CCO-LTSS Partnerships MOU Template

MOU Period: January 1, 2025____ through December 31, 2026_____

Please submit your CCO's CCO-LTSS MOU(s) by March 31, 2025 through the CCO portal at via the Contract Deliverables portal located at https://oha-cco.powerappsportals.us/. This report content is subject to public posting and redaction. It will be shared without redaction with the Centers for Medicare and Medicaid Services (CMS) and with the Oregon Department of Human Services. Final MOUs will be posted at https://www.oregon.gov/oha/hsd/ohp/pages/cco-ltss.aspx

CCO Name: Columbia Pacific CCO, LLC **OHA Contract # 161757-6**

Partner AAA/APD District (s) Names/Locations:

- Northwest Senior & Disability Services (NWSDS) in a) Warrenton, Clatsop County; b) Tillamook, Tillamook County;
- Columbia County APD in St. Helens, Columbia County; 3) Community Action Team (CAT) (AAA) in St. Helens, Columbia County.

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

Executive Summary

2024 was a significant year for LTSS intensive care coordination services at CPCCO. The switch of documentation and management platforms to Epic Compass Rose in November 2023 and the passing of new OARs in late 2024 meant that Q1 and Q2 2024 were spent reviewing, rewriting, rebuilding, and retraining care coordination workflows and monitoring activities. Despite these and other operational barriers, CPCCO increased the number of members referred for LTSS year-over-year from 2023-2024. Staffing levels remain adequate for the expected volume of referrals in 2025-2026.

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s):	APD/AAA Lead(s):
For CPCCO and its local AAA/APD, governance and oversight of the partnership is provided through quarterly meetings between the two groups. LTSS-eligible members with Medicare plans other than CareOregon Advantage, will have additional stakeholders included in their IDT meetings as appropriate. CPCCO 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. All CPCCO health plan members are eligible to participate or be members of CPCCO's Community Advisory Councils. CPCCO has one local council in each county and a regional council made of the Chair and Co-Chairs of the local councils. There are established bi-directional communication pathways to assure member and community voice in decision-making at the CCO. Every effort is made to recruit, engage and support advisory council members to assure that they are representative of the community. To that end, there are currently two CAC members in Tillamook County and two CAC members in Clatsop County who represent the LTSS member and provider community.	Northwest Senior and Disability Services (NWSDS) is the Area Agency on Aging for Clatsop and Tillamook Counties. APD covers Columbia and Washington Counties, the remaining catchment areas for CPCCO. As the AAA for the area, eligibility specialists determine if an applicant qualifies for Medicaid/Oregon Health Plan, and Case Managers determine whether in-home services are appropriate for individuals needing assistance with daily living. The agency also provides health and wellness services, fall prevention services, nutrition services, and behavioral health services. AAA: The agency's Board of Directors consists of County Commissioners from each of the counties in our service district. In addition, the Board is assisted by a Senior Advisory Council and a Disability Services Advisory Council. There are representatives from both districts on both consumer boards. Both councils make recommendations on programs, policies, and decisions affecting agency services.

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	CPCCO developed and is currently using an information sharing framework with our local AAA/APD to ensure clear communication pathways for prioritization, referrals, or any other exchange required to assess members receiving Medicaid-funded LTSS services. This includes the sharing of key data and activities/processes used to identify, assess, and prioritize high needs members, such as risk stratification level and screening, relevant utilization history, referrals, HUSN history, clinical status, contact information for CCO staff leading the risk assessment, or similar exchange required to assess members receiving Medicaid-funded LTSS services. Acting with intentional continuous improvement, the communication framework is reviewed at IDT meetings and updated as needed. CPCCO identifies and prioritizes high need members through the following means: • OHA's 834 file - The member's chart is updated within CPCCO's care management platform to reflect if they are flagged as LTSS on this file	AAA/APD developed and is currently using an information sharing framework with CPCCO to ensure the clear communication of key data and activities/processes used to identify, assess, and prioritize high-needs members receiving Medicaid-funded LTSS services. This includes risk stratification level and screening, relevant utilization history, referrals, HRSN history, clinical status, contact information for CCO staff leading the risk assessment, or similar exchange required to assess members. APD/AAA identifies and prioritizes high need members through the following means: • 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 for needs. • Monthly report from CPCCO's care management platform of current LTSS members receiving Care Coordination	Monitor for months with no referrals received Monitor for deviation from agreed upon information sharing framework	# of members with LTSS that prioritization data was shared during each month [Monthly/Year Total] # of CCO referrals to APD/AAA for new LTSS service assessments (for persons with unmet needs) [Monthly/Year Total] # of APD/AAA referrals to CCO for ICC review [Month and Year Totals]

	• Monthly report from CPCCO's care management platform of current LTSS members receiving Care Coordination services – Pulled by CPCCO and shared with AAA/APD. • Referrals - Received from member or external partners, such as APD/AAA and LTSS partners. • *LTSS Monthly Prioritized Data Report* - CPCCO uses PointClickCare's event notifications to pull a monthly report of LTSS members who had a Hospital Event Notifications (HEN), and/or Skilled Nursing Facility Event Notifications (SNF) that is shared with AAA/APD. A review of CPCCO's referral numbers over the past three years shows a steady increase in volume. Any individual member can be considered for intensive care coordination by CPCCO or AAA/APD. The universal screening process, administered by CPCCO, assesses individuals for critical risk factors that trigger intensive care coordination for high needs members receiving Medicaid-funded LTSS services. These range from care coordination and transitional care assessments, health risk assessments, cognitive and functional assessments, and others. CPCCO 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 PointClickCare LTSS	services – Pulled by CPCCO and shared with AAA/APD. LTSS Agency Partners submit referral forms to CPCCO on members they would like to staff at the next bi-weekly IDT Conference Meeting. AAA/APD will assist with care coordination within the scope of its funded programs but shall not assume responsibility for unfunded care coordination tasks assigned to CCO. AAA/APD provides CPCCO access to information needed to identify LTSS members with high care needs, as requested. The information may include: • 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 plans. • Loss of housing due to an eviction notice or involuntary move out • Any other bio-psychosocial factor(s) influencing their stability in their current environment. LTSS Agency Partners review cases of those CPCCO high-risk members identified on the shared spreadsheet in advance of the next scheduled IDT Conference Meeting.		

	member list with an internal list of high needs members and those receiving care coordination. CPCCO 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. CPCCO staff reviews records of members referred by LTSS partners in advance of the next IDT Conference Meeting. CPCCO shares information from screenings, assessments, and/or changes in health status with designated AAA/APD staff through secure e-mail, secure text/chat, Epic, PointClickCare, phone, fax, or during IDTs. Referrals are tracked and care coordination work (member ICTs and ICPs, and transitions) is monitored leveraging the reporting tools within Epic Compass Rose.			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	CPCCO recognizes the value of team-based care for improving member outcomes, and agrees to the following:	AAA/APD agrees to the following processes and activities to ensure individualized person-centered care plans:	# of members with LTSS that are addressed/staffed via	# of members with LTSS that are addressed/staffed via IDT

	• Use 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). • Consider a broad list of possible ICT resources, including the member/member's representative, the CCO, the member's PCP or specialist(s), and LTSS/AAA/APD representatives. • Develop individualized, person-centered care plans built using information about the supportive and therapeutic needs of each member, including LTSS needs. • Engage member and/or their representative in care planning, as appropriate, through regular contact during Care Coordination engagement. • Maintain up-to-date care plans that reflect member/representative preferences and goals. • Share care plans with members of the care team, as necessary. CPCCO 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 CPCCO and their LTSS Agency Partners. CPCCO leverages health information technology (PointClickCare and Epic) to access accurate and up-to-date patient information and use	• Support coordination of care for members with both routine and intensive care coordination needs. • Invite the member or their authorized representative to attend the IDT, virtually or in-person when safe to do so. • AAA/APD notifies 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 provider(s), to assist CPCCO with maintaining up-to-date care team documentation. AAA/APD will provide data to the extent that existing reporting mechanisms allow. New tracking or reporting obligations shall not be implemented without prior agreement on funding and feasibility. Prior to the IDT, and during care planning, the Case Manager outreaches to the member or authorized representative to inform of the case staffing and solicit input regarding goals, preferences, and needs. Maintain referral process in which the APD/CPCCO IDT and Care Plan Referral Form is used to request Care Coordination support with IDT and Care Planning.	case conference monthly	meetings monthly. [Monthly/Year Total] % of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month. % 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) [Monthly/Year]

	appropriate and secure systems 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.	• Develop and verbally share individualized person-centered care plans with relevant care team members during IDTs. • Continuously improve the processes and performance of the IDTs. • 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 information with the IDT when staffing clients at CPCCO case meetings. AAA/APD will participate in performance tracking to the extent that data is readily available and reporting does not exceed existing programmatic capacity. New reporting requirements must be negotiated annually. AAA/APD follows the process developed in partnership with CPCCO for scheduling and facilitating IDT meetings on a regular basis (2x/month per CCO). AAA/APD will participate in governance and advisory processes as appropriate and as resources allow. If participation in biweekly MDTs presents a resource constraint, an alternative frequency may be agreed upon between the parties.		

DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	CPCCO individualized care plans (ICPs) incorporate 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. CPCCO factors in relevant referral, case management, and screening information from LTSS partners in development of collaborative care plans. While engaged with CPCCO's Care Coordination or Intensive Care Coordination, LTSS members are actively involved in the design and implementation of their treatment and care plans. CPCCO identifies opportunities to focus on preventive approaches, screenings, and strategies to reduce unnecessary hospitalizations, ER visits, and maintain or improve the health of members with LTSS. Care plans are coordinated, reviewed, updated, and shared with the member and their care team (LTSS providers, APD/AAA partners, clinical, social service and behavioral health providers). CPCCO staff update ICPs every 30 days until the case is closed.	AAA/APD actively engages individuals in the design, and where applicable, implementation of their LTSS service plan. County partners bring all relevant LTSS member information to the Interdisciplinary Care Team (IDT) meetings to coordinate care for joint clients. LTSS partners will factor in relevant referral and case management information from CPCCO 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: ○ Homelessness ○ Misuse of medications ○ No phone ○ Lack of accessible transportation ○ Minimal or insufficient social supports Discussions are integrated into individual service or care plans, documented and shared in the "Action Items" section of meeting notes, and distributed by LTSS partners to attendees. Updates are provided at the next meeting.	% of care plans created or updated every 30 days for LTSS members engaged in care coordination	# of members with LTSS that received individualized care plans during each month [Monthly/Year Total] % of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals [month/year]

	Individualized care plans developed by the IDT will be discussed with and approved by the member involved, as appropriate, 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 shared care plan will be produced and shared among the care team. CPCCO staff will share care plans with LTSS partners at bi-weekly IDT Conference Meetings.			
DOMAIN 4: Transitional care practices/Care Setting Transitions				
DOMAIN 4: Transitional care practices goals	CPCCO utilizes PointClickCare (PCC) and Epic Compass Rose 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. CPCCO maintains a process for referrals into a Transitional Support program, whether received from external partners (such APD/AAA), member self-referral, or through internal review based on these notifications. CPCCO incorporates effective deployment of cross-system resources, such as PCC and access to the EHR systems of local partners (i.e. post-acute facilities, hospital systems) during member transitions episodes.	AAA/APD partners coordinate post-placement 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 CPCCO for LTSS members and completes LTSS assessments and re-assessments as defined by the state and/or requested by CPCCO. Reassessments are done in coordination with the member. Any relevant findings are shared with CPCCO. 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.	Readmission rates filtered by LTSS and County/CCO	# of transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? Total number of transitions tracked per month (baseline) % 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? [Monthly/Year]

	CPCCO works with hospital discharge planners to ensure DME, medication, and transportation are arranged prior to discharge. When systems issues are identified that impact transitions (delays with a DME vendor, for instance), CPCCO staff work with partners to reduce barriers and expedite discharge. Every month, CPCCO cross-references members with the LTSS flag on the 834 file from OHA with a list pulled from PCC of members who have discharged within the past month or are currently inpatient or receiving post-acute care and sends the report to LTSS Agency Partners to make sure both parties are aware of LTSS members experiencing transitions.	AAA/APD reviews the CCO's monthly Transitions Report, based on PCC HEN and SNF notifications, and uses it to identify if the LTSS members may require additional information sharing or care planning. AAA/APD participation in care transitions shall be limited to its statutory and contractual obligations. This MOU shall not be used to shift costs or responsibilities to AAA/APD without prior agreement and funding.		# of members receiving post-transition meeting of the interdisciplinary team (IDT) within fourteen (14) days of a transition between levels, settings or episodes of care. % of these post-transition IDT meetings that included the member or member's representative in the meeting
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	CPCCO is committed to reducing duplication of services and assessments and improving member experience and outcomes through more integrated approaches to care planning. Clear, detailed, specific communication processes are essential to ensuring this takes place. The information sharing framework described in Domain 1 serves as the foundation for these processes. For referrals, IDT team meetings, care planning, and care transitions, CPCCO Regional Care Team staff update their county contacts according to that guidance.	AAA/APD partners are committed to reducing duplication of services and assessments and improving member experience and outcomes through more integrated approaches to care planning. AAA/APD completes LTSS assessments and re-assessments as defined by the state and/or requested by CPCCO and shares any relevant findings with CPCCO. AAA/APD participate in IDT meetings and, as appropriate, care planning related to LTSS members. The IDT scheduling process and standing agenda items for joint meetings ensure	% of members with LTSS whose care plans were shared with relevant partners through the portal	# of CCO PointClickCare Platform HEN notifications monthly result in CCO follow-up or consultation with APD/AAA teams for members with LTSS or newly in-need of LTSS assessments. [Monthly/Year] # of CCO PointClickCare Platform SNF notifications monthly that result in CCO follow-up or consultation with APD/AAA teams for members with LTSS or newly in-need of

	CPCCO uses an ad hoc report from Epic Compass Rose at least monthly, to track the status of current LTSS members engaged in care coordination. CPCCO uses the PointClickCare (PCC) system to track hospital event notifications (HENs) and Skilled Nursing Facility (SNF) notifications, which are also presented to care coordination staff as event flags in a member's chart in Epic Compass Rose. The encounter and care planning information from PCC is used to determine if LTSS members may require more assistance with care coordination, such as intensive case management. These notifications strengthen continuity of care between facilities and generate referrals. CPCCO provides external partners with access to Epic Compass Rose, allowing them to have direct visibility into the care coordination activities and care plan, and avoid delays associated with information sharing across teams. CPCCO and AAA/APD jointly developed an IDT scheduling process and standing agenda, which facilitates clear and effective cross-system collaboration for LTSS members.	clear and effective cross-system collaboration for LTSS members. AAA/APD reviews the CCO's monthly Transitions Report, based on PCC HEN and SNF notifications, and uses it to identify if LTSS members may require additional information sharing or care planning. AAA/APD will participate in performance tracking to the extent that data is readily available and reporting does not exceed existing programmatic capacity. New reporting requirements must be negotiated annually. AAA/APD will provide data to the extent that existing reporting mechanisms allow. New tracking or reporting obligations shall not be implemented without prior agreement on funding and feasibility.		LTSS assessments [Monthly/Year] 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				
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 March 31, 2025. OHA/DHS review will occur after CCO submits the MOU. Neither OHA nor DHS will require review or co-signature to the MOU.

