Activate Care is used to document and track LTSS members. This software system allowed for the creation of automated workflows with imbedded enrollment and intake tasks for our intensive care coordination program.<br><br>One of these automated tasks is a reminder for care coordinators to update their | |

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| | the best care coordinator based on the member's needs (nurse or THW), the coordinator completes the social needs assessment, PRAPARE, to further understand the member's current needs and inform the development of an individualized care plan. The care plan is reviewed and discussed with the care coordination specialist and/or THW team lead. The car coordinator then discusses the care plan with the member. The process of care coordination and care planning is neatly organized through our care coordination cloud-based software platform, Activate Care.<br><br>In 2021, Advanced Health fully operationalized the Activate Care (cloud-based) care coordination platform to document ICC LTSS members care plans. During this year, Advanced Health worked closely with Activate Care technical support to develop an individual portal into the Activate Care system for APD LTSS case managers' access. | telephone, secure email and/or potentially Activate Care. Care plan development can occur in the IDT meeting and/or by consultation with CCO care coordinators.<br><br>As of 2022, APD continues to increase their referral rate for LTSS members for care coordination as indicated by our recent MOU activities report submission. | member care plans at least every 90 days. Activate Care also monitors and records the timeliness of these care plan updates.<br><br>In addition to the use of Activate Care, at the end of every month, the ICC director also reviews the status of each LTSS member and expects an update on the current healthcare plan goals with each care coordinator.<br><br>According to our 2021 ICC care coordination activity report for 2Q, 89% of our members were screened in the required time frames and 100% of members were assigned to a care coordinator within 3 business days.<br><br>Activate Care also allows for granular measurement of member progress on goals. 30% of our members "Achieved" all identified care plan goals, 46% partially met identified goals | |

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| | While software technical issues were being addressed in 2021, CCO care coordinators updated APD LTSS case managers on the LTSS members care plans either through individual phone calls and/or the monthly IDT meetings.<br><br>ICC staff also update the LTSS member's Care Guidelines in Collective Medical as needed to communicate with APD case management and other who may encounter member at a hospital or ED.<br><br>When the LTSS member needs assistance in navigating the social system and/or requires access to social support services, usually an intensive care THW is assigned to the member's care. These individuals are best at finding and building supports links in the community. Flex funds and/or vouchers are utilized in support of reducing discovered SDOH barriers.<br><br>For members with **Special Health Care Needs (SHCN)**, determined through a comprehensive | | and 5% had at least half of identified goals fully met. | |

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| | assessment and noted to have ongoing special conditions requiring a course of treatment or regular care monitoring, Advanced Health allows direct access to a specialist, at no cost to the member. The specialist should be appropriate for the member's condition and identified needs. The PCP can simply refer the member to the specialist without an authorization. The referring provider should also notify Advanced Health of the referral by submitting the **Physician Authorization Form**, found on our website, marking the **SHCN Box** at the top of the form and providing the name and contact information of the specialist. This will allow the creation of an authorization number to be provided to the specialist for billing purposes. This authorization will include pre-approved visits (i.e.6 visits in 6 months) allowing the member to establish with specialist and receive care. | | | |

| DOMAIN 4: Transitional care practices | | | | |
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| DOMAIN 4: Transitional care practices Goals | Advanced Health assigned a transition of care RN and an ICC program manager (MSN, QMHP) as the CCO points of contact to oversee transitioning LTSS members. Advanced Health's TOC nurse and ICC program manager coordinate with APD on almost a daily basis now because of the rapport build through continued weekly hospital complex case meetings and a monthly CCO/APD LTSS member case review. ICC traditional health workers are also assigned cases from the TOC nurse, when, SDOH needs to also be addressed.<br><br>Since transitional care needs could arise at any time, we have discovered that the weekly and monthly meeting schedule sometimes is not sufficient. Presently, CCO and APD staff coordinate on a regular basis through ad hoc meetings to problem solve transitional problems. | APD case managers and CCO care coordinators attend weekly BAH meetings for discharge planning – DNS works with CM/traditional health worker. APD does not provide emergent services instead addresses on following business day due to capacity for emergency services.<br><br>APD advises CCO care coordinators of LTSS consumers that could benefit from coordinated care and staff these individuals at our standard meetings.<br><br>APD's diversion and transition (D/T) team is a specialized unit for this type of care.<br><br>Two populations that fall in this domain are existing LTSS consumers that are hospitalized and/or new LTSS consumers.<br><br>For current LTSS consumers in the hospital, the assigned APD case manager and D/T unit work with the consumer and | Transition of care activities are being monitored by TOC nurse self-report in a Microsoft Teams channel tracking sheet using the supplied LTSS template, as well as workflow templates for TOC tasks tracked in Activate Care.<br><br>Activate Care also records and tracks outreach notes by use of checkboxes which are categorized by activity, mode, outcome, participant, and setting.<br><br>A report, or extract, can be produced by the Activate Care system to show how many outreaches were made involving such activities as CCO-to-CCO transition, SNF and HEN notifications, APD participants and skilled nursing facility settings. | |

