CCO-LTSS Partnerships MOU Template:

MOU Period: April 1st, 2025 through March 31st, 2027

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: Eastern Oregon Coordinated Care Organization (EOCCO) OHA Contract # 161758-6

Partner AAA/APD District (s) Names/Locations: Aging and People with Disabilities (APD) Districts 9, 11, 12, 13, & 14

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

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s):	APD/AAA Lead(s):
EOCCO will Monitor and evaluate appropriateness of care including transitions in care, progress toward meeting goals, barriers to those goals, collaborate with community partners, providers, APD, and other state entities as appropriate to help achieve desired member outcomes. EOCCO will document the coordination in the care plan regardless of member engagement. EOCCO's care team provides care management to all EOCCO members including dual eligible members. **EOCCO MDT participants:** Government Care Manager Supervisor, Director Utilization and Medical Management, Healthcare Services Project Manager, Behavioral Health Care	AAA/APD will Provide expert resource information on services available within the local community as well as foster new community partner relationships to meet the future needs of the community resource development while developing professional relationships with key community partners, such as the hospital discharge planners, EOCCO representatives, nursing home discharge planners, DNS and resident care managers. APD Team is made up of: district managers and county supervisors.

Services Manager, Complex Clinical Manager, and Integrated Care Services Coordinator	

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	• EOCCO stratifies the risk of all members. A member's functional needs assessment information contributes to the risk score and risk level. • EOCCO will share the risk level and risk score of members receiving LTSS services through APD, with the APD branches in our service area via ShareFile. • APD staff can refer members with potential need for Care Coordination risk assessments as APD staff identify concerns or gaps or changes in health status via the	• APD makes referrals for members with potential need for care coordination or when APD staff identify concerns or changes in health status which are considered high needs. • APD provides a monthly LTC report for members in common, receiving long-term services and supports, providing levels of care on a monthly basis. When members choose to participate in an IDT meeting APD Case manager, Diversion Transition staff or supervisor assigned will	**Process Monitoring** 1. Review biweekly meeting prioritization methods applicable to each organization in quarterly MDT collaboration meeting. 2. Document specific prioritization methods for best practices tracking. **Measures of Success:** 1. Number of referrals into MDT by region. 2. Discuss additional measures of success for prioritization of high needs members during Quarterly MDT meetings.	# of members with LTSS that prioritization data was shared during each month/year Annual Average monthly # of members with LTSS for whom prioritization data was shared [monthly #/total in year]— calculated by OHA from data submitted. # of CCO referrals to APD/AAA for new LTSS service assessments (for persons with unmet needs). # of APD/AAA referrals to CCO for care coordination review # of completed referrals for care

	MDT referral process. • EOCCO tracks referrals to APD (SNF admit notifications, and referrals for assessments/reassessments) via the MDT spreadsheet that is shared with APD and also documented in our CM system. • EOCCO will share Health Related Social Needs (HRSN) information, if member receives HRSN services, with APD during our bi-weekly meetings. • EOCCO and APD will hold quarterly meetings to review metrics and measures of success and discuss any barriers of success.	email the appropriate email distribution with a time and date to meet. EOCCO will assign a CM to attend. APD CM will call the assigned EOCCO CM at the scheduled time. •		

				coordination review [Monthly/Year Total]
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	• MDT meetings are held bi-weekly for each MDT region. Meetings are on a recurring schedule and updated yearly. • MDT team includes Physical Health and Behavioral Health Case Managers, APD Diversion Transition Coordinators, APD Supervisors, Hospital Case Workers, and a Community Paramedic.	• APD will visit with the member or member representative, in person or by phone, to establish care transition direction, goals and preferences • Members/families (if member chooses) are included in care planning by individual case managers and shared with the MDT teams. Member's goals are documented in	**Process Monitoring:** 1. Identify use of risk stratification list for members receiving LTSS services. 2. Identify providers and community agencies that could attend MDT bi-weekly meeting to discuss specific complex cases on an as needed basis.	# of members with LTSS that are addressed/staffed via IDT meetings monthly. % of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month. total annual IDT meetings completed by CCO-APD/AAA teams.

