

Memorandum of Understanding

Long Term Care Coordination between Pacific Source Community Solutions, Inc. and Department of Human Services Aging & People with Disabilities Program District 11

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. In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCO's 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 between PacificSource Community Solutions, Inc. and Aging and People with Disabilities District 11. The mutual goal of the proposed agreement is to improve person-centered care, align care and service delivery and provide the right amount of care, in the right place at the right time for beneficiaries across the LTC system; based on the roles and responsibilities of each entity, recognizing the purpose is to ensure coordination between two systems to provide quality care, produce the best health and functional outcomes for individuals to prevent escalation of costs for both systems.

DHS APD District 11 covers the following geographic area: Klamath County (Chemult, Diamond Lake 97731, Crescent 97733, Gilchrist 97737 and East Lake 97739). Each entity agrees to participate in an annual MOU. The following work plan has activities for the period of July 1, 2014 – June 30, 2015.

PSCS & DHS APD District 11 ~ Long Term Care MOU

Domain 1: Prioritization of High Needs Members

Objective	Activities	Shared Accountability	Deliverables & Outcomes
<p>Aligned definition of high needs members</p>	<p>Identify high needs users considering these primary identification factors:</p> <ul style="list-style-type: none"> • APD SPL Levels 1-13 • ER and Hospital Utilization • PSCS Risk Score • Complex Conditions • Claims Data • Mental Health • Behavioral Health • Chemical Dependency • Complicating Circumstances • New Information 	<p>APD: LTSS Innovator Agents (LTSS IA), Case Managers (CM), Transition Coordinators (TC), and Supervisory Team</p> <p>PSCS: Member Support Specialists & Care Team</p> <p><i>District LTSS IA will conduct a Quarterly process review providing support to PSCS and APD</i></p>	<p>Identification of high needs members by APD and PSCS using agreed upon primary identification factors</p> <p>Aligned definition for care coordination will potentially reduce avoidable ED visits and hospital readmissions while increasing care coordination for identified high needs members</p>
<p>Monthly information sharing from APD LTC list and PSCS complex patient reports</p>	<p>APD LTC list report (SPL's 1-13) shared timely with PSCS MSS team</p> <p>PSCS Complex Patient Report per County/ service area shared timely with APD</p>	<p>APD: LTSS IA</p> <p>PSCS: Member Support Specialists and Care Team</p>	<p>APD and PSCS develop high needs patient reports to inform agenda and discussions of Integrated Care Management (ICM) meetings and related activities</p> <p>APD and PSCS develop prioritized lists of members who have high health care needs</p> <p>Monthly reports shared in a timely fashion</p>
<p>Identify Candidates for Individualized Care Plans (ICPs)</p>	<p>APD and PSCS will utilize reports to identify candidates for ICMs and other members who would benefit from care coordination, ICPs and case management</p>	<p>APD: LTSS IA, supervisory team and field staff</p> <p>PSCS: Member Support Specialists and Care Team</p> <p><i>LTSS IA to track ICM process and report on client impact/outcomes to PSCS and APD</i></p>	<p>Enhance coordination between PSCS and APD via ICM meetings and related activities</p> <p>PSCS & APD identify candidates for ICMs and other members who would benefit from care coordination and case management from among prioritized list of high needs members</p>

Domain 2: Development of Individualized Care Plans

Objective	Activities	Shared Accountability	Deliverables & Outcomes
Individualized Care Plans (ICPs) are informed by ICM meetings	APD & PSCS share data (e.g., CAPS assessment) to inform each other, increase care coordination, and improve the efficient use of resources for each member APD & PSCS use member data to identify service gaps, develop ICPs, and to improve integrated care management	APD: CMs and TCS PSCS: Member Support Specialists and Care Team <i>LTSS IA will conduct a quarterly process review to evaluate the impacts of information sharing to review with APD & PSCS</i>	PSCS & APD share Individualized Care Plans (ICPs) for selected members via ICM meetings and related activities with a goal of improving health outcomes, client health literacy and ensure that plans reflect member or family/caregiver preferences and goals to ensure engagement and member satisfaction with care Increased flow of information and alignment of care for identified members Coordinated APD and PSCS follow-up on ICPs developed via ICM meetings and related activities

Domain 3: Transitional Care Practices

Objective	Activities	Shared Accountability	Deliverables & Outcomes
Increased coordination and communication to ensure timely and comprehensive patient centered transition	Define and share existing processes for transitional care <i>01/01/2015</i> APD and PSCS identify opportunities to improve transitions via collaboration, including education on LTC service choice and placement options, with providers, hospital discharge planners, nursing facility case managers, PSCS Member Support and APD Transition teams APD and PSCS will explore mutually agreeable processes regarding transitions of care (e.g., nurse case managers meeting with transition coordinators and other appropriate parties. PSCS and APD will explore strategies to enhance information sharing between hospitals, APD, PSCS, LTC facilities and others	APD: LTSS IA, CMs, TCS and Supervisory Team PSCS: Member Support Specialists and Care Team <i>LTSS IA will monitor improvements in transitions to assist and establish relevant communication pathways</i>	APD & PSCS mutual understanding and documentation of processes of transitional care to increase coordination Increased coordination to expedite appropriate transitions in care

