OHA/DHS Guidance

Shared Accountability for Long Term Services & Supports (LTSS) – Memorandum of Understanding (MOU)

Shared Accountability

Each CCO is responsible for delivering high quality, person-centered health care to members, including members receiving Medicaid-funded LTSS community based care including adult foster homes, residential care facilities, assisted living facilities, nursing facilities, in home services and supports and other settings. Medicaid-funded LTSS services are legislatively excluded from CCO budgets and are paid for directly by the Department of Human Services (DHS). Local LTSS offices authorize, manage and monitor these LTSS services. In some regions of the state, these responsibilities are carried out by DHS/ Aging and People with Disabilities (APD) field offices, and in other regions, DHS has contracted with Type B Area Agencies on Aging (AAAs).

In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTSS system are responsible for coordinating care and sharing accountability for outcomes for the individuals served by both CCOs and the local LTSS office. OHA/DHS worked closely with stakeholders to develop four strategies for shared accountability, including:

1. Requirements to coordinate in the CCO contract (MOUs) and Oregon Administrative Rule;
2. MOU outlining how the CCO and LTSS local office will communicate, coordinate and how the partners will hold each other accountable;
3. Reporting of key domain activity measures (see Domain Activity measures, Monitoring, Evaluation section); and
4. Shared financial accountability, including incentives or penalties related to performance on key metrics is a long range goal and there is no current timeframe for this work.

The purpose of these strategies is to ensure that coordination between the two systems is occurring. A second and equally important purpose is systems alignment to provide quality care, produce the best health and functional outcomes for individuals, avoid cost shifting between systems

and prevent escalation of costs for both systems. A strong partnership focused on these goals supports Oregon's triple aim of better care, better health and lower costs.

One of the four accountability strategies is the completion of a MOU between the CCO and the local Aging and People with Disabilities (APD)/Area Agency on Aging (AAA) office. MOUs are a tool for sustaining and enhancing working relationships and processes between these entities and holds both systems accountable for outcomes.

Purpose/Scope of this Guidance:

This document is intended to provide guidance and technical support for the completion of an MOU with an emphasis on local flexibility and innovation.

The guidance content outlines specific minimum expectations for CCOs and LTSS offices about three required domains in MOUs. It includes the process and timeline for review/approval of MOUs and expectations around monitoring including MOU domain activity measurements and evaluation. In addition, the guidance provides information around eight optional domains that OHA/DHS encourages MOU partners to include in their agreements.

This guidance covers MOUs between CCOs and:

- Type B Area Agencies on Aging (AAA)
- State of Oregon Aging and People with Disabilities (APD) districts
- Other partners mutually agreed on by the CCO and the AAA or APD district

This guidance does not cover:

- MOUs or contracts that CCOs are required to have with local mental health authorities, community mental health programs, community developmental disability programs or support service brokerages.
- The three-way contract required for the Medicare/Medicaid Alignment demonstration between the Center for Medicaid Services (CMS), the State, and the CCO.
- MOUs or contracts that CCOs may choose to enter into in order to provide transformational services envisioned beyond the expectations outlined in this document.

Process for creating a MOU:

The MOU will be created jointly by CCO and the LTSS office serving that area. It should reflect the capabilities and resources of the local entities and may be different from MOUs created by other organizations around the state.

A discussion about shared goals may assist in creating agreements that are strong and relevant. Shared goals include:

- Providing better care and services
- Creating better health outcomes
- Preventing/avoiding cost shifting
- Reducing disparities based on race, ethnicity or limited language or issues of health literacy
- Creating a better experience for the individual
- Lowering costs; and
- Pursuing innovative and transformational approaches to care

A suggested beginning point for discussion is to get an understanding of each entity's current capabilities, processes, language and terminology, and limitations in each of the required domain areas. Having a shared understanding of the services, philosophy, and operational capabilities of both the CCO and LTSS office should aid in the development of the MOU.

Key considerations in MOU development include:

- Who is the lead contact in each organization for day to day operation of MOU?
- What is the process for assessing whether the MOU meets local goals?
- What are the methods for resolving disputes/problem solving?

