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Memorandum of Understanding

InterCommunity Health Network CCO (IHN-CCO) and Oregon Cascades West Council of Governments Senior and Disability Services (OCWCOG-SDS) for Long Term Services and Supports

Business Addresses:

IHN-CCO	OCWCOG
2300 NW Walnut BLVD Corvallis, Oregon 97330	1400 Queen Ave SE Albany, Oregon 97322

MOU Period: Jan. 1, 2022, through Dec. 31, 2022, Submit *CCO-LTSS MOU by January 15th to CCO.MCODeliverableReports@state.or.us.*

CCO Name: InterCommunity Health Network (IHN) OHA Contract # 161760

Partner AAA/APD District (s) Names/Locations: Oregon Cascades West Council of Governments, Senior and Disability Services; Benton, Lincoln, and Linn Counties

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

Purpose: The mutual goal of this 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 Long-Term Services and Supports system. This is a non-binding agreement between InterCommunity Health Network Coordinated Care Organization (IHN-CCO) and Oregon Cascades West Council of Governments (OCWCOG) Senior and Disability Services (SDS). This document clarifies the roles and responsibilities of each entity to ensure coordination between two systems and to provide quality care, produce the best health and functional outcomes for individuals to prevent escalation or duplication of costs for respective systems.

Decisions: The parties will use the Consensus Model for decision-making.

Costs: There will be no monetary penalties or exchange of payment resulting from this MOU. Long-Term Services and Supports (LTSS) are excluded from the Coordinated Care Organization (CCO) contract and funded by Medicaid and paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTSS services. IHN-CCO and the LTSS system will share responsibility in coordinating care for individuals receiving Medicaid-funded long-term care services.

Operations and management roles: 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, InterCommunity Health Network CCO and Oregon Cascades West Council of Governments agree to participate in the following activities.

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CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s): Marci Howard, Manager of Community Care Coordination	APD/AAA Lead(s):
CCO will clearly articulate: 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. How Affiliated MA or DSNP plan participates in the MOU work for FBDE. The Community Advisory Council (CAC) ensures the integrated healthcare needs of Benton, Lincoln and Linn County IHN-CCO members and their communities are effectively and efficiently addressed. This includes members receiving Medicaid funded Long-Term Services and Supports (LTSS.) The CAC's responsibilities include identifying and advocating for preventative care practices to be utilized by IHN-CCO, developing, and overseeing the IHN-CCO Community Health Assessment (CHA), adopting a Community Health Improvement Plan (CHIP). Members have included those receiving Medicaid funded LTSS. The Delivery System Transformation (DST) Committee's objectives are to improve the health delivery system by bringing the community together to pursue the Quadruple Aim and support, sustain and increase transformational initiatives. Anyone who supports, promotes, or positively affect the health outcomes of IHN-CCO members can attend and this includes Medicaid funded Long-Term Services and Supports. The DST Committee charters multiple interdisciplinary workgroups to support universal care coordination, health equity, Social Determinants of Health (SDOH), The IHN-CCO Regional Planning Council is a workgroup charged by the IHN-CCO Board of Directors with planning and coordinating the local system of health services and supports. OCWCOG is represented in this Council. IHN-CCO is part of Samaritan Health Plans which is an integrated nonprofit healthcare organization. SHP also services Medicare through Samaritan Advantage Plan, HMO (SAHP) and Special Needs Plan for Duals (D-SNP) in Benton, Lincoln, and Linn Counties.	**AAA/APD will clearly articulate:** How AAA/APD governance Lead(s) for participation at the community level in the Board/Advisory panel for LTSS perspective/Care Coordination. 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). OCWCOG is governed by a Board of Directors (BOD) consisting of local elected officials who serve on Commissions and Councils within and including Linn, Benton, and Lincoln Counties. The Senior Services Advisory Council (SSAC) and Disability Services Advisory Council (DSAC) consists of a representative from the OCWCOG Board and community citizens, 50% of which must meet our service criteria, that advise and advocate regarding policies, quality of services, and other priorities effecting delivery of Long Term Services and Supports. OCWCOG SDS is required as an Area Agency on Aging to create a four-year Area Plan that addresses the needs of older adults, adults with disabilities, and their caregivers while assessing the strength and weaknesses of current community resources available to them. The Area Plan is developed with broad public input as required by the Older Americans Act (OAA) and includes focus areas identified by the State. Once approved, this strategic plan serves as a basis for planning, program development and funding priorities for the people and regions we serve in our three-county planning and service area, including IHN-CCO members.

