CCO-LTSS Partnerships Memorandum of Understanding

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 Eastern Oregon Coordinated Care Organization (EOCCO) **OHA Contract #** 161758-6

Partner AAA/APD District (s) Names/Locations Aging and People with Disabilities (APD) Districts 9, 11, 12, 13, & 14

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):
EOCCO willMonitor and evaluate appropriateness of complex care and special health needs action plans including transitions in care, assess progress toward meeting goals and barriers to those goals, collaborate with invested community partners, providers, APD, and other state entities as appropriate, and modify the plan to help achieve desired member outcomes. When member has been offered service options and/or engaged in those services, document and ensure that data entry is completed. All EOCCO members including those with FBDE in relation to Medicare and the Summit Health Plan (EOCCO's affiliated Medicare Advantage Plan) have the same outreach, planning and documentation shared in the same manner. EOCCO's care team provides care management to dual eligible Medicare, Summit Health Plan, and EOCCO members Summit Health Plan: Care Manger SupervisorEOCCO: Moda Health: Government Care Manager Supervisor, Director Utilization and Medical Management, and Healthcare Services Project Manager GOBHI: Care Services Manager, Complex Clinical Manager, and Integrated Care Services Coordinator	AAA/APD will Provide expert resource information on services available within the local community as well as foster new community partner relationships to meet the future needs of the community resource development while developing professional relationships with key community partners, such as the hospital discharge planners, EOCCO representatives, nursing home discharge planners, DNS and resident care managers. APD Team is made up of: district managers and county supervisors.

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

MOU Service Area: Baker, Harney, Malheur, Union, Wallowa, Umatilla, Morrow, Gilliam, Wheeler, Sherman, and Lake Counties				
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	1. EOCCO receives LTSS list from APD that includes SPLs, ADLs, and ED utilization information EOCCO uses this list and claims data to assign a risk score and create a high risk list. The high risk list is then shared with APD. ICC referrals are prioritized from the high risk lis. EOCCO reviews the high risk list for members in each county over a risk score of 25. Those are assigned to a case manager for outreach. Members with a score of over 25 are rescreened at least	1. APD makes referral to EOCCO for members with potential need for intensive care coordination or when staff identify concerns or changes in health status which are all considered high needs. 2. APD sends list of consumers with LTSS services that includes: 3. Referrals for members identified as having special healthcare, behavioral health, or dental needs are tracked on the MDT spreadsheet.	**Process Monitoring** 1. Review prioritization methods applicable to each organization in quarterly MDT collaboration meeting. 2. Review appropriate prioritization methods for bi-weekly MDT collaboration meetings. 3. Document specific prioritization methods for best practices tracking. **Measures of Success:** 1. Number of referrals into MDT by region. 2. Discuss additional measures of success for prioritization of high	# of members with LTSS that prioritization data was shared during each month/year Annual Average monthly # of members with LTSS for whom prioritization data was shared [monthly #/total in year]—calculated by OHA from data submitted # of CCO referrals to APD/AAA for new LTSS service assessments (for persons with unmet needs) # of APD/AAA referrals to CCO for ICC review # of completed referrals for ICC review [Monthly/Year Total]

	yearly or more often if needed. Members that have complex needs or meet the requirements for MDT are referred via the referral process. Behavioral Health uses this list to determine if there are possible ACT referrals even if the score is not over 25. 2. Any member who is referred to ICC from DHS is fully assessed for ICC services. 3. EOCCO screens all members annual via the Health Risk Assessment. Members who have identified risk or care coordination need are offered Care Management services. 4. Send and receive referrals from community healthcare providers to APD for LTSS supports and services, or	3. Monitor for LTC service eligibility/need 4. Update contact lists, Exhibit A, for both EOCCO and APD at quarterly meetings 5. Continue to identify risk through community, monthly meetings, and ongoing contacts with consumers and APS referrals 6. Use communication methods described in Domain 5.	needs members during Quarterly MDT meetings.	