Minimum Domains:

The minimum domains that must be addressed in the LTSS/CCO MOU are:

1. Interdisciplinary care coordination
2. Transitional care practices
3. Member engagement

The guidance has sections for each required domain and documents expectations for the CCO and LTSS office that must be addressed in the

MOU. The discussion questions that follow are suggested questions to assist in working out the agreed upon activities that meet the expectations. The questions are not required to be asked or formally submitted as part of the MOU process. For the required domains, domain activity measurements are listed after the discussion questions.

MOU partners are encouraged to also include optional MOU domains that are relevant to alignment and coordination. Expectations, discussion questions and guidance for optional domains are included in this guidance. The optional domains are:

A. Use of evidence based and best practices
B. Health Promotion and Prevention
C. Access to Member Resources and Responsibilities to Facilitate Access
D. Governance structure
E. Cross System Learning
F. Expanding relationships with Person Centered Primary Care Home (PCPCH) and LTSS providers
G. Safeguards for members
H. Information Sharing

In addition, as part of the framework for the discussion, MOU partners should consider that Health System Transformation efforts place emphasis on wellness and prevention and include newer roles and approaches. These include flexible services such as new non-traditional health care workers (community health workers, peer wellness specialists and health care navigators), as well as flexible service approaches. Discussion and shared understanding about these approaches and resources should inform collaboration and planning to reach shared goals.

Finally, discussion should include expectations around an acceptable level of performance related to shared accountability for individuals receiving LTSS served by the CCO. More information on shared accountability can be found in the Domain Activity Measures, Monitoring and Evaluation section.

DHS/OHA is available for technical support upon request. The contact person to request assistance is: Naomi.E.Sacks@dhsoha.state.or.us

DHS/OHA Review/Approval Process:

DHS/OHA will review MOUs to ensure that each of the three required domains are sufficiently addressed. In addition, DHS/APD central office will sign all MOUs with APD LTSS local offices, and will countersign MOUs with Type B AAAs.

Time Line- CCO/LTSS MOU

The original guidance for MOUs was written in 2012. This guidance has been updated to reflect current practice after three years of annual MOUs. MOUs for 2016-2017 should be consistent with the revised guidance. This may be achieved through new MOUs or by updating a 2015-2016 MOU to comply with this guidance (such as changes in the required domains) and going through the review and signature process. All 2016-2017 MOUs must end June 30, 2017.

Effective July 1, 2017, MOUs will be two year agreements to match the state biennium.

The MOU development cycle begins with sharing of any guidance updates, negotiation of new MOU, submission to DHS for DHS/OHA review, DHS/OHA technical assistance feedback if needed, CCO/AAA or APD signatures or revisions based on technical assistance and re-submission for review, return to DHS/OHA for final approval, signatures and execution.

Standard Timeline:

- April /May-CCO and AAA/APD offices define process for completing MOU, meet as needed to complete MOU and send to DHS/OHA for review.
- June 1 –**No later than deadline:** MOUs due to APD/OHA for review.
- June 15 –**No later than deadline**: APD/OHA review completed and feedback provided.
- June 30- **No later than deadline**: MOU fully signed by CCO and APD/AAA parties and returned to DHS for execution.
- July 1 – 2016-2017 MOU operational Ongoing- Monitoring, Domain Activity Measurement and evaluation

Domain Activity Measures, Monitoring and Evaluation

Domain Activity Measures:

This guideline includes domain activity measures to be reported quarterly to measure progress related to the three required MOU domains. In addition, the completion rate of shared accountability activities will be reported. Domain activity measures reporting will be posted on the shared accountability web site, reported to APD/AAA and shared with OHA.

MOU partners are encouraged to develop domain activity measures or other evaluation tools for any optional domains included in their MOUs.

Shared Accountability Mechanisms:

MOU requirements include stating how the CCO and the LTSS office will hold each other mutually accountable for agreed upon activities.

Suggested shared accountability activities include the following:

1. Regularly scheduled at a minimum quarterly meetings to review and assess:
    a. whether MOU agreements have been carried out and to what extent
    b. identification of strengths of the MOU
    c. challenges or barriers to meeting MOU agreements
    d. unexpected opportunities
    e. informal/anecdotal outcomes

2. Documentation of meetings and a work plan or other methodology to track next steps and follow up

3. MOUs revision to adjust agreement to reflect substantive changes *Note: MOU revisions must go through the same review and approval process as new MOUs;*

4. Identify domain activity measures or other evaluation tools related to optional MOU domains or other specific CCO/LTSS office joint efforts or goals;

5. Measure and report outcomes for the CCO members in LTSS to assess coordination and joint efforts impacts on individuals served by both systems, for example: track and share service utilization and costs pre and post care conferences. Include measurement and reporting related to health equity.