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<table>
<tr><th colspan="5">MOU Service Area:</th></tr>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS: Domain Addressed</th><th>CCO Agreed to Processes & Activities</th><th>LTSS Agency Agreed to Processes & Activities</th><th>Process Monitoring & Measurement: Specific Identified Local Measures of Success</th><th>Annual Report on Specific Statewide Measures of Success (provide data points*) — monthly & annual [REQUIRED data points at minimum}</th></tr>
<tr><td colspan="5">DOMAIN 1: Prioritization of high needs members</td></tr>
<tr><td>DOMAIN 1 Goals: Prioritization of high needs members</td><td>IHN-CCO responsibilities:
Screen IHN-CCO members including those receiving LTSS. Include LTSS risk assessment and screening information
Define how communication and coordination with LTSS occurs
Ensure LTSS staff have contact information to refer members to Intensive Care Coordination (ICC)
Track referrals received from LTSS
Track referrals made to LTSS
Process and Activities:

IHN-CCO Care Coordination Department screen the IHN-CCO population to identify prioritized populations and members with special health care needs, including members receiving LTSS. LTSS members are identified from the 834 Enrollment Report with a ‘yes’ indicator for LTSS/LTC flag. Upon identification the member is assigned a care</td><td>OCWCOG-SDS responsibilities:
Provide IHN-CCO with information to identify members with LTSS high health care needs
Share risk assessments, service priority levels, service, and care plans with IHN-CCO
Refer LTSS members to ICC
Process and activities:

OCWCOG-SDS will provide IHN-CCO the LTSS report monthly. The report is provided via SFTP site by the last day of each month. The LTSS report includes the following data sets:
Member Name and ID
Date of Birth
Telephone number
CCO Type (ex: CCOA)
Medicare Advantage Plan
Living Situation</td><td>% of LTSS members referred for ICC receive an ICC assessment within 30 days of referral.</td><td># 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]</td></tr>
</table>

	manager to complete an Intensive Care Coordination (ICC) assessment. LTSS providers and case managers can refer a LTSS member directly to ICC or care coordination services through email, fax, phone or through Unite Us- Community Oregon. Members who are directly referred from LTSS for ICC will have an ICC care manager assigned and will outreach to the member to complete an ICC assessment within 30 days of referral. Regardless of if member is programmatically identified or referred, the ICC care manager will contact the LTSS case manager and provider to gather necessary risk assessment and screening information, and to provide them with their contact information. The ICC care manager will include them in the interdisciplinary care team (ICT). Communication typically happens telephonically and is documented in the SHP Care Management platform. Communication between the care team happens often, no less than monthly at the ICT meetings. IHN-CCO care management team directly refer members to OCWCOG/SDS for LTSS via secure email, fax, or phone. The Community Partner Referral Process and form may be utilized and documentation and tracking of the referral for LTSS is in the SHP Care Management Platform by using the 'External Referral' form.	• Service Priority Level • Assistance needed in Cognition, Mobility, Bath Hygiene, Bowel Bladder and Dressing • Last Assessment Date • Mailing and Residential Address • LTC Provider including address • LTSS Case Manager and telephone number • Authorized Representative and telephone number • Risk Assessment outcome LTSS Prioritized Data SFTP process.p At referral or request, the LTSS case manager will provide additional information including but not limited to, additional risk assessment information, service plan and any other pertinent information necessary. OCWCOG SDS case managers can refer to the IHN-CCO Care Coordination Department via phone, fax, and secure email (preferred method). IHN-CCO staff can refer members for LTSS by calling the ADRC call center or by securely emailing a referral.		

