Memorandum of Understanding

Medicaid-funded long term care (LTC) services are legislatively excluded from Coordinated Care Organization (CCO) budgets and will continue to be paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services.

Purpose

In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to coordinate care and share accountability for individuals receiving Medicaid-funded long term care services.

This is a non-binding agreement ("Agreement") between Yamhill Community Care Organization (CCO), and NorthWest Senior & Disability Services (AAA), Clackamas County (APD) office, and Washington County (APD) office. The mutual goal of the Agreement is to improve person-centered care, align care and service delivery and provide the right amount of care at the right time for beneficiaries across the LTC system. In order to achieve these goals, the parties to this Agreement desire to set forth their respective roles and responsibilities to coordinate care and share accountability for Medicaid funded long term care.

Agreement

Now therefore, CCO and AAA/APD agree to participate in the following activities:

1. Prioritization of high needs members in LTC		
CCO Expectation	Area Agency on Aging (AAA)/Aging and People with Disabilities (APD) Expectation	CCO/AAA/APD agreements:
• CCOs will continue to work with AAA to refine universal screening processes that	• AAA/APD will provide CCOs with access to information needed to	In order to assist with selection of members designated as "high risk", AAA/APD agrees to share with CCO the service priority level and information from standardized

assesses individuals for critical risk factors that trigger intensive care coordination for high needs members receiving Medicaid funded LTC services. o CCO will factor in relevant referral, risk assessment and screening information from local AAA/APD offices and LTC providers. • CCOs will work with AAA to continue to refine how it will communicate and coordinate with AAA/APD when assessing members receiving Medicaid-funded LTC services.	identify members with high health care needs.	risk assessment in the Client Assessment and Planning System (CA/PS), of individuals with service priority levels ranging from 1-13, living in their own home or in a community based setting, or those individuals having the potential to need LTSS and intensive care coordination in the near future Additionally, AAA/APD agrees to share with CCO information regarding in-home service clients the Case Manager believes to be at risk due to accepting lower than authorized care plan, or anyone with a notice for eviction or involuntary move out. CCO agrees to share information from community health assessments and individual risk assessments of individuals and communities defined as high risk with designated AAA/APD staff. As CCO and APD data systems are improved to provide more consumer information, new data sources will be incorporated into information sharing. Methods of information sharing: • Information will be shared monthly by the 15th of the month. Information will be shared electronically if available, by fax or email to the designated contact person or back-up. CCO and AAA/APD agree to coordinate and each submit at least one case of mutual concern for discussion, using a standardized presentation format at least one week prior to the Multidisciplinary Care Team (MDT). These

		high need members will receive intense care coordination as defined in this document. Additionally, it is agreed that either CCO or AAA/APD may offer up individual members for consideration of intensive care coordination outside of the specific parameters listed here.
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		CCO and AAA/APD agree to conduct regular meetings, meeting at least quarterly, to discuss efficacy of this criteria and suggest areas of improvement. This domain will also be addressed in internal policies and procedures within each organization.

2. Development of individualized care plans		
CCO Expectation	AAA/APD Expectation	MOU activities
• CCOs' individualized person-centered care plans will include information about the supportive and therapeutic needs of each member, including LTC services and supports needs. o Plans will reflect member or family/caregiver preferences and goals	• AAA/APD will define how it will integrate key health-related information, including risk assessments generated by LTC providers and local Medicaid AAA/APD offices into CCOs' individualized care	The CCO will share information with AAA/APD on individual health goals, the client's choice of living situation as noted on DHS client choice form, and their stated client preferences and goals as documented in CA/PS. Contact information for surrogate decision makers will also be provided (conservator, legal guardian, and health care power of attorney) as Agency is aware. For members other than those receiving care in their

captured in AAA/APD service plans as appropriate. o Individualized person-centered care plans will be jointly shared and coordinated with relevant staff from AAA/APD, LTC providers, and other relevant members of the interdisciplinary care team.	plans for members with intensive care coordination needs.	own home; current care provider type and contact information will be relayed by AAA/APD to CCO. CCO will provide AAA/APD information regarding member's health goals to be included in AAA/APD long term care file. Information from all sources will be integrated into the member's individual service or care plans.
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		CCO and AAA/APD agree to conduct regular meetings, meeting at least quarterly, to discuss efficacy of this criteria and suggest areas of improvement. This domain will also be addressed in internal policies and procedures within each organization

3. Transitional care practices

CCO Expectation	AAA/APD Expectation	MOU activities
• CCO will demonstrate how it will coordinate and communicate with AAA/APD to incent and monitor improved transitions in care for members receiving LTC services and supports, so that these members receive comprehensive transitional care,	• AAA/APD will demonstrate how it will coordinate and communicate with CCO to incent and monitor improved transitions in care for members receiving	AAA/APD will notify CCO as soon as reasonable but not to exceed 7 days of receipt of information regarding member move or change in setting. Including; date of move, new address, type of LTC setting, member contact number, provider contact number. CCO to reciprocate if they are aware of move first; including acute hospitalizations.

as required by HB 3650.	LTC services and supports, so that these members receive comprehensive transitional care, as required by HB 3650.	AAA/APD and CCO will work collaboratively to develop agreements around post hospital/skilled placement and roles that are most efficient, yet prevent cost shifting or increases to LTC nursing home case load.
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		AAA/APD will continue to monitor ICF Nursing Home Count. Additionally, CCO and AAA/APD will collaborate on members who are transitioning between care settings to ensure positive outcomes for members.