Mimi Haley, CEO Columbia Pacific CCO DocuSigned by: Mimi Haley 2D4E439ED7614AB... 3/31/2025

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

Christina Pattugalan

3/31/25

Christina Pattugalan, District Manager, Washington and Columbia Counties, Aging and People with Disabilities

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

Lavinia Goto

3/31/25

Lavinia Goto, Project Manager, Long Term Care Innovation, NWSDS & Director of Operations, Oregon Wellness Network, O4AD

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

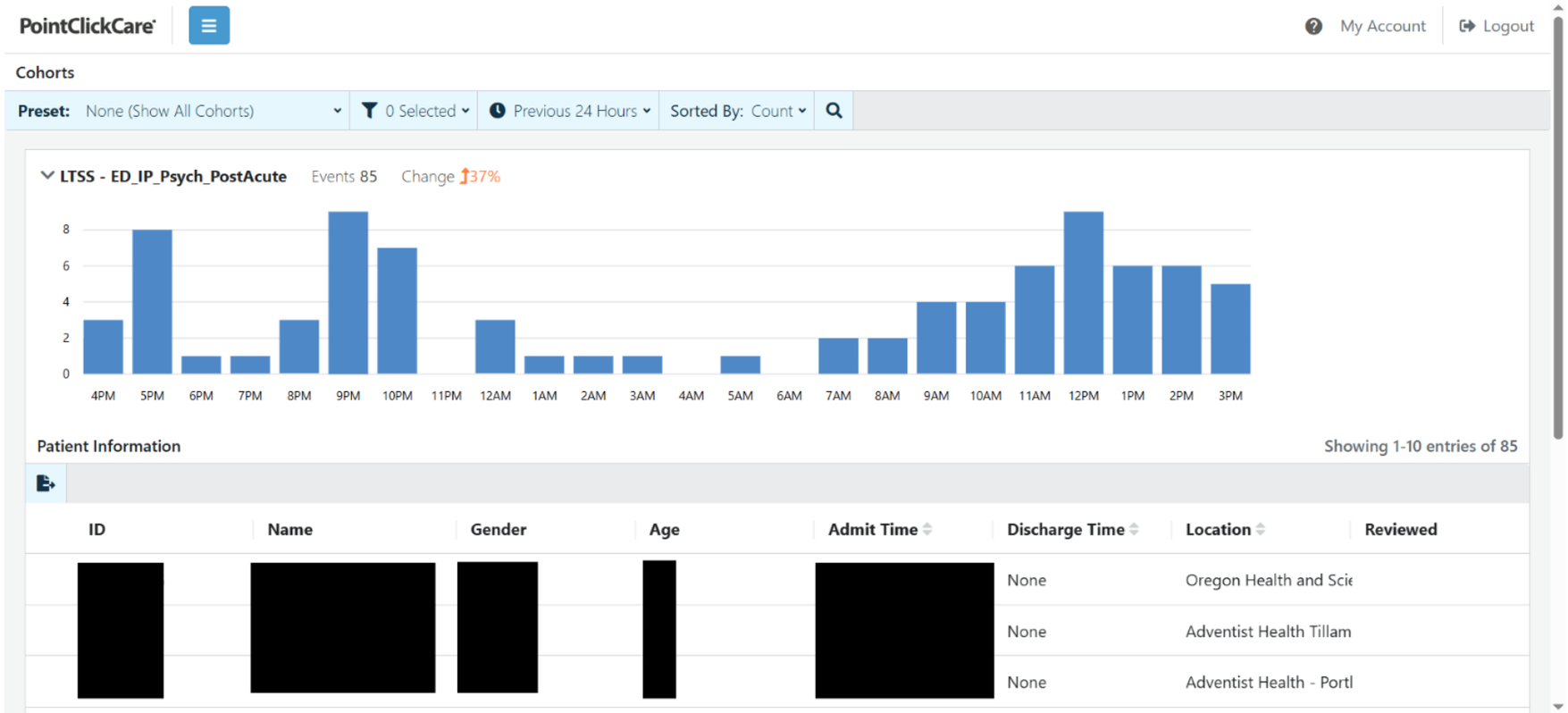
APPENDIX

Relevant Documents

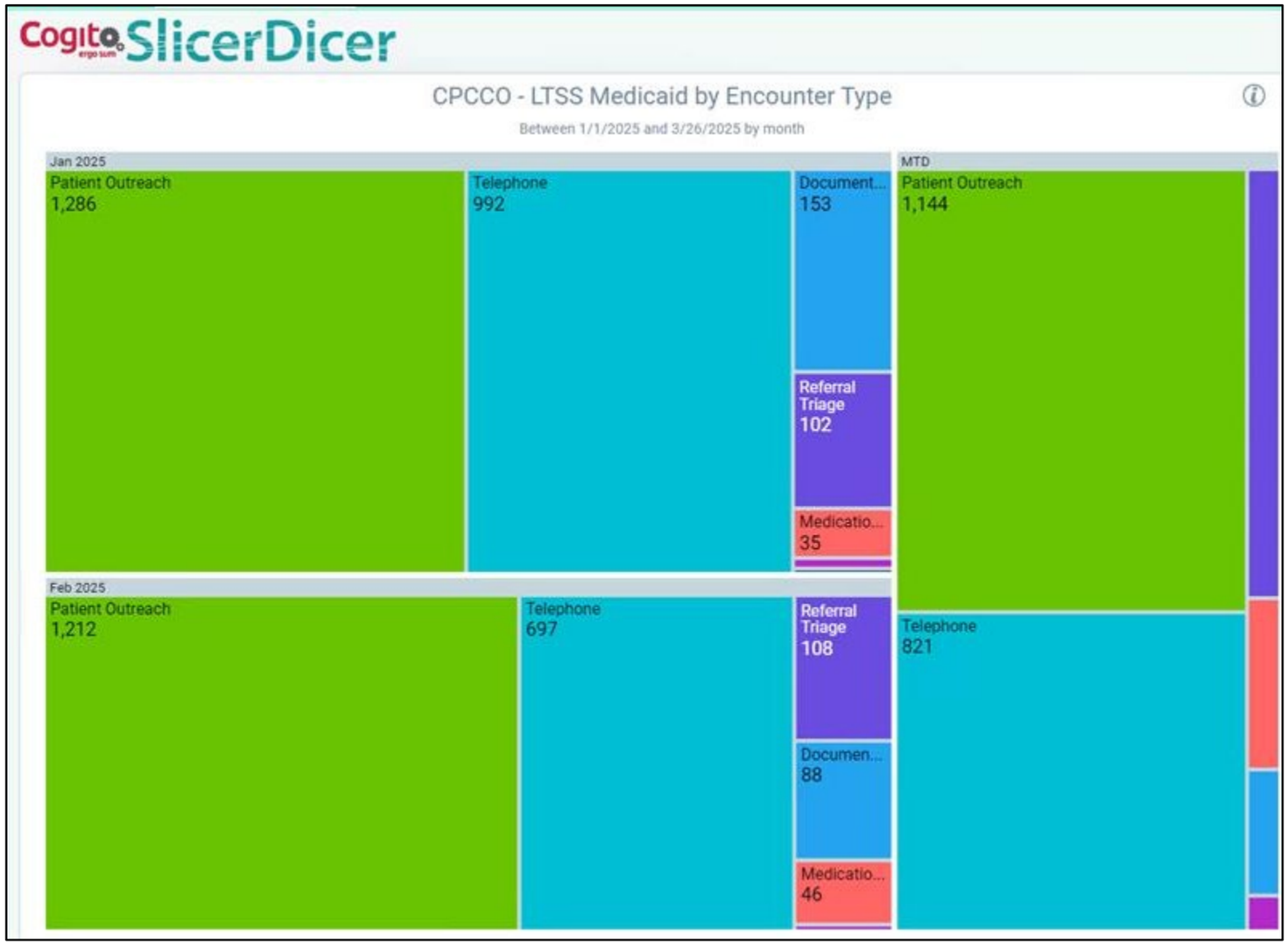
Care Coordination Documentation Policy
Care Coordination Policy (pending final approval for 2025 update)
Care Coordination Timeline of Activities
Transitions Timeline of Activities

Example Screenshots

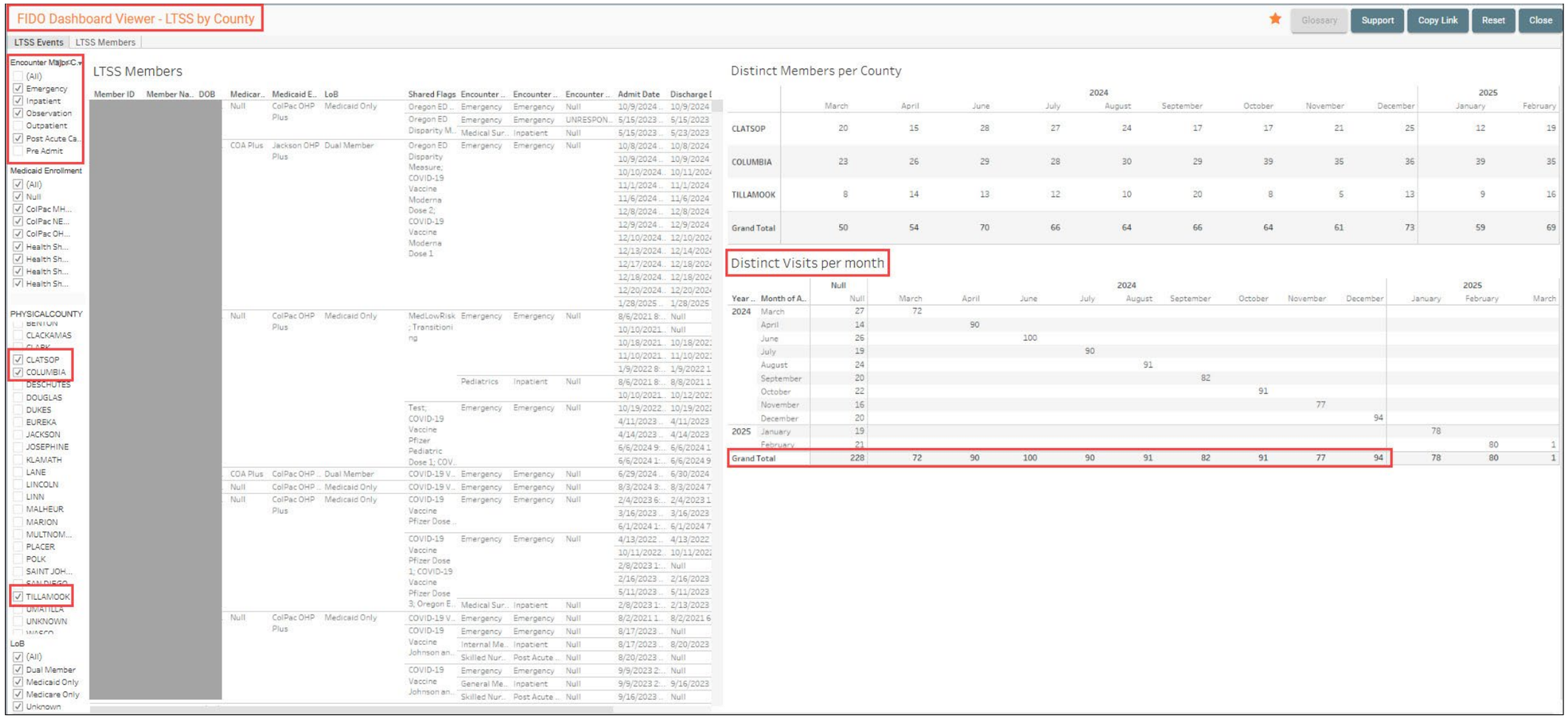
PointClickCare report identifying transitions in care



Epic Compass Rose dashboard used for tracking Care Coordination work with LTSS members



CareOregon dashboard used to track and report on LTSS members



CPCCO Communication Matrix

Contents

CPCCO to County Communication Matrix

County	AAA/APD contacts
Clatsop	Melissa Johnstone Melissa.johnstone@nwsds.org Lavinia Goto Lavinia.goto@nwsds.org
Columbia	Erica White Erica.m.white@dhsoha.state.or.us
Tillamook	Jake Pugh Jake.pugh@nwsds.org Lavinia Goto Lavinia.goto@nwsds.org

Type of communication	Responsible	Notified	What	When	Why
Monthly Prioritized Population List	CCO Quality Regulatory Specialist, Regional Care Team Manager	County AAA/APD contact above	• CCO's definition of prioritization data is LTSS members who were in ED, IP or post-acute care/SNF. • This report captures LTSS members in each county that were inpatient/admitted to a hospital/SNF or had an ED only visit (e.g. HEN and SNF notifications) during the	Monthly	• Incorporate hospital information obtained from PointClickCare into the prioritization process. • CCO and APD/AAA can monitor members with recent and frequent hospital or post-acute care encounters by reviewing list • Members with frequent visits or concerning diagnoses can be flagged

			reporting month and discharged the same month.		by APD/AAA for potential IDT based on their current needs. • Communicated to county AAA/APD via Secure email by RCT Manager
Transitions from Inpatient for Dual Members	CCO Triage Coordinator, RN Care coordinator, RCT care coordinators	Member's specific AAA/APD caseworker	Communication/coordination of care for LTSS members discharging from IP hospital/SNF	Upon discharge to community	• Decrease duplication of services • Increase coordination of care between organizations for optimal member support • Collaborate and problem-solve to address member needs • Prevent re-hospitalization • Ensure smooth transitions of care between systems
Typical Coordination	Care Coordinator or Intensive Care Coordinator	Member's specific AAA/APD caseworker	Communication/care coordination between systems	• Upon enrollment into a care coordination program • Ongoing as deemed appropriate • Upon re-assessment triggering event	• Decrease duplication of services • Increase coordination of care between systems for optimal member support • Collaborate and problem-solve to address member needs
Non-IDT case conferences	Care Coordinator or Intensive Care Coordinator	Member's specific AAA/APD caseworker	Invitation to participate in CCO hosted case conferences outside of standing IDT meetings	As appropriate	Care coordinators regularly convene care team meetings to support a members' care plan goals by inviting the care team to discuss progress, support and needs.
IDT Case conferences	Care Coordinator or Intensive Care Coordinator	AAA/APD, CMHP, OABHI, CCO partners	Formal/standing IDT meetings	2x monthly	Per the IDT meeting agenda, new case referrals are reviewed for identified members; additionally updates for previously reviewed cases occurs. Training opportunities are provided during meetings (i.e. Health Related Service Needs [HRSN], Funding, Palliative Care, etc.). Review of: Barriers, Learning Opportunities and Improvement for IDT process

Communication Matrix

IDT case conference minutes/ follow-up	Care Coordinator or Intensive Care Coordinator	AAA/APD, CMHP, OABHI, CCO partners	Minutes, care plans, follow-up tasks	• As appropriate following each IDT meeting • At beginning of each IDT meeting, follow ups are reviewed from previous IDT meeting	IDT Minutes are sent out to those in attendance for the IDT meeting via Secure email by the care coordinator that leads the IDT. Section of the minutes that is pertinent to identified member with care coordinator, enters this information into Epic Compass Rose, care coordination platform.
CCO care coordination team contact and referral information	Care Coordinator or Intensive Care Coordinator	AAA/APD, CMHP, CCO partners	• Regional Care Team referral information: 503-416-3743, ccreferral@careoregon.org • Specific Care Coordinator contact information	• Reviewed during IDT meetings • Upon outreach to member specific case workers upon enrollment into care coordination • In monthly prioritized population data sharing communication	Referrals are made to the RCT through the RCT Phone Line, Care Coordination Referral email, Epic, etc. These referrals for LTSS members are prioritized by the Triage Coordinators and response to referent in 1 business day and assignment to care coordinator within 3 business days.
Sharing information related to screenings, risk assessments or changes in health status	Care Coordinator or Intensive Care Coordinator	AAA/APD, CMHP, OABHI, CCO partners and IDT	• Health Risk Assessment details • Care Coordination Assessment details • Transitional Support Assessment details • Pertinent chart notes • Risk Stratification level	• Shared as pertinent and appropriate through secure e-mail, secure text/chat, Epic, PointClickCare, phone, fax, or during IDTs • Reviewed during IDT meetings	To improve continuity of care and collaboration between services

AAA/APD to CPCCO Communication Matrix

County	CPCCO Contacts
Clatsop	Regional Care Team: 503-416-3743 or ccreferral@careoregon.org
Columbia	Regional Care Team: 503-416-3743 or ccreferral@careoregon.org
Tillamook	Regional Care Team: 503-416-3743 or ccreferral@careoregon.org

Type of communication	Responsible	What	When
Transitions Follow Up	CM	Consumer staffed at IDT meeting	Monthly
Typical Coordination	CM	Contact with CM	As needed
Non-IDT case conferences	CM & Quality Assurance CM (QACM)	Contact with CM	As needed
IDT Case conferences	IDT group	Consumer staffed at IDT meeting	Monthly
IDT case conference minutes/follow-up	IDT group	Consumer staffed at IDT meeting	Monthly
APD/AAA team contact and referral information	CM	Contact with CM	As needed
Sharing key health-related information including risk assessments, service priority levels, risk stratification levels, and individualized LTSS care plans	CCO	Monthly CCO report	Monthly

Notify CCO contacts if member barriers are identified (homelessness; medication misuse; no phone; lack of accessible transportation, etc)	CM	Contact with CM	As needed

Title: Care Coordination Encounter Documentation		Version: 4	Ref #: 764
Owner: Karissa Smith (Vice President, Care Coordination)			
Approved by ELT/CEO: 05/08/2024	Effective Date: 08/18/2020	Next Review: 05/08/2026	
Applies to *(check all that apply)*: ☒ *Medicare* ☒ *Medicaid* ☐ *Housecall Providers* ☒ *CareOregon Corporate*			

PURPOSE:
This policy defines and establishes guidelines for documentation in our care management platform. This is to ensure that high standards for documentation and management of health care records are maintained that are consistent with HIPAA, regulatory, ethical and current best practice requirements.

