ATTACHMENT 1 – Application Cover Sheet

Applicant Information - RFA # 3402

Applicant Name: InterCommunity Health Network Coordinated Care Organization (IHN-CCO)

Form of Legal Entity (business corporation, etc.) InterCommunity Health Plans (IHP) dba InterCommunity Health Network Coordinated Care Organization (IHN-CCO), health care contractor. IHP is a public benefit corporation organized and operated exclusively for charitable and educational purposes and functions as a 501(c)(4) under the IRS. State of domicile: Oregon

Primary Contact Person: Kim Whitley Title: Chief Operating Officer

Address: 815 NW 9th Street, Suite 103

City, State, Zip: Corvallis, Oregon 97330

Telephone: (541) 768-5328 Fax: 541-768-4518

E-mail Address: kwhitley@samhealth.org

Name and title of the person(s) authorized to represent the Applicant in any negotiations and sign any Contract that may result:

Name: Kelley Kaiser, Kim Whitley Title: Chief Executive Officer, Chief Operating Officer, respectively

By signing this page and submitting an Application, the Authorized Representative certifies that the following statements are true:

1. Applicant does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, sex, disability, sexual orientation or national origin, nor has Applicant or will Applicant discriminate against a subcontractor in the awarding of a subcontract because the subcontractor is a minority, women or emerging small business enterprise certified under ORS 200.055.
2. Information and costs included in this Application will remain valid for 180 days after the Application due date or until a Contract is approved, whichever comes first.
3. The statements contained in this Application are true and, so far as is relevant to the Application, complete. Applicant accepts as a condition of the Contract, the obligation to comply with the applicable state and federal requirements, policies, standards, and regulations.
4. The undersigned recognizes that this is a public document and will become open to public inspection, except as described in Section 7.8.
5. Applicant has followed the instructions provided and has identified any deviations from specifications within its response. Applicant confirms that any instructions or specifications that it felt were unclear have been questioned in advance of this Application.
6. Applicant acknowledges receipt of all addenda issued under this RFA, as listed on OHA's web portal.
7. If awarded a Contract, Applicant will be required to complete, and will be bound by, a Contract described in this RFA. Applicant agrees to the Core Contract terms and conditions in Appendix G, except to the extent Applicant has timely requested a change or clarification or filed a protest in accordance with the RFA.
8. If awarded a Contract, Applicant will meet the highest standards prevalent among Medicaid health plans in Oregon.
9. Applicant and its Affiliates complied with the Code of Conduct in Section 7.15 of the RFA in connection with the RFA.
10. Applicant accepts the terms and conditions for OHA's web portal, as posted on the web portal.
11. Applicant will negotiate in good faith regarding the statement of work for the Contract.

Signature: Kelley Kaiser Title: Chief Executive Officer Date: 4-25-12

(Authorized to Bind Applicant)

ATTACHMENT 6 – ATTESTATIONS, ASSURANCES AND REPRESENTATIONS

Applicant Name: InterCommunity Health Network Coordinated Care Organization (IHN-CCO)

Instructions: For each attestation, assurance or descriptive representation below, Applicant will check "yes," "no," or "qualified." On attestations and assurances, a "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no" or "qualified." On informational representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all attestations, assurances, and informational representations. The table headings indicate if an item is an attestation, assurance, or informational representation.

These attestations, assurances, and informational representations must be signed by one or more representatives of Applicant who have knowledge of them after due inquiry. They may be signed in multiple counterparts, with different representatives of Applicant signing different counterparts.

Unless a particular item is expressly effective at the time of Application, each attestation, assurance or informational representation is effective starting at the time of readiness review and continuing throughout the term of the Contract.

Attestations for Appendix A – CCO Criteria

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation A-1. Applicant will have an individual accountable for each of the following operational functions:				
• Contract administration	X			
• Outcomes and evaluation	X			
• Performance measurement	X			
• Health management and care coordination activities	X			
• System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO	X			
• Mental health and addictions coordination and system management	X			
• Communications management to providers and Members	X			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
• Provider relations and network management, including credentialing • Health information technology and medical records • Privacy officer • Compliance officer	X X X X			
Attestation A-2. Applicant will participate in the learning collaboratives required by ORS 442.210.	X			
Attestation A-3. Applicant will collect, maintain and analyze race, ethnicity, and primary language data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities.			X	Applicant will comply with all requirements in Attestation A-3, with the exception of ethnicity, as this information is not currently being tracked.

Attestations for Appendix B – Provider Participation and Operations Questionnaire

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation B-1. Applicant will, as demonstrated with policies and procedures, (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse providers for dispensing a 72-hour supply of a drug that requires prior authorization in accordance with OAR 410-141-0070.	X			
Attestation B-2. Applicant will comply with all applicable provider requirements of Medicaid law under 42 CFR Part 438, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing	X			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
payments to providers, and limits on physician incentive plans.				
Attestation B-3. Applicant will assure that all provider and supplier contracts or agreements contain the required contract provisions that are described in the Contract.	X			
Attestation B-4. Applicant will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested service area.	X			
Attestation B-5. Applicant will have all provider contracts or agreements available upon request.	X			
Attestation B-6. As Applicant implements, acquires, or upgrades health information technology (HIT) systems, where available, the HIT systems and products will meet standards and implementation specifications adopted under section 3004 of the Public Health Services Act as added by section 13101 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5.	X			
Attestation B-7. Applicant's contracts for administrative and management services will contain the OHA required contract provisions.	X			
Attestation B-8. Applicant will establish, maintain, and monitor the performance of a comprehensive network of providers to assure sufficient access to Medicaid Covered Services as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO. Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.	X			
Attestation B-9. Applicant will have executed written agreements with providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines.	X			
Attestation B-10. Applicant, through its contracted or deemed Participating Provider network, along with other specialists outside the network, community resources or social services within the CCO's service area, will provide ongoing primary care and specialty care as needed and				

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
guarantee the continuity of care and the integration of services through: • Prompt, convenient, and appropriate access to Covered Services by enrollees 24 hours a day, 7 days a week; • The coordination of the individual care needs of enrollees in accordance with policies and procedures as established by the Applicant; • Enrollee involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care; • Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and • Addressing diverse patient populations in a culturally competent manner.	X X X X X			
Attestation B-11. Applicant will establish policies, procedures, and standards that: • Assure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO, • Ensure access to medically necessary care and the development of medically necessary individualized care plans for enrollees; • Promptly and efficiently coordinate and facilitate access to clinical information by all providers involved in delivering the individualized care plan of the enrollee; • Communicate and enforce compliance by providers with medical necessity determinations; and • Do not discriminate against Medicaid enrollees, including providing services to individuals with disabilities in the most integrated setting appropriate to the needs of those individuals.	X X X X X			
Attestation B-12. Applicant will have verified that contracted providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified providers in the future.	X			
Attestation B-13. Applicant will provide all services covered by Medicaid and comply with OHA coverage determinations.	X			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation B-14. Applicant, Applicant staff and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities), and subcontractor staff will be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities).	X			
Attestation B-15. Neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation if applicable) or its subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services.	X			

Medicaid Assurances for Appendix B – Provider Participation and Operations Questionnaire

Assurance B-1. Emergency and Urgent Care Services. Applicant will have written policies and procedures and monitoring systems that provide for emergency and urgent services for all Members on a 24-hour, 7-days-a-week basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. (See 42 CFR 438.114 and OAR 410-141-3140]	X			
Assurance B-2. Continuity of Care. Applicant will have written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorizations to other providers. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider	X			

compliance. [See 42 CFR 438.208 and OAR 410-141-3160]				
Assurance B-3. Applicant will have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant's primary care and referral providers. Applicants will communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance. Applicants will document all monitoring and Corrective Action activities. Such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law. [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]	X			
Assurance B-4. Applicant will have an ongoing quality performance improvement program for the services it furnishes to its Members. The program will include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction. The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.200 and 438.240; OAR 410-141-0200]			X	Applicant will have ongoing quality performance improvement program for the services to members and meet all assurances in B-4, with the exception of ethnicity, as this information is not currently being tracked. See also attestation A-3.
Assurance B-5. Applicant will make Coordinated Care Services accessible to enrolled Members. The Applicant will not discriminate between Members and non-Members as it relates to benefits to which they are both entitled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42	X			

CFR 438.206 to 438.210; and OAR 410-141-3220]				
Assurance B-6. Applicant will have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix G "Core Contract". The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.228, 438.400 – 438.424; and OAR 410-141-3260 to 410-141-3266]	X			
Assurance B-7. Applicant will develop and distribute informational materials to potential Members that meet the language and alternative format requirements of potential Members. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.10; OAR 410-141-3280]	X			
Assurance B-8. Applicant will have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant, Member handbook, health education, availability of intensive care coordination for Members who are aged, blind and/or disabled and appropriate use of emergency facilities and urgent care. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.10; and OAR 410-141-3300]	X			
Assurance B-9. Applicant will have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Attachment 4, Core Contract. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]	X			
Assurance B-10. Applicants will provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled. The Applicant will	X			

communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3405]				
Assurance B-11. Applicant will maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant and its providers will not hold Members responsible for the Applicants or providers debt if the entity becomes insolvent. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 447.46 and OAR 410-141-0420]	X			
Assurance B-12. Applicant will participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards. Applicant has executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]	X			
Assurance B-13. Applicant will maintain an efficient and accurate system for capturing encounter data, timely reporting the encounter data to OHA, and validating that encounter data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the	X			

operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242; and the Contract]				
Assurance B-14. Applicant will maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242 and 438.604; and Contract]	X			

Informational Representations for Appendix B – Provider Participation and Operations Questionnaire

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-1. Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract.	X			
Representation B-2. Applicant has an administrative or management contract with a delegated entity to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program.	X			
Representation B-3. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the systems or information technology to operate the CCO program for Applicant.	X			
Representation B-4. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the claims administration, processing and/or adjudication functions.	X			
Representation B-5. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Enrollment, Disenrollment and membership functions.	X			
Representation B-6. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the credentialing functions.	X			
Representation B-7. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the utilization operations management.	X			
Representation B-8. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Quality Improvement operations.	X			
Representation B-9. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of its call center operations.	X			

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-1. Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract.	X			
Representation B-10. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the financial services.	X			
Representation B-11. Applicant will have an administrative or management contract with a delegated entity to delegate all or a portion of other services that are not listed.	X			

(Applicant Authorized Officer)
Signature: _____ Title: Chief Executive Officer Date: 4/26/2017

IHN-CCO
ATTACHMENT 7 –APPLICATION CHECKLISTS

1. Technical Application, Mandatory Submission Materials

☒ **a.** Application Cover Sheet (Attachment 1).'

☒ **b.** Attestations, Assurances and Representations (Attachment 6).

☒ **c.** This Technical Application Checklist (Attachment 7).

☒ **d.** Letters of Support from Key Community Stakeholders.

☒ **e.** Résumés for Key Leadership Personnel.
See attachments A.I.q_CEO_Resume.pdf, A.I.q_CFO_Resume.pdf, A.I.q_CMO_Resume.pdf, A.I.q_CIO_Resume.pdf, A.I.q_COO_Resume.pdf, in Appendix A response

☒ **f.** Organizational Chart.
See attachment A.I.r_ShpoOrgChart.pdf in Appendix A response

☒ **g.** Services Area Request (Appendix B).
See attachment B.1_ServiceAreaCapacityTable.pdf in Appendix B response

h. Questionnaires

☒ **(1)** CCO Criteria Questionnaire (Appendix A).

☒ **(2)** Provider Participation and Operations Questionnaire (Appendix B).

☒ **(3)** Accountability Questionnaire (Appendix C).

☒ • Services Area Table.
See separate attachment B.1_ServiceAreaTablev2.xlsx

☒ • Publicly Funded Health Care and Service Programs Table
See separate attachment B.3_PubliclyFundedService.xlsx

2. Technical Application, Optional Submission Materials

If Applicant elects to submit the following optional Application materials, the materials must be submitted with the Technical Proposal:

☒ **a.** Transformation Scope Elements (Appendix H).

☒ **b.** Applicant's Designation of Confidential Materials (Attachment 2).

Samaritan
Health Services

Building healthier communities together

3600 NW Samaritan Drive • Corvallis, OR 97330 • www.samhealth.org

April 6, 2012

To whom it may concern:

On behalf of Samaritan Health Services, I strongly support the goals of the triple aim delivered through the Coordinated Care Organization model in Oregon by InterCommunity Health Network Coordinated Care Organization (IHN-CCO) in Benton, Lincoln and Linn counties. As a regional planning group, we have been working with our community members and engaging stakeholders for over a year to prepare for planned implementation dates of August 1, 2012 and January 1, 2013 for Medicaid and Medicare members, respectively.

The IHN-CCO is a partnership between a fully capitated health plan, mental health organizations, dental care organization, three counties and local hospitals and health systems. As you already know, our commitment to Oregon's most vulnerable populations is unwavering and we plan to serve all ages across all types of care.

The IHN-CCO serves to coordinate care for Medicaid and Medicare populations in Benton, Lincoln and Linn counties. The opportunity to link, through the criteria in the CCO Request for Application, will provide for better client experiences, coordinated care, better health through education and care management with a goal of lower costs over time.

On behalf of Samaritan Health Services, I look forward to working with the IHN-CCO and participating in this transformational effort.

Sincerely,

Larry A. Mullins, DHA, FACHE
President/Chief Executive Officer

ACCOUNTABLE BEHAVIORAL HEALTH ALLIANCE

310 NW Fifth Street, Suite 206
Corvallis, OR 97330
Phone: (541) 753-8997
FAX: (541) 752-4877

April 9, 2012

Reference: IHN CCO Application

To Whom It May Concern:

On behalf of The Accountable Behavioral Health Alliance (ABHA), I am writing to support the application InterCommunity Health Network to become a Coordinated Care Organization model in Benton, Lincoln and Linn counties.

I have been an active member of the regional planning group that has been working for months on developing the core concepts, operating principles, and implementation plan for an IHN-CCO. We have been working with our community partners and stakeholders for over a year to prepare for the planned implementation dates of August 1, 2012 (for Medicaid members) and January 1, 2013 (for the addition of Medicare members).

The IHN-CCO is a partnership between a Fully Capitated Health Plan (IHN), two Mental Health Organizations (one of which is ABHA), a dental care organization, three counties, local hospitals and local healthcare systems. This partnership has organized itself quickly and purposefully. We share common values and a sense of urgency. Our commitment to Oregon's most vulnerable populations is unwavering, yet we know that we need to do things differently, work together differently, and organize ourselves differently if we are going to achieve the goals of the Triple Aim in our community.

We have run out of the luxury of time to do this. The State's budget crisis leaves us no choice but to do more with less. The CCO concept is designed to accomplish this. However, there is a big gap between bullet points on a piece of paper and a healthcare system that can translate those bullet points into effective action. National research shows that most ASOs have not succeeded in producing better outcomes and savings simultaneously. But we have no choice. There isn't a "better mouse trap" out there that we know of. The ingredients of the CCO design appear to make sense. What gives me hope and confidence that we will be one of the success stories is the partnerships that are developing among IHN CCO stakeholders and the leadership at IHN which is solid and forward-thinking. This is a good group to work with.

On behalf of ABHA, I look forward to working with the IHN-CCO and participating in this transformational effort.

Sincerely,

Seth Bernstein, Ph.D.