4. Member engagement and preferences		
CCO Expectation	AAA/APD Expectation	MOU activities
• CCO will actively engage members in the design and, where applicable, implementation of their treatment and care plans, in coordination with AAA/APD where relevant to LTC service	• AAA/APD will actively engage individuals in the design, and where applicable, implementation of their LTC service plan, in coordination	AAA/APD agrees to share with CCO pertinent details of individual member barriers to achieving health goals that staff are aware of. This includes; homelessness, misuse of medications, no phone, lack of accessible transportation, minimal or insufficient social supports. CCO will share with AAA/APD similar barriers to achieving

planning.	with CCO where relevant to health care treatment and care planning.	health goals; member routinely does not follow up with scheduled appointments, does not have primary care provider, known gaps in provider capacity in the community. Level of patient activation will be measured using PAM scores or other evidence-based instruments, before and after the implementation of any special programs as appropriate. Examples of special programs include YCCO Community Health Workers (CHW) Hub, Living Well Programs, TaiChi for Better Balance, Chronic Disease Self-Management program (CDSMP), Diabetes Self-Management Program (DSMP), Chronic Pain Self- Management Program (CPSMP), and other self-management programs
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		CCO and AAA/APD are each committed to establishing and maintaining effective communication through regularly scheduled meetings.

5. Establishing member care teams		
CCO Expectation	AAA/APD Expectation	MOU activities

• CCO will support the flow of information to AAA/APD.	• AAA/APD will define roles, responsibilities and process for assignment of and participation in the CCO care team, including coordination with CCO lead care coordinator, for members needing routine and intensive care coordination.	With regard to members identified as "high need" as outlined in number 1 of this document, AAA/APD and CCO agree to; develop efficient processes for multidisciplinary care team (MDT) meetings, identify contacts for MDT and convene MDT monthly.
• The CCO-appointed lead provider or care team will confer with all providers responsible for a member's care, including LTC providers and AAA/APD.	• AAA/APD will ensure that CCO providers/care teams are notified of which CCO members are receiving LTC, the relevant local AAA/APD office contact, and contact for relevant LTC provider.	Please see numbers 2 and 3 of this document.
• To support care teams, CCO will o Work with AAA/APD to ensure that it identifies members receiving LTC services. o Include LTC providers and AAA/APD case managers as part of the team based care	• AAA/APD will have knowledge of and actively participate in CCO team based care processes when appropriate.	CCO and AAA/APD recognize the importance of providing team-based care. The two organizations will work towards utilizing health information technology (e.g. Crimson Care Connect) that enables members of the interdisciplinary care team to assess patient information that is accurate and up to date. Both organizations agree that team-based care is essential to improving patient outcomes and are committed towards continuously enhancing the performance of the interdisciplinary care teams. We will continue to secure electronic e-mail thus facilitating the ready exchange of

approach.		information identified in this document.
• Adapt team-based care approaches and the use of the lead coordinator to accommodate the unique needs of individuals receiving LTC services.	• DHS will provide minimum standards to ensure participation by LTC providers in CCO care teams.	CCO and AAA/APD agree to work towards integrating appropriate staff into the interdisciplinary care team. This integration will enable both organizations to provide care that reflects the unique needs of each member. Both organizations will identify case management software that facilitates the documentation and provision of care provided by the interdisciplinary care team.
• MOU will address how CCO and APD/AAA will hold themselves accountable to meeting these expectations		CCO and AAA/APD agree to conduct regular meetings, meeting at least quarterly, to discuss efficacy of this criteria and suggest areas of improvement. This domain will also be addressed in internal policies and procedures within each organization.

Signatures and Contacts

For Yamhill Community Care Organization, LLC (CCO)
The designated contact person is:

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Authorizing Signature

June 9, 2014
Date

For NorthWest Senior & Disability Services (AAA)
The designated contact person is:

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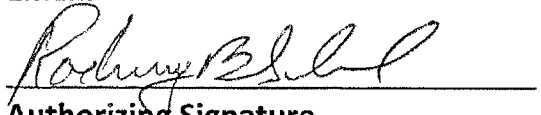

Authorizing Signature

6/19/14
Date

For Clackamas County (APD)
The designated contact person is:

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[signature] 6/19/2014
Authorizing Signature Date

For Washington County (APD)
The designated contact person is:

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Authorizing Signature Date

For DHS, Aging and People with Disabilities Division, Central Office
The designated contact person is:

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Authorizing Signature **Date**