POLICY:
Care Coordination staff are responsible for maintaining a complete and accurate record reflecting all interations and activities as they pertain to care coordination services for CareOregon (CO) members. This policy also applies to some non-CareOregon members during periods of CCO transition, enrollment, and for CPCCO Choice members.

The purpose of documentation in the care management platform is to:

- Document all interactions with and on behalf of CO members.
- Function as an official record of care coordination services provided.
- Ensure communication with care coordination staff.
- Facilitate integration of services across care teams.
- Substantiate ongoing monitoring of care plans.
- Avoid duplication of services.
- Assure compliance with regulatory and contractual obligations.

STANDARDS:
Documentation od care coordination activities must comply with the following:

- Complete within 3 business days/ 72 business hours, or sooner as deemed clinically appropriate for urgent/emergent issues.
- Be clear, accurate, relevant to care plan goals, and in English.
- Use approved abbreviations and symbols.
- Be sufficiently clear, structured and detailed to enable other members of the care team to assume care coordination of the member or provide ongoing service at any time.
- Include who the interaction was with, what occurred, and what the next steps are.
- Be written in an objective, person-centered manner and without subjective comments or demeaning or disparaging remarks.
- Indicate interpreter (name and specific language) involvement, if applicable.
- Before going on PTO, all documentation must be up to date and completed.

OTHER DOCUMENTS RELATED:

- RCT Care Coordination Policy
- Intensive Care Coordination Policy
- Care Coordination Timeline of Activities
- Approved Abbreviations
- Epic Compass Rose Tip Sheets

ROUTINE OVERSIGHT OF DOCUMENTATION:

- Supervisor will monitor caseloads using dashboards and other reports pulled from the care management platform as well as in 1:1 supervision.
- Supervisor will note any discrepancy and review documentation in care management platform.
- Supervisor may also review any relevant documentation in EMR based on the oberservations made in these reports OR if they are helping the care coordination staff and clinic communicate more appropriately
- Supervisor will be involved in regular, formal audits of case files, per 'PHP Analyses, Performance and Audits Policy.'

*Community-based staff with access to clinic or hospital electronic health records~~,~~ are responsible for following and adhering to that organization's documentation policy.

Title: Care Coordination		Version: 1	Ref #: 1251
Owner: Karissa Smith (Vice President, Care Coordination)			
Approved by ELT/CEO: 03/03/2025	Effective Date: 01/31/2025	Next Review: 03/03/2026	
Applies to *(check all that apply)*: ☒ *Medicare* ☒ *Medicaid* ☐ *Housecall Providers* ☒ *CareOregon Corporate*			

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Scope

This policy governs the care coordination services provided to CareOregon Advantage (COA) members and Oregon Health Plan (Health Share, Columbia Pacific (CPCCO), Jackson Care Connect (JCC) members). Care coordination services are primarily provided through care teams called Regional Care Teams (RCT) and supported by other outreach and coordination teams within the Care Coordination

Department. Regional differences may be applicable throughout this policy and will be called out in each section as appropriate. CareOregon and its subcontractors/delegates comply with requirements set by this policy.

Background

This policy replaces the previous RCT Care Coordination Policy and the Intensive Care Coordination Policy which will be retired upon the approval date of this policy.

Purpose

This policy is written in accordance with 42 CFR §438.208 and based off the care coordination requirements within the 2025 CCO Contract, OAR 410-141-3860 Care Coordination: Administration, Systems, and Infrastructure, OAR 410-141-3865 Care Coordination: Identification of Member Needs, and OAR 410-141-3870 Care Coordination: Care Coordination. This coordination guidance encompasses all services accessed to address members' physical, developmental, behavioral, oral and social needs (including Health-Related Social Needs (HRSN) and Social Determinants of Health and Equity (SDOH-E)).

Definitions

Care Coordinator	A single, consistent individual who is familiar with a Member's history, strengths, needs and support system; follows a Member through transitions in levels of care, Providers, involved systems and legal status; takes a system-wide view to ensure services are unduplicated and consistent with identified strengths and needs; and who fulfills Care Coordination standards as identified in this Contract.
Care Coordination	"Care Coordination" means the act and responsibility of CCOs to deliberately organize a members service, care activities and information sharing among all participants involved with a members care according to the physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) of the member. Care Coordination requirements are described in OAR 410-141-3860, 410-141-3865, 410-141-3870, and in accordance with CFR 438.208.
Care Coordination Risk	"Care Coordination Risk" means the risks associated with missed care coordination activities. "Suspected Care Coordination Risk" uses data sources to indicate a suspected risk level the CCO mines data to identify individuals with *suspected* high or moderate risk of poor care coordination outcomes. This defined as follows:

	Suspected High Risk ○ The member's care density ratio indicate a "likely coordination issue" in the ACG output based on *past* utilization activity. ○ In addition the care density cost savings ratio is greater than 0.20, indicating significant health system utilization is *predicted* over the next year given the member's ongoing needs related to chronic conditions. ○ The member's clinical needs are classified as either of the following population segments: ▪ Member with high risk pregnancy ▪ Members with multimorbid high complexity Suspected Moderate Risk ○ The member's care density ratio indicate a "likely coordination issue" in the ACG output based on *past* utilization activity. ○ In addition the care density cost savings ratio is greater than 0.20, indicating significant health system utilization is *predicted* over the next year given the member's ongoing needs related to chronic conditions. ○ The member's clinical needs are classified as either of the following population segments: ▪ Member with dominant psychiatric condition ▪ Members with major physical health-related chronic condition
Care Plan	"Care Plan" means a care plan that is developed for and in collaboration with the member, their family, representatives or guardian; and in consultation with the member's providers, community supports and services, where applicable, to ensure continuity and coordination of a member's care according to their needs. Care Plan requirements are described in OAR 410-141-3865 and 410-141-3870.
Care Profile	"Care Profile" means the electronic record a CCO develops and maintains for all members. The Care Profile is the platform that receives feeds from different data sources used to identify, track and manage a member's needs and risk level to direct the frequency of the CCOs outreach and Care Coordination activities/opportunities that shall be offered to the member. Care Profile requirements are further described in OAR 410-141-3865 and OAR 410-141-3870.
Care Setting Transitions	"Care Setting Transitions" means a transition between different locations, settings or levels of care.
Condition Specific Program	"Condition-Specific Program" and "Condition-Specific Facility" mean programs or facilities that treat a narrowly defined illness, disorder or condition, such as: • Behavioral and Mental Health conditions, Substance Use Disorder (SUD) or addiction, including but not limited to; ○ Alcohol; ○ Illicit Drugs; and

	○ Gambling. • Physical Health conditions, including but not limited to: ○ Cancer; ○ Diabetes; ○ Bariatric Care. • Developmental Disabilities.
Health Related Services	"Health-Related Services (HRS)" means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives.
Health Risk Assessment	"Health Risk Assessment (HRA)" means a survey or questionnaire administered verbally, digitally or in writing, to collect information from a member, their representative or guardian about key areas of their health, including their physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health). The HRA is intended to inform the coordination of services and supports that meet the members individualized needs as described in OAR 410-141-3860, 410-141-3865 and 410-141-3870.
Individual with Limited English Proficiency	"Individual with Limited English Proficiency" means a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.
Johns Hopkins ACG Risk Stratification	Johns Hopkins ACG model categorizes patients into low, medium or high-risk groups for health care utilization. This grouping is based on several factors: • Predictive cost factors • Clinical factors • Social factors • Behavioral factors
Medicaid-Funded Long-Term Services and Supports (LTSS)	"Medicaid-Funded Long-Term Services and Supports (LTSS)" means all Medicaid funded services CMS defines as long-term services and supports, including both: • "Long-term Care," the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals; • "Home and Community-Based Services," the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for

	Behavioral Health Services.
	"Plan Type" means the designation used by the Authority to identify which health care services covered by a client's OHP Plus or equivalent benefit package are paid by a CCO, by the Authority's fee-for-service program, or both. If a client does not have a plan type designation, then all of the client's health care services are paid by the fee-for-service program. Regardless of plan type, some health care services are carved out from CCOs by contract or rule and are instead paid by the fee-for-service program. The plan type designations are as follows: • CCOA: Physical, dental, and behavioral health services are paid by the client's CCO; • CCOB: Physical and behavioral health services are paid by the client's CCO. Dental services are paid the fee-for-service program; • CCOE: Behavioral health services are paid by the client's CCO. Physical health and dental services are paid by the fee-for-service program; • CCOF: Dental services are paid by the client's CCO. Physical health and behavioral health services are paid by the fee-for-service program, except for individuals receiving dental services through the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program defined in OAR chapter 141, division 120. Any reference to CCOF means the benefit package covers dental services only; and CCOG: Dental and behavioral health services are paid by the client's CCO. Physical health services are paid by the fee-for-service program.
Special Health Care Needs	"Special Health Care Needs (SHCN)" means individuals of any age who experience or exhibit signs of developing; • Physical, functional, intellectual or developmental disabilities; or • Long-standing or chronic medical condition(s); or • Complex behavioral health conditions, including "Substance Use Disorders" or "Serious and Persistent Mental Illness;" or • Live with other health or social conditions placing them at risk, that without intervention will likely cause negative impact to an individual's health or wellbeing.
Trauma Informed Approach	"Trauma Informed Approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment wherein there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system and then takes into account those signs, symptoms, and their intensity and fully integrating that knowledge when implementing and providing potential

	paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems and actively resist re-traumatization of the individuals being served within their respective entities.

Policy

All COA, CPCCO, JCC, and Health Share members have access to care coordination services. Our care coordination program is:

- Person-centered or person and family-centered for minors under age 18 and for adults 18 or older, who are under the legal authority of a family member or guardian;
- Trauma-informed and responsive;
- Culturally, linguistically and developmentally responsive and appropriate;
- Accessible to all members, including those with disabilities and persons who experience Limited English Proficiency and equitable access to services, consistent with 42 CFR §435.905, ORS 413.550 and Title VI, §1557 (ACA 1557);
- Delivered with a whole-person approach that encourages member self-determination and autonomy;
- Designed to account for the unique contextual needs of various member populations in relation to their families and communities, such as children, youth, young adults, and older adults, so that every member's needs are identified and addressed in a way that is appropriate for their situation; and
- Focused on prevention, safety, early identification, intervention, and ongoing management.

Access to care is an important part of care coordination. To maintain and monitor access to care, CareOregon:

- Contracts with Patient-Centered Primary Care Homes (PCPCH) to provide members a consistent and stable relationship with a care team, and supporting and collaborating with them in the overall coordination of the member's care;
- Develops and enters into agreements, memoranda of understandings (MOUs) with providers and other entities not contracted with the CCO, to ensure a member's access to coordinated physical, developmental, behavioral, oral, and social needs services across multiple providers;
- Uses Value Based Payments to encourage specialty and Primary Care Providers to coordinate care;
- Assigns all members to a Primary Care Provider (PCP Assignment - QNXT CPG - CAREOREGON INC)
    - A member may select a different Primary Care Provider at any time and/or request assistance with selecting an appropriate provider.

- Eligible members who are American Indian/Alaska Native may select as their primary care provider:
  - An Indian health care provider (IHCP) who is a primary care provider within the CCO's provider network; or
  - An out-of-network IHCP from whom the member is otherwise eligible to receive such primary care services.

Care Coordination Activities and Services

All members can access care coordination for immediate needs regardless if they have selected a Primary Care Provider (PCP) or completed a Health Risk Assessment (HRA). Care coordination services are primarily offered through designated outreach teams and through our Regional Care Teams (RCT). RCTs provide members with a consistent care team who collaborate across disciplines to develop and implement member-centric care plans through telephonic, electronic, or community-based interventions to:

- Identify needs on an initial and ongoing basis
- Ensure services are coordinated
- Ensure members have an ongoing source of care appropriate to their needs
- Resolve identified needs;
- Promote and improve member health outcomes;
- Improve a member's ability to manage, maintain and improve any chronic conditions or disabilities;
- Improve member satisfaction;
- Reduce health inequities; and
- Reduce barriers to accessing health care.

RCTs are regionally based multidisciplinary care coordination teams that include non-clinical care coordinators, clinical care coordinators (with background in nursing, mental health, substance use disorder, and pharmacy), and receive direct support from Medical Directors, Dental/Oral health teams, utilization management, and more.

All members are assigned to a Regional Care Team based off Primary Care Provider assignment or by the County they live in as outlined in the RCT Metro Realignment Logic Resource Guide. RCT Assignment and contact information for the assigned RCT is displayed in the member's care profile viewable through the member portal and CareOregon's mobile app.

Regional differences in the RCTs and in the care coordination services provided by each are outlined below:

- CPCCO: Care coordination services are provided through 1 RCT for all CPCCO members
- JCC: Care coordination services are provided through 1 RCT for all JCC members

- Health Share (Metro): Care coordination services are provided by 6 RCTs in collaboration with each Integrated Delivery System and with 3 delegated county care coordination teams serving the metro region.
- Dental Coordination: Delegated Dental Plan partners coordinate care as it pertains to the provision of dental services

Care coordination is provided for all members and across the continuum of care. RCTs are responsible for coordinating the provision of all covered services and some non-covered services for members.

CareOregon regularly promotes care coordination by informing members, providers, and community partners including, DHS Area Agency on Aging/Aging and People with Disabilities, Office of Developmental Disability Services, LTC, or LTSS case managers about the availability of care coordination. Contact information and referral pathways for Care Coordination Teams will be provided throughout the year via Provider Meetings, Provider E-mails, and Care Coordination 101 presentations. Information related to care coordination can be found on our website, within the welcome packet, and through outreach calls. Care coordination may be requested by the member, the member representative, the member's provider, or anyone else involved in the member's care at any time through our customer service line or by submitting a care coordination referral through the UniteUs platform.

Care Coordination Eligibility, Target Populations, and Risk Stratification

Care Coordination services are available to all members and are prioritized for specific populations including:

- Members identified as LTSS;
- Those with special health care needs;
- Members whose Health Risk Assessment (HRA) results indicate a care coordination need; and
- Those identified with "Suspected Moderate or High Care Coordination Risk".

Risk level, HRA results, LTSS, and SHCN indicators can be found in the member's care profile (snapshot tab within Epic Compass Rose).

Members identified as potentially eligible for, or requiring Long Term Service and Supports (**LTSS**), or having a Special Health Care Need (**SHCN**):

- Are comprehensively assessed, per 42 CFR 438.208(c)(2), as soon as their health condition requires, to identify those members who have an ongoing special condition that requires either:
    - A course of treatment; or
    - Regular care monitoring.
- Are promptly referred to Oregon Department of Human Services (ODHS) Aging and People with Disability (APD) programs, the Office of Developmental Disabilities Services (ODDS), Local Mental Health Authorities (LMHA) or other service programs where appropriate for completion of a comprehensive assessment and potential service planning as appropriate.

- Have direct access to specialists, as appropriate for the member's condition and identified needs.
- Care coordination teams also:
    - Collaborate with providers, case managers, or other coordinators to ensure LTSS or other care plans are integrated into the members CCO care profile or CCO care plan, and be reviewed and revised upon reassessment of functional need at least every 12 months, or upon a change in health related circumstance, or at the request of the member;
    - Ensure approval of the Care Plan is done in a timely manner, according to the needs of the member if this approval is required by the CCO; and
    - Ensure the care plan complies with any applicable State quality assurance and utilization review standards.