	Community Partner LTSS Referral Form.p Updates to processes for prioritization will be shared during the quarterly MOU meeting. A contact list is maintained between IHN-CCO and OCWCOG/SDS. MOU Leads for IHN-CCO will communicate any updates of the care management team to OCWCOG/SDS. This will occur as needed and at minimum on a quarterly basis.			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	**IHN-CCO responsibilities:** • Maintain contact list for and share with LTSS • Include care team members including LTSS, LTSS providers, health care providers and community partners in the ICT • Work with OCWCOG-SDS in identification of members to convene ICT meetings for • Regularly schedule ICT meetings • Track care plans for members with LTSS CSD-CC-CM-47 IHN-CCO Interdiscip **Process and Activities:**	**OCWCOG-SDS responsibilities:** • Actively participate in scheduled ICT meetings • Identify members that would benefit from ICT support • Notify IHN-CCO of LTSS members • Inform IHN-CCO of contact information for LTSS case managers and providers **Process and activities:** OCWCOG-SDS will provide IHN-CCO the LTSS report monthly. The report is provided via SFTP site by the last day of each month. LTSS staff are asked prior to every ICT meeting to identify any members that may benefit from support of the ICT team.	% of LTSS members referred for ICC have an initial ICT meeting.	# of members with LTSS that are addressed/staffed via ICT meetings monthly % of months where ICT care conference meetings with CCO and APD/AAA occurred at least twice per month total annual ICT meetings completed by CCO-APD/AAA teams % of times consumers participate/attend the care conference (ICT) by month/year % of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO)

	IHN-CCO care management staff are responsible for scheduling interdisciplinary care team (ICT) meetings. This is done through Microsoft Teams scheduling. Meetings are twice a month. Ad-hoc meetings can be requested by anyone on the ICT and IHN-CCO will coordinate and schedule. IHN-CCO care management staff lead sends an email out to the IHN-CCO and OCWCOG- SDS staff to identify members to include in the ICT process. Local Community Mental Health Programs (CMHPs) are included as integral participants to ICTs. IHN-CCO Policy- 47 IHN Interdisciplinary Care Team (ICT) outlines requirements and procedures for ICTs. When members are identified, IHN-CCO and OCWCOG-SDS staff determine who will take lead in engaging the member to participate. This is dependent on the relationships developed with the member and the current needs. The ICT consists of the member, member's representative (if applicable), member's primary care providers, LTSS case manager and providers, IHN-CCO care management staff, identified medical, behavioral health, oral health providers and social and support services. The ICT develops the Individualized Care Plan (ICP) which is a strategy used by the ICT to establish protocols and provide direction according to the member's needs and expressed goals. See Domain 3 for more information on the ICP process. The meetings shall provide a forum to:	LTSS consumers staffed during internal SDS multidisciplinary team for complex case consultation will be considered for referral to ICT team. When requested, OCWCOG-SDS will share current assessment and service plan. SDS Program Manager will coordinate attendance of SDS staff at ICT meetings and will assure appropriate representation from OCWCOG-SDS at each ICT meeting. Representation may include LTSS case management, Adult Protective Services, and supervisory staff with knowledge of cases being discussed. SDS staff will coordinate member's participation when SDS staff have identified the need for an ICT. Member-centered planning is the goal of the ICT and thus members are crucial to successful ICTs Members are encouraged to participate and are provided clear information on the purpose of the ICT, who will be present based on member's preferences and goals. Typically, the SDS case manager communicates directly with the member about the ICT and can answer any questions or concerns they may have. SDS staff will communicate with IHN-CCO care management team other care team members who the member would like		

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	Create a space for the member to provide feedback on their care, document member's goals, strengths and preferences; self-reported progress towards their ICP plan goals and their strengths exhibited in between current and prior meeting; Identify coordination gaps and strategies to improve care coordination with the member's service providers; Develop strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring. The ICC care manager communicates among ICT members to ensure the plan of care is followed and the appropriate disciplines within the team are completing action steps toward expected outcomes and goals. The ICC care manager supports the member and care team in reviewing the plan of care at each ICT meeting to ensure that all the appropriate disciplines within the team are completing action steps according to the plan of care and that care seamlessly moves the member toward their expected outcomes and goals. The ICP is documented in the SHP Care Management platform and is shared with the ICT members via mail, fax, or secure email.	invited, such as natural supports, long term care provider, other identified service providers and community partners. SDS may be assigned care plan goals and follow up needed from ICT meetings. If urgent need is identified requiring ICT support prior to the next scheduled meeting SDS program management will request an ad-hoc meeting by reaching out directly to IHN-CCO Care Management lead staff.		
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	**IHN-CCO responsibilities:** • Develop Individualized Care Plans (ICP) that: ○ Actively engage member in development of ICP	**OCWCOG-SDS responsibilities:** • Share risk assessment and service plan information for the ICP • Refer LTSS members to ICC	% of LTSS members referred for ICC receive an Individualized Care Plan	% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals

	○ Include information about supportive and therapeutic needs including LTSS ○ Focus on preventative approaches to reduce unnecessary hospitalizations, ER visits ○ Reflects member preferences and goals ○ Are jointly shared with LTSS case managers and providers • Track completion of ICPS **Process and Activities:** IHN-CCO Policy 46- IHN Individualized Care Plan (ICP) ensures members identified with chronic and/or complex behavioral, oral, and physical health condition(s) have an ICP developed. This includes LTSS members who are identified as high needs and high risk. Care management staff work with the member, primary care provider, LTSS case manager and provider, other health care providers and community partners to develop the ICP. If the member is also receiving Medicare, the affiliated Medicare plan and providers are involved in development of the ICP. LTSS case manager and provider may share information on the service assessment and person-centered service plan developed for LTSS. Information sharing and development of the ICP is completed through the ICT process. IHN-CCO care management staff include RNs, Social Workers, QMHP, QMHA, LCSW, and	**Process and activities:** The LTSS case manager is an integral part of the care team. They share LTSS risk assessment, service plan and any other pertinent information with the IHN-CCO care manager as well as with the ICT. Often this information is shared during review of the ICP during the ICT meeting. Information may be shared between the IHN-CCO care manager and the LTSS case manager through care coordination activities. OCWCOG- SDS LTSS case managers will follow up on and complete any action items assigned to the LTSS case manager in the Individual Care Plan. The Program Manager will supervise this work and assure this work is completed timely. Members involved with the ICT team will receive a direct case management contact monthly for a minimum of three months following referral to the ICT team. Pertinent information will be shared by long term case manager with ICT team participants.		% 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

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	Community Health Workers. The primary care manager is a clinician and the CHW support the ICP development by scheduling the ICT meetings, documenting updates to the ICP, and taking lead on goals related to Social Determinants of Health. Engaging the member in developing the ICP is essential. IHN-CCO care management staff utilize motivational interviewing, trauma-informed, culturally, and linguistically appropriate approaches to engage the member. The care manager outreaches to the member to complete an assessment and listens to member's vision, strengths, and goals. The care manager will explain what an ICT is, find out who is on the member's care team and what the member would like to get out of the ICT meeting. The care manager will also talk with the member about any supports needed should the ICT meeting become too stressful. Care manager will provide member with details on the ICT meeting including who plans to attend, date and time, location, and call-in information. ICPs include: • Member and caregiver prioritized goals and desired outcomes • Preferences and desired level of involvement • Timeframe for re-evaluation of goals • Resources to be utilized, including appropriate level of care			

	• Planning for continuity of care, including transition of care and transfers between settings • Advance care and end of life planning • Coordination of social and support services • A collaborative approach will be used, including family/caregiver participation • Barrier(s) to meeting the goals of the ICP are included and documented, even if none exist. Barriers may include but are not limited to: • Language or literacy level • Access to reliable transportation • Understanding of a condition • Motivation • Financial or insurance issues • Cultural or spiritual beliefs • Visual or hearing impairment • Psychological impairment All ICPs are member-centered and address member's preferred and/or needed services including culturally and linguistically appropriate services, alternate formats, and disability services. Member referrals to resources are facilitated and a schedule is developed with the member for follow-up to determine whether members act on those referrals. Follow up and communication with members may include but is not limited to:			

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	• Counseling • Follow-up after referral to a health resource • Member education • Self-management support • Determining when follow-up is not appropriate A self-management plan is developed and may include but is not limited to: • Performance of activities of daily living • Self-administration of medication • Self-administering medical procedures/treatment • Managing equipment • Maintaining compliance with prescribed diet • Charting of daily weight and blood sugar For members who are complex or have high-risk medication concerns, a clinician will provide medication reconciliation. ICPs will address action items to address reduction in Emergency Room utilization and readmissions, if applicable. ICPs are created and maintained in IHN-CCO clinical platform and are developed with the member and the care team. Typically, the IHN-CCO care manager work directly with the member to develop member goals to include in ICP. The ICP is then reviewed at the first care team meeting.			