6. Joint review and discussion of CCO performance on CCO metrics by disability and age when data is available. MOU activities may be designed to address disparities that are revealed.

To foster agreement on shared accountability activities, the following questions may help guide discussion:

1. What does each entity feel is an initial acceptable level of assistance that they can provide to each other to meet key performance expectations?
2. How might performance expectations be raised over time? What are the key or compelling transformative changes that entities would like to see for important populations or sub-populations in the community (e.g. increased tenure in HCBS for people with Mental Illness)?
3. How will each side hold itself accountable in addition to the shared accountability mechanisms holding each other accountable?
4. How will each side document, share and report out on progress and achievements in performance expectations?

In addition to domain activity measures and building mutual accountability into MOUs, DHS/OHA will monitor MOUs in a number of ways:

1. Troubleshooting, informal check-ins as requested by MOU partners
2. Joint evaluation in standing CCO meetings (OHA alignment or other as appropriate) to assess how shared accountability is working, whether MOUs are effective, and what structures and relationships have developed including identify challenges, barriers, best practices, lessons learned
3. CCO contract monitoring and participation in contract revisions to assure mechanisms are in place supporting full MOU implementatio

Required Domains:

Interdisciplinary Care Teams

CCO and AAA/APD partners will establish inter-disciplinary care teams, consisting of providers such as CCO, PCP, LTSS and APD/AAA representatives, as well as other agencies/services providers working with the members. The interdisciplinary care teams will coordinate care and develop individualized care plans for high needs, mutual members.

Minimum Expectations

MOU shall:

- Address how CCOs and APD/AAA share information to identify and select high needs members
- Include how often care teams meet
- Describe care team members from diverse disciplines and identify a lead from each partner agency
- Describe how LTSS providers will be included in care teams, when relevant
- Describe how members are included in the care coordination process
- Document how care plans are developed by the inter-disciplinary team
- Explain how members' goals and preferences inform and are documented in the care plan
- Explain how care plans are shared and updated among care team members

Questions for Discussion:

1. How has care coordination across our systems been going? Rate 1-5 and discuss reasons.
2. Describe your care coordination practices, including any specific practices related to members receiving long term services and supports, those not receiving LTSS services and members who are Medicare-Medicaid eligible.
3. Describe how you are screening for high needs members, including successes and challenges.

4. What other partners are you including in your care coordination activities?
5. Are you receiving and if so, what in the LTSS-CCO data report that APD/AAA shares monthly is useful to you in care coordination? Are there common definition elements (safety, preservation of living situation, costs, cultural and linguistic barriers, etc.?) that create natural focus areas and a shared definition?
6. What should be the process for prioritizing high risk members? How will the process assure that individuals who are traditionally underserved be included amongst the highest priority group for interdisciplinary care coordination? What other sources of data are you looking at to identify underserved populations? (Examples include those with chronic conditions and mental health or developmental disabilities, those with culturally specific needs, those with language or access barriers, people living in residential and institutional settings, those at risk of inpatient psychiatric hospitalization, those receiving intensive mental health services or those that have transitioned from the Oregon State Hospital.)
7. Who is tracking the follow up and outcomes from inter disciplinary care conferences?
8. Are there other individualized care plans you are aware of? For example at primary care clinics. Are there strategies for consolidating plans?

Domain Activity measures:

- % of CCO/APD/AAA teams that are meeting on a regular schedule to coordinate care for high need members;
- % of CCO MOU partners and APD/AAA districts that have integrated risk screening data to generate a list of prioritized high needs members to refer for care coordination;
- % of CCO individualized person-centered care coordination plans that document member or member representative preferences and goals;
- % of inter-disciplinary care teams that have a clearly-designated lead from CCO or other designated health care organization and from APD/AAA;

- % of teams that invite long term services and supports providers and PCPs when relevant, with appropriate releases as required by privacy rules and policy.

