CCO-LTSS Partnerships MOU:

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 InterCommunity Health Network Coordinated Care Organization (IHN-CCO) **OHA Contract #** 161760

Partner AAA/APD District (s) Names/Locations Oregon Cascades West Council of Governments, Senior and Disability Services; Benton, Lincoln, and Linn Counties

1400 Queen Ave SE Albany, Oregon 97322

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): Tracy Sasso, Director Care Coordination and UM	**APD/AAA Lead(s):** Randi Moore, Director - Senior, Disability, and Community Services Programs

CCO will clearly articulate in this section:	**AAA/APD will clearly articulate in this section:**
--How CCO governance structure will reflect the needs of members receiving Medicaid funded Long-Term Services and Supports (LTSS), for example through representation on the governing board, community advisory council or clinical advisory panel. --How Affiliated MA or DSNP plan participates in the MOU work for FBDE. The Community Advisory Council (CAC) ensures the integrated healthcare needs of Benton, Lincoln and Linn County IHN-CCO members and their communities are effectively and efficiently addressed. This includes members receiving Medicaid funded Long-Term Services and Supports (LTSS.) The CAC's responsibilities include identifying and advocating for preventative care practices to be utilized by IHN-CCO, developing and overseeing the IHN-CCO Community Health Assessment (CHA), adopting a Community Health Improvement Plan (CHIP). Members have included those receiving Medicaid funded LTSS. The Delivery System Transformation (DST) Committee's objectives are to improve the health delivery system by bringing the community together to pursue the Quadruple Aim and support, sustain and increase transformational initiatives. Anyone who supports, promotes or positively affects the health outcomes of IHN-CCO members can attend and this includes Medicaid funded Long-Term Services and Supports. The DST Committee charters multiple interdisciplinary workgroups to support universal care coordination, health equity, and Social Determinants of Health (SDOH). The IHN-CCO Regional Planning Council is a workgroup charged by the IHN-CCO Board of Directors with planning and coordinating the local system of health services and supports. OCWCOG is represented in this Council. IHN-CCO is part of Samaritan Health Plans which is an integrated nonprofit healthcare organization. SHP also services Medicare through Samaritan Advantage Health Plan, HMO (SAHP) and Special Needs Plan for Duals (D-SNP) in Benton, Lincoln and Linn Counties.	--How AAA/APD governance Lead(s) for participation at the community level in the board / Advisory panel for LTSS perspective/Care Coordination. --AAA/APD will articulate how the membership of the local governing boards, Advisory Councils, or governing structures will reflect the needs of members served by the regional CCO(s). OCWCOG is governed by a Board of Directors (BOD) consisting of local elected officials who serve on Commissions and Councils within and including Linn, Benton, and Lincoln Counties. The Senior Services Advisory Council (SSAC) and Disability Services Advisory Council (DSAC) consists of a representative from the OCWCOG Board and community citizens, 50% of which must meet our service criteria, which advise and advocate regarding policies, quality of services, and other priorities effecting delivery of Long-Term Services and Supports. OCWCOG SDS is required as an Area Agency on Aging to create a four-year Area Plan that addresses the needs of older adults, adults with disabilities, and their caregivers while assessing the strength and weaknesses of current community resources available to them. The Area Plan is developed with broad public input as required by the Older Americans Act (OAA) and includes focus areas identified by the State. Once approved, this strategic plan serves as a basis for planning, program development and funding priorities for the people and regions we serve in our three-county planning and service area, including IHN-CCO members.

CCO-LTSS APD/AAA MOU(s): See MOU Worksheets for additional detail on MOU expectations in each domain

MOU Service Area: Benton, Lincoln and Linn Counties				
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	**IHN-CCO responsibilities:** • Screen IHN-CCO members including those receiving LTSS. • Define how communication and coordination with LTSS occurs. • Ensure LTSS staff have contact information to refer members to Care Coordination. • Track referrals received from LTSS. • Track referrals made to LTSS. **Process and Activities:** IHN-CCO Care Coordination Department screen the IHN-CCO population to identify moderate and high-risk members and members with special health care needs, including members receiving LTSS. LTSS members are	**OCWCOG-SDS responsibilities:** • Provide IHN-CCO with information to identify members with LTSS high health care needs. • Share risk assessments, service priority levels, service and care plans with IHN-CCO. • Refer LTSS members to IHN-CCO Care Coordination. **Process and activities:** OCWCOG-SDS will provide IHN-CCO the LTSS report on a monthly basis. The report is provided via SFTP site by the last day of each month. The LTSS report includes the following data sets: • Member Name and ID. • Date of Birth. • Telephone number.	% of LTSS members referred for care coordination receive an assessment within 60 days of referral.	# 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 coordination review [Monthly/Year Total].