The **HRA** is administered to all new members within 90 days of enrollment, or sooner if a member's health status requires it. Assessment results and outreach attempts are documented in Epic Compass Rose. The full process is outlined in the PHP Health Risk Assessment Tool policy.

A **suspected care coordination risk level** is assigned to all members. Levels include:

- No/low care coordination risk
- Moderate care coordination risk
- High care coordination risk

Suspected care coordination risk is assigned based on an algorithm utilizing data we have in our system that indicates a member may have poor outcomes due to missed care coordination interventions. Data sources used in this algorithm includes:

- Johns Hopkins ACG Risk Stratification
- Enrollment information
- Claims
- Diagnosis codes
- Utilization and event notifications
- Pharmacy claims
- Health Risk Assessment information
- Health related circumstance changes
- Social needs and social risk data
- Care gaps
- Functional needs flagged through frailty markers, intellectual or developmental diagnoses, and use of durable medical equipment associated with functional needs
- Other information including data from ODHS and information collected from previous outreach and care coordination services

Members flagged with "suspected" moderate or high risk will be referred into care coordination for further assessment of risk level and needs. Members with "suspected" no/low risk will not automatically be referred into care coordination however care coordination team members can assess and indicate a

member's risk level at any time. Any member with care coordination needs or requests can receive the support of care coordination. The assigned care coordinator uses their subjective experience to determine the length and intensity of care coordination support needed, commensurate with the member's input and needs, including but not limited to:

- A summary of the member's needs, goals, preferences, and circumstances;
- Progress notes from any entity involved in the members care coordination team;
- Any relevant assessments;
- New medical diagnoses, courses of treatment, and emergent needs;
- Social needs (including Social Determinants of Health and Health Related Social Needs)
- Utilization of services as a result of claims review;
- Information received from the member, their representative or guardian or other involved providers or community supports;
- Change in health-related circumstances;
- Consultation with a clinician that has the appropriate clinical qualifications and expertise;
- Consultation with any other provider, case manager, or entity providing services.

The risk algorithm runs monthly to ensure ongoing data mining to catch new emergent needs for members who may be previously flagged a no/low risk. Members with continued moderate/high risk will be reassessed annually or sooner if indicated by a change in health circumstance.

Care Coordinator Assignment

Screening for care coordination services also occurs whenever a referral for care coordination is received. An initial response to care coordination requests will occur by the next business day. The referral is routed to the member's Regional Care Team and assigned to a care coordinator. Upon assignment the care coordinator will reach out to the member, introduce themselves, provide the member with their contact information, and provide information about care coordination services and what the member can expect while working with the care coordinator.

Care Coordinator assignment is based on the presenting needs of the member. Caseloads are monitored regularly by Care Team Supervisors and Managers to ensure that the number of members assigned to each care coordinator does not exceed their capacity to meet all the coordination needs of each member. If it is found that caseload capacity exceeds a care coordinator's ability to meet the needs of their assigned members a Care Team Supervisor or Manager may shift staffing amongst their team or reassign caseloads. If caseload capacity continues to be an issue for 90 or more business days, we will assess the need for additional capacity.

Care Coordination and ICC Services are available during normal business hours Monday-Friday.

Assessment for Care Coordination Needs

To support whole person care, a comprehensive needs assessment, called the Care Coordination Assessment (CCA), will be completed for members:

- Identified as having Special Health Care Needs
- Members receiving or in need of Long-Term Care Services and Supports
- Members referred to and enrolled into care coordination services
- Members identified as having moderate or high care coordination risk

All screenings and assessments are trauma-informed, culturally responsive, linguistically appropriate and person-centered and are documented within the care management platform, Epic Compass Rose.

Members will be assessed for:

- Immediate and ongoing care coordination needs (including but not limited to physical health, behavioral health, oral health, social determinants of health)
- Special Health Care Needs
- Need for Long Term Services and Supports (LTSS)

The CCA may be initiated by non-clinical staff (Triage Coordinator or Health Care Coordinator) prior to care coordinator assignment if applicable. Care Coordinator assignment is based on the needs of the member. The assigned care coordinator will complete the CCA within the timelines outlined below. For members with complex medical or behavioral health needs a Clinical Care Coordinator is assigned.

The assigned care coordinator gathers relevant information from multiple resources in order to complete the CCA within 10 days of assignment.

Resources of information used to complete the CCA include but are not limited to:

- The member and/or caregiver
- Providers
- Other individuals involved in the member's care
- Chart Review Information (Claims, Authorizations, Historical Care Coordination Notes, Hospital utilization, and other relevant information, etc.)

Results of the CCA and the creation of an initial Individualized Care Plan are documented within Epic Compass Rose and shared with the member (as appropriate), the member's providers, and other individuals involved in the member's care in accordance with applicable laws governing confidentiality.

Care Profile and Development and Implementation of Individualized Care Plans

All members have a Care Profile as defined in OAR 410-141-3500, including at minimum the identification of:

- Demographic information;
- Communication preferences and needs (e.g. preferred language, method of communication, Alternate Formats, Auxiliary Aids and Services);
- Care team members including all providers, entities, and appropriate individuals serving the member that have been formerly designated by the CCO as responsible for coordinating the individual services by the member.
- Contact information, role, and any assigned Care Coordination Responsibilities for those listed in (c).
- A summary of the needs, goals and preferences of the member initially and ongoing, when available;
- Suspected care coordination risk level;
- Any open or closed Care Plans; and
- An overview of the supports, services, activities, and resources that have been or will be deployed to meet the member's identified needs.

The following members will also have an individualized care plan:

- Members enrolled in a care coordination program
- CareOregon Advantage Members
- Members with special health care needs
- Members designated as needing or having long term services and supports
- Members identified with "Suspected Moderate or High Care Coordination Risk"
- Members identified as "MOC Most Vulnerable"
- Members receiving Health Related Social Needs Benefit Services

Individualized care plans are developed and utilized to address the needs of the member and are to incorporate the supportive and therapeutic and cultural and linguistic health of each Member. Care Plans are developed with the member whenever possible. If the member is not involved in the care planning process, the reason(s) why is clearly documented within a progress note.

Care Plans:

- Utilize relevant information from a variety of sources to inform the development or update a member's Care Profile, and/or Care Plan, this includes, but is not limited to:
    - Progress notes from any entity involved in the members care coordination team;
    - Any relevant assessments;
    - New medical diagnoses, courses of treatment, and emergent needs;
    - Social needs (including Health Related Social Needs and Social Determinants of Health and Equity)
    - Utilization of services as a result of claims review;
    - Risk Level;
    - Change in Health-Related Circumstances
- Are developed and updated in consultation with any provider, community partner, or other individual involved in the member's care

- Reflect member, family or caregiver preferences and goals to ensure engagement and satisfaction
- Are offered in the language spoken by the member
- Reviewed and updated by the assigned care coordinator throughout the episode of the case
- Are shared, as appropriate, with the member (in their desired method) and any individual involved in the member's care via mail, email, over the phone, and/or electronically through the member or provider portal
- May be shared as well with as State or other MCOs, PIHPs, and PAHPs, while protecting the member's privacy whenever possible and in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E to the extent that they are applicable

As appropriate, the assigned Care Coordinator will review the care plan with the member, and the member's caregiver when applicable, to ensure the understanding of the care plan and each person's role as it pertains to each care plan activity.

CareOregon ensures that Care Plans are:

1. **Promptly Available**: Care Plans are promptly accessible to members, their representatives or guardians, and all relevant providers and community partners involved in coordinating and providing services.
2. **Accessible in Preferred Format**: Members, their representatives, or guardians have immediate electronic access to their Care Plans or receive a copy in their preferred method of communication and language. Auxiliary Aids and Services and Alternate Formats are available at no cost within five (5) business days upon request.
3. **Timely Approval**: Care Plans requiring approval are processed in a timely manner according to the member's needs.
4. **Conditional Withholding**: Care Plans may be withheld from members only if providing access to the full plan is significantly detrimental to their care or health, as determined by the member's care team. Only the parts deemed detrimental may be withheld. In such cases:
    - Reasons for withholding the full or partial Care Plan are documented, including a specific description of the risk or potential harm to the member.
    - Attempts made to address the concern(s) are described.
    - The decision to withhold the Care Plan in full or in part is reviewed prior to each plan update.
    - The decision to continue withholding the Care Plan in full or in part is documented.

Care Plan Updates

For member's enrolled in active care coordination, care plans are considered a living document that are reviewed and updated throughout the life of a case. At minimum, the care plan is updated:

- Annually for members identified as suspected moderate or high care coordination risk

- Every 90 days for members enrolled in a care coordination program
- At the request of the member, their representative or guardian, or any provider serving the member
- Upon change in health-related circumstances as described in OAR 410-141-3865 (6)(g), functional need, or circumstance including but not limited to:
    - Hospital ER visits, hospital admissions or discharges (Including Institutions for Mental Disease);
    - Crisis Services (i.e., Mobile Crisis response Mobile Response and Stabilization Services);
    - High-Risk Pregnancy diagnosis;
    - Newly diagnosed or significant change to a chronic disease or condition;
    - Newly diagnosed or significant change to a Behavioral Health diagnosis or condition;
    - Newly diagnosed or significant change to a Intellectual/Developmental Disability (I/DD) diagnosis;
    - Event that poses a significant risk to the member that is likely to occur or reoccur or escalate without intervention;
    - Recent homelessness, or at risk for homelessness or non-placement;
    - Two or more billable primary ICD-10 Z code diagnoses within one (1) month resulting in a change in health status and/or risk level;
    - Two or more caregiver placements within past six (6) months;
    - Discharge from carceral settings (i.e., state or federal prisons, local correctional facilities, juvenile detention facilities, or Tribal correctional facilities) back to the community or another residential or care setting;
    - Admit to or discharge from a residential or long-term care setting back to the community or another care setting;
    - Exit from Condition Specific Program or Facility as defined in OAR 410-141-3500;
    - Enrollment or disenrollment in other service programs such as Long-Term Services and Supports, Intellectual/Developmental Disability services or Children's Intensive In-home services;
    - Orders for Home Health or Hospice services;
    - Newly identified or change to an identified Health Related Social Need (HRSN);
    - An identified gap in network adequacy that leaves the member without a needed service or care;
    - Life span developmental transitions such as a transition from pediatric to adult health care;
    - Entry into, discharge from, instability, or placement disruption while in foster care.

Care Plan Closure

Care plans may be closed in several scenarios:

- When requested by the member, their representative or guardian;
- When care coordination needs are met;

- No longer warranted by the member's risk level or circumstances; or
- There is no contact with the member, their representative or guardian after a minimum of three (3) attempts of outreach, utilizing at least two mixed modalities (e.g., paper, digital or verbal), including the Members preferred method of communication and language, over a sixty (60) day period, and with consultation and agreement of all available care team members. If the associated suspected risk level of that member remains a moderate or High level, the member will be monitored through the care profile and reassessed annually.
- If the member disenrolls from our CCO and transitions to a new CCO, to FFS, or other entity, the assigned care coordinator will coordinate with the receiving entity to ensure a seamless and warm handoff. (See Transitions of Care Policy for more detail on this process).

Communication and Collaboration with the Care Team

To promote healthy outcomes for the member and to reduce/avoid duplication of services, in accordance with 42 CFR 438.208 and other confidentiality laws, Care Coordinators are responsible facilitating enhanced communication, collaboration, and coordination.

- A member receiving services from multiple programs (e.g., Long Term Services and Supports, Intellectual and Developmental Disabilities, Child Welfare, Youth Wraparound, Intensive In-home Behavioral Health Treatment). The CCO is responsible for collaborating with those entities who are coordinating services the member is receiving; documenting the coordinating entities' activities; reducing duplication of activities;
    - All members enrolled in Plan Type CCOA or CCOB:
        - The CCO is responsible for leading and facilitating Care Coordination for all needs identified that are not addressed or coordinated by another program or entity.
    - All members enrolled in Plan Type CCOE, CCOF or CCOG:
        - The Oregon Health Authority's Medicaid Fee-For-Service (FFS) program is primarily responsible for Care Coordination and the CCO must proactively collaborate with FFS Care Coordination (e.g., referral to FFS Care Coordinator); and identify Care Coordination gaps or additional unmet needs that may require Care Coordination be provided by the CCO. The CCO is responsible for coordinating services covered under the member's plan type.

Care Coordinators will also ensure communication amongst those involved in the member's care including but not limited to:

- Any other MCO, PIHP, or PAHP; FFS Medicaid, FFS Medicare Advantage and SPN Plans and Medicare Providers for dual eligible members;
- Other CCOs serving members;
- Medical Providers, Specialty Providers, Oral Health Providers, and

Behavioral Health Providers;
- Community Mental Health Programs or other Local Public Health;
- Skilled Nursing Facilities when applicable;
- DHS Area Agency on Aging/Aging and People with Disabilities or
- DHS Child Welfare
- Developmental Disabilities Services
- Oregon Department of Education;
- Oregon Youth Authority;
- Other community and social support providers; and
- When applicable, with Friends, Family, Parents/Legal Guardians.

Care coordinators will convene and facilitate Interdisciplinary Team Meetings (IDT) for LTSS members, SHCN members, and for other members as needed according to the Member's Care Plan, including a post-transition meeting of the interdisciplinary team within fourteen (14) days of a transition between levels, settings or episodes of care. The IDT meetings must:

- Include the member, their representative or guardian, unless the member declines or the member's participation is determined to be significantly detrimental to the member's health;
- Consider relevant information from all providers and other entities serving the Member including but not limited to those listed in OAR 410-141-3860 (2) ;
- Provide a forum to:
  - Describe the clinical interventions recommended to the treatment team and identify the frequency of necessary Interdisciplinary Team Meetings appropriate to meet the Care Plan needs;
  - Create a space for the member to provide feedback on their care, self-reported progress towards their Care Plan goals, and their strengths exhibited in between current and prior meeting;
  - Identify coordination gaps and strategies to improve care coordination with the member's service providers;
  - Develop strategies to identify, address, monitor and follow up on needed referrals for specialty care, routine health care services (including medication monitoring), other community programs or social need services; and
  - Update the member's individual Care Plan and share the plan.

CareOregon mandates timely sharing and exchange of care coordination information among Primary Care Providers, contracted providers, and community partners via Electronic Health Information technology or other applicable methods to ensure continuity of care. Several systems are used in order to maintain this process.

- **PointClickCare** is a health information exchange that hospitals across Oregon connect to. Care Plan information, RCT assignment, and Care Coordinator contact information can be shared through this system.
- CareOregon recently implemented **Epic Payer Platform** which is the name of functionality within Epic that allows for data exchange between ourselves and select network partners to provide a more complete picture of our members' health, risks, and to facilitate closer communication. We receive clinical data exchange and scheduling notifications. Our network

partners who use Epic Payer Platform can see our care coordination notes as well.

- **CareOregon Link** is an extension of Epic Compass Rose that is used with designated external partners including our delegated care coordination teams and other partners in the network allowing them to view member information and care coordination activities within our instance of epic

Transitional Support and Follow Up

Transitional Support is provided to members experiencing a Care Setting Transition, regardless of where the member is receiving services to ensure:

- Members are transitioned into the most appropriate independent and integrated community settings and provided follow-up services as medically necessary and appropriate prior to discharge to facilitate successful handoff to community providers;
- Appropriate discharge planning and care coordination for adults who were members upon entering the Oregon State Hospital and who shall return to their home CCO upon discharge from the Oregon State Hospital;
- Care Coordination and discharge planning for out of service area placements, for which an exception shall be made to allow the member to retain Home CCO enrollment while the member's placement is a temporary residential placement as defined in OAR 410-141-3500, or elsewhere in accordance with OAR 410-141-3815. CCOs shall, prior to discharge, coordinate care in accordance with a member's discharge plan;
- Coordinate and authorize care when it has been deemed medically appropriate and medically necessary to receive services outside of the service area because a provider specialty is not otherwise contracted with the CCO; and
- Coordinate the members care when they are temporarily outside their enrolled service area.