	The MDT will discuss any additional provider types that may be needed in Quarterly meetings. • MDT team will prioritize high risk members in the MDT meetings, share care plans which includes member's Service Priority Level (SPL), goals, available service hours, Home Care Worker details, Emergency response system, access to meals on wheels, recent ED visits and transitions between levels, settings or episodes of care. • Care coordination is provided with the member, their representative or guardians participation to the extent they desire or are able. The member, their representative or guardian may be satisfied with and understand the care plan, including any of their own roles and responsibilities. • Discuss possible HRSN and/or HRS needs in bi - weekly MDT meetings and	Care plans which are discussed in MDT meetings as needed on an ongoing basis. and can be shared upon request. Continued staffing of cases via email and phone calls. • APD will include providers in individual conversations with CM.	**Measures of Success:** 1. Compare the highest risk LTSS members on the risk stratification report with the members staffed in MDT meetings. 2. Discuss challenging cases and identify additional providers/agencies that could have attended MDT meetings.	

	track any needs in our MDT spreadsheet. • Information is tracked on MDT spreadsheet that is shared via Share File and includes notes, care plans and needs discussed during MDT meetings. Communications also flow through designated email distribution for each MDT region.			

				% 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).
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	EOCCO Care plans include: • Member and CM goals • Interventions on how to meet those goals • Barriers to the goals • Expected outcomes Care Plan details: • The CCO has individualized person centered care plans and include LTSS service and supports needs. LTSS members are reviewed in biweekly meetings and care plans updated as needed. • Care Plans for both EOCCO and APD/AAA reflect the member or family/caregiver	• APD will provide person centered case management with individuals in the design of their LTSS service plan, in coordination with EOCCO when health care treatment and care planning are active. • APD contacts EOCCO when they have referrals or otherwise have identified gaps or concerns about health care needs. • APD agrees to share CAPS assessments, risk mitigation plan, goals, and strengths/preferences.	**Process Monitoring:** 1. Consider a process to monitor and track current care plans for members with LTSS **Measures of Success:** 1. Number of cases with shared/completed care plans?	% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals. % of CCO person-centered care plans for members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties.

	preferences as determined in the EOCCO Care Coordination case or the APD service plan • Individualized person centered care plans will be shared between APD, LTSS providers, and EOCCO Case Managers for members each group is involved with. • EOCCO engages all care coordination members in the design of their treatment and care plans. In addition this is coordinated with APD when members have LTSS services. • EOCCO will review ED visits and hospitalizations on LTSS members to identify if there are strategies to help mitigate risk. In addition the EOCCO and APD will review preventative approaches during the quarterly MDT meetings			

	that could improve the health of LTSS members. • EOCCO will notate care plan goals that have been met in CCA by updating the status.			
DOMAIN 4: Transitional care practices/Care Setting Transitions				
DOMAIN 4: Transitional care practices Goals	• EOCCO will share the EOCCO LTSS Admissions Weekly Report via Sharefile for APD to download and review. This report includes inpatient admissions and discharges and/or ED visits from the previous week. • EOCCO Nurse Care Coordinators submit an MDT referral/APD Notification when a member admits into a SNF to the appropriate email distribution. These cases are assigned to a Case Manager for care setting transition coordination.	• APD case workers will participate in IDT meetings when appropriate. • D/T workers will participate and coordinate with EOCCO to discuss ongoing transition members and coordinate with EOCCO as needed. • Member service plans from APD will include preferences and goals. EOCCO and APD D/T caseworkers will coordinate service plans to meet member Medical and social goals during transitions. • EOCCO will contact the local office with LTSS referrals. APD	**Process Monitoring:** 1. Discuss evidence based transition of care models and how they can be applied to transitional care practices within MDT. 2. Discuss best practices within each MDT organization for coordinating and communicating transitions in care for members receiving LTSS services and supports. **Measures of Success:** 1. Track post-conference transitions – specifically for transitions that were not smooth.	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? % transitions where discharge orders (DME, medications, transportation) were arranged