	identified from the 834 Enrollment Report with a 'yes' indicator for LTSS/LTC flag. Upon identification the member is assigned a care manager to complete an assessment. LTSS providers and case managers can refer an LTSS member directly to IHN-CCO Care Coordination services through email, fax, or phone. Members who are directly referred from LTSS for CC will have an IHN-CCO care manager assigned who will outreach to the member to complete an assessment within 60 days of referral. Regardless, if a member is programmatically identified or referred, the IHN-CCO care manager will contact the LTSS case manager and provider to gather necessary risk assessment and screening information, and to provide them with their contact information. The IHN-CCO care manager will include them in the interdisciplinary care team (ICT). Communication typically happens telephonically and is documented in the SHP Care Management platform. Communication between the care team happens often and is facilitated at the ICT	• CCO Type (ex: CCOA). • Medicare Advantage Plan. • Living Situation. • Service Priority Level. • Assistance needed in Cognition, Mobility, Bath Hygiene, Bowel Bladder and Dressing. • Last Assessment Date. • Mailing and Residential Address. • LTC Provider including address. • LTSS Case Manager and telephone number. • Authorized Representative and telephone number. • Risk Assessment outcome. LTSS Prioritized Data SFTP process.p At referral or request, the LTSS case manager will provide additional information including but not limited to, additional risk assessment information, service plan and any other pertinent information necessary. OCWCOG SDS LTSS case managers can refer to the IHN-CCO Care Coordination Department via shared database,		

	meetings. IHN-CCO Care Coordination team directly refers members to OCWCOG/SDS for LTSS via secure email, fax or phone. The Community Partner Referral Process and form may be utilized and documentation and tracking of the referral for LTSS is in the SHP Care Management Platform by using the 'External Referral' form.  Community Partner SHS Referral Form.pd Updates to processes for identifying members will be shared during the quarterly MOU meeting. A contact list is maintained between IHN-CCO and OCWCOG/SDS. MOU Leads for IHN-CCO will communicate any updates of the care coordination team to OCWCOG/SDS. This will occur as needed and at minimum on a quarterly basis.  CSD-CM-50 Care Coordination Policy.pd *The above policy is pending OHA*	phone, fax, and secure email (preferred method). IHN-CCO staff can refer members for LTSS by calling the ADRC call center or by securely emailing a referral.		

	approval- submitted to OHA 2/11/25 as part of the Care Coordination P&P deliverable.			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	**IHN-CCO responsibilities:** • Maintain contact list for and share with LTSS. • Include care team members including LTSS, LTSS providers, health care providers and community partners in the ICT. • Work with OCWCOG-SDS in identification of members to convene ICT meetings. • Regularly schedule ICT meetings. • Track care plans for members with LTSS. CSD-CM-47 Interdisciplinary Care *The above policy is pending OHA approval- submitted to OHA 2/11/25 as part of the Care Coordination P&P deliverable.* **Process and Activities:** IHN-CCO Care Coordination staff are responsible for scheduling interdisciplinary care team (ICT) meetings. This is performed through Microsoft Teams scheduling. Meetings are	**OCWCOG-SDS responsibilities:** • Actively participate in scheduled ICT meetings. • Identify members that would benefit from ICT support. • Notify IHN-CCO of LTSS members. • Inform IHN-CCO of contact information for LTSS case managers and providers. **Process and activities:** OCWCOG-SDS will provide IHN-CCO the LTSS report on a monthly basis. The report is provided via SFTP site by the last day of each month. OCWCOG- SDS LTSS staff are asked prior to every ICT meeting to identify any members that may benefit from support of the ICT team. LTSS consumers staffed during internal SDS multidisciplinary team for complex case consultation will be considered for referral to ICT team. When requested, OCWCOG-SDS will share current assessment and	% of LTSS members referred for IHN-CCO Care Coordination have an initial ICT meeting.	# 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. % 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).