	The member and care team discuss goals, update according to needs and assign action items. The ICP is then shared with the member and care team members via mail, fax, or email. The ICP is reviewed at each ICT meeting and is updated at least every 90 days. It may also be reviewed and updated if a member experiences a change, such as and not limited to; change in health status or transition of care. Upon each update, the ICP is shared again with the member and care team members via mail, fax, or email.			
		DOMAIN 4: Transitional care practices		
DOMAIN 4: Transitional care practices Goals	**IHN-CCO responsibilities:** • Coordinate and communicate with OCWCOG-SDS on transitions of care • Ensure discharge planning and follow up **Process and Activities:** IHN-CCO care management team meets with LTSS case managers on an at least quarterly basis for 'Coffee Breaks' to educate and inform one another on care transition practices within each organization. The meetings are focused on the following: Updates to care transition processes and procedures in each organization; training on program updates or implementations that may impact care transitions, such as Health-Related Services and review of joint transition process. The joint transition process was developed in previous MOUs. It includes the following:	**OCWCOG-SDS responsibilities:** • Coordinate and communicate with IHN-CCO on transitions of care • Ensure discharge planning and follow up **Process and activities:** OCWCOG-SDS coordinates with IHN-CCO to support on in the transition of members between LTSS care setting levels of care. This includes: • Completing a LTSS assessment • Options counseling about LTSS placement options • Provider authorization and payments • Ancillary services such as durable medical equipment (DME) or	% of LTSS members receiving ICC receive an updated transition of care Individualized Care Plan	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? % 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]

	Roles and Responsibilities: IHN-CCO: The Primary Care Provider (PCP) is responsible for coordinating transitioning members out of the hospital settings into the most appropriate, independent, and integrated care settings, including LTSS, hospice and other palliative care settings. IHN-CCO care management staff coordinate with the PCP, care setting, discharge planners, LTSS case manager and providers by developing a plan to support a successful transition. Review and determine individual Flexible Service requests from member, providers or LTSS case manager. **Frequency of meetings: '**Coffee Break' meetings are at least quarterly and are an opportunity to develop relationships amongst IHN-CCO care management staff and LTSS case managers. The agenda includes a discussion of changes in programs, processes, procedures, and staffing. Presentations are shared including the appropriate contact if there are follow up questions. Escalation pathways are evaluated at each meeting. **Identify cross system resources:** During the ICT meetings availability of resources and services are addressed. The IHN-CCO care manager and LTSS case manager may address options to support member through LTSS ancillary services and/or individual Flexible Services. This may also include identifying other programs LTSS has through the AAA, such as PEARLS or Meals on Wheels. These	environmental modifications if necessary • Post transitions follow up and support Case Managers outreach to IHN-CCO care management team via phone, email and/or fax to discuss member transitions and convening ICT. Other care team members may be contacted to be notified of the transition and the upcoming ICT meeting. LTSS Case management can be performed by an ongoing case manager, a PAS (Pre-Admission Screening) case manager, or by a Diversion Transition case manager depending on the complexity and urgency of the transition. OCWCOG-SDS staff participate in the ICT which supports the member in the transition of care. Frequent check in meetings may be requested to support post-discharge. Case managers will also request individual Flexible Services from IHN-CCO if appropriate.		

