CCO-LTSS Partnerships MOU Template:

MOU Period: Jan. 1, 2022____ thru Dec. 31, 2022_____

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

CCO Name - Umpqua Health Alliance, LLC_____ OHA Contract # 161767_____

Partner AAA/APD District (s) Names/Locations - DHS Aging and People with Disabilities District 6 office (APD) and Douglas County Senior Service (AAA)_____

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

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s): Keala Meyer, RN, BSN, UHA Care Coordination Project Manager	**APD/AAA Lead(s):**
CCO has a robust membership on the Community Advisory Council that represents members and CCO has a member and community member on our board of directors to represent our members as the voice of consumers. CCO works in collaboration with ATRIO and P3 Health Partners to provide care coordination and transitional care to FBDE members. Referrals are placed by the CCO to P3 Health Partners case managers to provide medical support for FBDE members. P3 Health Partners send referrals to CCO care coordinators to assist with services not provided by ATRIO. The teams hold an interdisciplinary team meeting once a month to collaborate care for the FBDE LTSS members.	The regional Area Agency on Aging is the Douglas County Senior Services Department (DCSS) for District 6. Aging and People with Disabilities (APD) for District 6 (Douglas County) has two offices located in Roseburg and Reedsport Oregon. One advisory council assists with this advocacy. The Disability Services Advisory Council (DSAC) is being formed and will meet to advise local Aging and People with Disabilities (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	UHA utilizes a flag report built from the 834 eligibility file to determine members receiving LTC LTS services. The report is used to coordinate care based on the individualized needs specific to each member, assess for additional needs and collaborate with medical team that is caring for the member. This list of members will be shared via secure email with the APD supervisor or delegated staff member. UHA screens members upon enrollment and annually for risk using a Health Risk Screening. Members identified as those needing LTSS will be referred internally to an ICC care coordinator. The ICC care coordinator will contact the member and conduct a	APD/AAA will participate in bi-monthly IDT meetings to coordinate planned care for CCO members. APD/AAA will report out on status of referrals received at bi-monthly IDT meeting. The following information will be shared at each meeting as needed: provider information, care supports in place, Medicare plans, assessments, treatment and care plans, care transitions, discharge follow-up care, referrals, case worker contact information and any other necessary information to assist in the coordination of	CCO will track referrals to APD/AAA for LTSS needs assessments. CCO will track referrals from APD/AAA for ICC risk assessments. LTSS members with high or unmet needs will be discussed during IDT meetings.	# 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

	needs assessment. Members with needs for LTSS services will be referred to ADP/AAA by the UHA coordinator through phone contact with the screener of the day. APD/AAA will submit referrals for ICC via secure email sent to CaseMangement@umpquahealth.com, the assigned ICC will outreach to the member or designated caregiver to complete an ICC assessment and develop a care plan which will be shared with the member's ADP/AAA caseworker as well as the members medical care team. UHA coordinators and ADP/AAA caseworkers will work collaboratively ensure a member's LTSS needs are met without duplication of services. Information will be shared via bi-monthly IDT meetings or secure email. This includes but is not limited to the member's Health Risk Screening, ICC assessment, individualized care plan, and APD/AAA service plan.UHA will provide APD/AAA staff with updated department and care coordinator contact information. This information	care for the CCO member such as legal guardian information. APD will identify members who have a health condition or are considered a priority population to refer for ICC to the CCO. APD will review reporting of members that declined ICC and determine if outreach from APD case worker may support member in accepting or identify a barrier to being able to participate.		# of completed referrals for ICC review [Monthly/Year Total]

	will be shared via email with the ADP/AAA supervisor.			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	The CCO ICC care coordination team will collaborate with all providers responsible for a member's care, including Medicare and LTSS providers when appropriate, and APD/AAA staff. The care team will include CCO ICC coordinator, APD/AAA case worker, LTC providers, member's PCP, local hospital care managers, as well as other agencies/service providers working with members. To support care teams, UHA will: Schedule bimonthly IDT meetings and Ad hoc conferences for prioritized members These meetings are held via zoom and are reoccurring with invites sent through the end of the year. Members are added to the agenda by the member's care team. The agenda is compiled by UHA and sent out to IDT participants 24-48 hours prior to the meeting. Members added to the IDT agenda are those that are in the acute care setting and skilled nursing facilities, and are experiencing	APD/AAA will participate in interdisciplinary care team meetings to support their member. APD/AAA will define roles, responsibilities and process for assignment of and participation in the CCO IDT team, including coordination with CCO lead care coordinator, for members needing routine and intensive care coordination. Processes by which APD/AAA will ensure that CCO providers/care teams are notified of which CCO members are receiving LTSS services, the relevant local AAA/APD office contact, and contact for relevant LTSS provider. Process clearly articulates how CCO includes APD/AAA (outline scheduling processes); how APD/AAA is contacted for regular IDT meetings or	CCO will track LTSS members that were staffed at the bimonthly IDT meetings that successfully complete identified treatment/care plan goals.	# 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 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)

