CCO-LTSS Partnerships MOU Template:

MOU Period: Jan. 1, 2022, through Dec. 31, 2022

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

CCO Name Jackson Care Connect **OHA Contract # 161761-6**

Partner AAA/APD District (s) Names/Locations: Rogue Valley Council of Governments Area Agency on Aging, and Aging and People with Disabilities District 8

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): Erica Idso-Weisz, Ginger Scott	APD/AAA Lead(s): Laura O'Bryon, Jeremy Wolf
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. JCC will meet quarterly with LTSS partners to discuss activities and other topics of interest. For those with Medicare plans other than Care Oregon Advantage, additional stakeholders will be included in IDT meetings as appropriate. JCC is currently actively recruiting a member who receives services through AAA/APD for our consumer advisory council, and it has been suggested we add a provider who practices in one of our local skilled nursing facilities to our clinical advisory panel.	**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). The regional Area Agency on Aging is the Senior and Disability Services Department (SDS) for District 8 (Jackson and Josephine Counties) and is located within Rogue Valley Council of Governments (RVCOG) in Central Point, Oregon. Two advisory councils assist with this advocacy. The Senior Advisory Council (SAC) is made up of up to 21 community members, appointed by the RVCOG SDS Board of Directors, and is mandated under the federal Older Americans Act to advise the Area Agency on Aging Program Director. The Council provides advice and assistance with new program development and service implementation to meet the needs of seniors and people with disabilities, are advocates and sources on information to the community, and advise on key issues and emerging trends. The Disability Services Advisory Council (DSAC) is made up of up to 11 members of the community and meets monthly to advise local APD offices on program policy and the effectiveness of services provided (such as Medicaid and SNAP) to both seniors and younger people (18-64) living with disabilities.

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

MOU Service Area:				
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	JCC developed a communication matrix with AAA/APD to ensure clear communication pathways for prioritization, referrals or any other such exchange required to assess members receiving Medicaid-funded LTSS services. The matrix is reviewed at IDT meetings and updated, if needed. JCC maintains a universal screening process with AAA/APD. The process assesses individuals for critical risk factors that trigger intensive care coordination for high needs members receiving Medicaid-funded LTSS services. Any individual member can be considered for intensive care coordination by JCC or AAA/APD. JCC identifies and prioritizes high need members through the following means: • OHA's 834 file - The member's chart is updated within JCC's care management platform to reflect if they are flagged as LTSS on this file	AAA/APD developed a communication matrix with CCO and will use it to ensure clear communication pathways for prioritization, referrals or any other such communication required to assess members receiving Medicaid-funded LTSS services. AAA/APD and JCC defined a universal screening process to assess individuals for critical risk factors, which trigger intensive care coordination for high needs CCO members receiving Medicaid-funded LTSS services. Any individual member can be considered for Intensive Care Coordination by JCC or AAA/APD. APD/AAA identifies and prioritizes high need members through referrals, screenings, care planning and IDTs. Notifications of client status changes received from hospital social workers or Community partners (e.g Home Health or Hospice) are reviewed to evaluate for needs.	HRA and HRS completed by LTSS member per month	# 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]

	• Monthly report from JCC's care management platform of current LTSS members receiving Care Coordination services – Pulled by JCC and shared with AAA/APD. • Referrals - Received from member or external partners, such as APD/AAA and LTSS partners. • Assessments and screenings - Administered by JCC to identify issues requiring prioritization, care coordination or referrals to AAA/APD. Assessments and Screenings include Care Coordination Assessments (CCA), Transitions Assessments and Health Risk Screenings (HRS) or Health Risk Assessments (HRA). JCC shares a monthly report of current LTSS members receiving Care Coordination services with AAA/APD using a secure spreadsheet. The report is used to determine staffing at the next scheduled bi-weekly IDT meeting. The report is created by merging the Collective LTSS member list with an internal list of high needs members and those receiving care coordination. JCC documents community health assessments, relevant behavioral health information pertinent to care coordination and risk assessments of individuals and communities defined as high risk or high utilizer when received from APD/AAA. JCC staff reviews records of members referred by LTSS partners in advance of the next IDT Conference Meeting.	APD incorporates data sources of consumer information into information sharing methods. LTSS agency partners submit referral forms to JCC on members they would like to staff at the next bi-weekly IDT Conference Meeting. AAA/APD provide CCOs access to information needed to identify LTSS members with high care needs, as requested. The information may include, but is not limited to: • Service Priority Levels from CA/PS standardized risk assessments (1-13 living in their own home or community-based setting) • In-home service clients the AAA/APD Case Manager believe are at risk due to accepting lower than authorized care plan • Loss of housing due to an eviction notice or involuntary move out, or • Any other bio-psychosocial factor(s) influencing their stability in their current environment LTSS agency partners review cases of those JCC high risk members identified on spreadsheet in advance of the next scheduled IDT Conference Meeting.		