	EOCCO for case management or care coordination for special healthcare or dental needs. 5. Notify APD by email or MDT referral form, Exhibit B, when coordination is needed for high risk members. 6. Update contact lists, Exhibit A, for both EOCCO and APD at quarterly meetings 7. Referrals for members identified as having special healthcare, behavioral health, or dental needs are tracked on the MDT spreadsheet. 8. Use communication methods described in Domain 5.			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	1. Hold Bi-weekly meetings including APD for each MDT region to review	1. APD has lead coordinators for each area. They collaborate	**Process Monitoring:**	# of members with LTSS that are addressed/staffed via IDT meetings monthly

	Care Coordination Trackers to track: a. Periodic secure emails and/or phone conversations between APD and EOCCO b. Case collaboration for members/consumers referred to MDT. 2. Provider engagement is encouraged during case manager/clinical conversations with the provider. a. Providers are noted in the face sheet of HMS. Providers are included in conversations with EOCCO CM and reported back to MDT. 3. Member's goals and preferences are documented in HMS: this is noted in the care plan with the goals identified if they are in ICC.	with EOCCO about consumer needs then make referrals to Case Managers or Diversion Transitions coordinators. Then report back to the Collaboration team through the MDT email and bi-weekly meetings. 2. APD communicates and staff with EOCCO as needed to identify other possible services available to the member/consumer. 3. APD will visit with the member or member representative, in person or by phone, to establish care transition direction, goals and preferences. Members will be offered: a. Equal access to all LTC Services and Supports options b. Equal choice of service providers within the local area,	1. Identify use of high risk list for information on LTSS services. 2. Identify providers and community agencies that could attend MDT bi-weekly meeting to discuss specific complex cases on an as needed basis. 3. Discuss and track agencies for coordination with social and support services and resources to address social determinants of health. **Measures of Success:** 1. Begin tracking number of members/consumers with LTSS. 2. Number of cases with engagement from each MDT organization (i.e. how many cases with all collaborating – APD, GOBHI, and MODA).	% of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month total annual IDT meetings completed by CCO-APD/AAA teams % of times consumers participate/attend the care conference (IDT) by month/year % of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO)

	4. Engage with agencies for coordination with social and support services and resources to address social determinants of health. a. Agencies that are currently engaged include: NEMT, food banks, rental assistance programs, peer support programs and medical/behavioral health providers. 5. MDT meetings use a team-based care approach and ensure barriers to participation of the member receiving LTSS services are not a barrier to member/consumer participation in the IDT meeting. a. Members do not attend bi-weekly	dependent on availability c. The least restrictive care setting based on client choice, safety, and availability d. Additional learning/training opportunities that foster self-management of chronic conditions, new diagnoses and to gain adequate understanding of current health practice. e. Health and wellness training that promotes prevention and self-direction 4. Members/families are included in care planning by individual case managers and shared with the MDT teams. 5. Member's goals are documented in Care plans which are		

	collaboration meetings but are encouraged to engage in their care plans with the Case Managers. b. If member engagment is desired, the Physical Heatlh, Behaviorial Health, or APD case manager will set up a separate meeting with the rest of the care team. 6. Hold a Quarterly APD/EOCOO conference (in addition to bi-weekly meetings) Scheduled in the 3rd week of each quarter to: a. Review processes b. Discuss evidence-based successes c. Examine barrier trends d. Discuss updates to contacts for leads. e. Identify community partners that would	discussed in MDT meetings as needed on an ongoing basis. and can be shared upon request. Constantly staffing cases via email and phone calls. 6. APD will include providers in individual conversations with CM. a. Providers have not joined in the past but are able to join the bi-weekly MDT meetings on a case-by-case basis.		

	benefit from sending MDT referrals. 7. Hold a Semi-Annual community partner conference call/meeting to: a. Review of regional processes, successes and barriers b. Provide community training and education related to referral processes 8. EOCCO will engage member by phone with the member/member representative, critical care nurse, discharge planner or hospital case manager prior to MDT referral when possible and appropriate to gain member input on care plan preferences and options for post hospital placement and LTC. a. Member preferences need to be current and updated prior to			

	any care planning meetings depending on stability of current health conditions.			
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	1. Individualized Care Plan requests from member/rep, EOCCO CM or APD case manager or Transition coordinator are developed by the case managers or care coordinators and are discussed in the bi-weekly MDT meetings. 2. Care plans are shared with the PCP and the member via paper copy and mailed to the member. Physical Health and Behavioral Health CM's share a documentation system and are able to view care plans and changes in real time. Care plans are shared with APD case managers verbally and shared visually as requested. This is done by printing a PDF of the	1. APD will continue current practice of staffing cases bi-weekly at MDT or as needed. a. Care plans and risk assessments shared as requested. 2. When appropriate, APD will actively engages individuals in the design of their LTSS service plan, in coordination with EOCCO when health care treatment and care planning are active. 3. APD contacts EOCCO when they have referrals for ICC or otherwise have identified gaps or concerns about health care needs. Referrals are made via referral forms, Exhibit B, to the appropriate MDT team.	**Process Monitoring:** 1. Consider a process to monitor and track current care plans for members with LTSS **Measures of Success:** 1. Number of cases with shared/completed care plans?	% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals % of CCO person-centered care plans for members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties

	care plan and then sending via secure email.. 3. EOCCO's individualized person-centered care plans include member goals as well as integrated health and social care needs as identified by the ICC assessment. 4. Care plans include member or family/caregiver preferences and goals captured in APD service plans as appropriate. Although it is not required that a member be aware of the referral to MDT, it is strongly suggested so that when a case manager reaches out, the member is aware of the case being discussed. Suggested language to use when discussing with member: "I am not sure how else to help in this particular situation, but I would like			

	to make a referral to another team of individuals for you so that they can discuss additional resources or programs that may be helpful." 5. For members not aware of the MDT referral at time referral is made, members are made aware during outreach call to them. If the information that an MDT referral is made would be significantly detrimental to the member's care or health, the member may be excluded from this information. The EOCCO must document the reasons for the exclusion, including specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk.			

	6. EOCCO case managers build a care plan based on member preferences and goals. This is done at initiation of ICC/CC services. ICC/CC care plans are the driving focus of further outreach to the member and are updated as interventions are completed and goals met or realigned. ICC care plans are updated at a minimum of at least every 90 days. This is ensured by running weekly reports to monitor. Care plans include the items that are most important to the member. Member's are also educated and encouraged to consider health promotion and wellness to their care plans 7. End of life planning resources are found in the HMS Essette charting system for the EOCCO. This information can be			

	printed and sent to the member in large print and in the member's language. 8. CCOs will identify opportunities to focus on preventive approaches, screenings and strategies to reduce unnecessary hospitalizations, ER visits and maintain or improve health of members with LTSS. Current strategies include but not limited to provider and member education, actively engaging member in treatment planning when applicable, and connecting member to additional resources if necessary.			
DOMAIN 4: Transitional care practices				
DOMAIN 4 Goals: Transitional care practices	1. Care coordination teams meet Monday through Friday to review the EOCCO emergency department census to	9. APD has transitional care coordinators (10) who will follow consumers for 90 days after Diversion or Transition.	**Process Monitoring:** 1. Discuss evidence based transition of care models and how they can be applied to transitional	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition?

	coordinate outreach and care for Members that are high utilizers (>3 ED visits in 6m) who have been seen repetitively for the same dx or for a dx that could be managed outside of the ED. of a visit to an emergency room and/or an admission to inpatient care, whether medical or behavioral health related. Coordination, collaboration, and referrals begin at the time of initial notification of the need through the emergency room census reports. 2. Care coordinators receive notification when one of their ICC members are seen in the ED or admitted to the hospital. A reassessment trigger form and f/u call is completed within 3 days for possible additional needs or update of care plan. A	10. D/T coordinators will handle all local transition and diversions using resources from communities. Insurance and Medicaid funds. a. High risk cases will be communicated to the EOCCO through the MDT email system. 11. APD Case Managers and Transition Coordinators will work together with the member to determine: a. Financial eligibility b. Activities of Daily Living (ADL) eligibility c. Member preferences and goals, and assess for risks and barriers 12. APD Case managers and Transition Coordinators working together with the member and EOCCO case managers or care coordinators to: a. Develop a functional and safe care plans,	care practices within MDT. 2. Discuss best practices within each MDT organization for coordinating and communicating transitions in care for members receiving LTSS services and supports. **Measures of Success:** 1. Track post-conference transitions – specifically for transitions that were not smooth.	% transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge? % CCO region to CCO region transfers that communication was made to appropriate APD/AAA office(s)? # of Debrief meetings held quarterly to post-conference transitions where transition wasn't smooth (improvement process approach)? [Q1, Q2, Q3, Q4]

	referral to the MDT or other resource is made if indicated. 3. An MDT referral is made for complex transition of care from a skilled nursing facility-to-home or hospital-to-home. a. End of life planning resources are found in the HMS Essette charting system for the EOCCO. This information can be printed and sent to the member in large print and in the member's language. b. End of life planning resources are found in the HMS Essette charting system for the EOCCO. This information can be printed and	b. Care plans and/or assessment summaries are shared when requested amongst entities c. Assess for and acquire needed Durable Medical Equipment (DME), d. Offer risk mitigating options such as Emergency response systems, LTC Community Nursing, K-Plan chore services, electronic back-up systems, assistive technology, environmental modifications, transition services, & voluntary member training services (i.e. ERC), and/or Home Delivered Meals. 13. APD will offer EOCCO health related services when medically appropriate.		