	This includes: ○ Coordination of appropriate discharge planning and ensuring services are in place prior to discharge ○ Coordination of scheduling for key follow-up appointments, planning for transportation needs, medication reconciliations and durable medical equipment needs before transition happens. ○ Consideration of Health Related Social Needs (HRSN) services that may support a care setting transition.	will follow its current LTSS new intake process per local protocol. • APD will work with CCO, OHA and medical providers on durable medical equipment and environmental modifications needed for successful transitions. • APD will make referrals to EOCCO for HRSN related services using the appropriate EOCCO HRSN webform		

				prior to discharge/did not delay discharge? % CCO region to CCO region transfers that communication was made to appropriate APD/AAA office(s)? # of Debrief meetings held quarterly to post-conference transitions where transitions wasn't smooth (improvement process approach)? [Q1, Q2, Q3, Q4].
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	• Questions and follow-up on individual members are shared via secure email to the appropriate distribution email. • Reports and lists of member information are shared via appropriate ShareFile folder. • EOCCO shares the EOCCO LTSS admissions weekly report with APD on Mondays via ShareFile folders. This includes IP/ED/SNF admissions.	• APD uses PointClickCare to monitor hospital events with LTSS consumers • APD will provide information form the last CAPS Assessment for Goals, preferences	Process Monitoring: 1. EOCCO will review how Point Click Care is being used and identify additional ways to use it for: a. Reporting b. Care planning c. Coordination processes. 2. Discuss and document how APD utilizes Point Click Care and how it could be used for: a. Reporting b. Care planning c. Coordination processes.	# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments. # of CCO Collective Platform SNF notifications monthly that result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments.

			3. Ensure MDT processes are clearly documented and updated as needed. a. Processes will clearly designate leads from each agency for ensuring communication for roles and responsibilities for key activities. b. Ensure processes are updated when there are changes (i.e. when a lead contact changes) **Measures of Success:** 1. Number of referrals received for each MDT region. 2. Number of SNF APD notifications by region.	

				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 or DHS will require review or co-signature to the MOU.

Nicole Fenimore Digitally signed by Nicole Fenimore Date: 2025.03.20 11:12:17 -07'00' 3/20/25

Nicole Fenimore, RN, EOCCO, Government Care Manager Supervisor

Gloria Pena Digitally signed by Gloria Pena Date: 2025.03.25 08:29:11 -07'00'

Gloria Pena, APD District 11, District Manager

Karissa Reed Digitally signed by Karissa Reed Date: 2025.03.20 13:26:06 -07'00' 3/20/25

Karissa Reed,MS LPC, EOCCO, Clinical Care Coordination Manager

Kimberly Norton Digitally signed by Kimberly Norton Date: 2025.03.21 14:36:03 -07'00'

Kim Norton, APD Districts 13 & 14, District Manager

David Brehaut Digitally signed by David Brehaut Date: 2025.03.24 10:22:37 -07'00'