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<td>JCC shares information from screenings, assessments or changes in health status with designated AAA/APD staff through secure e-mail, GSI, Collective, phone, fax or during IDTs.

Relevant Process Documents:

• JCC Communication Matrix
• Domain 1 – Referrals and Assessment Screening Process Documents (JCC) –Parts 1-4
• Domain 4 – Transitional Care Process Documents (JCC) – Part 4

• Intensive Care Coordination P&P:
  ○ Screening (pg. 8)
  ○ Rescreening (pg. 9)
  ○ Care Coordinator Assignment and Caseload Capacity (pgs. 9-10)
  ○ ICC Services/Activities (pgs. 10-11)
  ○ Assessment for Health Risk and Care Coordination Needs (pgs. 11-12)</td>
<td>Relevant Process Documents:

• JCC Communication Matrix
• Domain 1 – Referrals and Assessment Screening Process Documents (JCC) – Parts 1-4
• Domain 2 – IDT Process Documents (JCC) – part 6</td>
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<tr>
<td colspan="5">DOMAIN 2: Interdisciplinary care teams</td>
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<td>DOMAIN 2 Goals: Interdisciplinary care teams</td>
<td>JCC recognizes the value of team-based care for improving member outcomes, and agrees to the following:
• Adaptive team-based care approaches that accommodate the unique needs of individuals receiving LTSS services by integrating appropriate people into the interdisciplinary care team (ICT).</td>
<td>To support coordination of care for members with routine and intensive care coordination needs, AAA/APD notifies the CCO providers and care teams which members receive LTSS support.

AAA/APD distributes the contact information for the member's relevant local AAA/APD office contact and LTSS</td>
<td># of members with LTSS that are addressed/staffed via case conference monthly</td>
<td># of members with LTSS that are addressed/staffed via IDT meetings monthly

% of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month</td>
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	• Inclusive ICT, Care Planning and IDT processes so the member/representative, LTSS agency partners, Medicare and LTSS providers and community partners are involved, as appropriate. • Individualized, person-centered care plans built using information about the supportive and therapeutic needs of each member, including LTSS needs. • Engaging member and/or their representative in care planning, as appropriate, through regular contact during Care Coordination engagement. • Up to date documentation of care plans that reflect member/representative preferences and goals. • Sharing of care plans with members of the care team, as necessary. JCC utilizes health information technology (eg Collective, EPIC and GSI) to assess accurate and up-to-date patient information and use appropriate and secure systems (eg provider portal, secure e-mail, Collective) to electronically share information and facilitate the ready exchange of pertinent member information. Patient outcomes are improved by continuously adjusting the processes and performance of the interdisciplinary care teams through a reoccurring IDT agenda item to discuss cross-systems learning, system barriers and process improvement.	provider(s), to assist JCC with maintaining up-to-date care team documentation. AAA/APD agrees to the following processes and activities to ensure individualized person-centered care plans: • Prior to the IDT, and during care planning, the Case Manager outreaches the client or authorized representative to inform of the case staffing and solicit input regarding goals, preferences, and needs. • Maintain referral process in which the APD/JCC IDT and Care Plan Referral Form is used to request Care Coordination support with IDT and Care Planning • Develop and verbally share individualized person-centered care plans with relevant care team members during IDTs • Continuously improving the processes and performance of the interdisciplinary care teams • Use appropriate and secure systems to electronically share information and facilitate the ready exchange of pertinent member information. • Provide DHS' minimum standards to ensure active participation by LTSS providers in CCO care teams, when appropriate. • Share relevant referral, case management and screening		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)

	JCC and AAA/APD maintain an efficient process for scheduling and facilitating Interdisciplinary Care Team (IDT) meetings on a regular basis. IDTs occur 2x/month between JCC and their county contacts.
	