Transitional Care Practices:

CCO and AAA/APD partners will develop coordinated transitional care practices that incorporate cross system education, timely-information-sharing when transitions occur, minimal cross-system duplication of effort, and effective deployment of cross-system nursing and psycho-social resources at any time members experience a transition in their care setting.

Minimum Expectations

MOU shall:

- Document how partners are sharing information about transitions, transition resources
- Identify areas for training needs and plans for training
- Describe how to access information and how information sharing will happen
- Identify cross system resources and how they may be used during transitions
- Describe how partners will document/map transition processes. The written document/map should detail roles and responsibilities, minimum frequency of meetings or communications and method of communication.

Questions for Discussion:

1. How are members engaged in transitions and their preferences respected? What tools, checks or safeguards does each system use to ensure comprehensive transition care planning? Can these tools be shared?
2. Are you meeting any statutory, contract or administrative rule time frames for communication around transitions? If not, are there barriers that we can address together?
3. How do the systems work together to address member choices in transitions that increase risk? How are flexible services and

approaches, Medicaid long term services and supports benefits and other resources included in transition planning?

4. How are transitions defined? (examples: hospital to NF, home, nursing facilities to CBC, after evictions, across CCO and APD/AAA borders (out of area), LTSS service to non-services, out of programs (no longer eligible) What transitions are we working on together?
5. How are transitions tracked? What are measures of successful transitions? How do we hold each other accountable for performance on transitions?

Domain Activity measures:

- % of MOU partners that have mapped the transitional care practices in their areas
- % of MOU partners that developed a procedure for coordinating and communicating around transitions of care

Member Engagement:

CCO and AAA/APD partners will increase member/client engagement in the care conference process.

Minimum Expectations

MOU shall:

- Address, at a minimum how members are engaged or present in inter-disciplinary care coordination teams and care planning
- Address member /client access to needed services
- As applicable, promote self-management of chronic conditions and participation in health promotion /prevention activities
- Describe how member input for care conferences is captured within four weeks prior to the care conference and included in the care conference
- Explain how the care plan is reviewed with the member within four weeks after the care conference

Questions for Discussion:

1. How are individuals currently engaged in their care?
2. How are individual preferences currently captured?
3. How can the CCO and AAA/APD share information on individual preferences?
4. How can client specific supports for individual engagement and preferences be coordinated between the AAA/APD and CCO?
5. What are concerns and perceived barriers to full member engagement?

Domain Activity measures:

- % of members that are engaged in the care conference process prior to a conference
- % of time the care plan is reviewed with the consumer after the care conference

Optional Domains:

Health System Transformation efforts place emphasis on wellness and prevention and include new roles and approaches that should be considered during your discussions. These include flexible services such as new non-traditional health care workers (community health workers, peer wellness specialists and health care navigators), evidence-based health promotion, prevention, and self-management activities, as well as flexible service approaches (see glossary for definition). Discussion and shared understanding about these approaches and resources should inform collaboration and planning to reach shared goals. Below are additional domains of coordination and alignment found in the Strategic Framework for Coordination and Alignment between CCOs and Long Term e of the potential for improved coordination and alignment of LTC and CCO activities, but are not required to be addressed in the final MOU.

A. Use of evidence based and best practices
B. Health Promotion and Prevention

C. Access to Member Resources and Responsibilities to Facilitate Access
D. Governance structure
E. Cross System Learning
F. Expanding relationships with Person Centered Primary Care Home (PCPCH) and LTSS providers
G. Safeguards for members
H. Information Sharing

A. Use of Evidence based and Best Practices

CCO Expectations:	**APD/AAA Expectations:**
CCO will describe capacity and plans for ensuring that best, promising and evidence based practices are used for CCO members who are receiving LTSS	AAA/APD will describe capacity and plans for ensuring that best, promising and evidence based practices are applied to CCO members receiving LTSS and support CCO efforts to do likewise

Questions for Discussion

1. To what extent does each entity have knowledge of best practices around care coordination, care transitions and evidence based healthy aging programs?
2. What best and promising practices does each entity currently train/use that can be applied to interactions between the CCO/LTC systems?
3. Are flexible services included in the consideration of best practices?
4. Does either entity have a quality improvement program or joint initiatives related to care coordination, care transitions, or people who are eligible for Medicare and Medicaid? What capacity does the CCO have to coordinate care on non-aligned, dually-eligible members? What capacity does the LTSS system have to coordinate care on non-LTSS service members?
5. Other than joint training what ongoing methods such as pilots and collaborative projects can we use to identify and implement evolving best and evidence-based practices?
6. How will we hold ourselves accountable?