Domain 4: Member Engagement & Preference

Objective	Activities	Shared Accountability	Deliverables & Outcomes
Member preferences are accurately reflected in Individualized Care Plans (ICPs)	PSCS shares results of ICM interview and follow-up APD shares results of actively engaging members via choice counseling in the design and implementation of their LTC service plan	APD: CMS PSCS: Member Support Specialists and Care Team <i>LTSS IA will gather feedback for quarterly process review with APD & PSCS</i>	ICPs include increased member input informed by member preferences

Domain 5: Establishing Member Care Teams

Objective	Activities	Shared Accountability	Deliverables & Outcomes
Develop Integrated Care Management (ICM) teams to work jointly on Individualized Care Plans (ICPs) for identified members during ICM meetings and related activities	APD and PSCS coordinate involvement of appropriate providers and partners APD and PSCS explore existence of additional community resources to enhance members care	APD: LTSS IA, CMs and Supervisory Team PSCS: Member Support Specialists and Care Team	Identify participants and define roles of members of ICM team. <i>Team members identified and contact list created by 10/01/2014</i>
Develop schedule for regular CCO APD LTC ICM meetings	APD & PSCS conduct monthly ICM meetings and related activities	APD: LTSS IA, CMs and Supervisory Team PSCS: Member Support Specialists and Care Team	APD & PSCS conduct monthly ICM meetings and related activities including appropriate providers and partners, resulting in regular discussion of LTC members identified as candidates for ICPs and development of ICPs
Define ICM process for APD and PSCS	APD and PSCS identify member candidates for ICPs to be developed via ICM meetings and related activities and form agenda for ICM meetings APD and PSCS develop ICPs including action plans and follow-up activities APD and PSCS document ICM process, define performance metrics, and report on activities and outcomes	APD: LTSS IA, CMs and Supervisory Team PSCS: Member Support Specialists and Care Team <i>LTSS IA to track ICM process monthly for support, outcomes and evaluation to review with APD & PSCS</i>	Establish APD & PSCS process for conduct of ICM meetings and related activities APD & PSCS define, document, and report performance towards metrics measuring ICM impacts

Optional Domain A: Use of Best Practices			
Objective	Activities	Shared Accountability	Deliverables & Outcomes
Ensure consideration of best practices in the development of ICPs and the conduct of ICM activities	PSCS and APD identify and consider best practices via literature searches, discussion with other APD and COO organizations, and participation in related education and industry conferences	APD: LTSS IA, CMs and Supervisory Team PSCS: Member Support Specialists and Care Team	APD and PSCS concerted efforts to identify, share, and consider best practice approaches involving care coordination, transitions and evidence based health aging programs related to serving individuals in LTC setting <i>Evaluation of potential coordination and implementation by 06/01/2015</i>

Optional Domain B: Use of Health Information			
Objective	Activities	Shared Accountability	Deliverables & Outcomes
Develop mechanisms to improve sharing of information electronically	APD and PSCS explore development of electronic templates, EHR documentation, and information sharing to support the development of ICPs, electronic documentation and communication of relevant information	APD: LTSS IA and Supervisory Team PSCS: Member Support Specialists and Care Team	APD and PSCS develop electronic templates, EHR records, and information sharing protocols APD will support PSCS in developing electronic information sharing by developing mechanisms to improve the sharing of relevant DHS information with PSCS
Explore possibility of health information exchange	APD and PSCS explore strategies to connect the processes with Health Information Exchange platforms in planning and/or under development	APD: LTSS IA and Supervisory Team PSCS: Member Support Specialists and Care Team	APD and PSCS identify potential content and requirements involved in connecting to and accessing Health Information Exchange platforms

Optional Domain F: Learning Collaborative			
Objective	Activities	Shared Accountability	Deliverables & Outcomes
Provide education and resources to support process improvement and enhance collaborations	APD & PSCS will participate in learning collaboratives on relevant topics concerning LTC such as care coordination, best practices, APD programs, community resources, processes, PSCS policies, etc.	APD: LTSS IA, CMs and Supervisory Team PSCS: Member Support Specialists and Care Team	APD and PSCS familiarized with each other's systems, business models, policies, and practices Enhanced care coordination and integrated care management through participation in identified learning collaborative

Optional Domain H: Member Safeguards

Objective	Activities	Shared Accountability	Deliverables & Outcomes
Ensure ICPs are informed by member input and preferences, and the ICM process is responsive to provisions for member protection and ensuring member rights	APD and PSCS will review and strengthen the influence on ICP development, where appropriate, of member preferences, issues identified via grievance and appeals processes, and findings via other sources of member oriented activities	APD: LTSS IA, CMs and Supervisory Team PSCS: Member Support Specialists and Care Team LTSS IA will share trends with APD & PSCS	Increased member oriented development of ICPs via the ICM process

Designated MOU Contacts:

Pacific Source Community Solutions, Inc.

Name Dan Stevens

Email dan.stevens@pacificsource.com

Phone 541-706-5011

Authorizing signature 

Date 7/30/14

Department of Human Services Aging & People with Disabilities District 10

Name Gloria Peña

Email Gloria.Pena@state.oreg.us

Phone (541) 851-8922

Authorizing signature 

Date 7/31/14

Department of Human Services, Central Office

Name Patricia Buxter

Email patricia.buxter@state.oreg.us

Phone 503-945-5858

Authorizing signature 

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