Post Hospital Extended Care

Care Coordination services for members experiencing Post Hospital Extended Care in accordance with OAR 411-070-0033:

- Post Hospital Extended Care Coordination (PHEC) is a twenty (20) day benefit included within the Global Budget and the CCO shall pay for the full twenty (20) day PHEC benefit when the full twenty (20) days is required by the discharging provider. CCOs shall make the benefit available to non-Medicare Members who meet Medicare criteria for a post-Hospital Skilled Nursing Facility placement.
- CCOs shall notify the Member's local ODHS APD office prior to the Member being admitted to PHEC. Upon receipt of such notice, CCO and the Member's APD office must promptly begin appropriate discharge planning.
- CCOs shall notify the Member and the PHEC facility of the proposed discharge date from such PHEC facility no less than two (2) full days prior to discharge.
- CCOs shall ensure that all of a Member's post-discharge services and care needs are in place prior to discharge from the PHEC, including but not limited to Durable Medical Equipment (DME), medications, home and Community based services, discharge education or home care

instructions, scheduling follow-up care appointments, and provide follow-up care instructions that include reminders to;
    - Attend already-scheduled appointments with Providers for any necessary follow-up care appointments the Member may need; or
    - Schedule follow-up care appointments with Providers that the Member may need to see;
- CCOs shall provide the PHEC benefit according to the criteria established by Medicare, as cited in the Medicare Coverage of Skilled Nursing Facility Care available by calling 1-800-MEDICARE or at www.medicare.gov/publications
- CCOs are not responsible for the PHEC benefit unless the Member was enrolled with the CCO at the time of the hospitalization preceding the PHEC facility placement.

Documentation

All care coordination services and activities are documented by the Care Coordinator within CareOregon's care management platform, Epic Compass Rose including:

- Screenings and assessments
- Care Plan including needs, goals, and interventions
- Interactions with the member and the member's care team
- Interactions with the member or anyone else involved in the member's care
- Discussion and outcomes related to ICTs

Please refer to the Care Coordination Encounter Documentation Policy for more information

Care Coordination Monitoring and Performance Oversight

At CareOregon, our leadership team is committed to ensuring the quality, timeliness, and accuracy of care coordination activities. This policy outlines how we routinely monitor, oversee, and evaluate the documentation and performance of our teams.

Population-Level Monitoring: Leadership monitors population-level trends to identify cohorts requiring care coordination services.

Performance Analysis: Ongoing analysis of program performance and processes is conducted through reports, dashboards, random chart audits, and one-on-one supervision with care coordination staff.

Audit Process: The audit process is coordinated by the Care Coordination Quality Manager and the Care Coordination Director. Random samples of member cases are reviewed, tracked, and logged. Feedback is provided to staff to identify opportunities for improvement. Audit results are used for quality assurance, process improvement, and reporting purposes.

Supervisor Reviews: Supervisors conduct regular one-on-one reviews with staff, utilizing the Supervisor Dashboard to monitor documentation and care coordination activities. Supervisors also use the Supervisor Chart Review Form to review one chart per staff member per month.

Manager and Director Reviews: Managers and Directors perform chart reviews, selecting 3-5 charts each per month. Information from these reviews is analyzed to identify trends and implement necessary training.

Caseload Monitoring: Caseloads are regularly monitored to ensure care coordinators can meet the needs of their assigned members. If caseload capacity exceeds a care coordinator's ability, staffing may be adjusted. Persistent issues will prompt an assessment for additional FTE and capacity.

Delegated Team Oversight: Monitoring and oversight of delegated care coordination teams in the metro area are conducted in accordance with 42 CFR §438.208, OAR 410-141-3860, OAR 410-141-3865, and OAR 410-141-3870. Delegated teams complete annual trainings and review CareOregon policies. Documentation of care coordination activities is maintained in Epic Compass Rose and other platforms, with reports available to track volume, timeliness, adequacy, and effectiveness. Regular meetings with delegated partners ensure quality oversight and corrective actions are taken if deficiencies are found.

Reporting: Care coordination activities and their effectiveness are documented in a Care Coordination report:

- Submitted to the Authority within 45 days after the end of each six-month period.
- Utilizing tools and guidance provided by the Authority on the CCO Contracts Forms webpage.
- Delegated care coordination teams participate in the completion of this report.

Ownership/Responsibilities

VP, Care Coordination	Overall accountability
Director, Care Coordination	Writer, Monitoring and Performance Management
Director, Coordination and Outreach	Writer, Monitoring and Performance Management
Care Coordination Nurse Manager	Reviewer, Training Oversight

Compliance Reinforcement

Care Coordination leadership including VP, Directors, CC Quality Manager, Care Team Managers, and Care Team Supervisors will provide oversight that the policy is being reinforced.

Regulations

42 CFR §438.208

OAR 410-141-3860 Care Coordination: Administration, Systems, and Infrastructure

OAR 410-141-3865 Care Coordination: Identification of Member Needs

OAR 410-141-3870 Care Coordination: Care Coordination.

Related

Care Coordination Documentation v.4

PCP Assignment - QNXT CPG - CAREOREGON INC

Transition of Care v.1

Supervisor Chart Review Form

RCT Metro Realignment Logic Resource Guide

Member Provider Support – Timeline of Activities

Documents Sections (click to jump to section) -

- -

Member Provider Support - Program Information

Program Purpose	▪ Provide ongoing Care Coordination
The Member Provider Support Program is applicable for:	✓ General care coordination cases Including: ▪ Choice Model ▪ Intensive care coordination cases ▪ Maternal Child Health ▪ Model of Care (MOC) most vulnerable ▪ Housing Care Coordination

Member Provider Support Program - Documentation Requirements

Member Provider Support **program added** + **episode statuses**

- referred > enrolled > close

Support & Service Type – added as applicable

- *Choice Model*
- *Choice Model – Longterm Psychiatric Care*
- *Intensive Care Coordination*

Care coordinator assigned

- *Episode Responsible Staff*

Referral Intake [assessment]

- Data capture for incoming referral information
- Includes the documentation of referral receipt + initial response to referent

---

Referral note [note type – informed by Referral Intake data]

Pre-determined Outreach Tasks

- *Primary Care Coordinator to complete initial outreach call with member*
- *Outreach to Referent in 1 business day*

- *Outreach PCP*

Pre-determined *Member Provider Support* Program <u>Targets</u> -

- *Initiate Transitions Assessment*
- *Initiate Care Plan*

Pre-determined *Member Provider Support* Checklist Tasks

- ICT / Case Conference(s)
- *Outreach to PCP* – populates after completion of initial Outreach Task

Assessments

- CCA - Care Coordination Assessment [program target]
- If applicable/appropriate –
  - *Social Determinants*
  - *Health Risk Assessment Tool*

Care Plan [**target**]

Member Provider Support – Timeline of Activities

Referral & General Intake Activities	
Timing	Staff: Triage Coordinator, HCC, and/or Assigned Care Coordinator
Within **1** business day of ***<u>referral receipt via</u>*** - ✓ *email* ✓ *fax* ✓ *phone call/VM* ✓ *direct referral*	> **<u>Referral is documented</u>** – ▫ **Referral Intake** [assessment] which includes: o Data capture for incoming referral information o Documentation of initial response to referent ▫ **Referral Note** [specific note type] **> <u>Member Provider Support Program Added</u>** ▪ **Program** (episode) **status > *<u>Referred</u>*** ▪ If applicable **-** *Intensive Care Coordination Support & Service Type* added ▪ ***Episode Responsible Staff:*** ▪ RCT Pool ▪ Individual care coordinator if known at time of referral, e.g. HRS entering a referral received from clinic ▫ Member demographics updated as applicable

Timing	Staff: RCT Pool "Divers"
Within **3** business days of ***referral receipt***	▫ If applicable, team huddle to determine case assignment ▪ **Note**: See RCT Transfer guidance below for re-referring to corrected RCT ▫ Member Provider Support ***Responsible Staff*** **Updated** ▪ Program (episode) updated from RCT Pool – ***Provider*** **> assigned Care Coordinator** **!** *Note: Case re-assignment from the pool to an induvial is completed via updating the Member Provider Support episode's Responsible Staff, not by removing the Pool or Individuals from the Care or Case Team.*
RCT Transfers	▪ There are occasions when a referral may land with a Regional Care Team that does match where a member receives their primary care services. 1. The initial RCT to receive the referral keeps the episode status as *Referred* (do not update to *Enrolled)* 2. Someone from the initial RCT documents/completes the following as referral 'triage' steps via a *Patient Outreach* encounter linked to the episode: ▪ Research into member's correct PCP/RCT (e.g. referral info, review of claims in FIDO, QNXT, etc.) ▪ Manually update the member's *Care Team* with correct PCP information ▪ When applicable, document actions taken to correct the PCP assignment in QNXT ▪ Clear rationale if unable to update PCP in QNXT (ICF resident, care through VA, etc.) 3. Update the episode's *Responsible Staff* to the corrected RCT Pool. **Note**: Adding text to the *Episode Overview section* (episode comments box) is optional and should only be secondary to entering an encounter with the information noted above.

Assigned Care Coordinator - Referral Intake Activities: *Outreach, Assessment, Care Plan*	
Timing	Staff: Assigned Care Coordinator
Within **5** business days of ***Care Coordinator assignment***	**Program Update -** ▫ **Member Provider Support Program Status Updated** ▪ Program (episode) status **>** ***Enrolled***
	Record Review & Intake - ▫ **Information Gathering - Review Records** ▪ Internal chart review of Compass Rose – ▪ referral information ▪ past documentation / encounters ▪ coverage information ▪ Review FIDO, QNXT, PointClickCare as needed ▪ Review external EMR(s) as needed ▫ **Document Progress Note with findings**
	Determine Outreach Plan – e.g. order of outreach calls, appropriateness of outreach to member, etc. ▪ *If notifying the member about their care coordination status or involving the member in the HRAT or CCA process could be detrimental to their health or well-being document the reason within a progress note.*
	Outreach [Outreach Tasks] ▪ *Outreach objectives: Communicate Care Coordinator assignment, identify/clarify/discuss care support needs with referent, PCP, and member.*
	Act on Outreach Plan via Outreach Task completion or task modification [***Contacts section + Reason for Outreach + Outreach Management***] ▪ *Primary Care Coordinator to complete initial outreach call with member* ▪ *Outreach to Referent in 1 business day* ▪ *Outreach PCP* ▪ **Add outreach content to Progress Note**, as applicable
	Assessment [Target] ▫ If able/appropriate based on chart review and/or outreach, **initiate *Care Coordination Assessment***

	Add assessment content to Progress Note, as applicable
	Care Plan [Target] ▫ If able/appropriate based on chart review and/or outreach, initiate a *Care Plan*
	Share Care Plan as appropriate [**Checklist Task**]
Timing	Staff: Assigned Care Coordinator
Within **10** business days of ***Care Coordinator assignment***	**Update Member Information -** ▫ **Update Member's Care Team & Patient Contacts Sections –** ○ **Care Team –** clinical and direct care providers ○ **Patient Contacts –** natural supports, Case Workers, DME providers **Address Targets x 2 -** ▫ **Assessment** ○ If able/appropriate based on chart review and/or outreach, **initiate *Care Coordination Assessment*** ▫ **Care Plan** ○ Ensure a ***Care Plan*** is initiated ○ **Share** the ***Care Plan*** as appropriate [**Checklist Task**] **Additional Outreach & Communications/Interactions -** ▫ Continue member engagement as appropriate ○ Document all attempts to outreach member via *Outreach Tasks* and/or *Contacts* section (incoming/outgoing calls, text, etc.) ▫ Contact member's PCP and other applicable care team members such as Aging & People with Disabilities/LTSS Case Worker ▫ Continue engagement with primary care clinic and/or other care team members as needed ▫ Communicate Care Plan as applicable **Coordination** – [**Checklist Task**] ▫ Document an Interdisciplinary Care Team Meeting and/or Care Conference as applicable ▫ Use ***ICT or Case Conference note*** (Coordination activity tab)

<table>
<tr><th colspan="2">Ongoing Care Coordination Activities</th></tr>
<tr><td>Timing</td><td>Staff: Assigned Care Coordinator</td></tr>
<tr><td rowspan="4">As applicable throughout case

Minimally, members should be engaged and charts updated monthly</td><td>Communications –
Respond to phone calls, e-mails, texts, etc. from member and/or Care Team
Document all communications via Contacts section (incoming/outgoing calls, texts, Face-to-Face visits, emails, etc.) and progress notes</td></tr>
<tr><td>Care Plan Updates –
Review Care Plan at least monthly
Update Care Plan, including progress towards goals
Continue to share Care Plan with member and Care Team</td></tr>
<tr><td>Reassessment – based on “trigger events”</td></tr>
<tr><td>Healthwise Materials
UniteUs Referrals</td></tr>
<tr><td>Monitoring & Paused Statuses</td><td><u>Monitoring</u> uses:
Choice Model
For all other MPS episodes - used at Care Coordinator's discretion when:
There are no current/active care coordination needs for 30+ days, but there are anticipated support needs beyond 30 days, e.g. upcoming appointment, scheduled procedure
Please be sure the rationale for keeping a case in monitoring status is clearly documented
<u>Paused</u> uses:
At the discretion of the assigned Care Coordinator based on a member's clinical or situational factors –
Example - Member enrolled in Member Provider Support experiences a hospitalization event requiring Transitional Support program enrollment where MPS goals/work would be secondary to acute care support needs
When paused, the assigned Care Coordinator has the option to:
1. Continue "working" the paused Episode
> Note: Encounters will need to be linked with the paused episode when updating things such as tasks, targets, and care plans.
2. Update the due dates for the paused Episode's pending tasks & targets
> Note: Encounters will need to be linked with the paused episode when updating things such as tasks, targets, and care plans.</td></tr>
</table>

Case (Episode) Closure Activities	
Timing	Staff: Assigned Care Coordinator
As appropriate per individual case ▸ Member declines further care coordination engagement	**CLOSURE INDICATORS** – ▪ Completion of all applicable tasks and targets ▪ All care coordination/transition plan/care plan needs met ▪ Actively engaged with PCP and/or Care Team ▪ Member declined further care coordination engagement ▪ Member has not responded to outreach x3 attempts ▸ **NOTIFY THE MEMBER AND THE CARE TEAM OF CLOSURE** ▪ Communicate steps for re-referral to care coordination if indicated in the future ▪ Document last interactions with the member and care team ▸ **RESOLVE CARE PLAN** ▸ **DOCUMENT FINAL PROGRESS NOTE** *Document the reason for case closure including* – ▪ A summary of the work done, noting referrals and goals/issues completed ▪ Reasons for any unmet goals/referrals. ▪ Indicate if the care plan shared with member and/or provider; if it was not, indicate the reason. ▪ Any directions to guide the intake/care coordination process in the future if the member should be re-referred **MEMBER PROVIDER SUPPORT PROGRAM UPDATED** ▪ Program (episode) status **> *Closed*** ▪ Select appropriate ***Closed Reason*** **!** *Note: Case closure is completed via updating the Member Provider Support episode's status, not by removing users from the Case or Care Team.*

Update log:

3/24	K. Knight	Edits
5/24	K. Knight	RCT Transfers. Episode Staus; approved E. Adler

Transitional Support Program

Sections -

- -

Transitional Support - Program Information

Program Purpose:	▪ Facilitate safe discharge planning and transitions between levels of care ▪ Support member's connection to appropriate settings and services
The Transitional Support Program is applicable for -	✓ **CareOregon Advantage** (COA - Medicare) members who are admitted to a facility* as inpatient or under observation status – medical or psychiatric ✓ **Spirit of Healing and Tribal Care Coordination –** members who are admitted to a facility* as inpatient or under observation status – medical or psychiatric ✓ **Medicaid members who are referred into care coordination related to an admission event** – medical or psychiatric ✓ **Medicaid members engaged in *Member Provider Support* program who are admitted to an acute care facility*** – medical or psychiatric ** Facilities include acute care facilities (hospitals), psychiatric hospitals or units, Skilled Nursing Facilities, inpatient rehabilitations centers (physical rehabilitation), long-term acute care, etc.* Reference: **Transitional Support - Referral Pathway & Care Coordination Responsibilities Grid**
Notification of the transitional event -	**COA Members** ▪ Triage Coordinators identify the *initial* Physical Health admission event for COA members and update the member's chart with applicable admission and discharge information via the *Notification of Hospitalization* assessment. ▪ COA *readmissions* are identified by the assigned care coordinator via the *Pt Admitted/Discharged Report* (Dashboard/In Basket) when the member is currently enrolled in an episode of *Transitional Support.* ▪ Triage Coordinators will support secondary readmission identification and episode documentation. **OHP Members** ▪ New care coordination referrals based on an admission event (e.g. referrals from hospital discharge planners or Metro-County Care

Coordination "screen-outs") will generally be entered by Triage Coordinators.
- The assigned Care Coordinator should ensure a *Notification of Hospitalization* assessment is on file and enter one if not.
- For members already enrolled in an episode (*Member Provider Support* or *Transitional Support*), the assigned Care Coordinator will receive notice of admissions or readmissions via the *Pt Admitted/Discharged Report* (Dashboard/In Basket).