Guidance:

Plan to describe or offer best practices re: care coordination/transitions/ health aging. Identify resources to support best practices.

B. Health Promotion and Prevention

CCO Expectations:	**APD/AAA Expectations:**
CCO measurements OAR 410-141-3160 shall ensure access to effective wellness.	APD/AAA will provide health promotion and prevention services or work in collaboration with CCOs and other partners to support access and engagement in such services.

Questions for Discussion:

1. What programs does your organization already support or supported in the past?
2. What barriers might impede new prevention programs?
3. What needs have been identified in your community (through community health assessment or other data sources) that health and prevention programs might address? Are services available in the community to address health issues of CCO members?
4. Is health prevention/promotion part of member individualized care plans?
5. Are flexible funds used for health prevention/promotion activities?

Guidance:

The use of evidence based programs is expected. Pilots to explore partnerships to increase consumer access and engagement in evidence based programs is encouraged. Pilot tracking and sharing of outcomes will assist with planning and investing in future joint efforts.

C. Access to Member Resources and Responsibilities to Facilitate Access

CCO Expectations:	APD/AAA Expectations:
Tools developed for members will be accessible to individuals receiving LTSS services and supports and/or their family or representative.	AAA/APD will provide if requested, information to members, family caregivers and LTSS providers about member's rights in regard to CCO services.

Questions for Discussion:

1. Are partners holding themselves mutually responsible for providing accurate, comprehensive, consistent, consumer friendly informational materials? Are members directed to the best sources of information?
2. Are partners well informed about each other's services?
3. Is targeted communication to members discussed with partners before release to members to enhance communication effectiveness? How are needed materials and learning opportunities currently made available to members? What are the important factors (health literacy, culturally appropriate transmission of information) in making information accessible to individuals receiving long term care? How can we ensure that we incorporate these factors into outreach, education materials, or any other form of communication?
4. Are there new ways to meet consumer expectations that information and guidance will be available about public programs, health benefits and services?
5. Would cross training between entities be beneficial in assisting members and providers to understand beneficiary materials?
6. Are there provider systems in place to track referrals and follow-up? Is feedback given to any referral source?
7. Do LTSS providers see they have a role in sharing information and

Guidance:

Sharing each other's current standards and practices may assist with identifying strategies for greater consistency and efficiency in member access to information.

E. Governance Structure

CCO Expectations:	**APD/AAA Expectations:**
CCO will clearly articulate: How CCO governance structure will reflect the needs of members receiving LTC services and supports, for example through representation on the governing board, community advisory council or clinical advisory panel.	AAA/APD will participate at the community level in the board / Advisory panel for LTSS perspective. AAA 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). APD will articulate how APD will include CCO participation in their policy development structures.

Questions for Discussion:

1. What types of governance structures might benefit from each entity's involvement? How?
2. What roles and responsibilities could both entities play in each other's governance structures to support better consumer representation and consideration of LTC consumer needs?
3. How can AAA/APD expertise in LTC consumer needs be helpful and /or included in CCO structures?
4. How can CCO medical expertise be helpful and included in AAA/APD governance structures?
5. How do population and service data in your service area influence governance structure membership?
6. How will we hold ourselves accountable?

Guidance:

In developing MOU, APD/AAA management will participate in CCO boards or any CCO LTC advisory panels and similarly, CCO representatives will participate in the AAA advisory council and/or APD/AAA policy and development.

F. Cross System Learning

CCO Expectations:	**APD/AAA Expectations:**
Each CCO participates in the cross system learning	AAA/APD will participate in cross system learning

Questions for Discussion:

1. How can we create and support a learning environment between our organizations?
2. What does cross system learning mean to each entity?
3. What resources and people are available to support cross system learning?
4. What cross system learning topics are the top priorities for local action, for example, care coordination, evidence based health promotions, transitions across settings, eligibility for long term services and supports?
5. How will we hold ourselves accountable?

Guidance:

There is mutual responsibility to foster cross system collaborations, training and shared learning to reach the Triple Aim. Local offices may wish to have their own cross system learning training or on-going joint efforts and action to focus on best practices.