	Relevant Process Documents:
	
	• JCC Communication Matrix
	
	• Domain 2 – IDT Process Documents (JCC) – Parts 1-8
	
	• Intensive Care Coordination P&P:
	  ○ Communication (pgs. 13-14)
	  ○ Information sharing (pg. 14)
	  ○ ICTs (pgs. 14 – 15)
		information with the care team when staffing clients at JCC case meetings.
		
		AAA/APD follows the process developed in partnership with JCC for scheduling and facilitating Interdisciplinary Care Team (IDT) meetings on a regular basis (2x/month per CCO).
		
		The client or authorized representative will be invited to attend the IDT virtually during COVID, or in person when safe to do so.
		
		Relevant Process Documents:
		
		• JCC Communication Matrix
		• Domain 2 – IDT Process Documents (JCC) – Parts 1-8		

DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	JCC's process for developing and sharing individualized care plans incorporates active treatment plans, supportive and therapeutic needs and member preferences and goals. The care plan promotes self-management of chronic conditions and encourages participation in health promotion and prevention activities. JCC will factor in relevant referral, case management and screening information from LTSS partners in development of collaborative care plans. While engaged with JCC's Care Coordination or Intensive Care Coordination, LTSS members are actively involved in the design and, where applicable, implementation of their treatment and care plans. Care plans are coordinated, reviewed, updated and shared with the member and their care team, as appropriate (LTSS providers, APD/AAA partners, clinical, social service and behavioral health providers). JCC staff will flag care plans for updates every 30 days until case is closed. Individualized care plans developed by the IDT will be discussed with and approved by the member involved, as appropriate and as long as discussing the care plan is not detrimental to the member. Whenever possible, members may be present in IDT meetings and care planning. For every case reviewed at the IDT meeting, an individualized	AAA/APD actively engages individuals in the design, and where applicable, implementation of their LTSS service plan. LTSS partners will factor in relevant referral and case management information from JCC staff in development of collaborative care plans. AAA/APD shares key health-related information, such as risk assessments generated by LTSS providers and their local AAA/APD offices and member, family and/or representative preferences and goals related to service plans. AAA/APD notifies their CCO contact(s) if they identify member barriers to achieving health goals, such as (but not limited to): • Homelessness • Misuse of medications • No phone • Lack of accessible transportation • Minimal or insufficient social supports County partners bring all relevant LTSS member information to the Interdisciplinary Care Team (IDT) meetings to coordinate care for joint clients. Discussions are integrated into individual service or care plans, documented and shared in the "Action Items" section of meeting notes, distributed	# of care plans created or updated every 30 days for LTSS members engaged in care coordination	% 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

	shared care plan will be produced and shared among the care team. JCC staff will share care plans with LTSS partners at bi-weekly IDT Conference Meetings.
	
	For every case reviewed at the IDT meeting, an individualized shared care plan will be produced and shared among the care team.
	
	Relevant Process Documents:
	• JCC Communication Matrix
	• Domain 3 – Individualized Care Plan Process Documents (JCC) – Parts 1-4
	• Intensive Care Coordination P&P:
	  o Care Plans (pg. 12)
	  o Care Plan Updates (pgs. 13)
		by LTSS partners to attendees. Updates are provided at the next meeting.
		
		Collaborative care plans are documented and shared in the “Action Items” section of meeting notes, distributed by LTSS partners to attendees. Updates are provided at the next meeting.
		
		Relevant Process Documents:
		• JCC Communication Matrix
		• Domain 3 – Individualized Care Plan Process Documents (JCC) – Parts 1-4		