For all admissions -
- An *Admission Encounter* will appear under *Chart Review* if the hospitalization event is noted in PointClickCare (*Admission Encounter* data source).
- Admission data also appears in the *Recent Visits* section of a member's *SnapShot.*

Transitional Support Program - Documentation Requirements

- ***Transitional Support*** **program added** + **episode statuses** [*identified > enrolled > close]*
- **Support & Service Type**, as applicable -
  - Medicare
  - Readmission

- **Assessments**
  - *Notification of Hospitalization*
    - Admission & discharge information
    - Note for Behavioral Health Transitional Support
  - *Transitions Assessment* [**program target**]
  - *Behavioral Transitions Assessment* – as applicable
  - *Follow Up Post Discharge*

  - If applicable/appropriate –
    - *Social Determinants* [**program target**]
    - *Health Risk Assessment Tool* [**program target for COA**]

- **Outreach Tasks x4**
  - *Initial Member Outreach*
  - *Outreach PCP*
  - *Inpatient Care Team Outreach*
  - *72 hour post discharge outreach*

- **Care Plan** [**program target**]

- **Pre-determined *Transitional Support* Program Targets – all admissions:**
  - *Initiate Transitions Assessment*
  - *Initiate Care Plan*
  - *Prioritize Face to Face Meeting with Member*
  - *Member has PCP follow-up w/in 14 days of discharge*
  - *Member is Stable*
  - *Initiate/Complete Social Determinants* (assessments)
- **Additional Medicare-specific Targets:**
  - *Meals Post Discharge*
  - *Health Risk Assessment*
  - *Medication Reconciliation*
- **Pre-determined *Transitional Support* Program Checklist Tasks**
  - ICT / Case Conference(s):
    - *Inpatient* [**progress note**]
    - *Post-discharge* [**progress note**]
  - *Share Care Plan with Member*
  - *Share Care Plan with Care Team*
  - *Outreach Aging & People with Disabilities* – as applicable
  - *Healthwise Education* – as applicable

Transitional Support – Timeline of Activities

<table>
<tr><th colspan="2">Notification of Transitional Event & Intake Activities</th></tr>
<tr><td>Timing</td><td>Staff: Triage Coordinator, HCC, and/or Assigned Care Coordinator</td></tr>
<tr><td rowspan="2">Within 1 business day of notification of Admission*

* or Discharge if no prior notification of admission</td><td>TRANSITIONAL SUPPORT PROGRAM ADDED
▪ Program (episode) status > Identified*
* if admission event identified by TC, HCC, outside referent

COA Members
▪ Medicare Support & Service Type added
▪ Episode assigned to RCT Pool</td></tr>
<tr><td>NOTIFICATION OF HOSPITALIZATION [ASSESSMENT] ENTERED
OHP Members
▪ Reassessment (admission = trigger event):
Assigned Care Coordinator enters both admission and discharge data
▪ Readmission:
Assigned Care Coordinator enters both admission and discharge data
▪ New referral:
TC or HCC enters admission data</td></tr>
</table>

COA Members

- **New admission**:
  Triage Coordinators enter initial admission *and* discharge data
- **Readmission**:
  Assigned Care Coordinator enters both admission *and* discharge data w/ TC as backup

Staff: Transitions Triage Pool "Divers"

- If applicable, team huddle to determine case assignment
  - **Note**: See **RCT Transfer** guidance below for re-referring to corrected RCT

TRANSITIONAL SUPPORT PROGRAM UPDATED

- Program (episode) ***Responsible Staff*** updated from pool to ***Provider*** **> assigned Care Coordinator**

! *Note: Case re-assignment from the pool to an individual is completed via updating the Transitional Support episode's Responsible Staff, not by removing the Pool or individuals from the Care or Case Team.*

RCT Transfers

- There are occasions when a referral may land with a Regional Care Team that does match where a member receives their primary care services.

1. The initial RCT to receive the referral keeps the episode status as *Identified* (do not update to *Enrolled)*

2. Someone from the initial RCT documents/completes the following as referral 'triage' steps via a *Patient Outreach* encounter linked to the episode:

   - Research into member's correct PCP/RCT
     (e.g. referral info, review of claims in FIDO, QNXT, etc.)
   - Manually update the member's *Care Team* with correct PCP information
   - When applicable, document actions taken to correct the PCP assignment in QNXT
   - Clear rationale if unable to update PCP in QNXT
     (ICF resident, care through VA, etc.)

3. Update the episode's *Responsible Staff* to the corrected RCT Pool.

Note: Adding text to the *Episode Overview section* (episode comments box) is optional and should only be secondary to entering an encounter with the information noted above.

	Staff: Assigned Care Coordinator **1. TRANSITIONAL SUPPORT PROGRAM UPDATED** ▪ Program (episode) status **> *Enrolled*** **2. REVIEW RECORDS** ▪ If available, review the associated hospital's EMR to determine member's current clinical status, appropriateness for outreach, and information related to discharge planning. ▪ *Reminder: The Admission Encounter includes the associated facility. The admission status (inpatient or observation) …* **3. INITIATE *TRANSITIONS ASSESSMENT*** ▪ At minimum, assessment questions 1-3 ▪ *Note for Behavioral Health Transitional Support* **4. INITIATE PROGRESS NOTE - TRANSITION INTAKE** ▪ **Template: *Transition Intake*** ▪ *Note*: *The Notification of Hospitalization populates information into the Transition Intake template.* **5. INITIATE INPATIENT CONTACT – *OUTREACH TASKS*** *Outreach objectives: Communicate Care Coordinator assignment, identify & discuss transitional support needs.* ▸ Member ▸ Primary Care Provider ▸ Inpatient Care Team, including discharge planner **6. INITIATE CONTACT** – Any other support services member may be engaged in (i.e. DD, LTSS/APD). ▪ *Note: Outreach Aging & People with Disabilities will appear as a Checklist Task*
While Member is Inpatient* ** Timing & activities will vary based on nature & length of admission*	Staff: Assigned Care Coordinator **ADDRESS PROGRAM TARGETS AS ABLE -** ▫ **Initiate Transitions Assessment** ▫ **Initiate Care Plan** ▫ **Prioritize Face to Face Meeting with Member** ▫ COA-only: **Meals Post Discharge** ◆ *As appropriate, discuss benefit with member and discharge planner* **COMMUNICATIONS -** ▸ Attempt to contact member 2x/week, as appropriate ▫ **Share Care Plan** when appropriate [Checklist Task]

	▫ Document all attempts to outreach member via *Outreach Tasks* and/or *Contacts* section (incoming/outgoing calls, text, etc.) ▶ Remain in contact with hospital or facility discharge planner ▶ Engage primary care clinic and/or other care team members as needed to support safe discharge planning ▫ **Share Care Plan** when appropriate [Checklist Task] **CLINICAL AND DISCHARGE PLANNING UPDATES -** ▶ Gather relevant information and update documentation - ▫ **Care Plan** ▫ **Transitions Assessment** ▫ **Progress Note** ▫ **Inpatient ICT -** *ICT Note + Checklist Task* ▫ **Member Demographics** – *language, phone number, etc.* ▫ **Care Team** ◆ *Identify and enter contact info of other clinical providers* ▫ **Patient Contacts** ◆ *As appropriate, identify and update contact info of family or other representatives involved in the member's care as appropriate.* ◆ *Identify need for/support access to* CO's PHI Release Form.

Discharge-specific Activities	
Timing	Staff: Triage Coordinator, HCC, or Assigned Care Coordinator
Within **3** business days of ***notification*** of **Discharge**	***NOTIFICATION OF HOSPITALIZATION*** [ASSESSMENT] **– NEW READING** ▶ **OHP Members** ▪ **Reassessment** (admission = trigger event): Assigned Care Coordinator enters discharge data ▪ **Readmission**: Assigned Care Coordinator enters discharge data ▪ **New referral**: Assigned Care Coordinator enters discharge data ▶ **COA Members** ▪ **New admission**: Triage Coordinators enter admission *and* discharge data ▪ **Readmission**: Assigned Care Coordinator enters admission *and* discharge data
	Staff: Assigned Care Coordinator
	INITIATE POST-DISCHARGE CONTACT – *OUTREACH TASK* ▫ Member

As needed, initial or additional outreach to -

- Primary Care Provider
- Inpatient Care Team, including discharge planner
- Any other support services member may be engaged in (i.e. DD, LTSS/APD)

COMMUNICATIONS -

- Attempt to contact member 2x/week post-discharge, as appropriate
- Document all outreach attempts to member via *Outreach Tasks* and/or *Contacts* section (incoming/outgoing calls, text, etc.)
- Document all communications via *Contacts* section (incoming/outgoing calls, texts, emails, etc.) and progress notes

CLINICAL AND POST-DISCHARGE UPDATES -

Gather relevant information and update documentation -

- **Assessments**
  - *As applicable, new reading*: ***Transitions Assessment***
  - *Complete*: ***Follow-up Post Discharge Assessment***
- **Care Plan**
- **Progress Note(s)**
- **Post-Discharge ICT** - ICT Note + Checklist Task
- **Member Demographics** – *language, phone number, etc.*
- **Care Team**
  - *Identify and enter contact info of other clinical providers*
- **Patient Contacts**
  - *As appropriate, identify and update contact info of family or other representatives involved in the member's care as appropriate.*
  - *Identify need for/support access to CO's PHI Release Form.*

ADDRESS PROGRAM *TARGETS* -

- **Initiate Transition Assessment**
- **Initiate Care Plan**
- **Prioritize Face to Face Meeting with Member**
- **Member has PCP f/u withing 14 days of DC**
- **Initiate/Complete Social Determinants**
- **Member is Stable**
- *COA-only:* **Meals Post Discharge**
  - *N/A for Observation stays*
  - *Referrals supported in UniteUs*
  - *Documentation tools: target completion, Post-Discharge assessment, progress note*
- *COA-only:* **Health Risk Assessment**
- *COA-only:* **Medication Reconciliation**
  - *Required for COA inpatient and SNF stays, not required for observations stays*
  - *Supported by CareOregon Pharmacists, reviewed/confirmed by assigned CC*

	SHARE CARE PLAN AS APPROPRIATE [Checklist Task]

Ongoing Transitional Support Activities	
Timing	Staff: Assigned Care Coordinator
Ongoing within **30 days post discharge**	**COMMUNICATIONS –** ▶ Attempt to contact member 2x/week post-discharge, as appropriate ▶ Document all outreach attempts to member via *Outreach Tasks* and/or Contacts section (incoming/outgoing calls, text, etc.) ▶ Document all communications via Contacts section (incoming/outgoing calls, texts, Face-to-Face visits, emails, etc.) and progress notes ▶ **Share Care Plan** as appropriate [Checklist Task] **RESPOND TO THE MEMBER AND CARE TEAM –** ▶ Respond to phone calls, e-mails, texts, etc. from member and/or Care Team ▶ Complete program tasks and target as applicable ▶ Assess and address readmission risks as appropriate ▶ Monitor for readmission event **POST-DISCHARGE UPDATES –** Continue to gather relevant information and update documentation – ▫ **Assessments** ▫ **Care Plan** ▫ **Progress Note(s)** ▫ **Post-Discharge ICT** – ICT Note + Checklist Task ▫ **Share Care Plan** as appropriate [Checklist Task]
Monitoring Status	Used at Care Coordinator's discretion to account for period of time in between: ▪ Member's care coordination needs have been met *or* ▪ **>** No modifiable risk factors identified for the member *or* ▪ **>** Active care coordination provided by external community entity has been confirmed/ coordinated with *and* ▪ **>** The required 30-day duration of T*ransitional Support* cases

Case (Episode) Closure Activities	
Timing	Staff: Assigned Care Coordinator

30 days from **discharge date**	**CLOSURE INDICATORS** – ▪ Completion of all applicable tasks and targets ▪ All care coordination/transition plan/care plan needs met ▪ Member following through with follow-up appointments independently ▪ Actively engaged with PCP ▸ **NOTIFY THE MEMBER AND THE CARE TEAM OF CLOSURE** ▪ Communicate steps for re-referral to care coordination if indicated in the future ▪ Document last interactions with the member and care team ▸ RESOLVE CARE PLAN ▸ **DOCUMENT FINAL PROGRESS NOTE** *Document the reason for case closure including* – ▪ A summary of the work done, noting referrals and goals/issues completed ▪ Reasons for any unmet goals/referrals. ▪ Indicate if the care plan shared with member and/or provider. If it was not, indicate the reason. ▪ Any directions to guide the intake/care coordination process in the future if the member should be re-referred **TRANSITIONAL SUPPORT PROGRAM UPDATED** ▪ Program (episode) status **> *Closed*** ▪ Select appropriate ***Closed Reason*** **!** *Note: Case closure is completed via updating the Transitional Support episode's status, not by removing users from the Case or Care Team.*

Additional Transitional Support Activities	
Skilled Nursing Facility stays	▸ Add *Checklist Task* - ***Follow SNF Stay*** ▸ *COA-only* – update due date for Meals Post Discharge target based on anticipated discharge from SNF
Readmissions	**Notification of the Transitional Event:** ▸ **All members already enrolled in *Transitional Support* with an assigned care coordinator -** ▫ Assigned Care Coordinator receives notice via *Pt Admitted/Discharged Report* (Dashboard/In Basket). ▫ An *Admission Encounter* appears in Chart Review ▫ Admission data appears in Recent Visits in *SnapShot* **Transitional Support Program Updated:** ▸ **Readmission Support & Service Type** is added to Episode ▫ Original episode is left open

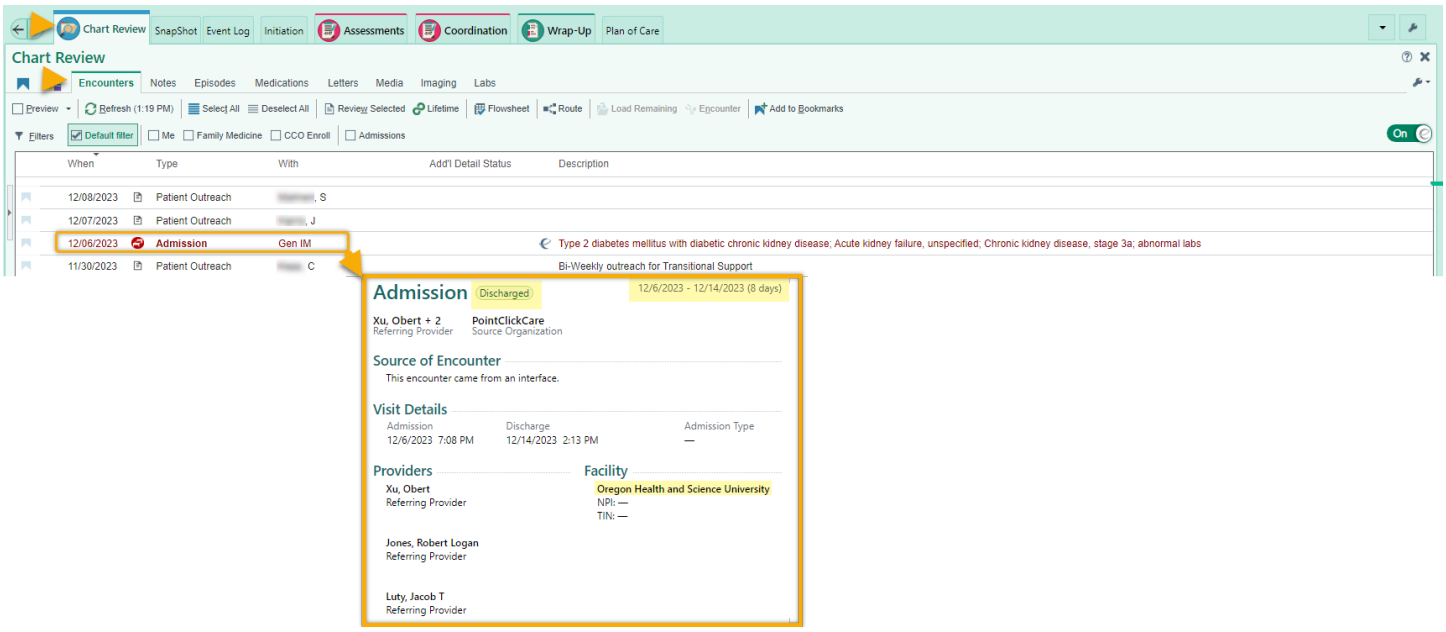
	Assessment: ▶ **New Readings –** ▫ *Notification of Admission* ▫ *Transitions Assessment* ▫ *Follow Up Post Discharge Assessment* **Note:** ▶ **Reassessment Note** documented (Coordination tab) **Outreach Tasks & Checklist Tasks:** ▶ **Engage the *Outreach Tasks* and *Checklist Tasks*** ▫ *Permission to remove (x) **duplicate tasks*** ▫ *Duplicate Checklist Tasks are without the Source: Readmission* ▫ *Duplicate Outreach Tasks have an older due date* ▶ **Targets** ▫ *Manually add applicable Targets as needed*
Out of Area or Out of State admissions	▶ Engage internal Case Conference.