	convened and facilitated as needed according to the member's needs. Ad-hoc meetings can be requested by anyone on the ICT and IHN-CCO will coordinate and schedule. IHN-CCO Care Coordination staff lead sends an email out to the IHN-CCO and OCWCOG- SDS staff to identify members to include in the ICT process. IHN-CCO Interdisciplinary Care Team (ICT) Policy outlines requirements and procedures for ICTs. When members are identified, IHN-CCO takes the lead in engaging the member to participate. The ICT consists of the member, member's representative (if applicable), member's primary care providers, OCWCOG- SDS LTSS case manager and providers, IHN-CCO Care Coordination staff, identified medical, behavioral health, dental health providers and social and support services. The ICT develops the Individualized Care Plan (ICP) which is a strategy used by the ICT to establish protocols and provide direction according to the member's needs and expressed goals. See Domain 3 for more information on the ICP	service plan. OCWCOG- SDS Program Manager will coordinate attendance of SDS staff at ICT meetings and will assure appropriate representation from OCWCOG-SDS at each ICT meeting. Representation may include LTSS case management, Adult Protective Services, and supervisory staff with knowledge of cases being discussed. OCWCOG- SDS staff will coordinate member's participation when SDS staff have identified the need for an ICT. Member-centered planning is the goal of the ICT and thus members are crucial to successful ICTs. Members are encouraged to participate and are provided clear information on the purpose of the ICT, who will be present based on member's preferences and goals. Typically, the OCWCOG- SDS LTSS case manager communicates directly with the member about the ICT and is able to answer any questions or concerns they may have. OCWCOG- SDS staff will communicate with IHN-CCO Care Coordination team and other care team members who the member would like invited, such as natural supports, long term care provider, other identified service providers		

	process. The meetings shall provide a forum to: • Create a space for the member to describe the clinical interventions recommended to the treatment team and identify the frequency of ICTs appropriate to meet the care plan needs. • Provide feedback on their care, self-reported progress towards their Care Plan goals, and their strengths exhibited in between current and prior meetings. • Identify coordination gaps and strategies to improve care coordination with the member's service providers. • Develop strategies to identify, monitor and follow up on needed referrals for specialty care, routine health care services (including medication monitoring), other community programs or social need services. • Align with and update the member's individual Care Plan and share with the member. The IHN-CCO care manager communicates among ICT members to ensure the plan of care is followed and the appropriate disciplines within the	and community partners. OCWCOG- SDS may be assigned care plan goals and follow up as needed from ICT meetings. If urgent needs are identified requiring ICT support prior to the next scheduled meeting OCWCOG- SDS program management will request an ad-hoc meeting by reaching out directly to IHN-CCO Care Coordination lead staff.		

	team are completing action steps toward expected outcomes and goals. The IHN-CCO care manager supports the member and care team in reviewing the plan of care at each ICT meeting to ensure that all of the appropriate disciplines within the team are completing action steps according to the plan of care and that care seamlessly moves the member toward their expected outcomes and goals. The ICP is documented in the SHP Care Management platform and is shared with the ICT members via mail, fax or secure email.			
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	**IHN-CCO responsibilities:** • Develop Individualized Care Plans (ICP) that: ○ Actively engage member in development of ICP. ○ Include information about supportive and therapeutic needs including LTSS. ○ Focus on preventative approaches to reduce unnecessary hospitalizations, ER visits. ○ Reflects member preferences and goals. ○ Are jointly shared with OCWCOG- SDS LTSS case managers and providers. ○ Track completion of ICPs.	**OCWCOG-SDS responsibilities:** • Share risk assessment and service plan information for the ICP. • Refer LTSS members to IHN-CCO Care Coordination. **Process and activities:** The OCWCOG- SDS LTSS case manager is an integral part of the care team. They share LTSS risk assessment, service plan and any other pertinent information with the IHN-CCO care manager as well as with the ICT. Often this information is shared during review of the ICP during the ICT meeting. Information may be shared between the IHN-CCO care	% of LTSS members referred for IHN-CCO Care Coordination receive an Individualized Care Plan.	% 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.

	Process and Activities: IHN-CCO Care Plan Policy ensures members identified as moderate or high risk and all LTSS members have an ICP developed. IHN-CCO Care Coordination staff work with the member, primary care provider, LTSS case manager and provider, other health care providers and community partners to develop the ICP. If the member is also receiving Medicare, the affiliated Medicare plan and providers are involved in development of the ICP. OCWCOG-SDS LTSS case manager and provider may share information on the service assessment and person-centered service plan developed for LTSS. Information sharing and development of the ICP is completed through the ICT process. CSD-CM-46 IHN-CCO Care Plan Policy.pdf *The above policy is pending OHA approval- submitted to OHA 2/11/25 as part of the Care Coordination P&P deliverable.* IHN-CCO Care Coordination staff include RNs, Social Workers, QMHP, QMHA, LCSW, and Community Health Workers. The primary care manager is a clinician and the CHWs	manager and the OCWCOG- SDS LTSS case manager through care coordination activities. OCWCOG- SDS LTSS case managers will follow up on and complete any action items assigned to the OCWCOG- SDS LTSS case manager in the Individual Care Plan. The OCWCOG- SDS Program Manager will supervise this work and assure this work is completed timely. Members involved with the ICT team will receive a direct case management contact monthly for a minimum of three months following referral to the ICT team. Pertinent information will be shared by long term case manager with ICT team participants.		