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	cross-system resources would then be included in the ICP. **Communication:** Occurs through the ICT and updates to the ICP. (See above Domains 2 and 3.) IHN-CCO Policy-41 Notification of Admissions and 53 Coordination of Care Transitions outlines how IHN-CCO care management staff are notified and support care transitions. IHN-CCO is notified of planned and unplanned care transitions through pre-service authorizations, notification of admissions, member, or care-giver self-report, monitoring of event notifications through Collective Plan and referrals from LTSS case managers and/or providers. IHN-CCO utilization review and care management staff work closely with LTSS case managers throughout the transition. Communication happens most frequently via phone once transition has been identified. Information sharing includes planning for transportation needs, durable medical equipment, approval of utilization management authorizations, LTSS services, placements, and next steps. Once a transition has been identified the IHN-CCO care managers begin to coordinate the transition to ensure the member is connected to the			

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	appropriate providers and services. This may include: • Contacting member and/or caregivers to determine their understanding of the transition • Contacting facility and providers to determine what information may be needed before the transition occurs • Communicating with the member, LTSS case managers and providers, and members of the ICT during the transition process • Discuss discharge plan with member and/or caregiver • Identify barriers and how to address them • Assure follow up services and appointments have been scheduled • ICP updates are documented in the care management system and communicated to the ICT The goal for any member transition of care is: • Assessment and evaluation of barriers to care, including access to newly prescribed medications			

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	• Creation or update of an ICP to address any new barriers with targeted interventions and SMART goals • Promote education opportunities for self-management activities identified in the ICP • Frequent communication with the member and the member's care team to ensure follow through on interventions to mitigate barriers to care • Coordination and communication with the ICT including PCP, LTSS case manager, provider, community resources, and other care team members • Frequent evaluation of the ICP to timely address member needs, including medication reconciliation by the Clinical Pharmacist • Facilitate and coordinate a safe transition through the different levels and episodes of care The member is supported through the transition of care by the ICT. The ICT effectively plans, communicates, and implements the transition and care planning follow up. Prior to discharge, the ICT will meet to review if appropriate services are in place to ensure a successful discharge. The ICP is updated and communicated to the ICT via mail, fax, or email.			

	Health-Related Services individual flexible services may be an important part of a transition of care. Examples of flexible services for a transition of care includes emergency shelter payments for members waiting on LTSS placement or Items for the living environment, not otherwise covered by LTSS, to support a health condition. IHN-CCO care management staff will evaluate opportunities to support member by reviewing and determining flexible services requests and identifying other community resources available for the member. If LTSS case manager requests the flexible service, IHN-CCO care management staff will work with them to determine if the flexible services meet requirements or if there are other resources available.			
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	**IHN-CCO responsibilities:** • Develop clear communication processes with LTSS that are detailed and specific • Share how Collective Plan is being used, including SNF notifications • Identify strategy to partner with LTSS system as part of the HIT roadmap **Process and Activities:** IHN-CCO Care Coordination department maintains a contact list to provide to OCWCOG-SDS at least	**OCWCOG-SDS responsibilities:** • Develop clear communication processes with LTSS that are detailed and specific • Share how Collective Plan may be used **Process and activities:** OCWCOG SDS program manager will provide a case manager contact list to staff of the IHN-CCO Care Coordination Department. A	% of 'Coffee Break' meetings convened	# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with APD/AAA teams for members 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

	quarterly. This contact list includes the care management staff, their roles, and how to contact them. This MOU provides detailed information on the role of the IHN-CCO care management staff as it relates to Intensive Care Coordination (ICC), care coordination, ICTs, ICPS and transitions of care. Any changes to the contact list are communicated immediately to OCWCOG-SDS. Collaborative communication is completed through the ICT. This is where the care team members provide their individual roles and responsibilities in supporting a member, as well as actions they will complete to support the member's ICP. Communication happens during the ICT meeting as well as via phone, fax, or secure email. IHN-CCO facilitate a quarterly 'coffee break' for care management and LTSS case managers. The agenda includes a discussion of changes in programs, processes, procedures, and staffing. Presentations are shared including the appropriate contact if there are follow up questions. Escalation pathways are evaluated at each meeting. Recent coffee breaks included presentations on Community Partner LTSS referral process, Hospital and Nursing Facility Social Services expedited LTSS process and Health-Related Services. The IHN-CCO care management manager facilitates scheduling the quarterly meetings and	new contact list will be provided whenever there is an update. OCWCOG SDS staff do not currently use Collective Platform in their work with LTSS consumers. If at any time this change, the SDS program manager will inform IHN-CCO and identify how they are using the system. Members identified by case managers or other AAA staff as needing more support will be staffed with AAA Program Manager who will Communicate with IHN-CCO Care Team Lead. Quarterly Coffee Break meetings provide an opportunity for IHN-CCO and AAA staff to discuss updates at each agency, concerns, or barriers experiences, and build collaborative relationships. Regularly scheduled ICT meetings provide regular opportunity to discuss and support shared consumers. LTSS does not use Collective Plan for event notifications or to document care planning or share information amongst the care team.		LTSS or new in-need of LTSS assessments