ABHA Executive Director

behavioral care network

Mid-Valley Behavioral Care Network

1660 Oak Street SE, Suite 230 ▪ Salem, Oregon ▪ 97301
PHONE: (503) 361-2647 ▪ FAX: (503) 585-4989 ▪ www.mvbcn.org

April 12, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Oregon Health Authority

RE: InterCommunity Health Network CCO Application under RFA 3402

Dear Ms. Hurst,

I am writing to express my strong support for the InterCommunity Health Network CCO Application. Mid-Valley Behavioral Care Network (MVBCN) has been one among a diverse group of community stakeholders who began meeting in February 2011 to develop the concepts and relationships for a successful Coordinated Care Organization.

The IHN-CCO is a collaboration of a fully capitated health plan, two mental health organizations, a dental care organization, three counties (Benton, Lincoln and Linn), the Area Agency on Aging, and local hospitals and health systems, including Federally Qualified Health Centers.

This planning effort and the content of the Application fulfill the health improvement ideals developed by the Legislature, the Oregon Health Fund Board, the Oregon Health Policy Board and our current Governor. The Application is the plan, and I am confident that the parties involved will succeed in developing an effective system of health services and supports to improve the health of our communities, improve the recipient experience of health care, and succeed within the funds available.

Please know that MVBCN is a fully committed partner in this effort. We expect to contract with the IHN-CCO and bring our best efforts to our collective success.

Sincerely,

James D. Russell
Executive Manager

BOARD OF COMMISSIONERS
408 SW Monroe Ave., Suite 111
P.O. Box 3020
Corvallis, OR 97339-3020
(541) 766-6800
FAX (541) 766-6893

April 17, 2012

To whom it may concern:

As the public representatives of Benton County, the Benton County Board of Commissioners supports the goals of improved population health, enhanced health care, and controlled costs delivered through Oregon's Coordinated Care Organization model by InterCommunity Health Network Coordinated Care Organization (IHN-CCO) in Benton, Lincoln and Linn counties. We have been active participants in a regional planning group, working with community members and engaging stakeholders for over a year to prepare for planned CCO implementation dates of August 1, 2012 and January 1, 2013 for Medicaid and Medicare members, respectively.

The IHN-CCO is a partnership between a fully capitated health plan, mental health organizations, dental care organizations, three counties and local hospitals and health systems. Our work together is reflective of the commitment these partners have to Oregon's most vulnerable populations and we have come together to assure that this CCO well serves our community, in all of its diversity.

The IHN-CCO will coordinate care for Medicaid and Medicare populations in Benton, Lincoln and Linn counties. The opportunity to join together in planning, financing, and delivering health care and health promotion, through the criteria in the CCO RFA, will provide for better client experiences, coordinated care, better health through education and care management with a goal of lower costs over time.

On behalf of Benton County government, our community, our Health Department and our Community Health Center, we look forward to working with the IHN-CCO and participating in this transformational effort.

Sincerely,

Jay Dixon, Chair
Benton County Board of Commissioners

Community Health Centers
of Benton and Linn Counties

April 4, 2012

To whom it may concern;

On behalf of the Community Health Centers of Benton and Linn Counties (CHC), the Board strongly support the goals of the triple aim delivered through the Coordinated Care Organization model in Oregon by InterCommunity Health Network Coordinated Care Organization (IHN-CCO) in Benton, Lincoln and Linn counties. The Health Center has been included in the regional planning group and involved in the work of the committee over the past year in engaging stakeholders and community members to prepare for planned implementation dates of August 1, 2012 and January 1, 2013 for Medicaid and Medicare members, respectively.

The IHN-CCO is a partnership between a fully capitated health plan, mental health organizations, dental care organization, three counties and local hospitals and health systems. The commitment to Oregon's most vulnerable populations is unwavering, and as a Federally Qualified Health Center, the CHC is committed to participating as a critical partner in serving all ages across all types of care.

The IHN-CCO serves to coordinate care for Medicaid and Medicare populations in Benton, Lincoln and Linn counties. The opportunity to link, through the criteria in the CCO RFA, will provide for better client experiences, coordinated care, better health through education and care management with a goal of lower costs over time.

On behalf of the Community Health Centers of Benton and Linn Counties, we look forward to working with the IHN-CCO and participating in this transformational effort.

Sincerely,

Tim McQueary, Board Chair
Community Health Centers of Benton & Linn Counties

Sherlyn Dahl, BSN, MPH
Executive Director

Community Health Center Sites:

Benton Health Center
530 NW 27th Street
Corvallis, OR 97330
(541) 766-6835
(541) 766-6366 - fax

Lincoln Health Center
121 SE Viewmont Avenue
Corvallis, OR 97333
(541) 766-3546
(541) 766-6143 - fax

Monroe Health Center
610 Dragon Drive
Monroe, OR 97456
(541) 847-5143
(541) 847-5144 - fax

East Linn Health Center
100 Mullins Drive #A-1
Lebanon, OR 97355
(541) 451-6920
(541) 451-6924 - fax

Business Office
Accounting
Business Services
Client Support Services
Contracts & Purchasing
(541) 766-6715
(541) 766-6164 - fax

Board of Commissioners

Courthouse, Room 110
225 W. Olive Street
Newport, Oregon 97365
(541) 265-4989
FAX (541) 265-4176

April 10, 2012

To whom it may concern:

On behalf of Lincoln County, we strongly support the goals of the triple aim delivered through the Coordinated Care Organization model in Oregon by InterCommunity Health Network Coordinated Care Organization (IHN-CCO) in Benton, Lincoln and Linn counties. As a regional planning group, we have been working with our community members and engaging stakeholders for over a year to prepare for planned implementation dates of August 1, 2012 and January 1, 2013 for Medicaid and Medicare members, respectively.

The IHN-CCO is a partnership between a fully capitated health plan, mental health organizations, dental care organization, three counties and local hospitals and health systems. As you already know, our commitment to Oregon's most vulnerable populations is unwavering and we plan to serve all ages across all types of care.

The IHN-CCO serves to coordinate care for Medicaid and Medicare populations in Benton, Lincoln and Linn counties. The opportunity to link, through the criteria in the CCO RFA, will provide for better client experiences, coordinated care, better health through education and care management with a goal of lower costs over time.

On behalf of Lincoln County, we look forward to working with the IHN-CCO and participating in this transformational effort.

Sincerely,

LINCOLN COUNTY BOARD OF COMMISSIONERS

DON LINDLY, Chair

BILL HALL, Commissioner

TERRY N. THOMPSON, Commissioner

Lincoln County Health & Human Services
36 SW Nye Street
Newport, OR 97365
(541) 265-4190
FAX (541) 574-6262
Hearing Impaired: (541)265-6915

4/16/12

To whom it may concern:

On behalf of Lincoln County, I strongly support the goals of the triple aim delivered through the Coordinated Care Organization model in Oregon by InterCommunity Health Network Coordinated Care Organization (IHN-CCO) in Benton, Lincoln and Linn counties. As a regional planning group, we have been working with our community members and engaging stakeholders for over a year to prepare for planned implementation dates of August 1, 2012 and January 1, 2013 for Medicaid and Medicare members, respectively.

The IHN-CCO is a partnership between a fully capitated health plan, mental health organizations, dental care organization, three counties and local hospitals and health systems. As you already know, our commitment to Oregon's most vulnerable populations is unwavering and we plan to serve all ages across all types of care.

The IHN-CCO serves to coordinate care for Medicaid and Medicare populations in Benton, Lincoln and Linn counties. The opportunity to link, through the criteria in the CCO RFA, will provide for better client experiences, coordinated care, better health through education and care management with a goal of lower costs over time.

On behalf of Lincoln County, I look forward to working with the IHN-CCO and participating in this transformational effort.

Sincerely,

Barbara L. Turrill, LPC, CADCIII, RDMT

Behavioral Health Division Director

LINN COUNTY GENERAL ADMINISTRATION
300 Fourth Avenue, SW (Room 201), P.O. Box 100, Albany, OR 97321-0031
Phone (541) 967-3825 FAX (541) 926-8228

Accounting/Payroll, Personnel Services, Data Processing,
General Services/Facilities, Printing/Supplies, Veterans' Services

BOARD OF COMMISSIONERS
John K. Lindsey
Roger Nyquist
Will Tucker

RALPH E. WYATT
Administrative Officer

April 18, 2012

To whom it may concern:

On behalf of Linn County, I hereby express our intent to contract with InterCommunity Health Network (IHN) as the Coordinated Care Organization (IHN-CCO) serving Benton, Lincoln and Linn counties. As part of a regional planning group, Linn County has been working with IHN, our community members and stakeholders for over a year to prepare for planned CCO implementation dates of August 1, 2012 and January 1, 2013 for Medicaid and Medicare members, respectively.

The IHN-CCO is a partnership between a fully capitated health plan, behavioral health organizations, dental care organization, Benton, Lincoln and Linn counties and local hospitals and health systems. Linn County shares with the IHN-CCO a commitment to Oregon's most vulnerable populations and plans to serve all ages across all types of care.

The IHN-CCO serves to coordinate and provide care for Medicaid and Medicare populations in Benton, Lincoln and Linn counties. I believe Linn County behavioral and public health services to be an integral provider and essential to the success of the IHN-CCO. This is an opportunity to link resources, through the CCO process, with the goal of providing better care management and services, better client experiences through coordinated care, and better client health through education, all at a lower cost achieved over time.

Sincerely,

Ralph E. Wyatt
Linn County Administrative Officer

c: Linn County Board of Commissioners
Frank Moore, Linn County Health Administrator

OREGON CASCADES WEST
Council of Governments

1400 Queen Ave.SE, Suite 201 • Albany, Oregon 97322
(541) 967-8720 • FAX (541) 967-6123

April 10, 2012

To whom it may concern:

On behalf of Oregon Cascades West Council of Governments (OCWCOG), I strongly support the goals of the triple aim delivered through the Coordinated Care Organization model in Oregon by Inter-Community Health Network Coordinated Care Organization (IHN-CCO) in Benton, Lincoln and Linn counties. As a participant in the regional CCO planning group, OCWCOG has been working with our community members and engaging stakeholders for over a year to prepare for the establishment of a CCO in our region.

The IHN-CCO is a partnership between a fully capitated health plan, mental health organizations, dental care organization, three counties, OCWCOG, and local hospitals and health systems. Collectively, this partnership has a strong commitment to Oregon's most vulnerable populations, including low income seniors and persons with disabilities who are served through OCWCOG's long-term care programs and who will be prime beneficiaries of the care to be coordinated through the IHN-CCO.

Sincerely,

Cynthia Solie

Cynthia Solie

Executive Director

Capitol Dental Care, Inc.

3000 Market Street NE, Suite 228 • Salem, OR 97301 • (503) 585-5205 • Fax: (503) 581-0043

April 14, 2012

To whom it may concern:

On behalf of Capitol Dental Care, Inc., I strongly support the goals of the triple aim delivered through the Coordinated Care Organization model in Oregon by InterCommunity Health Network Coordinated Care Organization (IHN-CCO) in Benton, Lincoln and Linn counties. As a regional planning group, we have been working with our community members and engaging stakeholders for over a year to prepare for planned implementation dates of August 1, 2012 and January 1, 2013 for Medicaid and Medicare members, respectively.

The IHN-CCO is a partnership between a fully capitated health plan, mental health organizations, dental care organization, three counties and local hospitals and health systems. As you already know, our commitment to Oregon's most vulnerable populations is unwavering and we plan to serve all ages across all types of care.

The IHN-CCO serves to coordinate care for Medicaid and Medicare populations in Benton, Lincoln and Linn counties. The opportunity to link, through the criteria in the CCO RFA, will provide for better client experiences, coordinated care, better health through education and care management with a goal of lower costs over time.

On behalf of Capitol Dental Care, I look forward to working with the IHN-CCO and participating in this transformational effort.

Sincerely,

William Hart Laws

President

DUAL DIAGNOSIS ANONYMOUS OF OREGON, INC.

P.O. Box 2883 541 SW 11th St Portland, Oregon 97208
Phone 503-737-4126 www.ddaoforegon.com

4-12-2012

Ms. Kelley Kaiser
CEO, InterCommunity Health Network

Dear Ms. Kaiser,

Dual Diagnosis Anonymous (DDA) of Oregon, Inc. would be pleased to have this letter included with the IHN-CCO application. DDA of Oregon currently works with Mid-Valley Behavioral Care Network (MVBCN) to support a DDA group in Albany and would like to partner with IHN-CCO to continue that service and extend into Lincoln and Benton Counties as well. Allow us to explain more about the value of DDA.

Dual Diagnosis Anonymous uses a peer support group model based on an authorized version of the 12 Steps of Alcoholics Anonymous plus an additional 5 Steps that focus on Dual Diagnosis (mental illness and substance abuse). DDA's unique 12 Steps Plus 5 Program offers hope for achieving the promise of recovery. Since our inception in September of 2005, "DDA peer support groups have spread widely throughout Oregon as a complement to integrated dual diagnosis treatments" (Psychiatric Services Journal, August 2010).

DDA of Oregon received the 2010 Addictions and Mental Health Division Hope, Resilience, & Recovery Outstanding Community Service Organization Award for its "outstanding impact in the field of alcohol and drug prevention, treatment, and recovery."

Patients who increase their reliance on self help groups lower subsequent health care costs significantly (Humphrey's et al, 2001). With over 3,500 contacts per month in Oregon, the average cost per contact in DDA is under $5.00. DDA provides an effective and economical service that reduces entry into the state hospital or prison systems, and reduces the use of professional health services. DDA is a good investment!

MVBCN has encouraged us to support IHN-CCO, and to hope that DDA can work with IHN-CCO in the years ahead. Please contact us to develop that possibility.

Sincerely Yours,

Claudia Grimm, President
DDA of Oregon, Inc. Board of Directors

Corbett Monica, Executive Director
DDA of Oregon, Inc.

Quality Care Associates

Quality Care Through Community Networking

April 19, 2012

To whom it may concern:

On behalf of Quality Care Associates (the local IPA), I strongly support the goals of the triple aim delivered through the Coordinated Care Organization model in Oregon by InterCommunity Health Network Coordinated Care Organization (IHN-CCO) in Benton, Lincoln and Linn counties. As a regional planning group, we have been working with our community members and engaging stakeholders for over a year to prepare for planned implementation dates of August 1, 2012 and January 1, 2013 for Medicaid and Medicare members, respectively.

The IHN-CCO is a partnership between a fully capitated health plan, mental health organizations, dental care organization, three counties and local hospitals and health systems. As you already know, our commitment to Oregon's most vulnerable populations is unwavering and we plan to serve all ages across all types of care.

The IHN-CCO serves to coordinate care for Medicaid and Medicare populations in Benton, Lincoln and Linn counties. The opportunity to link, through the criteria in the CCO RFA, will provide for better client experiences, coordinated care, better health through education and care management with a goal of lower costs over time.

On behalf of Quality Care Associates. I look forward to working with the IHN-CCO and participating in this transformational effort.

Sincerely,

Bruce W. Madsen M.D.,M.B.A.,M.H.S.A.

2815 SW Willetta • Suite A-4 • Albany, OR 97321-3448 • 541.928.3424 • Fax: 541.928.3234

The Corvallis Clinic
PHYSICIANS & SURGEONS

Aumann Building
444 NW Elks Dr.
Corvallis, OR 97330
(541) 754-1150
www.corvallisclinic.com

April 19, 2012

To Oregon Health Authority:

On behalf of The Corvallis Clinic, I strongly support the objectives and the efforts being put forth relating to the development of the Coordinated Care Organization model by Intercommunity Health Network Coordinated Care Organization (IHN-CCO) in Benton, Lincoln and Linn counties. As a regional planning group, we have been working with other community members and stakeholders for over a year to prepare for planned implementation dates of August 1, 2012 and January 1, 2013 for Medicaid and Medicare members, respectively.

The IHN-CCO is a partnership between independent community physicians, a fully capitated health plan, mental health organizations, dental care organization, three counties, and local hospital system. As your goals clearly state, we would like to have better population management and health status for a group that is at risk and the IHN-CCO has the potential to deliver upon these expectations.

The IHN-CCO serves to coordinate care for Medicaid and Medicare populations in Benton, Lincoln and Linn counties. The opportunity to link, through the criteria in the CCO RFA, will provide for better client experiences, coordinated care, better health through education and care management with a goal of lower costs over time.

While there is much detail to be resolved and work to be accomplished, The Corvallis Clinic looks forward to working with the IHN-CCO and participating in this transformational effort.

Sincerely,

Andrew M. Perry
Chief Executive Officer

KELLEY C. KAISER, MPH
2530 NW Windsor Pl.
Corvallis, OR 97330
(541) 757-6631 (h) ❖ (541) 768-5341 (w)

OBJECTIVE

To obtain a challenging position, which allows me to utilize my knowledge of HealthCare Administration focusing on leadership and operations

WORK EXPERIENCE

Samaritan Health Services ***April 2002 - Present***
Corvallis, Oregon
VICE-PRESIDENT HEALTH PLANS OPERATIONS

RESPONSIBILITIES INCLUDE: SERVE AS THE CHIEF EXECUTIVE OFFICER FOR SAMARITAN HEALTH PLANS AND INTERCOMMUNITY HEALTH PLANS AS DESCRIBED BLEOW.

Samaritan Health Plans ***January 2005 - Present***
Corvallis, Oregon
CHIEF EXECUTIVE OFFICER

RESPONSIBILITIES INCLUDE: LEADERSHIP POSITION FOR A HOSPITAL OWNED PHYSICIAN DRIVEN INSURANCE PLAN FOCUSING IN MEDICARE MANAGED CARE. RESPONSIBLE FOR THE DESIGN AND IMPLEMENTATION OF THE STRATEGIC PLAN WHICH INCLUDES: THE RESEARCH AND DEVELOPMENT OF NEW GROWTH OPPORTUNITIES, DEVELOPMENT AND MONITORING OF HEDIS MEASURES AS THEY RELATE TO NCQA STANDARDS, AND THE IMPLEMENTATION OF FURTHER EXPANSION TO ALL LINES OF BUSINESS. ADDITIONAL RESPONSIBILITIES INCLUDE COORDINATION WITH THE OWNER PHYSICIAN HOSPITAL ORGANIZATIONS (PHOS) TO INCREASE THE EFFECTIVENESS OF THE MANAGED CARE DELIVERY SYSTEM WITHIN OUR COMMUNITY.

InterCommunity Health Plans ***March 1999 - Present***
Corvallis, Oregon
CHIEF EXECUTIVE OFFICER

RESPONSIBILITIES INCLUDE: LEADERSHIP POSITION FOR A HOSPITAL OWNED PHYSICIAN DRIVEN MEDICAID MANAGED CARE PLAN. RESPONSIBLE FOR THE DESIGN AND IMPLEMENTATION OF THE STRATEGIC PLAN WHICH INCLUDES: THE RESEARCH AND DEVELOPMENT OF A MEDICARE PSO PLAN, DEVELOPMENT AND MONITORING OF HEDIS MEASURES AS THEY RELATE TO NCQA STANDARDS, AND THE IMPLEMENTATION OF FURTHER EXPANSION TO THE OREGON HEALTH PLAN. ADDITIONAL RESPONSIBILITIES INCLUDE COORDINATION WITH THE OWNER PHYSICIAN HOSPITAL ORGANIZATIONS (PHOS) TO INCREASE THE EFFECTIVENESS OF THE MANAGED CARE DELIVERY SYSTEM WITHIN OUR COMMUNITY.

InterCommunity Health Plans ***May 1998 – March 1999***
Corvallis, Oregon
CHIEF OPERATING OFFICER

RESPONSIBILITIES INCLUDE: THE OPERATION OF IHP AS IT ACCOMPLISHES ITS MISSION GOALS AND OBJECTIVES. RESPONSIBLE FOR THE OVERALL SUCCESS AND FUNCTION OF IHP, AND THE DAILY OPERATIONS THROUGH THE (1) PROPER AND TIMELY ADMINISTRATION OF POLICIES, PROCEDURES, AND BENEFITS, (2) SUPERVISION OF STAFF, (3) REPRESENTATION OF IHP TO THE STATE AND PROVIDERS AND (4) DEVELOPMENT OF PLANS TO MEET REGULATORY AND CONTRACTUAL COMPLIANCE FOR THE STATE OF OREGON AS THEY RELATE TO PROVIDER AND MEMBER SERVICES.

InterCommunity Health Network ***September 1995 - May 1998***
Corvallis, Oregon
GOVERNMENT PROGRAMS MANAGER

RESPONSIBILITIES INCLUDE: PERSONNEL AND DAILY OPERATIONS ENSURING THAT PROCEDURES AND BENEFITS ARE ADMINISTERED ON A TIMELY AND ACURATE BASIS. PROVIDER SERVICES, CONTRACTING, FINANCIAL AND STATISTICAL ANALYSIS, CLAIMS ADMINISTRATION ISSUES, AND GENERAL OPERATIONAL MANAGEMENT FUNCTIONS FOR PROVIDER AND MEMBER SERVICES.

Women's Care, PC ***June 1990 - September 1995***
Eugene, Oregon
ASSISTANT ADMINISTRATOR

ASSISTED IN OVERSEEING THE DAILY OPERATIONS OF THIS FOURTEEN-PHYSICIAN THREE COST CENTER PRACTICE.

RESPONSIBILITIES INCLUDE: ANALYSIS OF CPT CODES AND REIMBURSEMENT RATES, MAINTAINING MAL-PRACTICE AND GENERAL INSURANCE COVERAGE, AND SUPERVISION OF INTERNS. ASSISTED IN ALL ADMINISTRATIVE OPERATIONS OF THE CORPORATION INCLUDING, PAYROLL, EMPLOYEE BENEFIT PACKAGES, CORPORATE/PENSION PLAN RECORDS, AND GENERAL ACCOUNTING FUNCTIONS.

EDUCATION

Oregon State University ***Graduated June 1993***
Corvallis, Oregon
BACHELORS OF SCIENCE IN HEALTH CARE ADMINISTRATION

Oregon State University ***Graduated June 1999***
Corvallis, Oregon
MASTERS OF PUBLIC HEALTH IN HEALTH POLICY AND MANAGEMENT

COMMUNITY ACTIVITIES

OSU FEDERAL COMMUNITY CREDIT UNION – SUPERVISORY COMMITTEE SINCE 2009

ROTARY CLUB – MEMBER OF THE CORVALLIS ROTARY CLUB (CURRENT BOARD MEMBER) MEMBER SINCE 2005

CORVALLIS-BENTON CHAMBER COALITION – PAST BOARD CHAIR, MEMBER SINCE 2002 – MEMBER OF THE GOVERNMENT AFFAIRS COMMITTEE

OSU ALUMNI ASSOCIATION – ADVISORY COUNCIL MEMBER 2010 – CURRENT

2008 JUNIOR FIRST CITIZEN – CELEBRATE CORVALLIS

PROFESSIONAL ORGANIZATIONS/ASSOCIATIONS

AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES – ACTIVE MEMBER

AMERICAN ACADEMY OF MEDICAL ADMINISTRATORS – ACTIVE MEMBER

AMERICAS HEALTH INSURANCE PLANS MEMBER – ACTIVE MEMBER

MEDICAID ADVISORY COMMITTEE – OREGON, BOARD MEMBER (2001 – 2010) PAST CHAIR

CHAIR, OHP CONTRACTORS COMMITTEE (2001 – 2002)

VICE-CHAIR, OHP CONTRACTORS COMMITTEE (2000 – 2001)

RONALD S. STEVENS

1327 N.W. Souza Place
Corvallis, OR 97330
(541) 753-0996

EDUCATION:

Master of Business Administration, Accounting
University of Oregon
Graduated, December, 1978

Bachelor of Science, Agriculture
Oregon State University
Graduated, June, 1971

PROFESSIONAL:

Certified Public Accountant, Oregon
Fellow, Healthcare Financial Management Association
Certified Manager of Patient Accounts

EXPERIENCE:

Vice President Financial Services/Treasurer for Samaritan Health Services, Inc June 2003 to Present; Samaritan Health Plans Finance Officer August 2004 to Present; InterCommunity Health Plans Finance Officer February 1994 to Present; and Paradigm Indemnity Corporation Treasurer 1997 to Present.

Responsibilities: Financial operations of the health plans and captive insurance company; Direct the annual budget process, annual financial audit, and financial reporting systems; Direct the financial operations of the health plans, including monthly financial statements, estimation of claims IBNR, annual audit, and annual/quarterly filings to NAIC (National Association of Insurance Commissioners) and State of Oregon.

Vice President Financial Services/CFO, Samaritan Health Services, Inc. January 1998 to June 2003.

Vice President Financial Services/CFO, Good Samaritan Hospital, Corvallis, Oregon December, 1989 to June 2003.

Responsibilities: All aspects of the financial operations of the hospital including management authority for Accounting, Patient Accounts, Admitting, Information Systems, Medical Records, Materials Management, and Volunteer Services; Directed the annual budget process, annual financial audit, and financial reporting systems;

Completed the successful financing for the 1992 Revenue Bonds in the amount of $11.5 million and 1998 Revenue Bonds in the amount of $40 million, including a Standard & Poor's A Ratings utilizing the Hospital Facilities Authority of Benton County; Obtained approval to maintain interest rate subsidy and loan guarantee from Department of Health and Human Services on May 1, 1973 Hill-Burton loan.

Controller/Accounting Manager, Good Samaritan Hospital, Corvallis, Oregon
May, 1985 to November, 1989.

Responsibilities: The Accounting functions related to monthly financial statement reporting, budget preparation, annual financial reporting, Medicare cost report work-up, strategic financial planning, and tax return preparation; Supervised the functions of general ledger accounting, accounts payable, payroll, cost accounting, fixed assets, and financial analysis projects; Project Manager for selection and implementation of hospital information system modules for general ledger, payroll, accounts payable, admitting, medical records, patient accounts, and order entry.

Senior Accountant, Kohnen, Larson & Company CPAs, Corvallis, Oregon
January, 1979 to May, 1985

Responsibilities: Tax return preparation and review, monthly financial statement preparation, auditing and financial management consulting; Regional accounting firm responsible for performance of Good Samaritan Hospital audit until 1987.

COMMUNITY SERVICE:

Samaritan Village Board of Directors, June 2008 to January 2012.
OSU Federal Credit Union, Board of Directors, 1998 to present.
Rotary Club of Greater Corvallis, 1995 to 2000, Treasurer 96-97 & 97-98.
OSU Federal Credit Union, Supervisory Committee, 1995 to 1998.
United Way of Benton County, Board of Directors, 1989-1995.
Corvallis Boys & Girls Club, Board of Directors, 1982-1992.
Kiwanis Club of Corvallis, 1982-1985.
Corvallis Jaycees, 1979-1982, Treasurer 80-82.

Alissa P. Craft, DO, MBA
CURRICULUM VITAE

I. Personal Data

Name	Alissa Paula Craft
Address	Samaritan Health Plans 815 NW 9th Street, Suite 103 Corvallis, OR 97330
Phone	541-768-4889
Email	acraft@samhealth.org

II. Education

Master of Business Administration (MBA), 1999
University of Phoenix, San Diego, CA

Doctor of Osteopathic Medicine (DO), 1992
Kirksville College of Osteopathic Medicine,
Kirksville, MO

Bachelor of Science, Biology, 1987
Arizona State University, Tempe, AZ

III. Postgraduate Training

07/01/97-06/30/00	Fellowship, Neonatal-Perinatal Medicine University of California, San Diego San Diego, CA
07/01/96-03/31/97	Fellowship, Pediatric Intensive Care University of California, San Diego San Diego, CA
10/01/92-06/30/96	Internship and Residency Phoenix Children's Hospital/ Maricopa Medical Center Phoenix, AZ

IV. Professional Experience

2011-	Medical Director, Samaritan Health Plans Corvallis, OR
2009 – 2010	Director of Medical Education Samaritan Health Services, Corvallis, OR
2007 - 2008	Department Chair, Pediatrics Midwestern University Arizona College of Osteopathic Medicine

2006- 2007	Unit Director, Phoenix Children's Hospital Phoenix Perinatal Associates, Division of Neonatal Medicine
2005 - 2008	Associate Director, Department of Continuous Quality Improvement Pediatrix Medical Group Sunrise, FL
2002-2003	Children's Specialists – San Diego Division of Neonatal Medicine San Diego, CA
2000- 2002	Phoenix Perinatal Associates, Division of Neonatal Medicine Attending Neonatologist Phoenix, AZ

V. Certification

National Board of Osteopathic Medical Examiners
November 1, 1993
Certificate No. 21203

American Board of Pediatrics
October 11, 1995/ December 6, 2001
Certificate No. 055643

American Board of Pediatrics
SubBoard in Neonatal Perinatal Medicine
November 12, 2001/ March 2008
Certificate No. 003747

American Osteopathic Board of Pediatrics
June 2010

VI. Licensure

Arizona Board of Osteopathic Examiners in Medicine & Surgery
Date February 14, 1994
Certificate No. 2879

Osteopathic Medical Board of California
Date February 13, 1996
Certificate No. 20A6810
Inactive

Kansas Board of Healing Arts
Certificate No. 05-33188
Inactive

Oregon Medical Board
Certificate No. DO125776

VII. Honors and Awards

2011	Scholar in Residence American Association of Colleges of Osteopathic Medicine
2010 – 2011	AOA Health Policy Fellow
2007-2008	Costin Scholar Costin Faculty Development Program Midwestern University
2002-2003	Michael Allshouse Award Outstanding Teacher, Pediatric Residency Program Naval Medical Center San Diego
1992	F.M. Walter Living Tribute Award Kirksville College of Osteopathic Medicine
1992	Who's Who Among Colleges and Universities
1988-89	President's Scholar Award Kirksville College of Osteopathic Medicine
1988-92	US Navy Health Professions Scholarship

VIII. Professional Affiliations

American Academy of Pediatrics
American Osteopathic Association
Northwest Osteopathic Medical Foundation, Board Member
Old Mill Center for Children and Families, Board Member and Officer
Osteopathic Physicians and Surgeons of Oregon, Board Member
Phi Delta Epsilon International Medical Fraternity, Past President

IX. Invited Presentations

March 2011	Adverse Medication Events in the NICU TxANNP Conference San Antonio, TX
March 2011	Medical Errors, 10 Years After the IOM Report

Babysteps Conference
Pensacola, FL

April 2010 — Antibiotic Usage in the NICU
TxANNP Conference
Galveston, TX

March 2010 — Pharmacology for Neonatal Nurses
Babysteps Conference
Pensacola, FL

X. Academic Appointments

2009 - Associate Professor
Department of Pediatrics
Western University of Health Sciences

2007 - Clinical Assistant Professor
Department of Pediatrics
AZ College of Osteopathic Medicine

2002-2003 Clinical Instructor, Department of Pediatrics
University of California, San Diego

1998-2000 Clinical Instructor, Department of Pediatrics
University of California, San Diego

XI. Committee Memberships

2009 - Institutional Review Board
Samaritan Health Services
Chair, 2010 –

2005-2008 Institutional Review Board
Phoenix Children's Hospital

2004 Bioethics Committee
Banner Good Samaritan Regional Medical Center

1998-2000 Medical Risk Management Committee
University of California, San Diego

1994-96 Editorial Board
Pediatric Review, Phoenix Children's Hospital

XII. Bibliography

A. Original Reports

Craft A, Bhandari V, Finer N. The Sy-Fi Study. *Journal of Perinatology*, 2003; 23(1): 14-19.

Finer NN, Rich W, **Craft A**, Henderson C. Comparison of methods of bag and mask ventilation for neonatal resuscitation. *Resuscitation.* 2001; 49: 299-305.

Salerno CC, Pretorius DH, Hilton SW, O'Boyle MK, Hull AD, James GM, Riccabona M, Mannino F, **Craft A**, Nelson TR. Three dimensional ultrasonographic imaging of the neonatal brain in high risk neonates: preliminary study. *J Ultrasound Med.* 2000; 19: 549-55.

Finer NN, Vaucher Y, **Craft AP**, Clark R. Postnatal Steroids: Short Term Gain, Long Term Pain?. *J Pediatr* 2000; 137:9-13.

Craft AP, Ludwig D, Dudell G. Radiology Casebook: Gastric Perforation. *J Perinatol* 1999; 19 (3): 242-3.

Craft AP and Etzl M. Clinical Case: Cystic Lesions of the Lung. *Pediatric Review* 1995.

B. Reviews

Craft AP and Finer NN. Nosocomial CoNS Sepsis in Preterm Infants: Definition, Diagnosis, Prophylaxis, and Prevention. *J Perinatol.* 2001; 21: 186-92.

Coughlin C and **Craft A.** Hepatitis C- the silent epidemic. *J Emerg Med Serv.* 2000; 25: 114-29.

Craft AP, Finer NN, Barrington KJ. Vancomycin for prophylaxis against sepsis in the preterm neonate. *Cochrane Database of Systematic Reviews* 2000, Issue 1.

C. Book Chapters

Craft AP and Finer NN. Respiratory Distress Syndrome in Eds. Burg FD and Gershon A. Current Pediatric Therapy 17. 2002.

D. Abstracts

Craft AP and Bloom BT for PediQuIC (The Pediatrix Quality Improvement Collaborative). Improving Prophylactic Surfactant Administration in the NICU. Hot Topics in Neonatology 2004, Washington, DC.

Craft AP and Bloom BT for PediQuIC (The Pediatrix Quality Improvement Collaborative). Reducing Antibiotic Use in the NICU. The Improvement Opportunities? Hot Topics in Neonatology 2003, Washington, DC.

Craft AP, Bhandari V, Finer NN. The Sy-Fi Study. Society for Pediatric Research 2001, Baltimore, MD

Finer NN, Rich W, **Craft AP**, Henderson C. Comparisons of methods of bag and mask ventilation for neonatal resuscitation. Society for Pediatric Research 2001, Baltimore, MD.

Craft AP and Finer NN. A prospective analysis of premedication for endotracheal intubation in the NICU. Mead Johnson Nutritionals Western Perinatal Research Conference 2000, Palm Springs, CA.

Craft AP, Finer NN, Barrington KJ. The use of vancomycin for prophylaxis against sepsis in the preterm neonate. Hot Topics in Neonatology 1999, Washington DC.

Craft AP and Finer NN. Nosocomial sepsis in the neonatal intensive care unit: Are we speaking the same language? Hot Topics in Neonatology 1999, Washington DC.

Craft AP, Tellez D, Liu P and Bakerman P. Ketamine sedation in nonintubated children with severe asthma. Western Society for Pediatric Research 1999, Carmel, CA.

Craft AP, Barrington K, Henderson C, and Cochrane C. Bronchial lavage with KL4 surfactant: The value of PEEP in a model of MAS. Mead Johnson Nutritionals Western Perinatal Research Conference 1999, Palm Springs, CA.

Craft AP, Tellez D, Liu P and Bakerman P. Ketamine sedation in nonintubated children with severe asthma. Pediatric Critical Care Colloquium 1995, Sea Island, GA.

Robert J. Power

3850 SW Fairhaven Dr, Corvallis, OR 97333 541-768-4403 RPower@samhealth.org

Healthcare Chief Information Officer - expert in the delivery of technology required to support rapid and effective clinical and business decision making in the expanding healthcare environment. Skilled in all aspects of project management and delivery, from initial discovery and systems analysis to product implementation and enhancement to legacy management. Effective at identifying and nurturing IT talent, building strong, results-oriented teams needed to deliver quality driven care within a multi-facility organization. Key qualifications include:

- Strategic and Operational Planning
- HIPAA Privacy and Security Management
- JCAHO Patient Safety and Quality Planning
- Enterprise and community EMR/EHR delivery
- Physician Relations Management
- Healthcare IT Design and Implementation
- Integrated Delivery Systems Operations
- Emerging Technologies and Architectural Delivery Systems

PROFESSIONAL EXPERIENCE

Samaritan Health Services (SHS), Corvallis, OR
SHS – SHS operates five hospitals and 70 clinics located throughout Linn, Benton and Lincoln counties. The not-for-profit system employs approximately 5000 personnel.

Chief Information Officer – Samaritan Health Services (2010 to present)
Responsible for IT tactical operations, strategic planning, resource management, budgeting, and project management at SHS. Highlights:

- Oversight of 13 direct reports and 117 IT and Project Management employees.
- Managing the organization's strategy for meeting the objectives of meaningful use of clinical systems set forth in the American Recovery and Reinvestment ACT (ARRA) and HITECH.
- Activation of a Clinical Transformation Team to prepare the organization for implementation of advance clinical decision making tools utilizing evidenced-based medicine.
- Participation in state-wide initiatives related to Rural Tele-health TAO and OHN and Health Information Technology Oversight Council (HITOC).

HCA – Hospital Corporation of America, Nashville, TN 1995 to 2010
HCA – The Hospital Corporation of America operates 168 hospitals and approximately 119 freestanding surgery centers in 20 states and London, England. The for-profit, privately owned corporation has approximately 178,000 personnel across the enterprise. The organization is divided into thirteen regional Divisions reporting into a corporate operation in Nashville, Tennessee. I am currently the Chief Information Officer for the HCA - Continental Division, which has operations in Denver, CO, Oklahoma City, OK, and Wichita, KS.

Chief Information Officer – Continental Division (2005 to 2010)
Responsible for IT tactical operations, strategic planning, resource management, budgeting, and project management for HCA's Continental Division, a ten hospital, 13,000+ employee system within HCA. The division includes HealthONE, a seven hospital Joint Venture in Denver, CO, Oklahoma University Medical Center, a separate Joint Venture with the State of Oklahoma, as well as two wholly owned HCA facilities in Kansas and Oklahoma. Reporting to the Division CEO and CFO, manages 18 direct reports and 127 indirect report IT professionals in 11 locations in 3 states. Highlights include:

- Partnered with division leadership and the HealthONE Board of Directors to secure $23 million in funding to implement a technology refresh program to upgrade facilities infrastructure to

accommodate new advances in technology, including wireless infrastructure, guest networking for Internet access for physicians and families, delivery of PACS images to all care locations, and equipment upgrades to replace aging technology.

- Successful enterprise-wide implementation of T-EV Emergency Department Information System, including automation of clinician documentation and integration to Meditech patient care system. The consolidated enterprise model effectively eliminating $700,000 in equipment and maintenance costs incurred in the initial facility-based model.
- Drove implementation of GE Radiology and CV PACS in hub and spoke design for HCA's Oklahoma hospitals. The hub and spoke design allowed for true offsite disaster recovery/business continuity while minimizing cost.
- Participated in company-wide Ambulatory EMR selection process, including clinician surveying, RFP creation, vendor product review, and contract negotiations.
- Advisory participant of Colorado Regional Health Information Organization (CORHIO), including governance committee created to steer movement from volunteer organization into 501(c)(3) development, and initial seating of the first Board of Directors.
- Initiated HealthONE Executive IT Steering Committee to drive strategic Health Information Technology decisions.
- Facilitated team of HIM Directors and records managers to design and build a centralized, 90,000 square foot records center located in Stapleton Business Park – Denver. Operation includes records management and release of information (ROI).
- Oversight of Centralized Physician Order Entry in three hospitals within the organization.
- Directed testing and implementation of Meditech Patient Care Systems version upgrades within the organization.
- Implemented Telemedicine technology for remote stroke care program.
- Leveraged EMC storage technology to save $2.6 million in potential costs related to growth by creating an enterprise-wide storage solution, successfully reducing the cost of individual hospital storage.

Project Manager – HCA Regional Patient Account Services (2004 -2005)
Responsible for analysis, timeline development, task assignment and overall project plan for all projects at HCA's Consolidated Patient Account Services in Denver. Responsible for concurrent management and implementation of all back-office projects, including:

- Design and implementation of Centralized patient scheduling,
- Implementation of ABN/LMRP software,
- Sarbanes-Oxley policy and procedure development.
- Research and preparation of business case development for Patient Account Services strategic directives.
- Drove business plan development for converting HealthONE Legacy A/R systems to HCA's current billing and A/R systems.

Market Director of Information Technology HealthONE/HCA (1996 – 2004)
Directed IT operations within HealthONE facilities including Patient Accounting, Supply Chain, and acted as liaison to the Denver market for all HCA corporate initiated IT projects. Highlights include:

- Effectively reduced the IT operational budget by $1.2 million by consolidating redundant services, implementing strong software license management processes, and implementing key technology used for remote desktop troubleshooting.
- Implemented SSL/VPN solution and Metropolitan Area Network (MAN) to connect all HealthONE hospitals to successfully share information and imaging data, and to implement enterprise-wide software solutions.
- Provide guidance for centralized technical staff, business analysts and facility-based IT employees to ensure optimal employee performance and personal growth.
- As part of the newly formed HealthONE – HCA Joint Venture partnership, successfully implemented the Meditech Patient Care System and transitioned from HealthONE's legacy systems. Transition responsibilities included data center closure, elimination of legacy systems,

termination and transition of programming staff, negotiation of vendor shutdown contracts and removal of legacy mainframe equipment.

HealthONE Hospitals,
dba: American Medical International. A for-profit healthcare system 1980 to 1996
dba: P/SL HealthCare System, a Denver-based, not-for-profit system.

Various positions - Increasingly advanced positions within the organization, including:

- **Market Business Analyst** (1990 to 1996)
  Provided strong business analysis, design, testing, training and implementation of McKesson's suite of mainframe patient care products with an emphasis on registration and billing. Directed team that designed and performed data conversion of legacy systems as additional healthcare facilities were acquired.

Information Systems Instructor (1985 to 1990)

- Delivered centralized standardized training and education in a three-hospital system. Effectively increasing productivity in new employees by creating easily understood coursework that was used to train users as new technology was deployed or new employees joined the organization.

- **Patient Access Manager** (1980 to 1985)
  Hired as an entry-level combination mailroom/patient access role, mastered all aspects of patient access and within three years became the manager, overseeing all aspects of In-patient, Outpatient and ED registration at Presbyterian/St. Luke's Medical Center.

Education

Bachelor of Science, Business Management, summa cum laude Regis Jesuit College Denver, CO

Kim R. Whitley

3530 NW Mariposa
Albany, OR 97321

Mobile: 541-913-5950
kwhitley@samhealth.org

STRATEGIC MANAGEMENT EXECUTIVE
Cross-Functional Experience & Cross-Industry Expertise

My healthcare interests include prevention services, provider reimbursement models, regulatory compliance, healthcare EDI, and seeking solutions to the rising cost of healthcare. I have managed a variety of healthcare functions and developed and implemented several programs in various healthcare related fields. My unique experience allows me the opportunity to present on topics of cost containment, integrated healthcare management, EDI and various health access, insurance and administration issues.

- Budget /Expense Planning/Control & Margin Improvement
- Product Commercialization & Expansion Strategies
- Competitive Bidding Processes
- Contract Negotiations
- Quality Assurance
- Regulatory Compliance
- Sales & Marketing
- Business Development/Opportunity Identification
- Corporate Restructuring & Performance Enhancement
- Leading with a clear vision

Professional Experience

Samaritan Health Services, Corvallis, OR **3/01 - present**

CHIEF OPERATING OFFICER – SAMARITAN HEALTH PLAN OPERATIONS (8/05 – PRESENT)
DIRECTOR OF OPERATIONS – (2/03-8/05)
OPERATIONS MANAGER – (3/01 – 2/03)

Currently direct all operations for multiple lines of business within three corporations. Provide leadership for a 100+ person workforce and hold P & L responsibility. Oversee financial processes, all functional areas including: claims production, customer service, sales, business development, revenue enhancement, accounts receivable, professional development and health information management to maintain the provision of healthcare services for 40,000 + and over $150,000,000 in annual revenue.

Selected Results:

- Over the past five years successfully developed and implemented procedures to standardize processes for managed care organization enabling it to grow successfully. Elevated standards of quality by establishing procedures for quality assurance and continuity of services.
- Initiated and facilitated the successful implementation of a business intelligence solution to leverage information assets to allowing the organization to make high-value decisions for faster revenue growth, reduction of operational expense and delivery of a sustainable competitive advantage.
- Strategically planned and initiated the introduction of new lines of business to stabilize the healthcare delivery system while simultaneously managing and directing the operations of current Third Party Administrator and risk contracts including Medicaid and Medicare.

- Developed "Balanced Scorecard" corporate culture that has lead to strategic approach to annual goals resulting in greater collective understanding of vision and greater ability to make well informed business decisions at all levels of the organization.
- Implemented consistently successful strategic marketing plans to meet and exceed budget.
- Strategically negotiated financially beneficial contracts and successfully managed oversight of all outsourcing.
- Demonstrated profitability improvement through financial analysis, strategic planning and financial compliance within NAIC, DCBS, ERISA, DMAP and CMS rules and regulations.

Pointshare, Portland, OR/Bellevue WA

TECHNICAL ACCOUNT MANAGER 1/00 – 03/01

- Analyzed market and identified opportunities.
- Sold IT solutions to physician practices and hospitals
- Assessed customers' ongoing needs, suggested solutions, and managed contract negotiations.
- Analyzed, planned, implemented products, including budget, scope, resource allocation, and deadlines.
- Resolved customer product complaints of a technical nature, which required cross-department communication and negotiations to facilitate a solution.
- Organized and assessed Customer Feedback Sessions.

First Resort Clinic, San Leandro, CA

MARKETING/DEVELOPMENT ASSOCIATE 8/98 – 1/00

- Developed direct marketing strategies and fiscal marketing plan.
- Managed and organized marketing projects and events.
- Created, developed and edited all collateral materials.
- Wrote all grants and proposals.
- Cultivated relationships with major donors.
- Database management and integrity.
- Assisted with IT issues.

Catholic Charities, Pullman WA

CASE MANAGER 8/96-7/98

- Managed satellite agency.
- Developed programs and written guidelines
- Marketed services to target population and positioned organization to outside agencies.
- Organized, managed and evaluated volunteers.

Beverly Corporation, Payette Lakes Care Center, McCall, ID

DIRECTOR OF SOCIAL SERVICES, ADMISSIONS AND ACTIVITIES 5/94 - 8/95

- Managed personnel, budget and activities of three departments.
- Assured the adherence of staff to State/Federal rules and regulations.
- Developed programs and written guidelines.
- Directed all marketing and sales efforts including editing monthly newsletters, the development of collateral, grants and written proposals.

Council Hospital, Council ID

CONSULTANT **(simultaneously with Payette Lakes)** 10/94 - 8/95

- Brought the hospital "in line" with State/Federal rules and regulations.
- Developed quality assurance protocol and programs to improve quality.

Education

Master of Public Administration (MPA)
University of Idaho, Moscow ID
Bachelor of Science, Biology (BS)
Gonzaga University, Spokane WA
Bachelor of Arts, Psychology (BA)
Gonzaga University, Spokane WA

Professional Affiliations

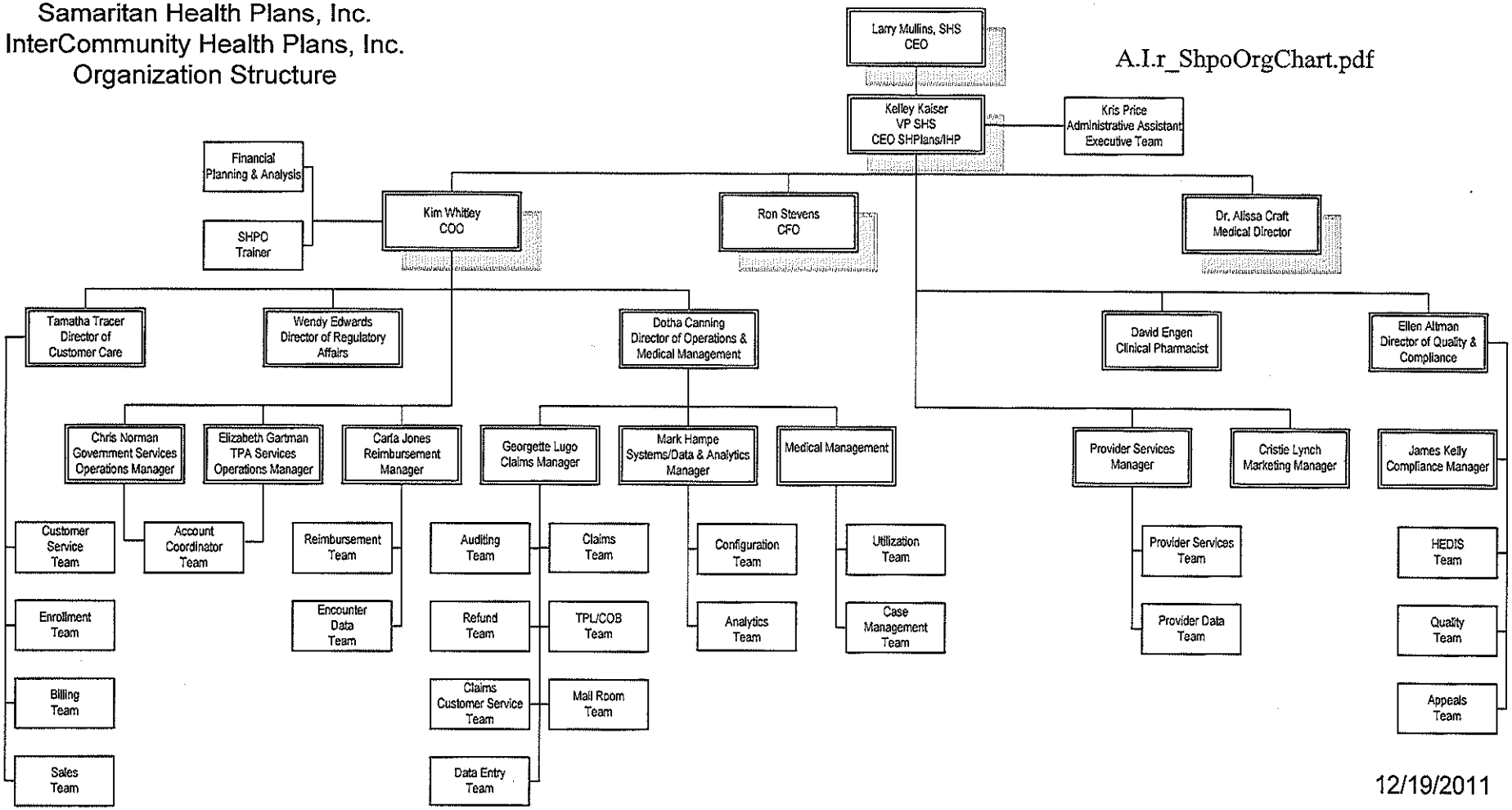
AHIP, America's Health Insurance Plans
Advisory Board Member

Outside Activities

Volunteer: Community Outreach, Inc.
Vice Chair, Albany Human Relations Commission

Samaritan Health Plans, Inc.
InterCommunity Health Plans, Inc.
Organization Structure

A.I.r_ShpoOrgChart.pdf



12/19/2011

IHN-CCO

RFA Attachment

Response to Appendix B

Section 1- Service Area Capacity

Service Area Capacity Table

Service Area Description	Zip Codes	Maximum Number of Members – Capacity Level
Linn	97389, 97374, 97329, 97358, 97386, 97377, 97322, 97327, 97336, 97360, 97446, 97335, 97355, 97345, 97321, 97348	Unlimited
Benton	97370, 97339, 97324, 97326, 97456, 97330, 97331, 97333	Unlimited
Lincoln	97368, 97380, 97367, 97388. 97394, 97391, 97390, 97364, 97343, 97357, 97498, 97366, 97365, 97376, 97341, 97369	Unlimited

IHN-CCO

APPENDIX A- CCO Criteria Questionnaire

A.I. Background Information

a. InterCommunity Health Plans (IHP) dba InterCommunity Health Network Coordinated Care Organization (IHN-CCO), health care contractor. Domiciled in the State of Oregon. IHP is a public benefit corporation organized and operated exclusively for charitable and educational purposes and functions as a 501(c)(4) under the IRS.

b. IHN-CCO is currently made up of the following Affiliates and sponsoring organizations relevant to the contract:

Samaritan Health Plans, Samaritan Health Services, InterCommunity Health Plans, Benton County public health, mental health and addiction services, Lincoln County public health, mental health and addiction services, Linn County public health, mental health and addiction services, Accountable Behavioral Health Alliance, Mid Valley Behavioral Care Network, Oregon Cascades West Council of Governments, Capitol Dental Care, The Corvallis Clinic, Quality Care Associates, Samaritan Mental Health, Federally Qualified Health Centers in Benton, Lincoln and Linn county.

c. August 1, 2012

d. No

e. No

f. Benton: 97370, 97339, 97324, 97326, 97456, 97330, 97331, 97333

Lincoln: 97368, 97380, 97367, 97388. 97394, 97391, 97390, 97364, 97343, 97357, 97498, 97366, 97365, 97376, 97341, 97369

Linn: 97389, 97374, 97329, 97358, 97386, 97377, 97322, 97327, 97336, 97360, 97446, 97335, 97355, 97345, 97321, 97348

g. 815 NW 9th Street, Suite 103 Corvallis, OR 97330

h. Benton, Lincoln and Linn counties, Oregon. Association of Oregon Counties has developed language for inclusion in Memoranda of Understanding and a county commissioner or delegate from each county has been added to the Governance Board of the CCO. Additional information is available upon request at readiness review.

i. IHN-CCO currently includes three MCOs with OHA contracts:

Fully Capitated Health Plan (FCHP): InterCommunity Health Plans dba InterCommunity Health Network is currently contracted as a FCHP in Benton, Lincoln, Linn and Tillamook counties with the State of Oregon and has served Medicaid clients since the 1994.

Mental Health Organizations (MHOs): Accountable Behavioral Health Alliance (ABHA) and Mid Valley Behavioral Care Network (MVBCN). ABHA is currently contracted as a MHO in Benton and Lincoln counties with the State of Oregon and has also served Medicaid clients since 1997. MVBCN is currently contracted as a MHO in Linn, Marion, Polk, Tillamook and Yamhill counties with the State of Oregon and has served Medicaid clients since 1997.

j. Yes, the identical organization is currently with a MCO, InterCommunity Health Plans. InterCommunity Health Plans dba InterCommunity Health Network is the current Fully Capitated Health Plan. InterCommunity Health Plans dba InterCommunity Health Network-Coordinated Care Organization (IHN-CCO) is the legal entity status of the newly formed Coordinated Care Organization.

k. See A.I.i, above.

l. With the exception of the FCHP contract currently in Tillamook county and the MVBCN contracts outside the IHN-CCO service area of Benton, Lincoln and Linn counties, IHN-CCO expects the FCHP and MHO contracts to be terminated immediately before the effective date of the CCO Contract, August 1, 2012.

m. In 1993 InterCommunity Health Network (IHN) was founded. IHN became InterCommunity Health Plan (IHP) in 1998, for the express purpose of accommodating a state law requiring health plans to identify themselves as such in their corporate names. In 2000 SHS received a Third Party Administrators (TPA) license and at the same time began to self-fund Samaritan Choice for its own employees and their dependents. In 2000 SHS took on the administration of the self funded benefits for the Siletz tribe in Lincoln county. In 2004 Samaritan Health Services applied for a Certificate of Authority to be licensed as a full risk state health insurer under the corporate name Samaritan Health Plans. Samaritan Health Plans, Inc. (SHPlans) is an Oregon private non-profit taxable corporation doing business as Samaritan Advantage Health Plan and licensed with a Certificate of Authority under the Department of Consumer and Business Service through the State of Oregon. In 2005 Samaritan Health Plans went live with Samaritan Advantage Health Plan and in 2006 SHPlans contracted with the State of Oregon Public Employees' Benefits Board (PEBB) to administer their self-funded benefits in our service area. In October of 2009, IHP expanded into Lincoln and Tillamook counties. In October 2009, Samaritan Health Plans was awarded a contract to manage the Healthy KidsConnect program. Intercommunity Health Plans and Samaritan Health Plans purchase services

from Samaritan Health Services, including staffing resources. The operational functions that oversee these services are called Samaritan Health Plan Operations.

Both MHOS have Adult Mental Health Initiative contracts which will continue for the three counties, and MVBCN has an SCF SE 26 contract for each psychosis intervention services (EASA) in Linn County which will continue.

n. Samaritan Health Plans maintains a Medicare Advantage contract with the Center for Medicare and Medicaid Services (CMS) for Benton, Lincoln and Linn counties, Oregon. This contract has been in effect since 2005 and includes contracting with Medicare as a Special Needs Plans currently in Benton and Linn counties, with federal approval to expand into Lincoln county effective January 1, 2013.

o. InterCommunity Health Plans is currently a health care contractor and not a licensed insurer. Our affiliate, Samaritan Health Plans, is licensed as a health care services contractor with the Oregon Insurance Division.

p. (1) IHN-CCO is currently analyzing all historical and current processes developed as a FCHP and MHO in addition to newer approaches such as bundled payments and payments based on particular quality indicators. We have upgraded our core IT system in order to accommodate any of the above alternative payment methodologies and are collaborating with our affiliates and sponsors to develop a timeline for implementation of the alternative payment methodologies once agreed upon. Additional information is available upon request at readiness review.

(2) IHN-CCO, building upon its historical proven ability to deliver these services as independent entities, is developing a coordinated delivery approach of physical health, mental health and chemical dependency services, oral health care and covered DHS Medicaid –funded LTC services through our collaborative Board, regional planning group, work groups and sub work groups to implement and operate all aspects of HB 3650, SB 1580 and the CCO RFA requirements. Additional information is available upon request at readiness review.

(3) IHN-CCO has a long history of experience engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the Medicaid enrollees and the community. When added together the FCHP and MHOs have over 45 years of experience working to improve the health of the most vulnerable individuals in the areas we have served. Additionally, we plan to expand and improve this approach through a unified analysis of county health status reports and survey tools as they are implemented in Benton, Lincoln and Linn counties. For example, see attachment A.I.p(3)_LinnCountyCAP.pdf. Additional information is available upon request at readiness review.

q. See attachments A.I.q_CEO_Resume.pdf, A.I.q_CFO_Resume.pdf, A.I.q_CMO_Resume.pdf, A.I.q_CIO_Refume.pdf and A.I.q_COO_Resume.pdf, respectively.

r. See attachment A.I.r_ShpoOrgChart.pdf.

s. No

A.II. Community Engagement in Development of Application

IHN-CCO is made up of Samaritan Health Services and Intercommunity Health Network leaders, Linn, Benton, and Lincoln County Public and Behavioral Health leaders, Accountable Behavioral Health Alliance and Mid-Valley Behavioral Care Network leaders, Cascades West Council of Governments leaders, Federally Qualified Health Centers in Benton, Lincoln and Linn counties, The Corvallis Clinic and Quality Care Associates leadership, physical health providers and local government leadership. The CCO will be drawing on expertise from a variety of groups around the region, including but not limited to Senior Services Advisory Council and Disability Services Advisory Council.

The Linn, Benton, Lincoln Coordinated Care Organization Regional Planning Group has been meeting since February 2011 and is committed to improving the health of our communities by coordinating health initiatives, seeking efficiencies through blending services and infrastructure, and engaging all stakeholders in a regional effort to steer local health services and systems toward meeting the Triple Aim of improving health; increasing quality, reliability, and availability of care; and lowering or containing the cost of care. Public agency and government representatives have come together with private healthcare leadership to unify our voice and action in this endeavor.

Representatives from the Regional Planning group have participated in six community forums, two in each county that we serve. The first series was in November 2011 and the second series of community forums was in March 2012. The goal of the forums was to share with the community the progress being made on developing a CCO and receive feedback from the community on what is important to them. All six of these meetings were well attended from community members.

The IHN-CCO has workgroup and a structure that feed into the application development, implementation and operations of the IHN-CCO as we get closer to the "go-live" date of August 1, 2012. The workgroups include members from all affiliate groups and stakeholders of the IHN-CCO as stated in A.I.b, above. Communication/Community Advisory Committee, Delivery Systems Transformation, Business Operations and Quality Affairs/Quality Improvement are workgroups of the IHN-CCO. There are sub-workgroups to the Delivery Systems Transformation: Patient Centered Medical Home, Data Analysis and Care Coordination work groups. There are also sub-workgroups to the Business Operations: County/State/Federal funding, Infrastructure and Information Technology. See Attachment A.II_IHN-CCO_Workgroup.pdf. Additional information is available upon request at readiness review.

Section 1- Governance and Organizational Relationships

A.1.1 Governance

a. In accordance with an April 11, 2012 resolution of the Board of Directors for InterCommunity Health Plans, Inc, the Governing Board composition of the IHN-CCO will comply with ORS 414.625(1)(o) to constitute a Coordinated Care Organization. This resolution includes adding, for example, Board members from each county included in the IHN-CCO (Benton, Lincoln and Linn), and one member representing the Community Advisory Council. This action requires approval by the Corporate member, Samaritan Health Services, at their next meeting in May 2012. Nominated and accepted nominations at the April 11, 2012 meeting include adding the following members:

Jay Dixon, Benton County Commissioner

Bill Hall, Lincoln County Commissioner

Linn County Commissioner or delegate

Dr. Mike May, SHS VP of Mental Health Services

To the current roster of the Governing Board:

Gil Beck, Community member and SHS Board member

Doug Boysen, SHS legal council

Bruce Madsen, Community physician

Mike Maksud, Community member

William McCarthy, Community member and SHS Board member

Doris Mimnaugh, Community member

Larry Mullins, SHS CEO and President

Jared Nelson MD, Community physician

William Rauch, Community member

Esther Schwartz, Community member

David Triebes, SHS Hospital CEO in Linn County

Linn County will provide nominations for the Governing Board to consider at their next meeting. The Community Advisory Council member will be nominated in accordance with A.1.1.b, below. Additional information is available upon request at readiness review.

b. See attachment A.1.1.b_CACAttachment.pdf

The IHN-CCO for Linn, Benton, and Lincoln counties charged a workgroup with the task of designing a Community Advisory Council (CAC) structure that would support significant community and customer involvement and input into the development and on-going operation of the CCO. The workgroup was tasked with ensuring the CAC would have the infrastructure necessary to meet the deliverables for CACs outlined in the CCO implementation plan and Oregon State law.

The workgroup has already defined a number of key attributes and principles that the CAC structure will address. The CAC will:

- help to empower consumers
- be reflective of member and community demographics
- be rewarding and enriching for CAC appointees
- be scale-able to include other consumers (e.g. private insurers) and areas of expertise as the mandates and areas of responsibility for the CCO and our region's vision for health care transformation evolve
- draw on existing advisory councils'/committees' and boards' expertise and membership
- reflect the diversity of need and experience that exists throughout the region (e.g. access to services is a more significant issue in rural areas than in the larger communities) and also recognize common concerns and needs
- be supported by local committee(s) within each county of the CCO so that CAC members have a "home" group more representative of local health issues and to allow for greater depth of representation and expertise that can feed information and input to CAC membership and the CCO
- consider establishing task-oriented groups as needed to explore local health issues and support the CCO in addressing them
- consider strategic memberships – full set of skills CAC needs and individuals that might bring those, including individuals that may enhance the credibility of the CAC (e.g. medical professionals)

In addition the workgroup identified a number of operational considerations for the CAC and supporting county level groups:

- The Council needs to meet in all counties
- Consider that using mileage reimbursement, stipends, technology, etc. to support and facilitate engagement of all – barriers will be different for different folks and areas of the region

- Support and resources for the CAC are essential. Clear expectations must be established for CAC members, including training on role; participation expectations; and duration of appointments
- We must remain realistic regarding how much the CAC can do as a mostly volunteer organization
- Specific localized issues should not be lost by rolling them up into a generic regional plan
- The CAC should follow public meeting laws/guidelines for both meetings and records

In consideration of these elements the workgroup has recommended the following structure to best serve the CCO region:

1. The "formal" IHN-CCO regional CAC is a council of 19 members.

2. The CAC members for the formal regional CAC will be appointed by a CCO Selection Committee comprised of staff and IHN CCO representatives who will ensure all three counties, physical health, mental health, long term care services and individuals are equally represented.

3. The Selection Committee will review nominations from each of the three counties to assure broad representation. It is expected that each county will have at least 6 nominees and, if a balanced representation is in question, will identify gaps and request a county to forward additional recommendations in any one of the following areas: physical health, mental health, long term care services.

4. It is expected 6 to 10 CAC member recommendations will come from each of the three counties – Linn, Benton, and Lincoln along with suggested recommendations for filling the 19th seat. The County Boards of Commissioners for each county will be highly involved in making the selection of the 6-10 individuals to be recommended for nomination from each county. The 6-10 individuals recommended must fall into the following general categories:

    - 1 county government representative (elected, appointed, or employee)
    - 5-9 other representatives of which at least a majority are OHP members

    In making the recommendations for appointment, each Board of Commissioners will take into consideration the following categories of experience that the CAC membership could benefit from. After selections are made, the County Boards and IHN will discuss the candidates and may adjust their selections to promote the best representation across these categories – experience can be through working in the field or significant life experience in the area:

OHP Members	Cultural/Demographic
Rural/Urban	Seniors

Transportation	Persons with Disabilities
Major Business	Children/Families
Public Health	Behavioral Health (Mental Health & Addictions)
Primary Care	Long-Term Care
Dental Care	Data/Fiscal/Health Insurance
County Health Advisory Boards	Established Health Care Advocacy Groups
Caregivers	Wellness and Prevention

5. Counties will maintain a pool of alternate committee nominees so that they are able to present additional choices to the selection groups as needed.

6. Each County will identify a committee structure to work in concert with the CAC at the local level and to support their appointed CAC membership. These local committee structures are intended to provide depth of representation and involvement with a focus on local health issues so as to further enhance the resources and effectiveness of the CAC.

7. Pending state funding the CCO will evaluate resources and supports related to the CAC.

8. The chair of the CAC will be elected from the appointed membership and will also serve as a member of the CCO Governing Board.

9. There will be 3 vice-chairs of the committee, 1 from each of the 3 CCO counties. These vice-chairs will each be selected by the council members from their own county.

Tasks:

1. A common application form will be developed to be used across the CCO region for individuals to apply for consideration as a CAC member. Initial recruitment for OHP member representation on the CAC will include direct communications sent to each current IHN-CCO member to ensure equal opportunity for involvement. Ongoing recruitment announcements for the CAC will be included in the IHN-CCO member handbook and website. Recruitment will also include strategies such as newspaper announcements, information in newsletters, announcements and word of mouth at existing advisory group/health advocacy group meetings, community CCO meetings and coalitions, etc. to assure broad, representative participation.

2. The goal is to have initial members appointed by no later than August 1, 2012.

3. Initial appointments to the CAC will be for 1 year only. This first year of the CAC will be considered a formative year and the council will be responsible for creating bylaws for the council that address terms of members and council decision-making processes. Additional information is available upon request at readiness review.

c. See A.1.1.b, above. Additional information is available upon request at readiness review.

d. Both MHOs folding into the IHN CCO have vast experience and multiple community and peer advisory committees they support and with which they are involved. The MHOs will work with current members to recommend strategies and members and provide best practice experience to help design CAC for success. Additional information is available upon request at readiness review.

A.1.2 Clinical Advisory Panel

a. IHN-CCO will modify its current Physician Advisory Panel within its historical FCHP to meet this requirement. The current FCHP Physician Advisory Panel provides assistance in developing the most comprehensive resource for clinical plan management and assuring best practices. The panel is comprised of physicians and health specialists from around the service area and may include our affiliates listed in A.I.b. In general, their role is to support our mission of delivering better health, at the appropriate time and the lowest cost. The panel provides oversight for health information and clinical guidelines and serves as spokespersons to educate and advocate the health care community and public about our services. This team monitors peer-reviewed medical journals to ensure research supported systems and practices are integrated into the care management model. This team will be evaluated and modified going forward to ensure appropriate representation of the additional mental health, dental and long term care needs of the members the IHN-CCO will be covering. Additional information is available upon request at readiness review.

b. IHN-CCO intends to establish a CAP. Additional information is available upon request at readiness review.

A.1.3 Agreements with Type B Area Agencies on Aging and DHA local offices for APD

a. We are currently developing an MOU with the Area Agencies on Aging (AAA) following the draft guidance from DHS/OHA. This is under review and discussions will begin about how to execute the MOU effectively in April and May, 2012. The CCO and the AAA will examine the draft together and use it to develop an MOU by July, 2012. Additional information is available upon request at readiness review.

b. We have already begun joint meetings between the CCO and the AAA; there will continue to be discussions related to the key issues identified in the draft MOU. Discussions will focus on the system coordination and collaboration issues that can be addressed in the first year of the CCO as a contracted entity with OHA. Activities and agreements will focus on realistic opportunities for collaboration for both parties based on best practices and within available funding to make systemic improvements for patients. Additional information is available upon request at readiness review.

A.1.4 Agreements with Local Mental Health Authorities and Community Mental Health Programs

IHN-CCO's intent in answering questions in this section is to take the best of all programs across the region and expand them region wide. Due to the page limitation, examples provided in specific answers may only describe the service in one county by specific provider types as an illustration of the good work going on where it is most developed.

a. InterCommunity Health Network and Benton, Lincoln and Linn counties are in the process of developing a Memo of Understanding to provide comprehensive and coordinated behavioral health services for Linn County. Medicaid mental health services are currently sub-capitated to the Linn County Department of Health Services, Mental Health Services (LCMHS), through the Mid-Valley Behavioral Heath Care Network (MVBCN). The MOU will allow these services to continue for the next year under the global budget, as the CCO infrastructure is established. In addition to Medicaid services, the Linn County Department of Health Services provides services that are not going to be under the Medicaid global budget. These services include the following:

Mental Health	Alcohol and Drug
Civil commitment PSRB Crisis Services (Emergency room diversion, crisis intervention, law enforcement liaison) Non-Medicaid services for child and adults with severe mental illness. Supported Housing School base Mental Health Parenting classes Transportation	Non-Medicaid services for children and adults Drug-free housing rent assistance and housing case management. Outreach, screening, recovery coaching and case management to Child Welfare parents and TANF recipients HIV testing A&D Prevention Problem gambling treatment and prevention School based A&D Parenting Classes Transportation

The above services will continue to be provided by LCDHS as they move into the new IHN CCO. Care coordination and integrated behavioral health (MH and A&D)/ physical health care will be ensured under the new CCO by organizing an integrated service delivery system under the four quadrant integration model. Under this model, patients with low behavioral health (depression, anxiety, PTSD, A&D / high physical health problems would be served in the person centered medical home (PCMH), who would employ a behavioral health specialist to provide screenings for substance abuse,

depression, anxiety, PTSD and psychosis. The PCMH behavioral health specialist would provide brief therapy and referral to specialty mental health and A&D treatment.

b. IHN-CCO will take a leadership role to facilitate and coordinate transitions from extended or long-term care. This coordination will include participation in IDT (treatment team) meetings with state hospital staff and will include utilization review and management. The applicant will approve, organize and distribute clinical packets to potential community mental health programs and residential providers. Currently a five day goal is challenging because: packets are not provided on the same day as an individual is determined ready to transition. Once packets are distributed it can take up to two weeks for the Applicant, CMHP's and residential providers to review and interview perspective individuals. Because of individual choice and lack of available licensed care openings, transitions can take weeks to occur. The IHN-CCO will develop strategies to strive for the ultimate goal of streamlining this process and work towards a five business day goal for transition. In an effort to ensure as timely a transition as possible, the IHN-CCO will authorize, review and distribute clinical packets within 72 hours to perspective CMHP's and residential providers to facilitate transitions. AMH's Co-management policy will be in effect to be an incentive to IHN-CCO and the county of responsibility to ensure transitions is prioritized. Additional information is available upon request at readiness review.

c. For a member with high needs that rise to the level where they impact the broader community including Community Emergency Service Agencies, a team process will be initiated in which the client's needs and community response can be directed. The County Crisis Team may be the initial responder to begin the process of intervention and develop a plan of response. The County Crisis team will coordinate with the local LMHAs and CMHPs to continue services as necessary. A determination as to ISA eligibility will be made by the CMHP's as part of the response plan for Children and Adolescents. Additional information is available upon request at readiness review.

A.1.5. Social and support services in the service area

IHN-CCO's intent in answering questions in this section is to take the best of all programs across the region and expand them region wide. Due to the page limitation, examples provided in specific answers may only describe the service in one county by specific provider types as an illustration of the good work going on where it is most developed.

a. IHN-CCO is responsible for coordinating care related to the needs of our members. For adults members, each of the CMHP programs have an identified exceptional needs care coordinators for the members who have severe and persistent mental health issues (AMHI) population. The ENCC's have a primary responsibility of advocating for and

assisting members to maintain successfully in the community. Part of the coordination extends to acute care and state hospital level of care including residential providers. The ENCC also oversees assertive community treatments teams which provide wrap around services and supports. In addition, AMHI individuals work with local CMHP's housing specialist to ensure safe and affordable housing and facilitate entitlements. Included in this process AMHI members have access to financial housing supports and rental assistance thought the AMHI project. IHN-CCO through the local CMHP's will have an identified housing specialist who provides care coordination, technical assistance and skill training to the SPMI population to foster safe and affordable housing assistance. Relationships with HUD and property management companies have been developed and fostered to encourage successful housing placements. The County Care Coordination Committee's, (CCCC's), which is required as part of the CCO Contract for the Integrated Service Array, are well established will be the planning and decision making body to provide community level planning, decision making and consultation for partner agencies and families of children and adolescents. The CCCC includes family representatives and members from all child serving agencies, (i.e. DHS, OYA, County corrections and law enforcement, school districts, department of disabilities, and other social service agencies). In addition, the Wraparound model will be the process for establishing child and family teams and bringing family members and systems together to determine and provide for the individual needs of the child and adolescent members. See attachment A.1.5.a_LinnHealthDeptServices.pdf.

There are numerous social service and community support resources that assist in the work of helping older adults and people with physical disabilities that are part of the OHP. One of the ways that the IHN-CCO will manage these relationships is to capitalize on the existing relationships that the AAA has in the community. Working through the AAA as a means of supporting these Medicaid and dual eligible clients will be an efficient use of expertise. Additional information is available upon request at readiness review.

A.1.6 Community Health Assessment and Community Health Improvement Plan

IHN-CCO's intent in answering questions in this section is to take the best of all programs across the region and expand them region wide. Due to the page limitation, examples provided in specific answers may only describe the service in one county by specific provider types as an illustration of the good work going on where it is most developed.

a. IHN-CCO has taken an encompassing collaborative approach to the community health assessment process that ensures the diverse populations with the CCO will be engaged

and represented. While specific policies around this requirement are in development below are examples of steps we have taken to date:

Examples of the IHN-CCO community health assessment process:

In 2012, Benton County Health Department is engaging in a Public Health Assessment process. The vision of this process is a forward-looking community in which everyone has equitable opportunities for health, starting in the places where health begins – where we live, work, learn, and play.

The Public Health Assessment will describe the current status of our diverse communities' health; define areas for improvement, focusing on those who face significant barriers to health; and identify organizations and community resources that can be used to improve health for the entire community.

Outreach efforts seeking community input include large community events, meetings with advisory committees and coalitions, and targeted outreach to harder to reach populations through web and paper surveys. These efforts, combined with the county's online Health Status Report (http://www.co.benton.or.us/health/health_status/index.php) and synthesis of cross-sectional and targeted assessments, will help to create a snapshot of community health that will inform the Community Health Improvement Plan, public health accreditation, and health care transformation that is happening at the state and local levels.

The LTC/AAA assessment process is under way and will be completed by the fall of 2012. While the timing of the assessment process does not lend itself to the current RFA timeline, the assessment process through the county health districts and the applicant will work to identify issues related to health improvements for older adults and people with physical disabilities in the current process.

See attachment A.1.6.b_BentonHealthStatusSnapshot.pdf. See also answer A.1.1.b.

In September 2011, Linn County began the Mobilizing Action through Planning and Partnerships process to conduct a health assessment of the county. MAPP is a tool developed by both the CDC and NACCHO. Our process allows us to strategically identify issues and develop a plan to improve specific health problems and disparities in our community.

Through the MAPP process we have engaged several community partners and members. This members include not only representation from Samaritan Health Services, but civic leaders, educators, and charitable organizations that work in the community on matters related to health, access, nutrition and equity.

The Linn County Community Health Assessment is a combination of various data sources. These data sources include secondary databases for health indices, primary data collect from a county administered survey, and qualitative data collect from a series of key informant interviews. We have also included the efforts of previous health assessments the county has performed, such as the CHANGE tool through the Healthy Communities process. Through MAPP, Linn County's CHA is an inclusive look at the overall health picture of the county. Additional information is available upon request at readiness review.

Lincoln County Health and Human Services-Public Health underwent a Healthy Communities assessment and developed an appropriate action plan in May, 2011. One key outcome of this process was formation of both a tobacco and a nutrition workgroup made up of committed and capable volunteers dedicated to meeting the goals in the work plan. Lincoln County is currently on working on Strategic Planning and Community Health Assessment/ Community Health Improvement Plan (CHA/CHIP).

Section 2- Member Engagement and Activation

A.2.1. Member and Family Partnerships

a. Members and their families are meaningfully engaged as partners throughout their entire experience with the IHN-CCO starting with enrollment and selection of their PCP or PCPCH. The Customer Care department engages members in their health and provides support performing member welcome calls and mailing member welcome materials within 30-days of their initial enrollment date. The Customer Service department also deploys educational messages on their automatic call distributer (ACD). The member hears information about health topics while waiting for a Customer Service Representative (CSR). Randomized surveys are also sent to our members when they have contacted the health plan by phone or in person to assess the quality and service that our Customer Service department delivers as a constant improvement process.

Engagement of members in the design and implementation of their treatment and care plans occurs in a multi-channel, coordinated process:

• Immediately upon enrollment

- Each member completes an election form to select their care focus, e.g., preventive, diet and nutrition, chronic care, etc., and outline any health goals they may have. Care focus options are described in simple terms. Multiple choices are acceptable for care focus. Members are provided information on available PCPs and the different focuses provided by PCPCHs with suggestions corresponding to their needs. Members are then encouraged to make the selection of a provider home that best fits their needs.
- At the same time, information is gathered on how the member prefers to receive information from the plan, for example (mail, phone, mobile, email, pick-up in person, etc.), language (English, Spanish, Russian), and format (large-print, TTY).
- IHN CCO is considering offering members the option to sign-up for the plan's mobile phone service, which provides a mobile phone and paid monthly service during membership, in exchange for participation in the plan's annual health risk assessment and biometric screening conducted in a primary care setting and agreement to receive text messages from the plan regarding health and wellness. Mobile phones are pre-programmed with numbers to contact the Member Services from 8 a.m. to 8 p.m., daily.

• Within 30 days after enrollment

- All members receive a mailing containing their ID card and options for New Member Orientation.

- New Member Orientation provides information about medical, dental, mental, and long-term care benefits. Spanish and hearing translators are available. All members receive a mailing containing their member handbook and other introductory materials based upon their care focus selections. Included in the mailing is a list of providers that match their care focus and health goals. Members are asked to select one from the list as their primary care provider.

• Ongoing

- Members will be assessed and appropriately assigned a Peer Support Specialist or Health Care Navigator, who will make initial contact to ensure members have received all appropriate member materials, selected their care focus, primary care provider, and outlined their health goals.

- Follow-up and ongoing contact may be continued by the Peer Support Specialist or Health Care Navigator or may be assigned to an RN Care Coordinator, depending upon the member's needs and health care status. This ongoing contact will ensure that members are:
  - Aware of the benefits available to them
  - Encouraged to participate in programs that will benefit them
  - Seeking appropriate level of care
  - Receiving appropriate follow-up to care

Three times per year, members receive a newsletter from the plan, which offers opportunities and incentives to engage in health and wellness education and preventive care.

Member kiosks, located in pharmacies, county health departments, urgent and emergency care facilities, provide important member information and a way to connect to the plan's and Member Services. Kiosks may be extended to local grocery stores and other retail outlets dependent upon local merchant support.

Primary Care practices receive monthly reports from the plan that list new and ongoing members. Practices encourage member participation in preventive care and special quality improvement projects.

Specialty Care practices will participate in quality improvement projects.

Mental Health Care includes the following standards:

Behavioral Health providers will follow current contracted requirement which include initiation and engagement standards which are:

• Initiation: Seeing a client twice within their first two weeks of treatment (including the assessment).

• Engagement: Historically, MHOs within the IHN-CCO see a client four times in their first four weeks of treatment (including the assessment). IHN-CCO will work to develop appropriate member engagement measures with regard to the implementation of integrated care which may or may not reflect this historical expectation. For example, as we integrate mental health into the Patient Centered Primary Care Home (PCPCH), this change will most likely result in an intervention lasting potentially only one or two encounters.

The IHN-CCO will provide all OHP members with a Member Handbook that outlines their rights and responsibilities, including active participation in their behavioral health services, their right to informed consent, as well as their right to access to mandated services (e.g., Peer Support Specialists, Health Navigators, and Interpreters). Historically, both MHOs have had significant member involvement in quality management activities as described in Appendix C of this RFA. Intensive services for children use Wrap Around teams based on the principles of family voice and choice. Behavioral Health providers historically contracted with ABHA and MVBCN will continue to provide Peer Delivered Services for both adults and youth and family. A major focus of these services is on empowering members/patient engagement. Health Navigators will assist eligible uninsured community members in signing up for services, making appointments, and they check in with clients when appointments are missed.

For Long Term care, there are currently over 1,900 people in the Medicaid LTC system in the region. Each individual has OHP as his or her medical plan and has a AAA Case Manager. The CCO, with support from the AAA will assist the OHP members to engage in the new partnership, enabling them to be full partners in their health care. Additional information is available upon request at readiness review.

b. IHN-CCO will ensure a comprehensive communication program to engage and provide all members, not just those members accessing services, with appropriate information by:

Encouraging members

IHN-CCO is considering several methodologies to encourage members to be active partners in their health care: Some examples are:

• Incentives – Members who participate in certain preventive care (medical and dental), complete certain prescribed follow-up (medical and mental), choose to receive ongoing health and wellness reminders, and take part in certain healthy activities will receive incentives ranging from health-related merchandise to mobile phones/service, as examples. Details will be worked out during the implementation phase of the CCO between May and August of 2012 and pending state funding.

• Education – Health and wellness education will be provided to members based on their care focus choices and stated health goals. Education will be made available in a number of ways: online, member kiosks, mailings, phone calls, text messaging (opt-in), newsletters, classes, as examples.

• Peer Support – Members will be invited to join peer support groups for a variety of needs (chronic care, diet and nutrition, parenting, elder care, etc.).

• Provider Support – Members will be encouraged by their providers (medical, dental, mental) to participate in their health through a variety of ways (health risk assessments, treatment plans, goal setting, etc.). Behavioral Health providers historically contracted with MHOs will encourage behavioral health clients to collaborate on their treatment plans, set goals, and provide feedback regarding their recovery and service participation. We will also continue a recovery model based on empowerment in all of our clinical initiatives and provide peer-run services which enhance social connections and self-help.

The IHN-CCO will also work with the AAA to develop ways to reach out to members who are part of the LTC system. Together there will be approaches developed to activate members in LTC, encourage prevention and early intervention approaches to health and support members with navigators in coordination with AAA LTC Case Managers.

Educating members

Members will be educated on how to navigate the coordinated care approach and connect with resources for advocacy through a variety of ways. Examples include

• New Member Orientation classes available monthly through the service area

• Personalized member materials provided based upon the member's selection of care focus and stated health care goals

• Member Kiosks made available throughout the service area in convenient, public locations

• Peer Support Specialists, Health Care Navigators, and RN Care Coordinators' ongoing contact with the member

• Peer Support Groups made available through the support of the CCO

• Consumer Advisory Council membership opportunity

Currently, MVBCN has partnered with IHN in diabetes PIP providing hands-on case management support to enable Members to bring their diabetes under control. ABHA has approached IHN to start a similar project.

Providing plain language

Health literacy is a challenge that is currently being met by the IHN-CCO and its partners through ongoing training for both providers and communication staffs. This is an important aspect to explaining members' rights and responsibilities under the plan. Experience with the Oregon Health Plan has provided the CCO knowledge of those areas which are most commonly misunderstood or misinterpreted. These areas are the focus of information provided at the point of service (provider offices, urgent care, emergency care, pharmacies) and are highlighted in New Member Orientation and associated member materials.

Engaging CAC and measuring patient engagement

See also A.1.1.b, above.

Member engagement and activation will be evaluated. The IHN-CCO is considering various ways to obtain this information so that it is valid and reliable. Potential ways to monitor and engage include: CAC members are required to attend and evaluate one Orientation each year and review attendee survey results monthly. As well, the CAC participates in usability studies of the member mobile website and kiosk to gain a deeper understanding of how these portals work and to provide member/consumer perspective to the CCO. On an ongoing basis, the CAC reviews and evaluates member engagement strategies and results, and serves as a sounding board. Recommendations received from the CAC regarding member engagement and activation is the starting point for further research and alerts the CCO to warning signs and changing trends and helps predict the behavior of members prior to a change. Additional information is available upon request at readiness review.

Section 3- Transforming Models of Care

A.3.1. Patient-Centered Primary Care Homes

a. The IHN-CCO has the following plans to support the provider network through the following provisions:

Technical Assistance

The IHN-CCO IT Workgroup is developing strategies to track and increase adoption rates of EHRs. This includes an analysis of how best to technically support providers in order to facilitate adoption and usage. Potential strategies include:

- Awareness communication

- Provide Information and education based on survey results

- Educational forums put on by CCO to include process definitions, educational resources, mentor resources, etc

- Decision making help

- Triage/advice on systems

-Working closely with HITOC

Tools for Coordination

The IHN-CCO is developing a strategy for tools to coordination across all participating providers and will support the use and development of protocols and baseline standards to meet HST standards. These will include:

- Link patients with community resources to facilitate referrals and respond to social service needs.

- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.

-Track and support patients when they obtain services outside the practice.

- Follow-up with patients within a few days of an emergency room visit or hospital discharge.

- Communicate test results and care plans to patients/families.

Management of Provider Concerns

The IHN-CCO will work toward a unified approach using processes historically developed as a Fully Capitated Health Plan and Mental Health Organizations.

Relevant Member Data

The IHN-CCO will work toward a unified approach using processes historically developed as a Fully Capitated Health Plan and Mental Health Organizations.

Training and tools necessary to communicate in a linguistically and culturally appropriate fashion with Members and their families.

The IHN-CCO will work toward a unified approach using processes historically developed as a Fully Capitated Health Plan and Mental Health Organizations. Additional information is available upon request at readiness review.

b. In addition the fully supporting the IHN-CCO Community Advisory Board, the IHN-CCO will put in place strategies to ensure:

- Patient and family values are respected and member needs expressed

- Patients are encouraged to expand their role in decision-making, health-related behaviors, and self-management.

- Providers are communicating with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.

- Members are provided self-management support at every visit through goal setting and action planning.

- The IHN-CCO will obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.

Additional information is available upon request at readiness review.

c. The IHN-CCO will facilitate and evaluate, with participating providers, the development and integration and advancement of medical homes available. We will develop baseline standards and tools designed to help systems and provider practices move toward the "state-of-the-art" in delivering patient-centered care in the context of a medical home.

PCPCH will be encouraged to use the tools to help their teams identify areas for improvement.

The IHN-CCO will give preference to providers who have achieved the highest tier possible when assigning members.

The IHN-COO will develop a plan including targets and benchmarks to increase the number of enrollees being served by the highest level PCPCHs.

The IHN-CCO will develop a concrete plan including targets and benchmarks to assist and support providers in moving to the highest level PCPCH status.

The IHN-COO will set clear protocol/expectations/standards for fax, and secure message and descriptions of the standard we want to achieve. We will require this through MOUs and contractual language in addition to ongoing collaborative meetings. Additional information is available upon request at readiness review.

d. IHN-CCO case managers will support coordination of care between PCPCH and LTC providers as needed using the treatment plans established by the PCPCH.

PCPCH-oriented services will work in coordination with the current system of supports for members supported by Medicaid funded LTC services and supports. The AAA Case Managers, as well as the supports through the ADRC will assist in the work of supporting the development of the primary care home. The LTC system of providers will also be mutually supported by the applicant and the AAA staff to ensure appropriate use of medical care, coordination of services, care transitions from hospital, ED and SNF services and diversion from NF when alternative placements are appropriate as determined by the member/family as well as professionals who have completed care plans. Additional information is available upon request at readiness review.

e. The IHN-CCO will give preference to providers who have achieved the highest tier possible when assigning members regardless of provider type. Additionally, the IHN-CCO will be working very closely with all safety net providers to create a supportive network for its members that achieve the triple aim. Effective utilization of all safety net providers is imperative toward achieving this goal. Additional information is available upon request at readiness review.

A.3.2. Other models of patient-centered primary health care

a. The IHN-CCO community of providers encompasses various models of the PCPCH. An analysis performed by the IHN-CCO PCPCH Workgroup found that these models do fit together and can be accommodated by ensuring health practitioners from different entities are communicating using agree upon protocols. Additional information is available upon request at readiness review.

b. IHN-CCO's entire focus will be to achieve the goals of Health System Transformation and the triple aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. IHN-CCO will be evaluating how the following influences the triple aim and then develop strategies to affect them:

- Understanding and monitoring of our enrolled population, specifically related to the partnerships developed with individuals and families, how members access and move through a redesign of primary care, the affects of population health management, and broad system integration.

A commitment to our members and responsibility of our affiliates and sponsors for all three aims for that population. Additional information is available upon request at readiness review.

c. The IHN-CCO will develop agreed upon protocols for communication and coordination to allow for creative approaches in the model and clear expectations for patients regarding two way communication and coordination between all providers. Additional information is available upon request at readiness review.

d. The IHN CCO will develop agreed upon protocols for communication and coordination to allow for creative approaches in the model and clear expectations for patients. Additional information is available upon request at readiness review.

A.3.3. Access

a. The IHN-CCO is comprised of one FCHP, two MHOs, and multiple safety net services which include community health workers, personal health navigators and certified qualified interpreters in our three-county service area (Benton, Lincoln and Linn counties). These individuals comply with provider network requirements as part of their Medicaid managed care contracts. For example, IHN (FCHP) currently contracts with providers in our servicing counties. We contract with 95% of the providers, ensuring that all members in all communities have adequate access to providers and services. Our minority and under-served population outreach includes member materials in non-English languages, translation services, and other culturally-appropriate education through IHN-CCO staff and contracted providers. As we are contracted with the majority of providers (and in some communities, every provider) our delivery system matches the population's needs. Additional information is available upon request at readiness review.

b. IHN-CCO does not anticipate any barriers to access, as we have long-established provider networks that will be employed in the coordinated care organization in all three counties. Additional information is available upon request at readiness review.

c. IHN-CCO is developing an implementation and communication plan, including a detailed member education strategy to include multiple methods and mediums (mail, email, web and print) to explain the transition to the CCO model. Additional information is available upon request at readiness review.

A.3.4. Provider Network Development and Contracts

a. The IHN-CCO will build on existing physical and mental health provider networks that deliver coordinated care and team based approach by moving toward an integrated approach between behavioral health, Patient Centered Primary Care Homes LTC and the community safety net programs. IHN-CCO will coordinate care with out-of-network providers to ensure access for all members to a full range of services to accommodate their needs. The PCPCH, care coordination and delivery systems work groups will be developing an implementation plan prior to the "go-live" date of August 1, 2012. Additional information is available upon request at readiness review.

b. IHN-CCO's historical mental health organizations, MVBCN and ABHA, have successful strategies for screening, diversion and utilization management of inpatient care for both adults and children. Strategies include use of person-centered crisis plans, crisis/respite placements, and a mental health supported detox option when the presenting need is a substance-use disorder rather than a primary mental health problem. Additionally, a medically managed detox program within a residential chemical dependency treatment center provides an alternative to hospital-based detox. Case management services will be applied to prevent readmissions. The IHN-CCO will develop monitoring tools to assess unnecessary inpatient utilization from a coordinated perspective that can be evaluated over time. Additional information is available upon request at readiness review.

c. IHN-CCO's historical mental health organizations, MVBCN and ABHA, have provided children and adults at the highest level of care with individual and family driven team-based care management focused on increasing ability to achieve personal goals. Available supports include a wide array of in-home and community-based services. Teams work closely with residential facilities to ensure that treatment plans address the skills needed for success in the community. We anticipate that teams will participate as needed with the care managers across the CCO for members with significant health challenges to allow all community resources to be assessed and accessed for each individual member at the most appropriate and independent setting Additional information is available upon request at readiness review.

A.3.5. Coordination, Transition and Care Management

a. Health Plan case managers will support coordination of care between providers as needed using the established communication mechanisms in the SNP Model of Care. These include Interdisciplinary Care Team meetings and the establishment of communication protocols regarding members with severe and persistent mental illness.

IHN-CCO will support use and development of protocols for coordination of practice/system based EMR, secure messaging, faxing, etc.