	increased complexities in the transfer process. The following information to be shared at each meeting as needed: provider information, care supports in place, Medicare plans, assessments, treatment and care plans, care transitions, discharge follow-up care, referrals, case worker contact information and any other necessary information to assist in the coordination of care for the CCO member such as legal guardian information. CCO care coordinators will invite members and/or family or authorized representatives to contribute to IDT meetings. The UHA ICC will be in contact prior to the meeting to ensure the members' goals and preferences are documented in the treatment/care plan. UHA care coordinators will document the IDT meeting, coordination and next steps in the member's chart in Arcadia, UHA's CM platform. Updates to member's care plan will be added and	conferences that ensures APD/AAA will be able to participate in CCO IDT team processes when appropriate Methods to support the appropriate flow of relevant information, implement a standardized approach to effectively plan, communicate, and implement cross-agency care planning and follow-up.		

	shared with APD/AAA caseworker via secure email. Adhoc IDT meetings will be scheduled as needed by the UHA ICC or APD/AAA caseworker. In addition to the UHA ICC and APD/AAA caseworker the member, and/or family or authorized representative, PCP, LTSS service provider, as well as other agencies/service providers working with the member will be invited. Documentation will be added to the member chart and shared as described above.			
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	UHA ICC develops person-centered care plans by identifying preferences and goals of the LTSS member or family/caregiver in collaboration with APD/AAA case workers, members' PCP, LTC provider, affiliated DSNP case managers and community and social support providers. Care planning begins with the ICC completing a Health Risk Assessment along with ICC assessment with the member or member representative	APD will provide consumer preference from CA/PS to ensure alignment with care plan APD/AAA will actively engage individuals in the design, and where applicable, implementation of their LTSS service plan, in coordination with CCO where relevant to health care treatment and care planning.	CCO will track completed care plans for members with LTSS. CCO will utilize the Collective Medical platform to identify and engage members with LTSS to reduce unnecessary hospitalizations, ER visits and engage members with LTSS.	% 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

	that identifies special health care needs, complex medical conditions, advance care planning needs, barriers to care, including language access, SDOH, NEMT. A medication review/reconciliation is also completed during the assessment. The results of these assessments drive the goals and interventions within the care plan. UHA will continue to collaborate with the member's care team to follow up on the goals set forth in the care plan. Collaboration ensures services are not duplicated while the member is connected to resources to meet their individualized goals. Care plans will be shared during bimonthly IDT meetings, discussion with the member, and via secure email with member permission. Care plans will be updated and shared among the care team at least every 90 days or when a member's care plan changes as a result of a triggering event as defined in OAR 410-141-3870.	APD/AAA will contact CCOs when they have referrals for ICC or otherwise have identified gaps or concerns about health care needs of members with LTSS.		
DOMAIN 4: Transitional care practices				
DOMAIN 4: Transitional care practices Goals	UHA has policies in place to guide care coordination for members as they	APD will communicate and collaborate on transitions of care identified within LTSS/Home and Community	CCO will monitor transitions of care where collaboration occurred with APD/AAA. CCO will identify successes, delays	% transitions where CCO communicated about discharge

	transition from one care setting to another or home. UHA discharge planners complete an inpatient assessment to identify needs early in admission to ensure a successful transition to the next care setting or back home. When members are found to have new or increased LTSS need the discharge planner will assist the member to contact the APD office or contact the office on the member's behalf to begin coordination of a screening for services. If the member is already receiving LTSS through APD/AAA the discharge planner will coordinate with the APD Transition Team to review changes in condition and collaborate to provide a resolution to changes. Discharge planners also work closely with the hospital care managers to ensure a safe discharge plan is in place prior to the member transitioning out of the acute care setting. Discharge planning includes DME, NEMT, medications, home health services and to ensure the entirety of discharge orders follow the member to the next setting or home. Discharge planners communicate changes in condition and	Based Care supporting least restrictive consumer choice. This is managed through a Transition and Diversion team who review and update through assessment. They will reach out as needed to CCO staff to communicate consumers preparing for transition to ensure that discharge orders are in place. APD will assist in warm hand off to a receiving APD agency. Document how partners are coordinating to ensure successful transitions, transition resources including but not limited to: • Process to coordinate appropriate discharge planning and ensure LTSS services are in place prior to discharge where needed • Communication strategies and expectations (how do you address regular hour vs.	of discharge and areas where improvement can be made. CCO will conduct debrief meetings when the transition was not smooth.	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]