Dave Brehaut, APD Districts 9 & 12, District Manager

Exhibit A: Contact List

Contact List			
APD District 11	**APD District 9 & 12**	**APD District 13 & 14**	**EOCCO**
Gloria Pena District Manager Glora.pena@odhs.oregon.gov 541-851-8922	Dave Brehaut District Manager david.brehaut@odhs.oregon.gov 541-966-6232	Sheila Hayes Baker City Supervisor sheila.a.hayes@odhs.oregon.gov 541 523-5846 (office) 541-709-8034 (cell)	Nicole Fenimore, RN Government Care Management Supervisor Moda Health Nicole.Fenimore@modahealth.com 503-952-5274
Shawn Georgiou, Dist. 11 Human Services Case Manager, Supervisor Shawn.georgiou@dhsoha.state.or.us 541-885-7648	Angel Moreno, Dist. 12 Hermiston Supervisor & APS angelita.m.moreno@odhs.oregon.gov 541-564-5674	Liz Muniz Ontario Supervisor & Diversion Transition Supervisor Elizabeth.muniz@odhs.oregon.gov 541-889-8596 (office) 541-709-7195 (cell)	Jessica Baurer Director, Medical Management Moda Health Jessica.Baurer@modahealth.com 503-412-4010
Alison West, Dist. 11 Diversion/Transition Coordinator Alison.West@odhs.oregon.gov (541) 885-7625	Mike Warner, Dist. 12 Pendleton Supervisor & Licensing mike.warner@odhs.oregon.gov 541-966-6224	Kim Norton District Manager Kimberly.k.norton@odhs.oregon.gov 541-263-1791 (cell)	Kristi Swank Sr. Quality and Compliance Project Manager, Healthcare Services Moda Health Kristi.swank@modahealth.com 503-265-4722
Alison West, Dist. 11 Diversion/Transition Coordinator Alison.West@odhs.oregon.gov (541) 885-7625	Becky Miltenberger, Dist,12 Hermiston Supervisor & Diversion Transition Becky.J.MILTENBERGER@dhsoha.state.or.us 541-564-6041	Kimberly Neault Burns and John Day Supervisor kimberly.d.neault@odhs.oregon.gov 541-575-0255 (office) 541-620-3957 (cell)	Ashley Reeser, MA LPC Integrated Services Director GOBHI areeser@gobhi.org 971-256-6024
Wendy Howard, Dist. 11 Diversion/Transition Coordinator Wendy.Howard@odhs.oregon.gov (541) 885-7626	Suzanne Carlson Dist. 12 Diversion/Transition Coordinator becky.j.miltenberger@odhs.oregon.gov 541-966-6234	Courtney VanArsdale District 13/14 Diversion Transition Coordinator Courtney.d.vanarsdale@odhs.oregon.gov (541) 805-1636 (cell)	Karissa Reed, MS LPC Clinical Care Coordination Manager GOBHI kreed@gobhi.org 971-361-9781
	Jacque Gribskov, Dist. 12 Diversion/Transition Coordinator jacqueline.gribskov@odhs.oregon.gov	Jaime Mordhorst, District 13/14 Diversion/Transition Coordinator JAIME.M.MORDHORST@odhs.oregon.gov	Rod Harwood Older Adult Behavioral Health Specialist – District 13/14

	541-720-0782	541-709-8324 (cell)	GOBHI rharwood@gobhi.org 541-298-2101
	Melissa Fitzpatrick, Dist. 12 Diversion/Transition Coordinator melissa.fitzpatrick@odhs.oregon.gov 541-371-0687	Aaron Lenox, District 13/14 Enterprise and LaGrande Supervisor Aaron.lenox@odhs.oregon.gov 541-975-8686 (cell) 541-963-7276 (office)	Crystal Harrel Clinical Care Coordinator GOBHI charrel@gobhi.org 541-526-4355
	Jamie Preston Dist. 9 Diversion/Transition Coordinator Jamie.M.preston@dhsoha.state.or.us 541-296-4661		
	Colleena Tenhold-Sauter Supervisor CM/DT colleena.tenhold-Sauter@dhsoha.state.or.us 541-506-3533		
	Jennifer Weiss Dist 9 Diversion/Transition Coordinator Jennifer.a.weiss@state.or.us 541-506-5274		

Exhibit B: Multi-Disciplinary Team (MDT) Referral Form

☐ APD notification ONLY
☐ MDT referral

Multi-Disciplinary Team (MDT) Referral Form

This referral form is for difficult cases that require additional input and resources. This referral form is designed to reach EOCCO/Moda Health Supervisor, Case Management, and Greater Oregon Behavioral Health Inc (GOBHI) as well as Aging & People with Disabilities (APD) in order to collaborate together to meet the needs of Complex EOCCO Members.