Update log:

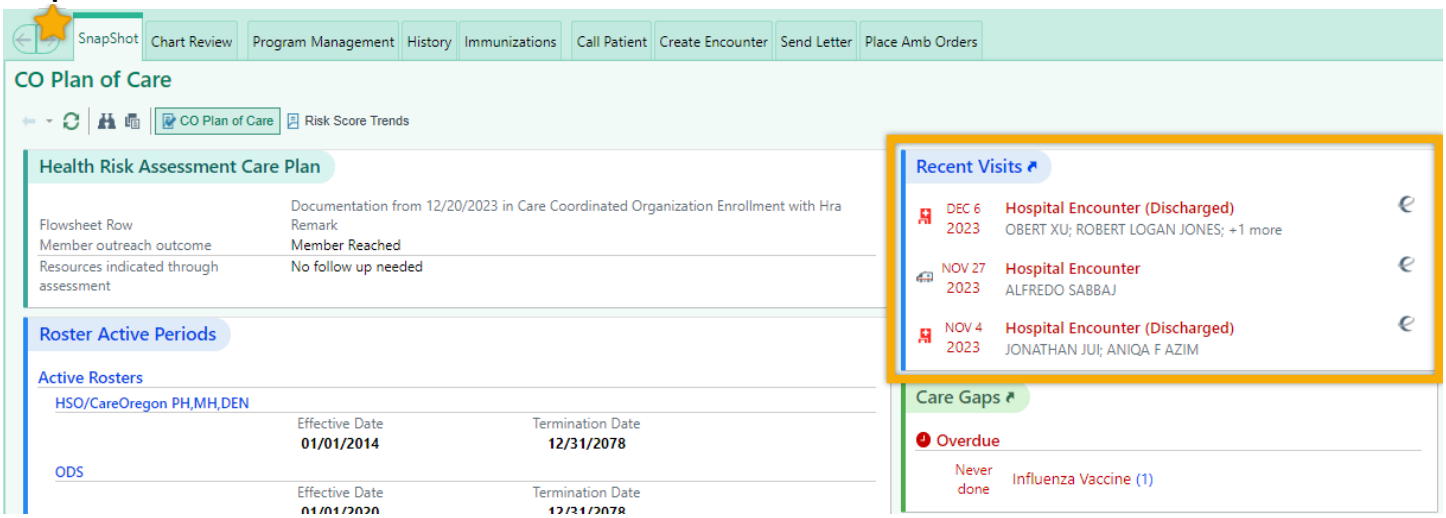
2/24	E. Adler	Posting
3/24	K. Knight	Readmissions
5/24	K. Knight	Monitoring status; RCT Transfers Approved – E. Adler