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| | Core activities to support the types of care transitions: hospital to home, hospital to rehab, rehab to home; new long term care placement is discussed via a variety of ways as listed above. In some instances, ICC nursing staff and LTSS case managers have met face to face to support some of our most vulnerable members. One example of in-person coordination is transitional planning at our Coal Bank Village pallet shelter.<br><br>Our transitions of care nurse is responsible for helping with medical/dental care transitions, SNF authorizations, ensuring DME and transportation coverage, identify flex fund opportunities, medication support, follow up appointments and labs/other orders. | hospital to get them stabilized in the community. Biggest obstacle is community placement capacity. | | |
| **DOMAIN 5: Collaborative Communication tools and processes** | | | | |
| DOMAIN 5: Collaborative Communication tools and processes Goals | Advanced Health and the APD District 7 office periodically exchange updated staff and contact information by email to properly maintain the monthly | | Currently a new process is being discussed internally between customer service and ICC for working towards a more targeted general care | |

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| | virtual meeting IDT schedule and Activate Care access.<br><br>Advanced Health customer service and ICC Directors met with Collective Medical technical support monthly in 2021 to address the additional requirements from this MOU. Work was completed during this year in the creation of an ICC, TOC group and setup the above-mentioned cohort groups for monitoring and potential referral to ICC.<br><br>Advanced Health presently uses Collective Medical to monitor tagged members in several different type of groups such as ICC, Transitions of Care and LTSS Pacific source dual eligible. In some cases, ICC coordinators update the Collective Medical guidelines to communicate with other care team professionals of the member's health status, special health care needs and safety considerations.<br><br>Collective Medical cohorts were built to monitor at risk populations and since APD case managers add | | coordination and/or population health review of the entire LTSS population for care coordination needs of LTSS members who do not need or want ICC level of care and/or *for referral to Advanced Health's ICC team*. (Presently, AH uses the HRA to screen for ICC needs of the population)<br><br>Additional staff would be needed to systematically review the entire LTSS group for transition of care, care coordination needs, care planning and assessment for potential referral to ICC. Talks are underway with Advanced Health's CIO to utilize the suite of LTSS tags in the 834 Loop 2750 for identification of LTSS members for improving our flat file to Collective Medical. | |

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| | themselves as providers in Collective, we cross reference at risk populations (via cohort identification) with the provider list.<br><br>Advanced Health reviews the Collective Medical cohorts: Hospital Event Notifications (HEN) for all ED and IP admissions, 7+ ED visits in 3 months and SNF admissions throughout 2021 when there was capacity to refer members for intensive care coordination. In addition, our TOC nurse maintains a SNF notification tagged group for monitoring purposes. | | | |
| **OPTIONAL DOMAIN A: Linking to Supportive Resources** | | | | |
| OPTIONAL DOMAIN A: Linking to Supportive Resources Goals | | | | |
| **OPTIONAL DOMAIN B: Health Promotion and Prevention** | | | | |
| OPTIONAL DOMAIN B: Safeguards for Members Goals | | | | |
| **OPTIONAL DOMAIN C: Safeguards for Members** | | | | |
| OPTIONAL DOMAIN C: Cross-System Learning Goals | | | | |

**SIGNATURES: Include Name, Job Title, Agency, Signature, Date**

Signatures of All MOU parties (APD/AAA and CCO) should be included and signed prior to December 31st. OHA/DHS review will occur after CCO submits the MOU. Neither OHA or DHS will require review or co-signature to the MOU.

Advanced Health CCO Authorized Signature

Ross Acker, MS, LPC
Ross Acker, MS, LPC (Apr 27, 2022 14:20 PDT)

Apr 27, 2022

Leah Lorincz, RN
Leah Lorincz, RN (Apr 27, 2022 15:01 PDT)

Apr 27, 2022

Ross Acker, MS, LPC, Director of Care Coordination

Leah Lorincz, RN, BSN, Director of Member Services

APD Field Office Authorized Signature

Josh Harlukowicz

Apr 27, 2022

Christy Shipman
Christy Shipman (Apr 27, 2022 16:33 PDT)

Apr 27, 2022

Josh Harlukowicz, COO – DHS District 7

Christy Shipman – APD District 7 Manager

# AH-CCO-LTSS-MOU-CY2022

Final Audit Report 2022-04-27

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