Member Information:					
Member Name:		County of Residence:		Date of Referral:	
ID/Prime#:		DOB:			

Status:			
Current Location/Placement:			
If member is at a Skilled Nursing Facility fill this line in	Admission Date:	Approved thru:	20th day:
Anticipated Placement:			
Reason for Referral:			
Notes:			

Contact Info:			
Is member aware of referral?		Phone# of member	
Person completing this form:		Phone# of referring person for questions. Required for ICM referrals	

Baker, Harney, Grant, Malheur, Union & Wallowa Counties please email completed form to East6MDT@modahealth.com

Umatilla & Morrow Counties please email completed form to UMMDT@modahealth.com

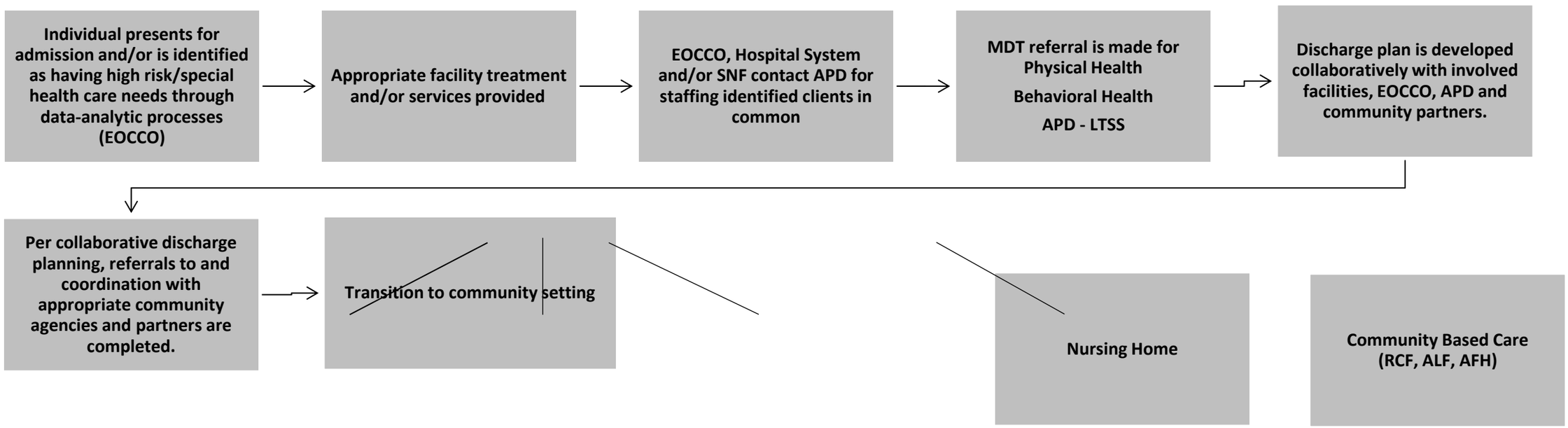
Gilliam, Wheeler, Sherman & Lake Counties please email completed form to West4MDT@modahealth.com

Note: If you have any questions regarding the referral process please call 1-844-827-7467 for assistance.

Exhibit C: Transitional Care Practices Process Map

Transitional Care Practices – Process Map

DHS APD and Eastern Oregon Coordinated Care Organization



Coordinating and communicating around transitions of care

Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTSS services. In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, EOCCO and the LTSS system need to coordinate care and share accountability for individuals receiving Medicaid-funded Long Term Care Services. (Supported by OAR 410-141-3160)
The mutual goal of the proposed agreement is to improve person-centered care, align care and service delivery, and to provide 'the right amount of care in the right place at the right time' for beneficiaries across the LTSS system. The proposed agreement is based on the roles and responsibilities of each entity and the coordination between systems of care to provide quality services, and is targeted to promote the best health and functional outcomes for individuals, thereby reducing preventable cost escalation.

