Memorandum of Understanding
Long Term Services and Supports between InterCommunity Health Network CCO and
Oregon Cascades West Council of Governments Senior and Disability Services

Medicaid-funded Long Term Services and Supports (LTSS) are legislatively excluded from Coordinated Care Organization (CCO) budgets and will continue to be paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTSS services. In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCO's and the LTSS system will need to coordinate care and share accountability for individuals receiving Medicaid-funded long term care services.

This is a non-binding agreement between Intercommunity Health Network Coordinated Care Organization (IHN-CCO) and Oregon Cascades West Council of Governments (OCWCOG) Senior and Disability Services (SDS). The mutual goal of the proposed agreement is to improve person-centered care, align care and service delivery and provide the right amount of care, in the right place at the right time for beneficiaries across the LTSS system; based on the roles and responsibilities of each entity, recognizing the purpose is to ensure coordination between two systems to provide quality care, produce the best health and functional outcomes for individuals to prevent escalation of costs for both systems.

Based on the good faith description of the roles and responsibilities of the entities participating in the proposed agreement to coordinate care and share accountability for Medicaid funded long term care, Intercommunity Health Network CCO and Oregon Cascades West Council of Governments agree to participate in the following activities:

Domain 1: Individualized Care Teams (ICT)		
Objective	**Activities**	**Deliverables**
IHN and SDS will establish inter-disciplinary care teams, consisting of providers such as CCO, PCP, LTSS representatives, as well as other agencies/services providers working with the members. The interdisciplinary care teams will coordinate care and develop individualized care plans for high needs, mutual members.	SDS will send IHN-CCO the LTSS CCO report and IHN will integrate relevant information to generate a list of high needs members that will be used to identify members for care coordination and/or ICT. High needs members may be identified by considering these factors: • Mental/Behavioral Health • Chemical Dependency • ER and Hospital Utilization • Complex Conditions • Complicating Circumstances • Member self-referral	• SDS will send IHN the LTSS CCO report at least once a quarter, IHN will integrate relevant information to the LTSS CCO report to generate a list of prioritized high needs members to refer for care coordination.
	Interdisciplinary Care Team (ICT) meetings will be held at least twice quarterly, one in Lincoln county and one in Linn/Benton County, on members that are identified as high needs with an emphasis on consumers that may have a mental health condition. An individualized care plans will be developed during the ICT and will be shared with ICT participants through a secure group email. The Interdisciplinary Care Team will determine who the most appropriate individual is to share the care plan with the member, if the member was not present at the ICT. Members will be selected by the Interdisciplinary Care Team comprised of representatives from IHN-CCO, SDS, and county mental health agencies.	• IHN and SDS teams will meet at least twice a quarter to coordinate care for high need members.

	SDS Case Managers will engage with the member to determine goals and preferences for the ICT meeting and consumers level of involvement with the ICT. The member's goal and preference will be documented in the care plan that is created at the ICT meeting regardless of the member's participation in the ICT.	• IHN and SDS will develop individualized person-centered care coordination plans that document member or member representative preferences and goals for each member that an Interdisciplinary Care Team meeting is held for.
	IHN-CCO, SDS, and the County Mental Health Agencies will designate leads for the Interdisciplinary Care Team. The point of contacts for the ICTs will be: Senior and Disability Services: Sarah Ballini-Ross InterCommunity Health Network CCO: Karen Weiner Linn County Mental Health: Tanya Thompson Benton County Mental Health: Sherry Sullins Lincoln County Mental Health: Barbara Turrill and Valerie Davis	• IHN and SDS will have a clearly-designated lead for each inter-disciplinary care team meeting.
	PCP's or designated representatives, LTSS providers, and relevant community organizations will be invited to Interdisciplinary Care Teams when appropriate.	• IHN and SDS will invite long term services and supports providers and PCPs when relevant, with appropriate releases as required by privacy rules and policy.

Shared Accountability

IHN and SDS agrees to:

- Attend quarterly MOU meetings to evaluate activity progress and conduct process reviews as appropriate.
- SDS will conduct a Quarterly MOU activities report and share with MOU team and designated APD/OHA representative.

<table>
<tr><th colspan="3">Domain 2: Transitional Care Practices</th></tr>
<tr><th>Objective</th><th>Activities</th><th>Deliverables & Outcomes</th></tr>
<tr><td rowspan="2">IHN and SDS 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-social resources at any time members experience a transition in their care setting.</td><td>IHN-CCO and SDS will establish a subcommittee to develop protocols and referral paths for SNF and Hospital transitions.

The Transitions Subcommittee will:
Document how IHN, SDS, and other integral partners are sharing information about transitions.
Identify areas for training needs and create a plan to accomplish the necessary training.
Describe how to access information and identify how information sharing will happen.
Identify cross system resources and how they may be used during transitions.
Document or map the transition processes across the region. The document or map will identify roles and responsibilities, minimum frequency of meetings and/or methods of communication.</td><td>IHN and SDS partners that have mapped the transitional care practices in their areas by June 2017.</td></tr>
<tr><td>Documents developed by the subcommittee will be shared with appropriate partners.</td><td>IHN and SDS will have developed a procedure for coordinating and communicating around transitions of care by June 30, 2017.</td></tr>
<tr><td colspan="3">Shared Accountability
IHN and SDS agrees to:
Attend quarterly MOU meetings to evaluate activity progress and conduct process reviews as appropriate.
SDS will conduct a Quarterly MOU activities report and share with MOU team and designated APD/OHA representative.</td></tr>
<tr><th colspan="3">Domain 3: Member Engagement</th></tr>
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Objective	Activities	Deliverables & Outcomes
IHN and SDS will increase member/client engagement in the care conference process.	SDS Case Manager will engage the member to obtain their input and identify areas of need or services to be included in the draft individualized care plan prior to the ICT.	• SDS will engage with members to determine their goals and preferences prior to the Interdisciplinary Care Team.
	The Interdisciplinary Care Team will determine who the most appropriate individual is to review the care plan with the member, within in four weeks from the ICT meeting.	• The Interdisciplinary Care Team will designate an individual to review the care plan after the Interdisciplinary Care Team meeting.
	SDS and IHN will promote self-management of chronic conditions and participation in health promotion and/or prevention activities to members as applicable.	• SDS and IHN will refer members to relevant self-management programs when applicable.

Shared Accountability

IHN and SDS agrees to:

- Attend quarterly MOU meetings to evaluate activity progress and conduct process reviews as appropriate.
- SDS will conduct a Quarterly MOU activities report and share with MOU team and designated APD/OHA representative.

This MOU shall be effective upon the signature of Intercommunity Health Network CCO and Oregon Cascades West Council of Governments authorized officials. It shall be in force from July 1, 2016 to June 30, 2017.

InterCommunity Health Network CCO

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Authorizing signature

6/27/16
Date

Oregon Cascades West Council of Governments, Senior and Disability Services

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Date