	support the ICP development by scheduling the ICT meetings, documenting updates to the ICP and taking lead on goals related to Social Determinants of Health. Engaging the member in developing the ICP is essential. IHN-CCO Care Coordination staff utilize motivational interviewing, trauma-informed, culturally, and linguistically appropriate approaches to engage the member. The IHN-CCO care manager outreaches to the member to complete an assessment and listens to member's vision, strengths and goals. The IHN-CCO care manager will explain what an ICT is, find out who is on the member's care team and what the member would like to get out of the ICT meeting. IHN-CCO care manager will provide member with details on the ICT meeting including who plans to attend, date and time, location, and call-in information. ICPs include: • Member and caregiver prioritized goals and desired outcomes. • Preferences and desired level of involvement. • Timeframe for re-evaluation of goals.			

	• Resources to be utilized, including appropriate level of care. • Planning for continuity of care, including transition of care and transfers between settings. • Advance care and end of life planning. • Coordination of social and support services. • A collaborative approach will be used, including family/caregiver participation. • Barrier(s) to meeting the goals of the ICP are included and documented, even if none exist. Barriers may include but are not limited to: • Language or literacy level. • Access to reliable transportation. • Understanding of a condition. • Motivation. • Financial or insurance issues. • Cultural or spiritual beliefs. • Visual or hearing impairment. • Psychological impairment.			

	All ICPs are member-centered and address member's preferred and/or needed services including culturally and linguistically appropriate services, alternate formats and disability services. Member referrals to resources are facilitated and a schedule is developed with the member for follow-up to determine whether members act on those referrals. Follow up and communication with members may include but is not limited to: • Counseling. • Follow-up after referral to a health resource. • Member education. • Self-management support. • Determining when follow-up is not appropriate. A self-management plan is developed and may include but is not limited to: • Performance of activities of daily living. • Self-administration of medication. • Self-administering medical procedures/treatment. • Managing equipment. • Maintaining compliance with prescribed diet. • Charting of daily weight and blood sugar.			

	ICPs will address action items to address reduction in Emergency Room utilization and readmissions, if applicable.			
DOMAIN 4: Transitional care practices/Care Setting Transitions				
DOMAIN 4: Transitional care practices Goals	**IHN-CCO responsibilities:** • Coordinate and communicate with OCWCOG-SDS on transitions of care. • Ensure discharge planning and follow up. **Process and Activities:** IHN-CCO Care Coordination team meets with OCWCOG- SDS LTSS case managers on an at least quarterly basis for 'Coffee Breaks' to educate and inform one another on care transition practices within each organization. The meetings are focused on the following: Updates to care transition processes and procedures in each organization; training on program updates or implementations that may impact care transitions, such as Health-Related Services, Health Related Social Needs, and review of joint transition process. CSD-CM-52 IHN-CCO Care Setting Transitio	**OCWCOG-SDS responsibilities:** • Coordinate and communicate with IHN-CCO on transitions of care. • Ensure discharge planning and follow up. **Process and activities:** OCWCOG-SDS coordinates with IHN-CCO to support in the transition of members between LTSS care setting levels of care. This includes: • Completing an LTSS assessment. • Options counseling about LTSS placement options. • Provider authorization and payments. • Ancillary services such as durable medical equipment (DME) or environmental modifications if necessary. • Post transitions follow up and support. OCWCOG-SDS LTSS case managers outreach to IHN-CCO Care	% of LTSS members receiving IHN-CCO care coordination receive an updated transition of care Individualized Care Plan.	% 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? % 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].