Information Sharing

Refer to MOU contact list

Communications

Transitional care practices support timely information sharing to minimize duplication of efforts in cross-system care planning. APD and EOCCO agree to communicate complex transitions for identified members in common to ensure increased coordination for comprehensive patient-centered transition. (Supported by OAR 410-141-3860)

EOCCO agrees to communicate timely with local APD/SNF/Hospital designated staff when members transition to Medicaid-funded LTSS and whom are identified and prioritized regarding their complex, high risk/high utilization and/or special health care needs:

- Upon member discharge from inpatient hospital stays, and when members are transferring between different LTSS settings
- At the time of admission to a skilled nursing facility (SNF) under post hospital extended care benefits (PHEC).

APD agrees to communicate with EOCCO to support care coordination on identified complex transitions:

- Notify EOCCO MDT team, before transition, of out of county transitions to support continuity of care needs and concerns for high risk members and identified complex transitions.
- Submit request for care coordination or Intensive Care Coordination (ICC) to support smooth transition around DME requests, PCP involvement and continuity of care.

When EOCCO and/or APD is notified of an impending facility discharge of a member with high risk/high utilization and/or special health care needs, they will promptly communicate with each other regarding the assessed complex transition needs and to facilitate the coordination of care.

EOCCO and APD agree to post-transition care coordination for identified complex members during the 90-day transition coordinator follow-up for implementation of a member-specific, inter-disciplinary care team that supports the flow of information and assists in developing innovative approaches to members' special health care needs and social determinants of health. APD and EOCCO understand the primary goals of care coordination efforts are to: improve health outcomes; increase member engagement; reduce costs of care; increase provider cross discipline engagement; overcome barriers to social determinants of health; and promote health literacy.

APD Transition Coordinators Roles and Responsibilities (High Level Summary)

- Respond quickly to consumers in need of transition or diversion services. Complete comprehensive assessments based on face to face interviews, medical records & collaborative information.

- Empower and educate consumers to lead in the decision making process of their care planning, building strong relationships with community providers and partners to aide in the transition/diversion process.
- Coordinate and participate in necessary SNF and Eastern Oregon Coordinated Care Organization care conferences in an effort to engage consumers in defining their ideal service plan along with possible barriers to a successful transition.
- Act as a resource to Medicaid & Non-Medicaid clients for long term service and support options available in the local area. Provide ADRC information to applicants who may not want to apply for Medicaid long term care.
- Share their extensive knowledge of the special need rules, exception processes, specific need contracts and other unique services and/or equipment that will aide in the development of a successful client centered service plan.
- Provide expert resource information on services available within the local community as well as foster new community partner relationships to meet the future needs of the community resource development while developing professional relationships with key community partners, such as the hospital discharge planners, EOCCO representatives, nursing home discharge planners, DNS and resident care managers.
- Actively work towards meeting the statewide goal in reducing nursing facility and institutional residency rates.
- Implement and authorize a comprehensive person-centered service plan that transitions the consumer into the community. Monitor and update the service plan according to successes and barriers until the consumer is stable or up to 90 days and ensure that data entry is updated for the diversion and transition data base.
- Communicate effectively with case management and management team in maintaining office goals and protocols as well as acting as a resource to case managers seeking assistance with specialized placements.

EOCCO Transition Roles and Responsibilities (High Level Summary)

- Target the identification of high risk/high utilization members with special health care needs and communicate that information regularly to APD and to appropriate primary care providers involved with members.
- Promote community resource coordination, development and education, building partnerships between agencies, community partners, and providers and improving member access to those resources as well as needed health care services.
- Act as a liaison and facilitator with community partners, providers, facilities, APD and other state entities in the outreach for and development of member-specific collaborative complex care meetings and services.
- Triage complex member cases while working with internal and external care coordination and case management integrated health teams to reach targeted populations and facilitate social and health care systems collaboration.
- Provide complex case management services which promote quality, cost-effective outcomes by helping selected member populations to more effectively navigate health care systems and achieve effective utilization of health care services. Incorporate the essential functions of professional case management concepts to enhance members' quality of life and maximize health plan benefits. These functions include, but are not limited to:

  - Coordination and delivery of health care services
  - Consideration of factors impacting physical, psychological, cultural and social determinates of health.