G. Expanding relationships with Person Centered Primary Care Home (PCPCH) and LTSS providers

CCO Expectations:	**APD/AAA Expectations:**

CCO will encourage communication related to care coordination between LTSS providers and PCPCH providers. CCO will partner with the local AAA/APD office to develop a method for coordinating services with PCPCH providers for members receiving LTC services.	AAA/APD will encourage communication related to care coordination between LTSS providers and PCPCH providers. APD/AAA will partner with the CCO to develop a method for coordinating services with PCPCH providers for members receiving LTSS services.

Questions for Discussion:

1. How many and which PCPCH(s) contracts does the CCO have? What is the nature and scope of the PCPCH- CCO relationship(s)?
2. What is the relationship between LTSS providers and LTSS offices? How are LTSS providers involved in supporting or participating in care coordination activities?
3. What is the relationship among care coordination activities at the CCO, PCPCH(s) and LTSS and LTSS providers? What opportunities are there to coordinate with PCPCH(s) and LTSS providers, cross train to understand resources, navigate and access services across organizations?
4. Are alternate payment methodologies being used with PCPCH(s) and LTSS providers? What projects can the CCO and LTSS jointly support through alternate payment methodologies?
5. How will we hold ourselves accountable?

Guidance:

In a changing care environment involving the growing use of PCPCH and LTSS providers, how will each entity support members and each other with effective communication, coordination, and education?

H. Safeguards for Members

CCO Expectations:	**APD/AAA Expectations:**

CCO will coordinate access to peer wellness specialists, personal health navigators, and community health workers where appropriate and develop processes facilitating coordination with LTC services to maximize efficiencies. CCO will describe how planned or established mechanisms for managing member complaints and grievances will be linked to, coordinated with, and inform team- based care practices for members in LTC. CCO will foster with PCPCH and other medical partners an understanding of and respect for client's right to self-determination when there are safety risks and also engaging partners in managing risks.	AAA/APD will assist with access to choice counseling materials and processes and materials governing member rights, responsibilities, and understanding of benefits. AAA/APD will educate staff about access to peer wellness specialists, personal health navigators, and community health workers and facilitating coordination with LTC services to maximize efficiencies. AAA/APD will coordinate with CCOs on member complaints and grievances for CCO members. AAA/APD will educate CCOs, PCPCHs and other medical partners about client's right to self-determination and respecting client choices including when there are safety risks and also engage partners in managing risks.

Questions for Discussion:

1. What are the barriers to access in each system?
2. Is information about the use of ancillary services such as traditional health workers being shared across organizations?
3. How will the CCO and AAA/APD work together to ensure that members have information about how to navigate systems?
4. How will each entity work together to coordinate a no wrong door policy for member complaints and grievances?
5. How will traditional health care worker activities be aligned and coordinated with LTC services to support active member involvement in care?

6. How are the systems working together to ensure the client's right to self-determination is respected including situations in which there are safety risks?
7. How will we hold ourselves accountable?

Guidance:

The MOU should detail what is shared by each entity regarding the other. Agreements developed should take a "no wrong door" approach to addressing individual's questions/issues and seek to find solutions at the lowest level appropriate.

I. Information –sharing

CCO Expectations:	**APD/AAA Expectations:**
As part of the HIT improvement plan, CCO will identify a strategy to partner with the LTC system to improve upon any existing efforts to share information electronically.	AAA/APD will partner with CCO in developing electronic information sharing strategy. DHS/APD will develop mechanisms to improve the sharing of relevant DHS Information with CCOs.

Questions for Discussion:

1. What do we need to share and understand about our respective information systems?
2. What opportunities exist for electronic sharing of information?
3. What are the challenges to electronic information sharing and are there "low tech" solutions?
4. Who should be involved from our organizations in developing a plan for electronic data sharing?
5. How will we hold ourselves accountable?

Guidance:

This area covers the improvement of information-sharing between CCOs and APD/AAAs including sharing data on mutual members, sharing service/care plans, communicating about transitions of care, and communicating for the purposes of care coordination and care planning. MOU shall at a minimum include how information will be shared with current resources, goals or plans on how to improve or overcome technological limitations, shall describe what protocols are in place to assure member privacy while sharing information needed in order to best jointly serve members and encourage secure information exchange.