	The above policy is pending OHA approval- submitted to OHA 2/11/25 as part of the Care Coordination P&P deliverable. The joint transition process includes the following: **Roles and Responsibilities:** IHN-CCO: The Primary Care Provider (PCP) is responsible for coordinating transitioning members out of the hospital settings into the most appropriate, independent, and integrated care settings, including LTSS, hospice and other palliative care settings. IHN-Care Coordination staff coordinate with the PCP, care setting, discharge planners, OCWCOG- SDS LTSS case manager and providers by developing a plan to support a successful transition. **Frequency of meetings:** 'Coffee Break' meetings are at least quarterly and are an opportunity to develop relationships amongst IHN-CCO Care Coordination staff and OCWCOG- SDS LTSS case managers. The agenda includes a discussion of changes in programs, processes, procedures, and staffing. Presentations are shared including the appropriate contact if there are follow up questions.	Coordination team via shared database, phone, email and/or fax to discuss member transitions and convening ICT. Other care team members may be contacted to be notified of the transition and the upcoming ICT meeting. OCWCOG-SDS LTSS case management can be performed by an ongoing case manager, a PAS (Pre-Admission Screening) case manager, or by a Diversion Transition case manager depending on the complexity and urgency of the transition. OCWCOG-SDS staff participate in the ICT which supports the member in the transition of care. Frequent check in meetings may be requested to support post-discharge. OCWCOG-SDS LTSS case managers will also request support of social needs from IHN-CCO if appropriate.		

	Escalation pathways are evaluated at each meeting. **Identify cross system resources:** During the ICT meetings availability of resources and services are addressed. The IHN-CCO care manager and OCWCOG-SDS LTSS case manager may address options to support member through LTSS ancillary services and/or individual services, such as Health-Related Services or Health Related Social Needs. This may also include identifying other programs LTSS has through the AAA, such as PEARLS or Meals on Wheels. These cross-system resources would then be included in the ICP. **Communication:** Occurs through the ICT and updates to the ICP. (See above Domains 2 and 3.) IHN-CCO Care Setting Transitions Coordination Policy outlines how IHN-CCO Care Coordination staff are notified and support care transitions. IHN-CCO is notified of planned and unplanned care transitions through pre-service authorizations, notification of admissions, member or care-giver self-report, monitoring of event notifications through Point Click			

	Care and referrals from OCWCOG-SDS LTSS case managers and/or providers. IHN-CCO Utilization Review and Care Coordination staff work closely with OCWCOG- SDS LTSS case managers throughout the transition. Communication happens most frequently via phone once transition has been identified. Information sharing includes planning for transportation needs, durable medical equipment, LTSS services, placements, and next steps. Once a transition has been identified the IHN-CCO care managers begin to coordinate the transition to ensure the member is connected to the appropriate providers and services. This may include: • Contacting member and/or caregivers to determine their understanding of the transition. • Contacting facility and providers to determine what information may be needed before the transition occurs. • Communicating with the member, OCWCOG- SDS LTSS case managers and providers, and members of the ICT during the transition process.			

	• Discuss discharge plan with member and/or caregiver. • Identify barriers and how to address them. • Assure follow up services and appointments have been scheduled. • ICP updates are documented in the care management system and communicated to the ICT. The goal for any member transition of care is: • Assessment and evaluation of barriers to care, including access to newly prescribed medications. • Creation or update of an ICP to address any new barriers with targeted interventions and SMART goals. • Promote education opportunities for self-management activities identified in the ICP. • Frequent communication with the member and the member's care team to ensure follow through on interventions to mitigate barriers to care. • Coordination and communication with the ICT including PCP, OCWCOG- SDS LTSS case manager, provider,			

	community resources, and other care team members. • Facilitate and coordinate a safe transition through the different levels and episodes of care. The member is supported through the transition of care by the ICT. The ICT effectively plans, communicates and implements the transition and care planning follow up. Prior to discharge, the ICT will meet to review if appropriate services are in place to ensure a successful discharge. The ICP is updated and communicated to the ICT via mail, fax or email. Health-Related Services or Health-Related Social Needs may be an important part of a transition of care. IHN-CCO Care Coordination staff will evaluate opportunities to support member by reviewing and determining need and identifying other community resources available for the member. If OCWCOG- SDS LTSS case manager requests support, IHN-CCO Care Coordination staff will work with them to determine if the need meets the requirements or if there are other resources available.			

DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	**IHN-CCO responsibilities:** • Develop clear communication processes with LTSS that are detailed and specific. • Share how Point Click Care is being used, including SNF notifications. • Identify strategy to partner with LTSS system as part of the Health Information Technology (HIT) roadmap. **Process and Activities:** IHN-CCO Care Coordination department maintains a contact list to provide to OCWCOG-SDS at least quarterly. This contact list includes the care management staff, their roles, and how to contact them. This MOU provides detailed information on the role of the IHN-CCO Care Coordination staff as it relates to Care Coordination, ICTs, ICPs and transitions of care. Any changes to the contact list are communicated immediately to OCWCOG-SDS. Collaborative communication is completed through the ICT. This is where the care team members provide their individual roles and responsibilities in supporting a member, as well as actions they will complete to support the	**OCWCOG-SDS responsibilities:** • Develop clear communication processes with LTSS that are detailed and specific. • Share how Point Click Care may be used. **Process and activities:** OCWCOG SDS Program Manager will provide a case manager contact list to staff of the IHN-CCO Care Coordination Department. A new contact list will be provided whenever there is an update. OCWCOG SDS staff do not currently use Point Click Care in their work with LTSS consumers. If at any time this changes, the OCWCOG-SDS Program Manager will inform IHN-CCO and identify how they are using the system. Members identified by OCWCOG-SDS LTSS case managers or other AAA staff as needing more support will be staffed with AAA Program Manager who will communicate with IHN-CCO Care Coordination team. Quarterly ‘Coffee Break’ meetings provide an opportunity for IHN-CCO and AAA staff to discuss updates at each agency, concerns	% of ‘Coffee Break’ meetings convened.	# 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. 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).

	member's ICP. Communication happens during the ICT meeting as well as via phone, fax or secure email. IHN-CCO facilitates a quarterly 'Coffee Break' for IHN-CCO Care Coordination and OCWCOG-SDS LTSS case managers. The agenda includes a discussion of changes in programs, processes, procedures, and staffing. Presentations are shared including the appropriate contact if there are follow up questions. Escalation pathways are evaluated at each meeting. Recent 'Coffee Breaks' included presentations on Community Partner LTSS referral process, Hospital and Nursing Facility Social Services expedited LTSS process, Health-Related Services and Health-Related Social Needs. The IHN-CCO Care Coordination manager facilitates scheduling the quarterly meetings and works collaboratively with the OCWCOG-SDS director to ensure appropriate staff attend. IHN-CCO uses Point Click Care for event notification including SNF notifications. IHN-CCO Care Coordination staff are notified of the event, and they complete a	or barriers experiences, and build collaborative relationships. Regularly scheduled ICT meetings provide regular opportunity to discuss and support shared consumers. OCWCOG-SDS LTSS does not use Point Click Care for event notifications or to document care planning or share information amongst the care team.		

	member review and will determine if the member is receiving LTSS (will review LTSS monthly file received by OCWCOG-SDS.) Outreach to the OCWCOG-SDS LTSS case manager will be completed to discuss the event notification and next steps. IHN-CCO has developed cohort reports in Point Click Care to identify members who have been admitted to the ED or inpatient facility to intervene early and decrease unnecessary ED utilization and/or readmissions. Through the HIT roadmap, IHN-CCO is responsible to convene and align the community around a common referral process that can be electronically captured and made available to Primary Care at the time of service. IHN-CCO believes care coordination comes from a partnership amongst providers and community partners working towards a shared goal for the member. This work crosses the care spectrum from physical, behavioral, and dental health as well as community partners and OCWCOG-SDS LTSS. This requires not only a willingness to engage, but technical and operational resources that allow those parties			

	to interface in a timely and meaningful way. Electronic Health Record and other HIT usage is imperative in capturing the data necessary to engage in health information exchange. Two specific goals within the HIT roadmap that directly involve LTSS: 1) Collaborative use of Point Click Care. 2) Unite Us, which is a platform for closed loop referrals.			
OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals	Not Applicable (NA)	Not Applicable (NA)	Not Applicable (NA)	Not Applicable (NA)
OPTIONAL DOMAIN B: Health Promotion and Prevention				
OPTIONAL DOMAIN B: Safeguards for Members Goals	Not Applicable (NA)	Not Applicable (NA)	Not Applicable (NA)	Not Applicable (NA)
OPTIONAL DOMAIN C: Safeguards for Members				
OPTIONAL DOMAIN C: Cross-System Learning Goals	Not Applicable (NA)	Not Applicable (NA)	Not Applicable (NA)	Not Applicable (NA)

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.

DocuSigned by:
Bruce Butler
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Bruce Butler | CEO, Health Plans | 3/19/2025 | 07:52:12 PDT

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

DocuSigned by:
Ryan Vogt
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Ryan Vogt | Executive Director | 3/17/2025 | 16:49:12 PDT

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

DocuSigned by:
Randi Moore
4360039A224D457...

Randi Moore | Program Director | 3/17/2025 | 09:00:27 PDT

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