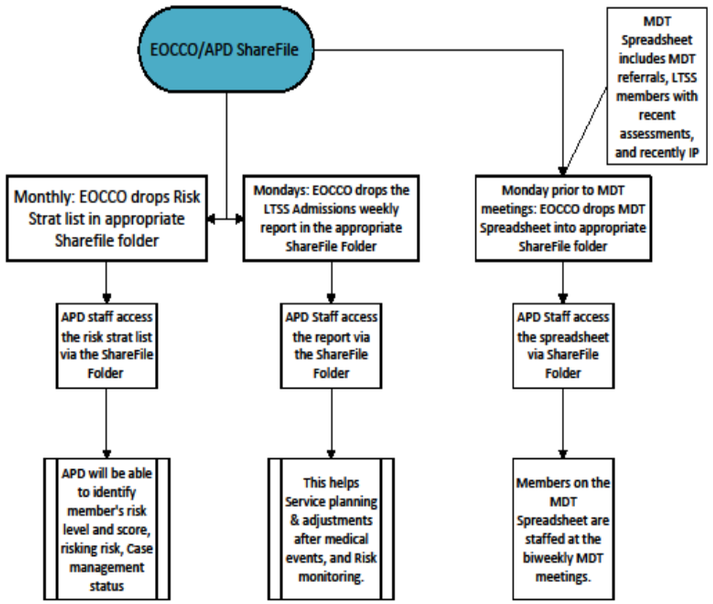
- Assessment of the patient's specific health plan benefits and additional medical, community, or financial resources available.

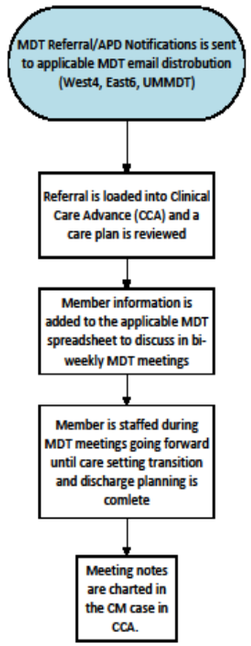
- Collect and assess patient information from APD and other appropriate and pertinent sources, including Collective Platform, related to member history, condition, and functional abilities, in order to develop a comprehensive, individualized care plan that promotes wellness, appropriate utilization, and cost-effective care and services.

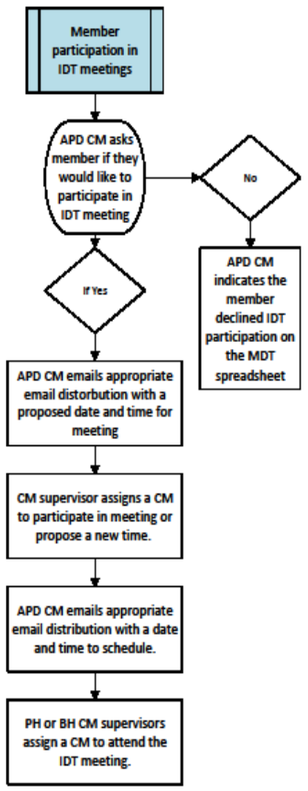
- Monitor and evaluate appropriateness of complex care and special health needs action plans including transitions in care, assess progress toward meeting goals and barriers to those goals, collaborate with invested community partners, providers, APD, and other state entities as appropriate, and modify the plan to help achieve desired member outcomes. When member has been offered service options and/or engaged in those services, document and ensure that data entry is completed.