	sent to the member in large print and in the member's language. c. End of life planning resources are found in the HMS Essette charting system for the EOCCO. This information can be printed and sent to the member in large print and in the member's language. 4. EOCCO must communicate timely with local APD offices when members are transitioning to Medicaid-funded LTSS (See Exhibit C): a. Upon member discharge from inpatient hospital stays, and			

	b. When members are transferring between different LTC settings 5. EOCCO must notify the local APD office: a. At the time of admission to a skilled nursing facility (SNF) under post hospital extended care benefits (PHECB) 6. EOCCO will notify the SNF of each extension of authorization. a. No later than two (2) working days before discharge from PHEC coverage b. The SNF notifies the member of the authorization.			
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	1. Current communication for MDT is done via secure email and in bi-weekly meetings with each MDT region.	1. APD sends referrals and shares information with EOCCO and the MDT teams by secure email and during bi-weekly collaboration meetings.	**Process Monitoring:** 1. EOCCO will review how the collective platform is being used and identify	# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with APD/AAA teams for members

	2. A referral form, Exhibit B, is completed by any agency or partner agency and sent to the appropriate MDT distribution list. See Referral form, Exhibit B, and guidance in Appendix I. 3. All new SNF requests are communicated to APD via MDT referral forms, Exhibit B, and emailed to MDT team as APD Notifications to notify of members who may need more than the 20-day benefit at a skilled nursing facility. a. With a minimum requirement to include SNF admit details. 4. Cases are all loaded into HMS for tracking and reporting on MDT outcomes. Case notes include email communication, bi-	2. Case managers or designated staff use collective regularly to identify hospitalizations that could lead to changes in care needs.	additional ways to use it for: a. Reporting b. Care planning c. Coordination processes. 2. Discuss and document how APD utilized collective platform and how it could be used for: a. Reporting b. Care planning c. Coordination processes. 3. Ensure MDT processes are clearly documented and updated as needed. a. Processes will clearly designate leads from each agency for ensuring communication for roles and responsibilities for key activities. b. Ensure processes are updated when there are changes (i.e. when a lead contact changes)	with LTSS or new in-need of LTSS assessments # of CCO Collective Platform SNF notifications monthly that result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments MOU includes written process documents (prioritization, IDT, care planning, transitions) that clearly designate leads from each agency for ensuring communication for roles and responsibilities for key activities and is shared and updated as needed (such as when lead contacts change).

	weekly meeting notes, and referral information. 5. Cases are tracked on a spreadsheet that includes progress notes and important information for each member. This is shared with APD via secure email before each bi-weekly meeting. 6. For referral sources outside of the MDT participants, progress notes and outcomesare sent back to the original requester via secure email 7. Collective is used to view all those involved in the member's care team and to monitor transition from one level of care to another (including acute care hospitals and SNFs). 8. ICC Case Manager's name and contact information are added to the care team list in Collective so PCP offices		**Measures of Success:** 1. Number of referrals received for each MDT region. 2. Number of SNF APD notifications by region.	

	have quick access to care team. In addition, the contact information is mailed to the PCP office.			

OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals	N/A for 2022. Will review and update as needed for 2023.	N/A for 2022. Will review and update as needed for 2023.	N/A for 2022. Will review and update as needed for 2023.	
OPTIONAL DOMAIN B: Health Promotion and Prevention				
OPTIONAL DOMAIN B: Safeguards for Members Goals	N/A for 2022. Will review and update as needed for 2023.	N/A for 2022. Will review and update as needed for 2023.	N/A for 2022. Will review and update as needed for 2023.	
OPTIONAL DOMAIN C: Safeguards for Members				
OPTIONAL DOMAIN C: Cross-System Learning Goals	N/A for 2022. Will review and update as needed for 2023.	N/A for 2022. Will review and update as needed for 2023.	N/A for 2022. Will review and update as needed for 2023.	

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.

Karissa Reed 4/29/22

EOCCO Authorized Signature
Karissa Reed, Clinical Care Coordinator Manager

Nicole Fenimore 4/29/2022

EOCCO Authorized Signature
Nicole Fenimore, Supervisor Care Management

Gloria Pena 4/29/2022

APD District 11 Authorized Signature
Gloria Pena, District Manager

David Brehaut 4/29/2022

APD District 9 and 12 Authorized Signature
David Brehaut, District Manager

Kimberly K Norton 04/29/2022

APD District 13 and 14 Authorized Signature
Kimberly Norton, District Manager