	discharge plans internally with the transitional care nurses, CHWs, assigned ICC when they are enrolled in services, and behavioral health coordinators for those needing behavioral health or SUD services. UHA's transitional care (TC) team contact members within 1 business day of discharge. The call to members coordinates a nurse home visit within 3 business days of hospital discharge, when the member is agreeable, that includes an assessment, medication reconciliation, education, and coordination of follow up care. Members that are not agreeable to a home visit are offered a phone or clinic visit. TC staff ensure discharge plans are in place, member has picked up medications and transportation is in place for follow up care. Referrals will be made for identified SDOH needs or assigned to a UHA CHW to assist member. Transitional care nurses collaborate with the member's care team to communicate changes in the care plan. A warm handoff is completed to the assigned UHA ICC and	evening/weekend transitions?) • Scheduling for key follow-up assessments, planning for transportation needs, medication reconciliations before transition happens • Processes to share information and support the appropriate flow of relevant information; implement a standardized approach to effectively plan, communicate, and implement transition and care planning and follow-up • Identify cross system resources and how they may be used during transitions Incorporates processes for planning for different types of transitions including transitions to and from hospitals from in-home, community-based facility, long term nursing		

	The transitional care team follows members during SNF and ICF stays communicating with facility staff, or member when feasible, to facilitate discharge home or to LTC placement. When UHA becomes aware that a member receiving LTSS though APD/AAA will be moving outside of Douglas County, the ICC will notify the member's APD/AAA case worker via secure email. Member's ICC will assist the member during the transition by coordinating continued access to services as defined in OAR 410-141-3850.	facilities and post-acute settings (skilled nursing facility care) as well as transitions between these settings. APD/AAA provides detail on best way to contact staff for LTSS assessments. APD will work with CCO, OHA and medical providers on durable medical equipment and environmental modifications needed for successful transitions.		
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	UHA uses Collective Medical to: • Provide the members assigned care coordinators name and contact information when enrolled in care coordination services. • Upload the transitional care assessment, individual care plan to share with provider offices utilizing collective medical andP3 care managers that provide case management	APD Transition and Diversion team monitor hospital event and skilled nursing facility notifications through Collective and will notify CCO on members noted as having a change of condition or change to their service plan	CCO will use Collective Medical to track HEN and SNF notifications that result in collaboration with or referral to APD/AAA teams for LTSS services.	# 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

	full benefit dual eligible members.. • Track ED visits, admissions, and discharges from hospitals and SNF. This facilitates appropriate discharge planning and referral to APD/AAA services when indicated. When an UHA member is identified for referral to APD/AAA, we telephonically reach out to the screener of the day at APD to initiate this referral process. Once a member is approved for services and assigned a case worker secure email and phone calls will be the main communication pathway between UHA and APD/AAA. UHA will provide contact information for designated leads, care coordinators and process documents to APD/AAA. These will be updated when roles or processes change.			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).
OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals	CCO will share with APD/AAA when and how our CHWs support out members. CCO will explain to APD/AAA the process for members and community	APD/AAA will share needed info/resources with CCO for members	CCO will document how and when information was shared with APD/AAA to support members/	

	partners to access Health Related Services for special requests to support uncovered health related expenses. CCO will share with APD/AAA additional supportive resources that the CCO or community partners can provide to members with LTSS.			
OPTIONAL DOMAIN B: Health Promotion and Prevention				
OPTIONAL DOMAIN B: Safeguards for Members Goals				
OPTIONAL DOMAIN C: Safeguards for Members				
OPTIONAL DOMAIN C: Cross-System Learning Goals				

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

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

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

DocuSigned by:
Brent Eichman
9E391EC121CF439...

Brent Eichman, Umpqua Health Alliance, Chief Executive Officer 4/29/2022

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

DocuSigned by:
Thomas Maloney
5EA148E5C65F94E4...

Thomas Maloney, APD District Manager District 6 4/29/2022

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

DocuSigned by:
Jeanne Wright
F94F01D2C11646B...

Jeanne Wright, Douglas County Senior & Disability Services Director 4/29/2022