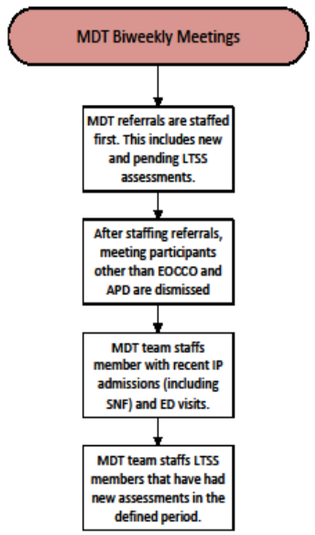
Shared Accountability

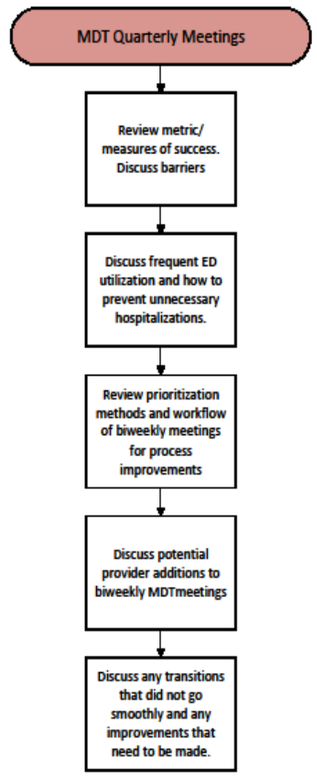
EOCCO and APD will monitor and review process map at quarterly MDT meetings and make adjustments as appropriate.


EOCCO/APD ShareFile
MDT Spreadsheet includes MDT referrals, LTSS members with recent assessments, and recently IP
Monthly: EOCCO drops Risk Strat list in appropriate Sharefile folder
Mondays: EOCCO drops the LTSS Admissions weekly report in the appropriate ShareFile Folder
Monday prior to MDT meetings: EOCCO drops MDT Spreadsheet into appropriate ShareFile folder
APD staff access the risk strat list via the ShareFile Folder
APD Staff access the report via the ShareFile Folder
APD Staff access the spreadsheet via ShareFile Folder
APD will be able to identify member's risk level and score, risking risk, Case management status
This helps Service planning & adjustments after medical events, and Risk monitoring.
Members on the MDT Spreadsheet are staffed at the biweekly MDT meetings.


MDT Referral/APD Notifications is sent to applicable MDT email distrobution (West4, East6, UMMDT)
Referral is loaded into Clinical Care Advance (CCA) and a care plan is reviewed
Member information is added to the applicable MDT spreadsheet to discuss in bi-weekly MDT meetings
Member is staffed during MDT meetings going forward until care setting transition and discharge planning is comlete
Meeting notes are charted in the CM case in CCA.


Member participation in IDT meetings
APD CM asks member if they would like to participate in IDT meeting
No
If Yes
APD CM indicates the member declined IDT participation on the MDT spreadsheet
APD CM emails appropriate email distorbution with a proposed date and time for meeting
CM supervisor assigns a CM to participate in meeting or propose a new time.
APD CM emails appropriate email distribution with a date and time to schedule.
PH or BH CM supervisors assign a CM to attend the IDT meeting.


MDT Biweekly Meetings
MDT referrals are staffed first. This includes new and pending LTSS assessments.
After staffing referrals, meeting participants other than EOCCO and APD are dismissed
MDT team staffs member with recent IP admissions (including SNF) and ED visits.
MDT team staffs LTSS members that have had new assessments in the defined period.


MDT Quarterly Meetings
Review metric/ measures of success. Discuss barriers
Discuss frequent ED utilization and how to prevent unnecessary hospitalizations.
Review prioritization methods and workflow of biweekly meetings for process improvements
Discuss potential provider additions to biweekly MDTmeetings
Discuss any transitions that did not go smoothly and any improvements that need to be made.