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	works collaboratively with the SDS director to ensure appropriate staff attend. IHN-CCO uses Collective Plan for event notification including SNF notifications. A report is provided each day and evaluated by the inpatient authorization specialists. Utilization review and care management staff are notified of the event, and they complete a member review and will determine if the member is receiving LTSS (will review LTSS monthly file received by OCWCOG-SDS.) Outreach to the LTSS case manager will be completed to discuss the event notification and next steps. IHN-CCO actively engages with providers and has convened multiple workgroups with providers, community partners, and stakeholders to investigate the use of Collective Plan for event notifications and care coordination. IHN-CCO care managers also attend in-person payor collaboratives to support the use of Collective Plan. IHN-CCO is working on developing cohort reports in Collective Plan to identify high risk members who have been admitted to the ED or inpatient facility to intervene early and decrease unnecessary ED utilization and/or readmissions. Workgroups continue with providers and community partners to expand the use of Collective Plan across the provider network. Currently however Collective Plan is not being used to share information amongst the care team.			

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	Through the HIT roadmap, IHN-CCO is responsible to convene and align the community around a common referral process that can be electronically captured and made available to Primary Care at the time of service. IHN-CCO believes care coordination comes from a partnership amongst providers and community partners working towards a shared goal for the member. This work crosses the care spectrum from physical, behavioral, and oral health as well as community partners and LTSS. This requires not only a willingness to engage, but technical and operational resources that allow those parties to interface in a timely and meaningful way. EHR and other HIT usage is imperative in capturing the data necessary to engage in health information exchange. Two specific goals within the HIT roadmap that directly involve LTSS: 1) Collaborative use of Collective Plan and 2) Unite Us, which is a platform for closed loop referrals.			

Optional Domain: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals	**IHN-CCO responsibilities:** • Share new resources available through IHN-CCO • Provide information eligibility and process for Health-Related Services flexible services	**OCWCOG-SDS responsibilities:** • Share program and resources available **Programs and Resources:**	Not Applicable (NA)	Not Applicable (NA)

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	• Share how IHN-CCO has deployed Traditional Health Workers and how to access them **Programs and Resources:** IHN-CCO Care Coordination department has expanded the internal care management team. The team consists of multiple Clinical Care Managers, Behavioral Health Care Managers, Health Care Guides and Community Health Workers. Care management programs include Care Coordination, Intensive Care Coordination (ICC), Maternity Case Management and Complex Case Management. Members may be referred for any care coordination needs by their primary care provider, other health care providers, LTSS case managers and providers and community partners. Referrals can be received via phone, fax, or secure email to carecoordinationteam@samhealth.org Referrals are evaluated by the Community Health Workers and typically an intake screening is completed to determine the most appropriate care pathway for the member. If a member qualifies for ICC, they will be assigned an ICC care manager who will complete an ICC assessment, develop an individualized care plan, and convene interdisciplinary care team meetings at least monthly. The Community Health Workers primary focus is addressing Social Determinants of Health. They evaluate the member's needs, identify appropriate community resources and partners to support. They also evaluate and determine the health-Related Services individual Flexible Services requests.	OCWCOG's Aging and Disability Resource Connection (ADRC) call center is a trusted source of information where people of all ages, abilities, and income levels - and their caregivers - can go to obtain assistance in planning for their future long-term service and support needs. The ADRC is designed to empower older adults and persons with disabilities to make informed choices about their services and supports. OCWCOG- SDS provides information and assistance for low-income older adults and people with disabilities who need to apply for medical, prescription, and food benefits. Administered by the Oregon Department of Human Services, there are a variety of programs available to assist Oregonians. OCWCOG- SDS administers Older Americans Act (OAA) Programs that provide critical services that allow older adults to remain in their own home as independently, safely, and for as long as possible. These programs include Meals on Wheels, family caregiver support services, health education, disease prevention, and support of elder justice issues. Programs and services available through SDS are discussed through the ICT		

	IHN-CCO Policy- 25 Health Related Services outlines the procedures for individual Flexible Services. Flexible Services are a type of Health-Related service which are cost-effective services offered to an individual member to supplement covered services. Requests for Flexible Services may be submitted to IHN-CCO from the member, member's Primary Care Provider, care management team, specialists, oral health providers, behavioral health providers, or participants of the ICT, including LTSS case managers and providers. Requests can be submitted via fax, secure email, or in-person, utilizing the Flexible Services request form found on the IHN-CCO member and provider websites. A member is not required to complete the form to submit a flexible service request. Flexible Service requests are evaluated within the Care Coordination care management team using the following criteria: • improves health outcomes compared to a baseline and reduces health disparities among specified populations. • Prevents avoidable hospital readmissions through a comprehensive program for hospital discharge. • Improves patient safety, reduce medical errors, and lower infection and mortality rates; and • Promotes or increases wellness and health activities. • Medicaid funded and/or non-Medicaid funded service alternatives such as but not limited to; Long Term Services and Supports and/or Developmental	meetings, 1:1 with members and between care team members. They are then integrated into the ICP as needed.		

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	Disabilities K Plan funding, Community Services Consortium and Department of Human Services. Flexible Services review requires the following documentation: • Flexible Services request form • Flexible Service integration into member's plan of care, if applicable • Cost • Servicing Provider including Employer Identification Number information (EIN) • Anticipated outcome All requests will be processed as quickly as the member's condition requires. If the request is complex in nature, it may take longer to process. IHN-CCO care management staff coordinate Medicaid funded and/or non-Medicaid funded covered, non-covered services and Health-Related Services with the member's providers and identified community resources focusing on improved health outcomes for the member. This includes evaluating and engaging other funding and/or resources available to support the member's needs. Care management staff coordinate Flexible Services through the member's ICT. Notification of Flexible Service refusal is sent to the member and the requesting provider. If a Flexible Service request is refused the member does not have appeal rights; however, may file a grievance following the instructions provided in the refusal notification. Integrating Traditional Health Workers (THW) into the service delivery system is a close collaboration			

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	with IHN-CCO staff, the THW Workgroup, THW Liaison, and the THW Training Hub. THWs have increased the diverse workforce that reflects IHN-CCO member composition. IHN-CCO has partnered with Oregon State University and Heart of the Valley Birth and Beyond developed the Community Doula Pilot, which trains bicultural and bilingual doulas that represent characteristics of IHN-CCO pregnant members, to impact health outcomes for postpartum members and their babies. Other sustained pilot programs for IHN-CCO members include bilingual health navigators embedded in schools, community health workers in Patient-Centered Primary Care Homes, and maternal care coordinators in obstetrics and gynecology clinics. To continue recruitment and retention of the THWs workforce on-going continuing education units (CEU) training will be held to maintain credentialing for THW and activities to foster networking and connections among the THW workforce. Also, the THW Workgroup will collaborate with other IHN-CCO Committees and Workgroups to support opportunities for other types of workers in the community to impact social determinants of health (example Community Paramedics and health educators). The THW Workgroup is building a THW network that will provide mentoring, supervision, and support for THWs in the tri-county region and will work with the Oregon Community Health Workers Association (ORCHWA) to aid in developing local support network in Linn, Benton, and Lincoln counties.			

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	LTSS case managers and providers can contact IHN-CCO care management staff (utilizing the contact list) to refer members in accessing THWs. Programs and services available through IHN-CCO are discussed through the ICT meetings, 1:1 with members and between care team members. They are then integrated into the ICP as needed.			

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.

DocuSigned by: Gabriel Parra 87264239D5A54D9... Gabriel Parra CSO IHN-CCO 4/29/2022 | 12:51:56 PDT

CCO Authorized Signature, Name, Job Title, CCO Name, Date

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APD Field Office Authorized Signature, Name, Job Title, APD Field Office Name, Date

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AAA Office Authorized Signature, Name, Job Title, AAA Office Name, Date

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