Transitional Support Activities – Visual Guide

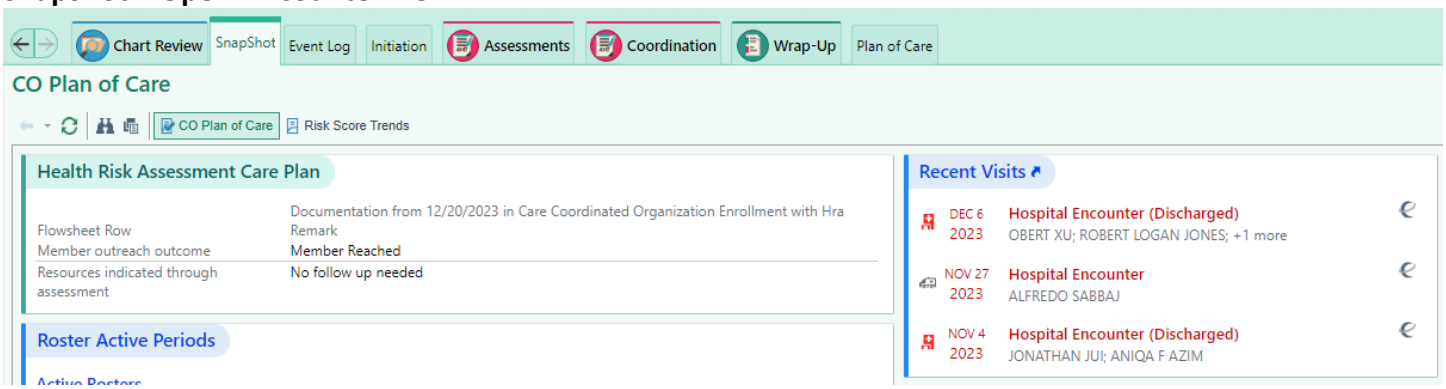
Admission Encounter –



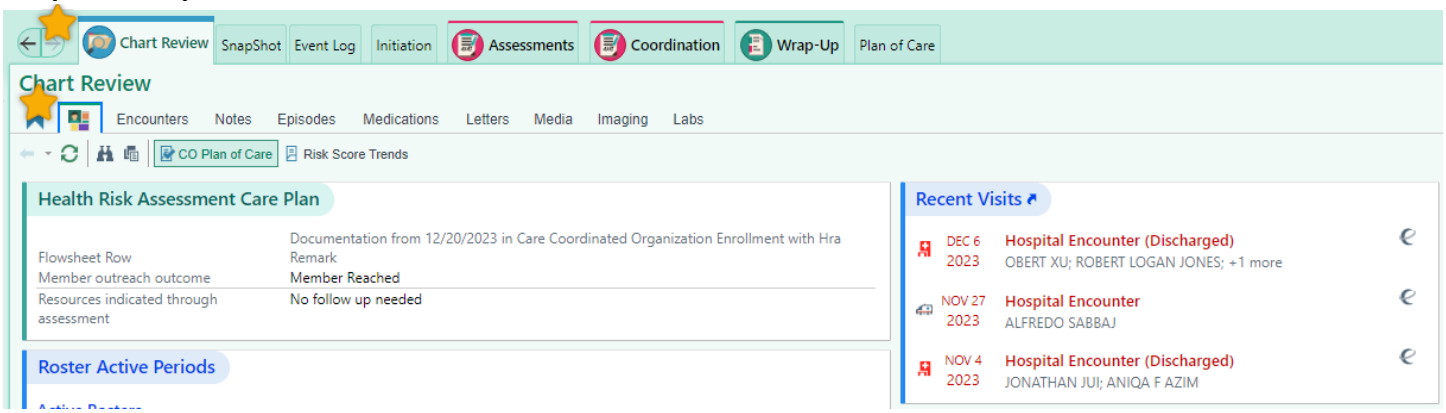
SnapShot – Chart view



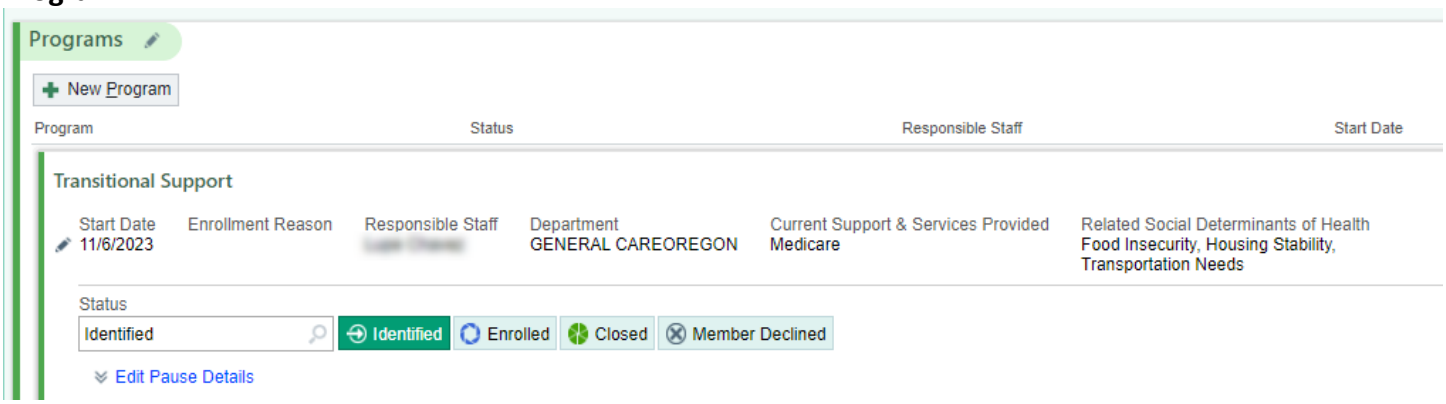
SnapShot – Open Encounter view #1



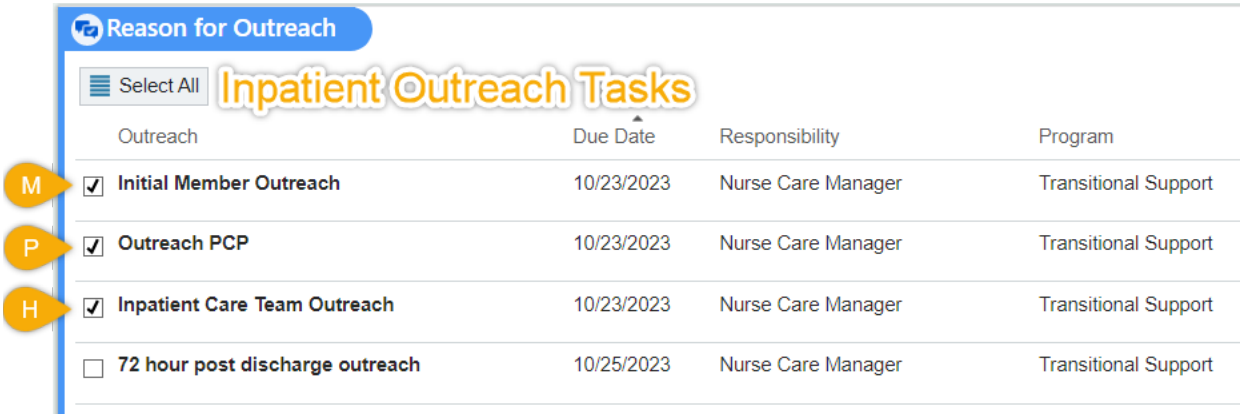
SnapShot – Open Encounter view #2



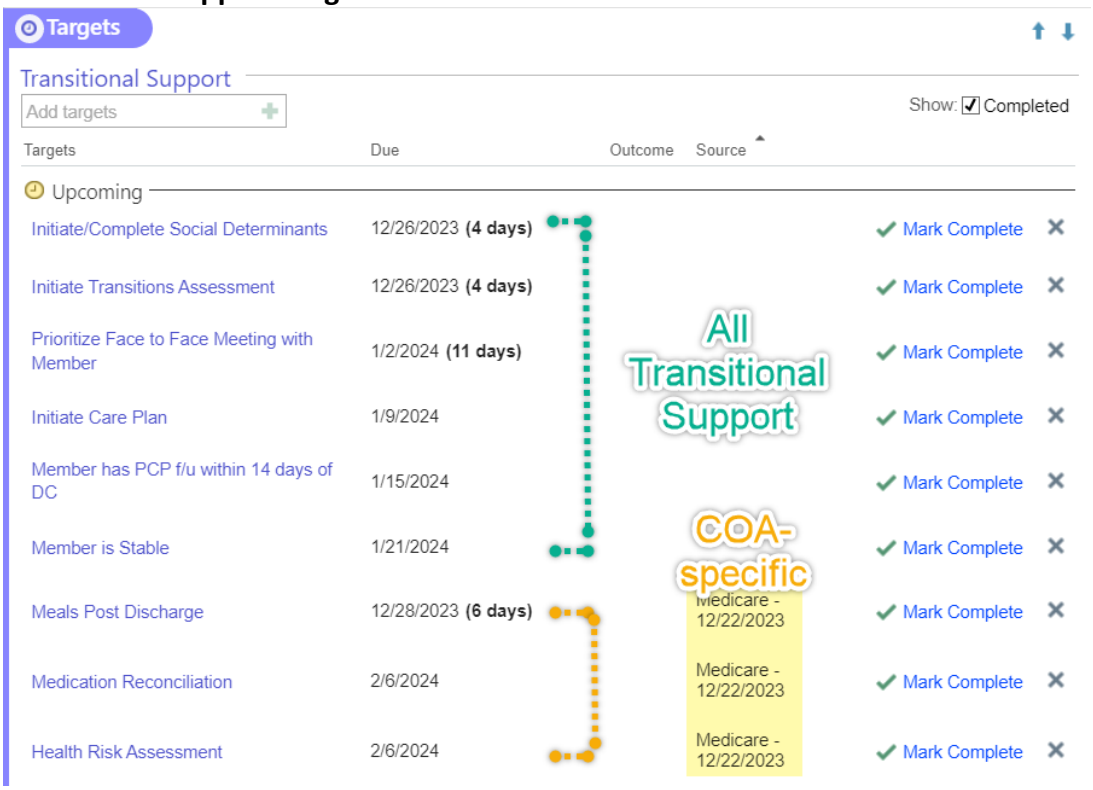
Program –



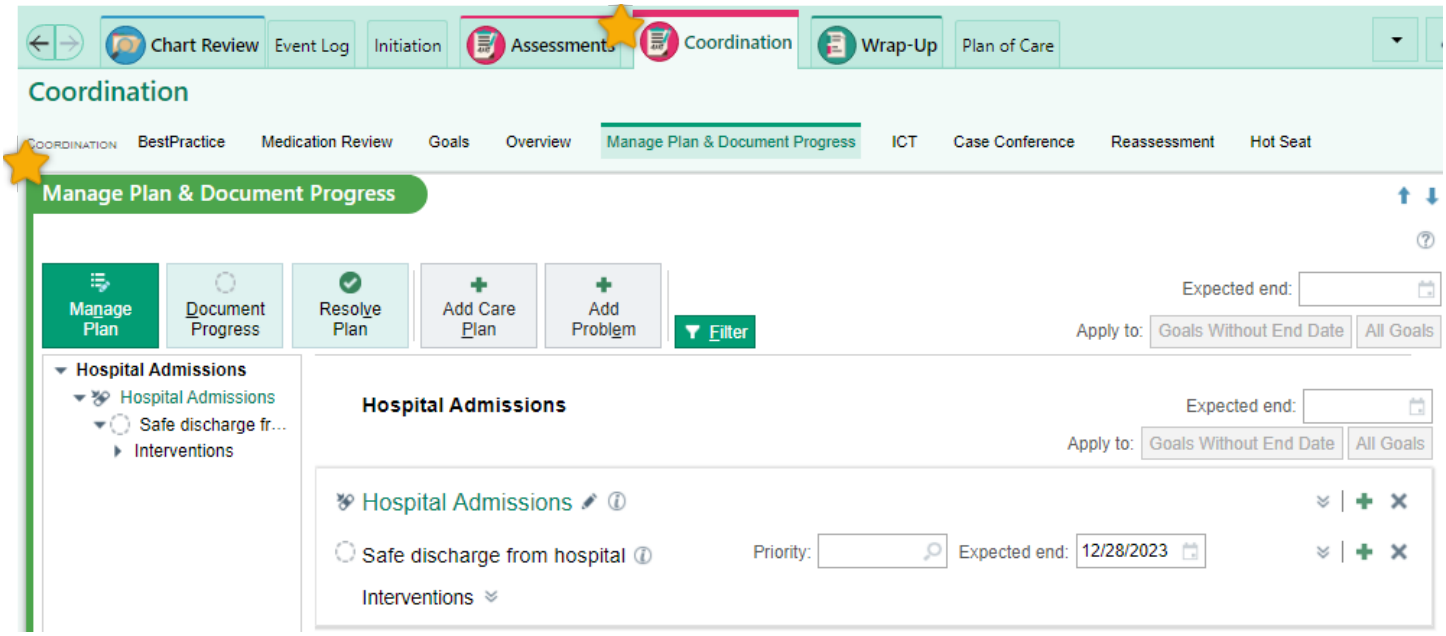
Inpatient Outreach Tasks –



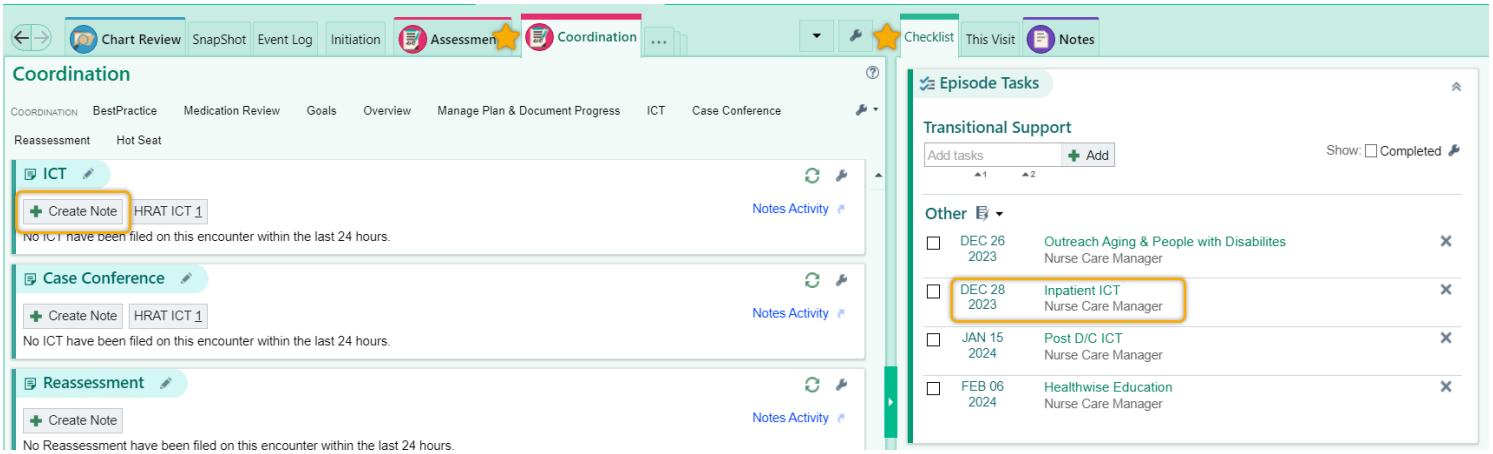
Transitional Support Targets –



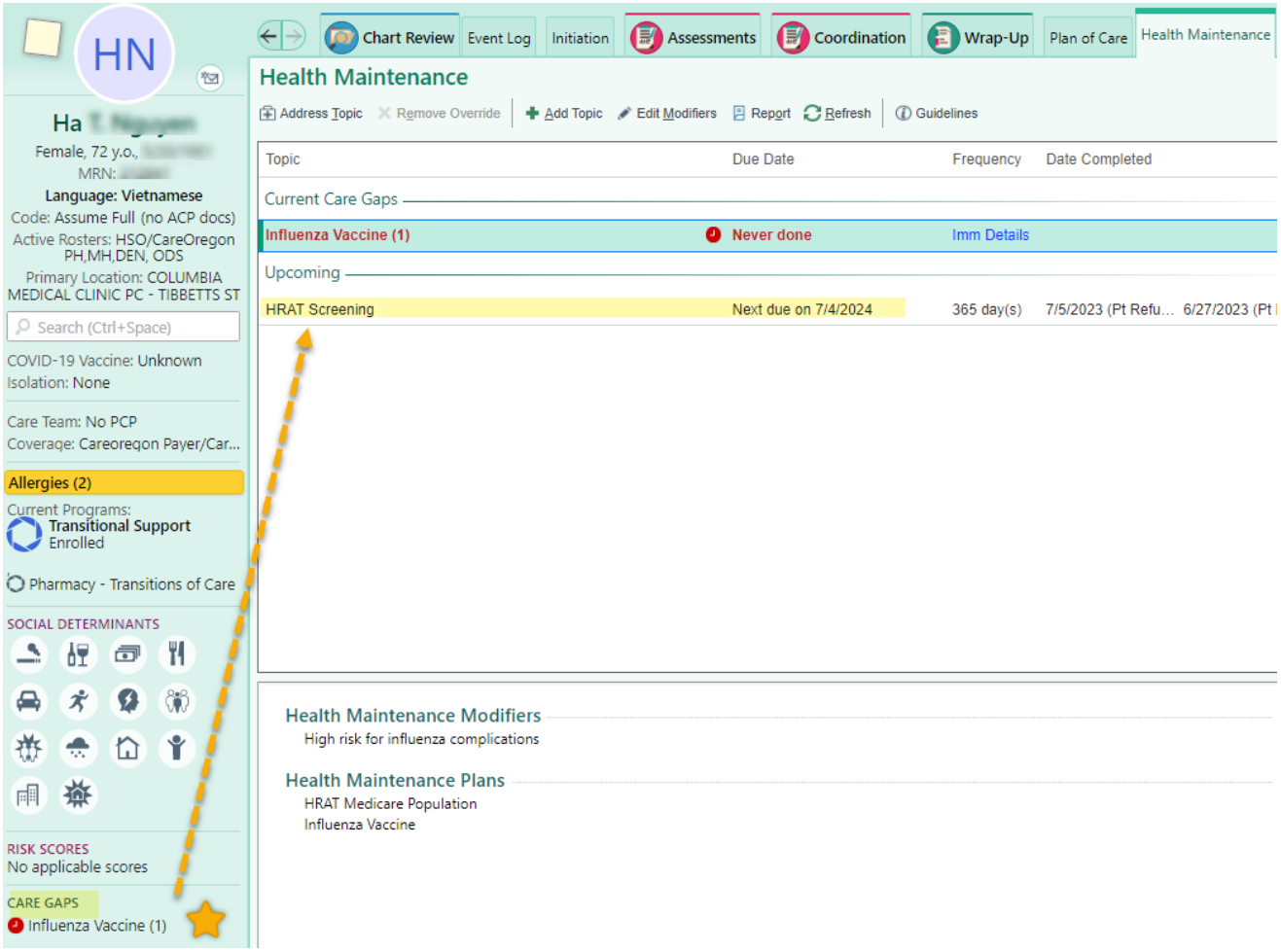
Care Plan –



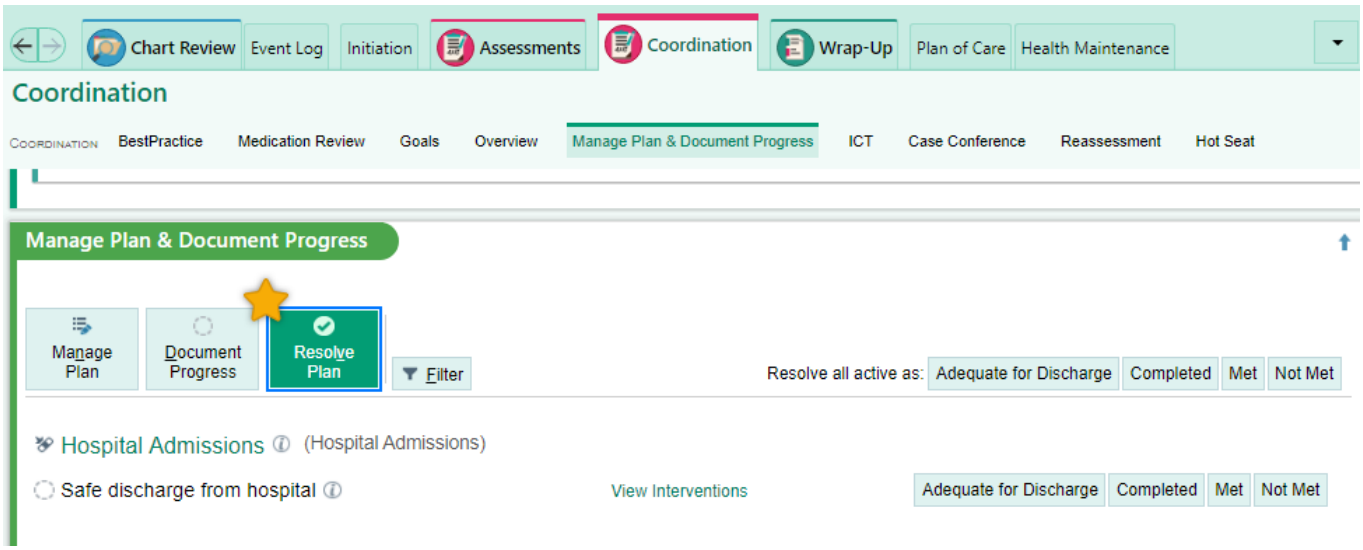
Inpatient ICT –



Health Risk Assessment –

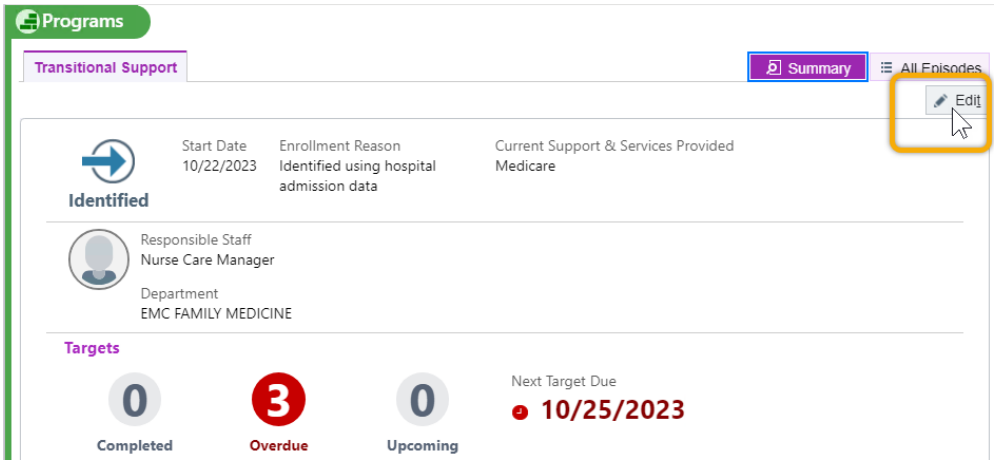


Resolve Care Plan -

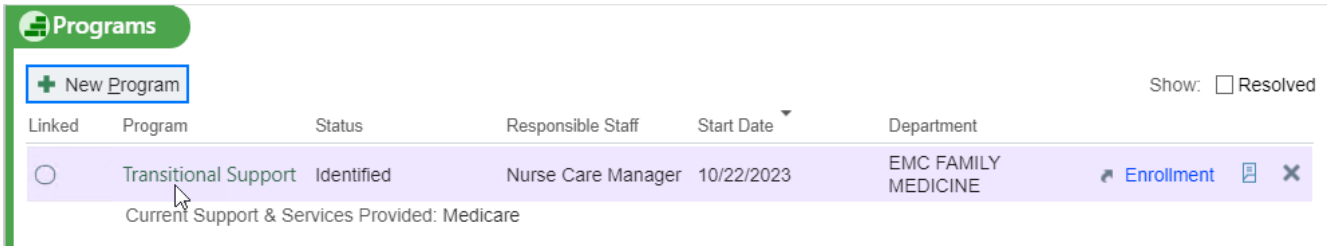


Readmissions Support & Service Type -

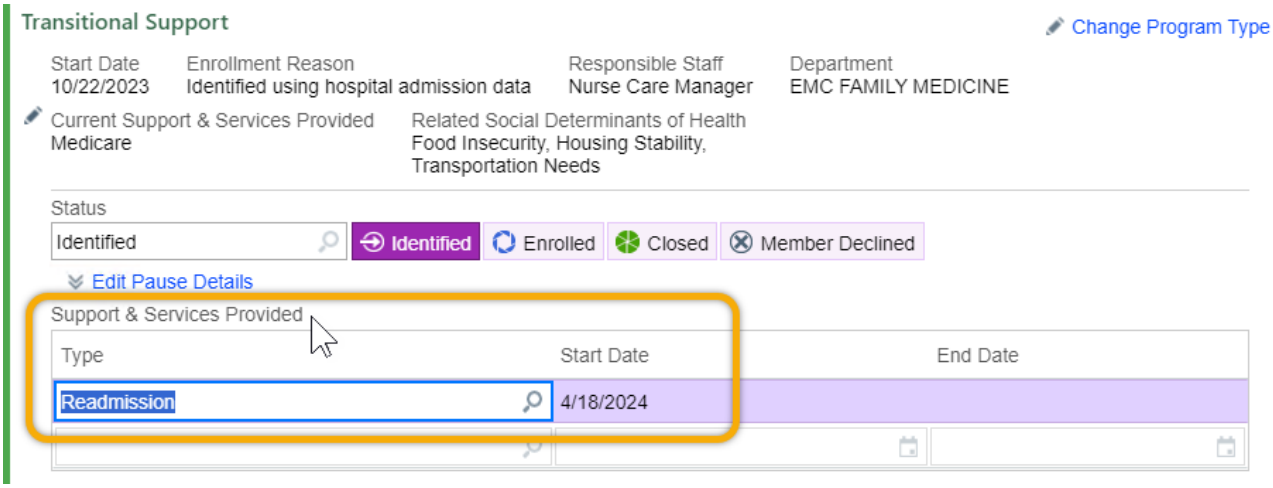
- A. **Linked encounter > *Edit* button**



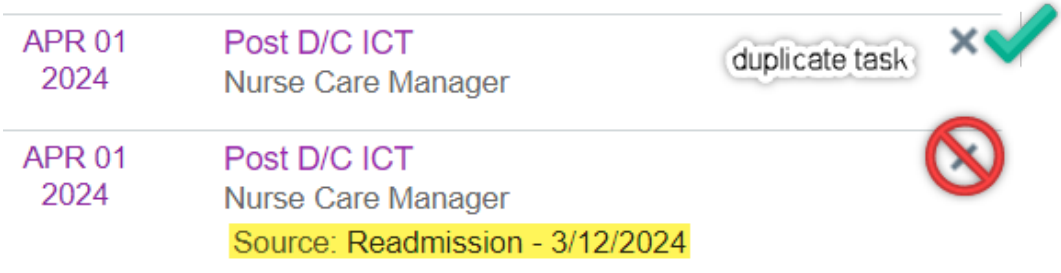
- B. **Unlinked encounter (don't forget to link!) > Click Transitional Support title**



- **Then enter Readmission under *Support & Services Provided* -**



Duplicate Checklist Tasks:



Duplicate Outreach Tasks: