CCO Deliverable CCO-APD/AAA MOU Summary Annual Report Table:

MOU Report Period: Contract Year Jan. 1, 2024, thru Dec. 31, 2024

Report Due May 30th Annually [for previous calendar contract year]

Submit your CCO's Report via the Contract Deliverables portal located at https://oha-cco.powerappsportals.us/. (The submitter must have an OHA account to access the portal.)

CCO Name: Yamhill Community Care (YCCO)

OHA Contract: 161768

Partner AAA/APD District (s) Names/Locations: Yamhill County APD, Washington County APD, Northwest Senior and Disability Services

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Report submitted by: Margaret Klein, RN, CCM, MSN, MSB, JD

Contact email: mriggsklein@yamhillcco.org

Contact title: Nursing Director

Contact phone: 503-887-7731 (mobile)

This report contains two key sections:

SECTION A: MOU MEASURES OF SUCCESS and

SECTION B: REPORT ON WORK TO IMPROVE QUALITY AND METRICS THROUGH YCCO-LTSS MOU ACTIVITIES

Section A: MOU Measures of Success: This section for reporting required domain metrics and any local MOU metrics

*See measurement specs included in **CCO-Specific CCO-LTSS MOU Report Guidance** document for any question on each metric.*

CCO-LTSS APD/AAA MOU(s):

DOMAIN 1: Prioritization of high needs members

<table>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th><th>Annual Report on Specific Statewide Measures of Success (provide data points*) – monthly & annual [REQUIRED data points at minimum}</th></tr>
<tr>
<td rowspan="6">DOMAIN 1 MOU Goals: Prioritization of high needs Members

To implement care coordination activities that prevent and/or reduce unnecessary ER visits or hospitalization, YCCO and AAA/APD partners will implement and share risk screening and assessment information on priority and high-risk populations identified for LTSS or ICC need</td>
<td rowspan="6"><u>Key elements summarized</u>:

Identification of needs through Member risk assessment to identify Members for care management for high needs.

Coordination and communication activities to streamline the process for IDT/MDT referral with agreement to submit at least one case of mutual concern for discussion every two weeks.

AAA/APD to share Member information monthly to facilitate Member identification and needs.</td>
<td rowspan="6"># of case of mutual concern submitted for review and discussion each month

Annual Average monthly # of Members with LTSS for whom prioritization data was shared [monthly #/total in year]—calculated by OHA from data submitted

Quarterly meeting minutes between agencies to assess the effectiveness of cross-agency risk assessment and screening processes</td>
<td># of Members with LTSS that prioritization data was shared during each month [Monthly/Year Total]</td>
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<tr><td>
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>1033</td><td>1033</td><td>1038</td><td>1039</td><td>1041</td><td>1041</td><td>1031</td><td>1001</td><td>966</td><td>975</td><td>949</td><td>915</td><td>1328</td></tr>
</table>
</td></tr>
<tr><td># of CCO referrals to APD/AAA for new LTSS service assessments (for persons with unmet needs) [Monthly/Year Total]</td></tr>
<tr><td>
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>0</td><td>1</td><td>1</td><td>3</td><td>4</td><td>3</td><td>2</td><td>1</td><td>8</td><td>4</td><td>4</td><td>4</td><td>35</td></tr>
</table>
</td></tr>
<tr><td># of APD/AAA referrals to CCO for ICC review [Month and Year Totals]</td></tr>
<tr><td>
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td></tr>
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DOMAIN 2: Interdisciplinary care teams

<table>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS:</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th><th>Annual Report on Specific Statewide Measures of Success (provide data points*) – monthly & annual [REQUIRED data points at minimum}</th></tr>
<tr><td>DOMAIN 2 Goals:
Interdisciplinary care teams

YCCO and AAA/APD partners will establish interdisciplinary care teams, consisting of providers such as YCCO, PCP, LTSS and APD/AAA representatives, as well as other agencies/services providers working with the members. The multidisciplinary care team (MDT) will coordinate care and develop individualized care plans for high needs, mutual Members. All individuals on the MDT will maintain confidentiality.</td><td><u>Key elements summarized</u>:

Bi-weekly MDT/IDT care conferences to be held for sharing information and care planning to include YCCO, agency partners and care team members.

Quarterly LTSS partner meetings to review elements of the MOU, identify strengths and/or barriers that may exist.</td><td># of Members with LTSS that are addressed/ staffed via MDT/IDT meetings monthly

# of quarterly meetings in the year with discussion that addresses
a. MOU agreements
b. identification of strengths of the MOU</td><td># of Members with LTSS that are addressed/ staffed via IDT meetings monthly [Monthly/Year Total]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>2</td><td>14</td><td>5</td><td>7</td><td>7</td><td>8</td><td>3</td><td>11</td><td>11</td><td>2</td><td>3</td><td>3</td><td>76</td></tr>
</table>
<u>96</u> % of months in year where IDT care conference meetings with YCCO and APD/AAA occurred at least twice per month (25 total sessions held in 2024 – two months with three meetings and one month with one meeting)

% of times consumers participate/attend the care conference (IDT) by month/year
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg</th></tr>
<tr><td>0</td><td>.70</td><td>0</td><td>.14</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>.07</td></tr>
</table>
% of consumers that are care conferenced/total number of CCO Members with LTSS (percentage of LTSS recipients served by CCO) [Monthly/Year]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg</th></tr>
<tr><td>.19</td><td>1.36</td><td>.48</td><td>.67</td><td>.67</td><td>.77</td><td>.29</td><td>1.10</td><td>1.14</td><td>.21</td><td>.32</td><td>.33</td><td>.63</td></tr>
</table></td></tr>
</table>

DOMAIN 3: Development and sharing of individualized care plans

<table>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS:</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th><th>Annual Report on Specific Statewide Measures of Success (provide data points*) – monthly & annual [REQUIRED data points at minimum}</th></tr>
<tr><td>DOMAIN 3 Goals:
Development and sharing of individualized care plans</td><td><u>Key elements summarized</u>:

YCCO and AAA/APD are each committed to establishing and maintaining effective</td><td>100% of cases reviewed at MDT have a documented person-centered care plan

% of YCCO individualized person-centered care coordination plans for</td><td># of Members with LTSS that received individualized care plans during each month [Monthly/Year Total]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>53</td><td>28</td><td>18</td><td>26</td><td>41</td><td>20</td><td>28</td><td>30</td><td>36</td><td>24</td><td>59</td><td>25</td><td>388</td></tr>
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YCCO and AAA/APD partners collaborate to ensure a person-center care plan is in place to address Members' needs.	communication through regularly scheduled meetings, meeting at least every two weeks in MDT/IDT meetings and in quarterly MOU meetings. Development and maintenance of Member Individualized care plans for Members enrolled in Care that reflect the Member's preferences and goals. YCCO and AAA/APD will share information on community resources and special programs.	YCCO members with LTSS that incorporate and document Member preferences and goals % of YCCO person-centered care plans for Members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties	% of CCO individualized person-centered care coordination plans for CCO Members with LTSS that incorporate/document member preferences and goals [month/year]

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Avg
100	100	100	100	100	100	100	100	100	100	100	100	100

DOMAIN 4: Transitional care practices

Shared Accountability Goals with APD/AAA or ODDS:	MOU Activities (from MOU)	Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)	Annual Report on Specific Statewide Measures of Success (provide data points*) – monthly & annual [REQUIRED data points at minimum}
DOMAIN 4: Transitional care practices Goals YCCO and AAA/APD partners will develop coordinated transitional care practices that incorporate cross system education, timely-information-sharing when transitions occur, minimal cross-system duplication of effort, and effective deployment of cross-system nursing and psycho-	<u>Key elements summarized</u>: YCCO is responsible for ensuring transition processes are provided in support of YCCO Members who receive LTSS services. Efforts of transition and communication attempts with AAA/APD will be documented in the Member Care Profile, with AAA/APD	# of identified settings where discussions to share information about transitions and transition resources occur and document in transitional care practices % transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition % transitions where discharge orders	a. **# of transitions** where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? [Monthly/Year]

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Avg
1	0	0	0	0	0	0	0	0	0	0	0	.083

b. **# total number** of transitions tracked per month (baseline)

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVG
18	21	10	18	33	12	18	20	26	15	9	18	18.2

c. % of transitions [Divide a. # of transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition by b. Total Monthly Tracked Transitions = c]

<table>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS:</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th><th>Annual Report on Specific Statewide Measures of Success (provide data points*) – monthly & annual [REQUIRED data points at minimum}</th></tr>
<tr><td rowspan="6">social resources at any time Members experience a transition in care setting. When appropriate, AAA/APD and YCCO will work collaboratively to develop agreements around post hospital/skilled placement and roles that are most efficient yet prevent cost shifting or increases to LTC nursing home case load.</td><td rowspan="6">documenting aligned efforts in the AAA/APD core system.</td><td rowspan="6">(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 the transition wasn’t smooth (improvement process approach)? [Q1, Q2, Q3, Q4]</td><td>
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>AVG</th></tr>
<tr><td>.06</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>.005</td></tr>
</table>
% transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge? [Monthly/Year]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg</th></tr>
<tr><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
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<tr><td>*Per new CY2024 OARS: # 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.</td></tr>
<tr><td>
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg</th></tr>
<tr><td>0</td><td>3</td><td>3</td><td>3</td><td>2</td><td>2</td><td>0</td><td>6</td><td>3</td><td>9</td><td>2</td><td>2</td><td>2.9</td></tr>
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<tr><td>*Per new CY2024 OARS: % of these post-transition IDT meetings that included the Member or Member’s representative in the meeting</td></tr>
<tr><td>
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<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Avg</th></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
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DOMAIN 5: Collaborative Communication tools and processes

Shared Accountability Goals with APD/AAA or ODDS:	MOU Activities (from MOU)	Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)	Annual Report on Specific Statewide Measures of Success (provide data points*) – monthly & annual [REQUIRED data points at minimum}
	Key elements summarized:	# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with APD/AAA teams	# 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. [Monthly/Year]

<table>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS:</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th><th>Annual Report on Specific Statewide Measures of Success (provide data points*) – monthly & annual [REQUIRED data points at minimum}</th></tr>
<tr><td rowspan="2">DOMAIN 5: Collaborative Communication tools and processes Goals

YCCO and AAA/APD partners commit to mutual responsibility to foster cross system collaborations, training, and shared learning to reach the Triple Aim. Local, regional, and statewide cross system learning training and action to focus on best practices.</td><td rowspan="2">YCCO facilitates a quarterly MOU meeting for partners to collaborate and define measurement and monitoring of the activities being coordinated between both entities. These meetings include review of MOU agreement, overview of progress, barriers and processes.

Ensure communication processes are clear and reflect capabilities and expectations to build cross-system collaboration to improve outcomes and reduce duplication.</td><td rowspan="2">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</td><td>
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>18</td><td>21</td><td>10</td><td>18</td><td>33</td><td>12</td><td>18</td><td>20</td><td>26</td><td>15</td><td>9</td><td>18</td><td>218</td></tr>
</table>
# 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. [Monthly/Year]
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>2</td><td>3</td><td>1</td><td>4</td><td>1</td><td>1</td><td>3</td><td>0</td><td>2</td><td>1</td><td>1</td><td>1</td><td>20</td></tr>
</table>
Yes - 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).
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OPTIONAL DOMAIN A: Linking to Supportive Resources

<table>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS:</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th></tr>
<tr><td>OPTIONAL DOMAIN A: Linking to Supportive Resources Goals

YCCO and AAA/APD will share resources and tools to address social determinants of health and/or population health efforts and how individuals receiving LTSS and/or their</td><td>Key elements summarized:

YCCO and AAA/APD will share resources and tools to address social determinants of health and/or population health efforts and how individuals receiving LTSS and/or their family or</td><td>
% of MDT meetings where cross system or shared learning took place.
<table>
<tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>.33</td><td>0</td><td>0</td><td>.50</td><td>0</td><td>0</td><td>.07</td></tr>
</table>
% of MDT meeting time spent on cross system or shared learning.
<table>
<tr><td>JAN</td><td>FEB</td><td>MAR</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV</td><td>DEC</td><td>Avg</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>.06</td><td>0</td><td>0</td><td>.08</td><td>0</td><td>0</td><td>.01</td></tr>
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<tr>
<td>family or authorized representative can access these services.</td>
<td>authorized representative can access these services.</td>
<td>
# of cross learning events.
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>2</td></tr>
</table>
# of referrals for social determinants of health and/or population health programs tracked.
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>1</td><td>0</td><td>0</td><td>2</td><td>1</td><td>2</td><td>3</td><td>3</td><td>2</td><td>0</td><td>2</td><td>0</td><td>16</td></tr>
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OPTIONAL DOMAIN B: Health Promotion and Prevention

<table>
<tr><th>Shared Accountability Goals with APD/AAA or ODDS:</th><th>MOU Activities (from MOU)</th><th>Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)</th></tr>
<tr>
<td>OPTIONAL DOMAIN B: Cross System Learning Goals

YCCO and AAA/APD partners will provide and/or support member access to evidence-based health promotion, self-management and prevention classes, group and individual.</td>
<td><u>Key elements summarized</u>:

YCCO will share health promotion and prevention activities and services available through YCCO.

AAA/APD will provide health promotion and prevention services and work in collaboration with YCCO and other partners to support access and engagement in such services; and will educate YCCO on current health promotion and prevention services that are offered.</td>
<td>
Percent of MDT cases where health prevention/promotion activities are a part of the shared care plan.
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
</table>
Percent of joint clients who were given information about or who were referred to health prevention and promotion activities/ services.
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
</table>
Percent of joint clients who accessed or received health prevention/ promotion services.
<table>
<tr><th>JAN</th><th>FEB</th><th>MAR</th><th>APR</th><th>MAY</th><th>JUN</th><th>JUL</th><th>AUG</th><th>SEP</th><th>OCT</th><th>NOV</th><th>DEC</th><th>Total</th></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
</table>
Narrative: During 2024 YCCO integrated Care Management services within the organization’s infrastructure. Referrals were made by Care Management staff to partner Community Benefit Organizations and through the Healthwise educational link, the infrastructure was not built to capture this information for reporting.
</td>
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OPTIONAL DOMAIN C: Safeguards for Members

Shared Accountability Goals with APD/AAA or ODDS:	MOU Activities (from MOU)	Process Monitoring & Measurement: Specific Local Identified Measures of Success (from MOU)

OPTIONAL DOMAIN C: Safeguards for Members Goals		This optional domain was not selected for reporting for 2024.

SECTION B: REPORT ON WORK TO IMPROVE QUALITY AND INCENTIVE METRICS THROUGH CCO-LTSS MOU ACTIVITIES:

For each section, check the box for each activity your CCO LTSS partnership completed during CY 2024. For each activity, indicate whether the activity utilized ICC staff, THWs or Collective Event Notifications by checking the box(es) next to each activity.

1. Statewide Quality Metric for CCO: All-cause readmissions

Which of the following actions did your CCO-LTSS partnership take during CY 2024?	Utilized Care Coordination Staff?	Utilized THWs?	Utilized PointClick Event Notifications?
☒ **Focus on reducing readmissions post-hospitalization for nursing home residents**	☒	☒	☒
☒ **Focus on reducing readmissions post-hospitalization to those discharged to home**	☒	☒	☒
☒ **Focus on high-risk transition period of Skilled Nursing Facility or/PHEC discharge to home**	☒	☐	☒
☒ **Ensure hospital discharge plans are available to member, member's caregiver, Primary Care Provider and LTSS facility and family member/representative immediately**	☒	☐	☒
☒ **On-site/home visits post hospitalization for those discharged**	☒	☒	☒
☐ **Remote member health status monitoring post hospitalization (i.e. telemonitoring)**	☐	☐	☐
☐ **Tracking completion of post-hospitalization follow-up appointments**	☐	☐	☐
☒ **TQS or PIP project focused on reducing preventable re-hospitalizations in members receiving LTSS services** **If yes, Project Completed in CY 2024?** Yes _X_ No _____ **If applicable:** TQS Project Component - Special Heath Care Needs (SHCN): Dual Eligible Population TQS Project Number NEW: Otago Fall Reduction Program for SHCN: Dual Eligible Population Members TQS project submission year 2024	☒	☒	☒
☐ **Other Specific Activity:**	☐	☐	☐

2. Other Metrics (select any that apply, add others your plan may be monitoring)

MOU activities specifically targeting other metrics improvement for members with LTSS in CY2024	Domain #	Activity #	Utilized Care Coordination Staff?	Utilized THWs?	Utilized PointClick Event Notifications?
☒ **SDOH: Social Needs Screening and Referral**			☒	☒	☐
☒ **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control;**			☒	☐	☐
☒ **Substance Use Disorder Screening -- Screening, Brief Intervention and Referral to Treatment (SBIRT)**			☒	☐	☐
☒ **Screening for Depression and Follow-Up Plan**			☒	☐	☐
☒ **Initiation and Engagement of Substance Use Disorder Treatment**			☒	☒	☒
☒ **Controlling High Blood Pressure**			☒	☒	☒
☒ **Follow-Up Measures** --Follow-Up After Emergency Department Visit for Mental Illness --Follow-Up After Hospitalization for Mental Illness			☒ ☐	☒ ☒	☒ ☒
☐ **Other Specific Metric Related Activity:**			☐	☐	☐

3. TQS Quality Improvement Projects:

Complete this section if you have a Quality Improvement Project that includes a focus on members with LTSS or specific activities that align with your MOU [not previously reported on metrics grid in Section A].

Please let us know if you had a TQS project that aligned with your CCO-LTSS MOU for members with LTSS checking or circling:	No _____	Yes X
If yes, please provide the following information about your project.		
TQS Project Component & Project #	NEW: Otago Fall Reduction Program for SHCN: Dual Eligible Population Members	
TQS Project Submission Year	2024	
TQS Project Status	Complete X	In Progress

If you have more than one project to report, copy this grid and add the information below.