DOMAIN 4: Transitional care practices				
DOMAIN 4: Transitional care practices Goals	JCC utilizes Collective Health to identify members in the ED, inpatient or discharging from the hospital. Notifications include encounters where a member is transitioning to or discharging from post-acute care. JCC maintains process for referrals into Transitional Support whether received from external partners, such APD/AAA, member self-referral or through an internal process based on Collective Health notifications. JCC incorporates effective deployment of cross-system resources, such as Collective Health and access to the EHR systems of local partners (ie post-acute facilities, hospital systems) during member case transitions. CCO incorporates pertinent member records into care plan using information sharing methods. JCC works with hospital discharge planners to ensure DME, medications and transport are arranged prior to discharge. When systems issues are identified that impact transitions (delays with a DME vendor, for instance) JCC staff work with partners as appropriate to reduce barriers and expedite processes. JCC has contracted with specially trained Paramedics in supporting JCC members transitioning out of the hospital. When LTSS are needed, they will work directly with our LTSS agency partners to connect to resources.	LTSS partners will coordinate post-placement needs supporting the member's health needs, care preferences, goals, and most cost-effective options to meet the members' needs. AAA/APD follows up as appropriate to any referrals made by JCC for LTSS and completes LTSS assessments and re-assessments as defined by the state and/or requested by JCC. Reassessments are done in coordination with the member. Any relevant findings are shared with JCC. AAA/APD participate in IDT meetings and, as appropriate, care planning related to LTSS members. The IDT scheduling process and standing agenda items ensure clear and effective cross-system collaboration for LTSS members. AAA/APD reviews the CCO's monthly Transitions Report, based on Collective HEN and SNF notifications, and uses it to identify if the LTSS members may require additional information sharing or care planning. **Relevant Process Documents:** • JCC Communication Matrix • Domain 4 - Transitional Care Process Documents (JCC) – Parts 1-7	Readmission rates filtered by LTSS and County/CCO	% 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]

	Every month, JCC cross-references members with the LTSS flag on the 834 file from OHA with a list pulled from Collective of members who have discharged within the past month or are currently inpatient or receiving post-acute care and sends it to their county contacts to make sure both parties are aware of LTSS members experiencing transitions.
	
	Relevant Process Documents:
	
	• JCC Communication Matrix
	• Domain 4 - Transitional Care Process Documents (JCC) – Parts 1-7
	• Intensive Care Coordination P&P:
	  o Settings and Levels of Care (pgs 15-18)
	  o Documentation (pg 18)			

DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	JCC pulls a report from GSI, the Care Management Platform, monthly of current LTSS members receiving Care Coordination and shares with LTSS agency partners. JCC uses Collective Platform information to track current LTSS members receiving Care Coordination services. Collective Platform contains encounter and care planning information that is used to determine if LTSS members may require more assistance with Care Coordination, such as intensive case management. JCC is able to provide external partners with access to our care management platform allowing them to have direct visibility into the care coordination activities and the care plan. JCC ensures regular communication with AAA/APD regarding LTSS members with Collective HEN and SNF notifications. JCC's care planning and care transition processes use these notifications to strengthen continuity of care between facilities and generate referrals into Care Coordination or Intensive Care Coordination, as appropriate. JCC and AAA/APD developed an IDT scheduling process and standing agenda. Which ensures clear and effective cross-system collaboration for LTSS members. CCO developed a communication matrix with AAA/APD to ensure clear communication	AAA/APD partners follow up as appropriate to any referrals made by JCC for LTSS members. AAA/APD completes LTSS assessments and re-assessments as defined by the state and/or requested by JCC and will share any relevant findings with JCC. Reassessments are done in coordination with the member. AAA/APD participate in IDT meetings and, as appropriate, care planning related to LTSS members. The IDT scheduling process and standing agenda items ensure clear and effective cross-system collaboration for LTSS members. AAA/APD reviews the CCO's monthly Transitions Report, based on Collective HEN and SNF notifications, and uses it to identify if the LTSS members may require additional information sharing or care planning.	# Care plans shared with relevant partners through the portal	# 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 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).

	pathways for prioritization, referrals or any other such communication required to assess members receiving Medicaid-Funded LTSS services. For referrals, IDT team meetings, care planning and care transitions, JCC Regional Care Team staff update their county contacts according to the communication matrix.			
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				

Note: Signature page sent in separate attachment

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

Signatures of All MOU parties (APD/AAA and CCO) should be included and signed prior to April 30. OHA/DHS review will occur after CCO submits the MOU. Neither OHA or DHS will require review or co-signature to the MOU.

CCO Authorized Signature: Jennifer Lind, CEO Jackson Care Connect

Jennifer Lind

Signature

Jennifer Lind, CEO

Print Name

APD Field Office Authorized Signature: Jeremy Wolf, Deputy District Manager, Aging and People with Disabilities, District 8

Signature

Print Name

AAA Office Authorized Signature: Constance Wilkerson, Director of Senior and Disability Services, Rogue Valley Council of Governments, Area Agency on Aging

Signature

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Jeremy Wolf

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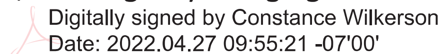
Constance Wilkerson



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Signature

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Print Name

Note: Signature page sent in separate attachment