The ability to keep accurate and timely information moving between IHN-CCO and the LTC system will be critical in the ability to provide coordinated care. There is a need for

information systems improvements to allow reporting of changes in status, ED visits, and changes in health that precipitate re-evaluation of the LTC placement as well as health changes that require increased levels of support in the members chosen living arrangement. See attachment A.3.5_ModelOfCare.pdf. Additional information is available upon request at readiness review.

b. In addition to A.3.5.a, above, PCPCH and Case Managers within the health plan will provide coordination between social and support services, members and providers. We will also create working taskforces to bring groups together to discuss relevant issues; support placement of navigators and other types of staff in positions of coordination between providers, community groups and social support systems. This will be developed during our implementation period of May-August 2012. For the Medicaid LTC members, a unique service plan provides a mix of support services to create a stable cost effective placement in the community. The relationship and communication between the AAA Case Manager and the staff of the IHN-CCO will be critical in creating a level of support for the members to engage in prevention and self management programs. Additional information is available upon request at readiness review.

c. The IHN - CCO is currently evaluating and will support the further development of current tools that can be used by all provider groups for these purposes. Additional information is available upon request at readiness review.

d. A variety of data analysis methodologies are utilized to identify members with multiple diagnoses and complex needs. This data is shared with providers via Health Plan Exceptional Needs Care Coordinator (ENCC) staff and standardized reports. They work with providers and community programs to coordinate services and supports for the complex needs of our members. ENCC availability and policies are communicated regularly to providers.

The IHN-CCO will also Support development of taskforces/groups made up of service providers to develop databases, registries, electronic communication tools and other ways of collecting this data and sharing for use in coordination. We will develop tools for Members to know how to access various different groups, as well as the groups knowing how to coordinate and provide services to members. Shared protocols for both providers and members will be created and distributed so IHN-CCO can begin to build a way to communicate these expectations to both providers and members See attachment A.3.5.d_IHNCCOCareCoordination.pdf. Additional information is available upon request at readiness review.

e. Working closely with county LTC agencies the IHN- CCO will identify the most severe and persistent mentally ill individuals (AMHI) population and provide monthly E-submission data reports to AMH/DHS outlining current status and care coordination

activities. The IHN-CCO will assure that AMHI individuals with the greatest needs in the community will be provided intensive outpatient Assertive Community Treatment, (ACT). This a team based, client centered model for providing Care Coordination which identifies needs and creates a plan of care based on those needs. Members receiving DHS Medicaid-funded services LTC services will be provided intensive services and care coordination depending on their individual needs.

Coordination of Care and Care Transitions work with members in the LTC system will be done through the joint efforts of the applicant and the AAA system of support. Care Coordination will involve sharing the care plans of the applicant and the AAA system as well as developing reporting and data sharing agreements that provide staff with the awareness of health and developing social issues. In addition, tested models of Care Transitions such as the Coleman Model are already being implemented in the region as a pilot program as well as expanded through a small amount of grant funding. This evidence based model can be expanded and works well with the Medicaid LTC population. Additional information is available upon request at readiness review.

f. The IHN-CCO will use health navigators, RN case managers, peer support specialists and health coaches as part of the delivery of coordinated care. The IHN-CCO delivery systems work group will further evaluate implementation plans and strategies around non-traditional health workers on an ongoing basis to meet the needs of health system transformation.

See 3.5.d, above, and attachment A.3.5.d_IHNCCOCareCoordination.pdf. Additional information is available upon request at readiness review.

g. The Customer Care department has the initial responsibility to ensure access to care and systems by contacting the members to ensure that they have an assigned Primary Care Physician (PCP) within the first 30-days of enrollment and addressing any questions the member may have. We have a listing of contracted providers and their practice status of "open", "limited" or "closed" that the Customer Care department utilizes. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure members are engaged and receive appropriate care and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

h. The Customer Service department is well-trained in the use of local interpreting services that are provided when a caller speaks a language that requires translation assistance.

The Customer Service department also uses an "Open/Closed" list with a listing of providers that speak languages that are conducive to the language that the member speaks. Customer Service representatives are trained to recognize members with higher level needs and Coordination between the Customer Service department and the Care Management Services department is a warm hand-off when coordinating appointments

for multiple/complex health issues, has had a major surgery or care from a hospital to tertiary or home care is needed. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure members are engaged and receive appropriate care and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

i. MHO processes currently in place for AMHI and children's intensive services will be employed to support members through mental health care transitions. IHN ENCC and Care Coordination utilize the Coleman Model to facilitate appropriate and safe transitions for members from one setting to another. In addition, we will facilitate the increased use of protocols by providers. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure members are engaged and receive appropriate care and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

j. IHN-CCO will facilitate improvements to the system of communication and reporting between our Care Coordination and ENCC staff and the AAA system which will strengthen this nationally recognized system of care and care transitions. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure members are engaged and receive appropriate care and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

k. See attachment A.3.5_ModelOfCare.pdf in addition to 3.5.i, above for information on the IHN-CCO Model of Care (MOC) based on the Medicare requirement for Special Needs Plan members. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure members are engaged and receive appropriate care and develop strategies to achieve health care transformation Additional information is available upon request at readiness review.

l. IHN follows the NCQA standards for Complex Case Management which includes, among other things, the processes for assessment and development of care plans. These require an evaluation of the member's mental health status, cultural, linguistic, visual and hearing needs, preferences or limitations as well as the availability of community resources. Each member will be initially assigned to a team comprised of the member's Primary Care Provider and a Care Manager. The Care Manager will contact the member to explain the program, initiate their participation and ensure completion of a Health Risk Assessment. With this information, the Care Manager assesses the members' health and psycho/social indicators, incorporating the member's survey input, electronic and other medical records, Health Risk Assessment, claims and pharmacy data as available. Following plan procedures, an expanded care team is assigned, addressing needs for services of other team members such as the DME coordinator (e.g., member has mobility issues), Clinical Pharmacist (e.g., member has multiple prescriptions), nontraditional

health workers, safety net referrals, Home Health, etc. Additional information is available upon request at readiness review.

m. IHN-CCO Case Management staff will utilize NCQA standards for Complex Case Management in our initial assessment process. In this process, staff review data sources available, document clinical history, assess activities of daily living, mental health status, including cognitive functions, evaluate cultural and linguistic needs, preferences and limitations, caregiver resources and involvement, available benefits from IHN-CCO and community resources and assess life planning activities. This process includes contact with the member or their designated caregiver and a review of both socioeconomic and psychosocial factors which may impact the member's health and functional status.

Individualized service plans for Medicaid LTC members exist through the AAA system of care for maintaining community based support. The IHN-CCO will work with the AAA system to create vehicles to collaborate to jointly support care planning processes and products that create a shared investment in the health and stability of shared members. A universal screening tool will be developed that works together with the AAA screening and care planning tools to ensure consistent outcomes for members. Additional information is available upon request at readiness review.

n. IHN-CCO incorporates all available data including information from local type B AAA and APD offices and LTC providers. IHN-CCO will communicate and coordinate with these offices regarding care plans for specific members. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure members are engaged and receive appropriate care and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

o. IHN-CCO Care Coordination staff will systematically utilize available data sources for significant changes in health status in order to reassess the needs of our members. These include ER, Home Health, Hospital admissions, laboratory, Utilization Management, claims and HRA reports. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation Additional information is available upon request at readiness review.

p. IHN-CCO will share and coordinate individualized care plans with providers including type B AAA, APD and LTC via communication protocols established through agreements or MOUs with these providers. The IHN CCO IT workgroup is developing an electronic approach and will be working closely with the INN-CCO delivery systems workgroup to determine standards for non-electronic work flow that will enable and support a transition to electronic modes of communication. Additional information is available upon request at readiness review.

A.3.6. Care Integration

IHN-CCO's intent in answering questions in this section is to take the best of all programs across the region and expand them region wide. Due to the page limitation, examples provided in specific answers may only describe the service in one county by specific provider types as an illustration of the good work going on where it is most developed.

a. Chemical dependency and mental health outpatient services for adults, adolescents, and children are provided through Benton, Lincoln and Linn counties, in addition to broader independent providers to ensure adequate access. These providers have the capacity to support Spanish speaking populations as well as interpretive services for multiple verbal languages as well as sign language. Select clinicians are bicultural as well as bilingual. Social detox services are available at out of region programs and are being explored in Albany and Newport for use by the region. Medical detox is provided through Good Samaritan Regional Hospital in Corvallis for severe alcohol and/or benzodiazepine dependency with medical complications.

   The IHN-CCO is looking into ways to proactively reach out to all providers in this group and support providers who are not EMR ready or otherwise not "coordination ready" to help them move along the continuum to be able to accept these Members in their care. For example, we may enlist earlier adopters as mentors for other groups. For single/small providers there may need to be some financial assistance to re-tool. This will be reviewed and discussed during implementation and Year 1 of the CCO. Additional information is available upon request at readiness review.

b. IHN-CCO will provide Members with mental health and chemical dependency prevention services early intervention, and community-based services in non-clinic locations (such as schools). IHN-CCO will provide a full array of services for individuals who have serious mental health and chemical dependency conditions which include but are not limited to medication assisted therapies, individual and group therapy, case management, skills training, respite, peer delivered services, residential care, and hospital level of care which includes acute and state hospital services. For chemical dependency, members are served by a psychiatrist within the chemical dependency program, or are referred to mental health and/or their PCP or a psychiatrist for medications to address mental health co-occurring issues. Opiate treatment may include methadone from two specific treatment centers we contract with (Willamette Valley Treatment Center or Marion County) or for Suboxone through a limited number of physicians in Benton and Linn Counties. Residential treatment centers are used throughout the state for that level of care, and the region includes two chemical dependency residential facilities in Corvallis, one for youth and one for women and women with children. Hospital level of care is provided for alcohol and benzodiazepine detox at Good Samaritan Regional Hospital for those with medical complications in

addition to addiction. Members are transitioned from higher levels of care directly into community-based outpatient clinics, offering a number of options for housing which would include Oxford Houses.

c. There are multiple points of entry into mental health and chemical dependency services. Referrals can come from all agencies. Members will be screened and assessed and referred to appropriate levels of care. If issues are significant, then the process of coordinating care will occur with mental health, chemical dependency or physical providers developing a plan of care. This plan is individualized to the needs of the member and includes crisis planning as necessary and appropriate. Mental Health and Chemical Dependency providers will coordinate with DHS Medicaid funded LTC providers when both/all agencies are involved with the members. For chemical dependency, we are beginning an SBIRT project to be used in Emergency Departments to screen for substance abuse and create a warm hand-off to chemical dependency providers. After SBIRT is implemented in each of the regions Emergency Departments, we will then explore implementation into medical homes, primary care and specialty settings.

The counties, SHS and others will move toward having mental health providers in their primary care practices. Coordinated care tools will be developed to be used by all types of service providers. Coordinating care with Medicaid LTC systems will be possible through building relationships with LTC providers and Case Managers. With good planning related to information sharing and coordinated care planning, health outcomes can be achieved for members who need the additional supports from both systems. Identification of members with high care needs or unstable health conditions as well as members who are in fragile social and living situations will allow both the applicant and the AAA system to develop appropriate services and supports over time. The focus will initially be on high users of medical services. In some instances these members will not be living in Medicaid funded LTC settings. The larger challenges will be members who are younger, more mobile and with whom it is more difficult to establish relationships. Engaging these individuals to assist them in fully participating in their care plan and to help create a sense of stability in the community will take additional staff time and require the development of positions to take on a navigator and coaching role. One of the areas to be discussed further with the AAA is how to maximize the current expertise within both systems and develop the navigator roles. The potential exists for the AAA to specialize with assisting older adults and people with physical disabilities in navigating the system and taking a role of creating the interface between the medical and the social systems on behalf of the member. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation Additional information is available upon request at readiness review.

d. The counties, SHS, TCC and IHN's historical network of providers have already worked hard to integrate prevention services in their clinics and in the community at large. By working with the IHN-CCO, models and tools can be developed to provide those who don't currently integrate this service with outside providers who can (under contract or other). For example, the IHN-CCO will work within the delivery systems workgroup to develop screening/contracting tools to ensure that providers meet certain requirements. Those requirements can be increased over time to further coordination and qualification standards. Gap analyses will be done to assess where different services are needed and not currently provided. Once identified, current providers or others can be identified who would be willing to provide those gap services.

The IHN-CCO has completed an initial gap analysis to determine the full service array available. Based on this analysis, we will develop a plan and implement as necessary and appropriate to achieve health care transformation.

The CCO is developing improvement measures to refine evidenced based practices and provide technical assistance through training and consultation. Behavioral Health has an approved array of Best Practices that are encourage to be used by providers. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation

For example, support for lifestyle practices that support good mental health and information about prevention programs will be made available as part of member education at the PCPCH and in the community. MVBCN has funded parenting classes in partnership with community agencies; linkages between pediatric care and these and other parenting supports available in the community can be strengthened. Counties provide extensive substance abuse prevention activities which can also be linked with primary care.

Currently, each county uses different strategies to link mental health and addiction treatment services with primary care services for their clients. We intend to compare these approaches and identify common expectations that support successful engagement with primary care and improved health status, especially for members with serious mental illness. For some individuals this will entail additional medical support provided in the behavioral health setting.

Robust crisis teams exist in all 3 counties and work closely with local hospitals to provide appropriate crisis response. The MHOs have nurtured practice improvements and implementation of evidence based practices addressing the specific needs of the Medicaid population and those with intensive needs. We have mapped the development of numerous services/practices across the 3 counties and will develop strategies to move

toward consistent practice. Additional information is available upon request at readiness review.

e. The IHN-CCO currently includes one DCO as a stakeholder and will being meeting with them and engaging with others to discuss next steps. Our plan is to have MOUs in place for DCOs in our service areas for a January 1, 2014 effective date. Our implementation schedule will reflect our MOU time lines and specific deliverables to ensure we are prepared for a "go-live" date of January 1, 2014. Additional information is available upon request at readiness review.

f. Through electronic data and communication tools dental providers will be invited to be part of the patient centered care team. Oral health prevention will be incorporated, along with other wellness messaging and interventions provided to members to encourage health. IHN-CCO will work to ensure and encourage consistent oral health messaging across provider types. Example: Pediatrician and dental provider both using First Tooth materials and an anticipatory guidance messages for young children and their caregivers, thereby re-enforcing the messages. Better coordination and communication tools will streamline and facilitate appropriate and timely dental referrals. The IHN-CCO will work toward this unified approach building upon processes historically developed as a Fully Capitated Health Plan, Mental Health Organizations and Dental Health Organizations. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

g. Samaritan Health Services operates an integrated delivery system which coordinates hospital and professional services. All PCP's employed or not have access to surgical notes, lab and radiology results within their offices. This allows for coordination between the PCP and specialists and inpatient and outpatient serves. As we move forward with the EPIC roll out we will have a master patient index that coordinates the services between the various settings. We will also implement EpicCare Link which allows non-SHS providers access to the clinical record as created by the hospital or other PCP or specialty provider. Using all these tools to enhance the services provided by the member's primary Care medical home will only enhance the care provided. Through the new EMR system providers will be able to order or refer on line and get an online response to their request as well as results following whatever service was provided. As we implement the new EMR the specifics around the sharing of information and the access to information will flow following HIPAA guidelines between all the providers involved and the member. Through the communication provided above, all transitions of care will be present in the EMR and will notify all providers involved in the treatment so that appropriate care can be provided at the appropriate time.

A.3.7. DHS Medicaid-funded Long Term Care Services

a. The Type B AAA organization in our region is a successful Medicaid system manager and has a deep expertise and professional staff that provides eligibility determination, assessment services, service planning, case management, care coordination and care transitions. The agency works with over 1,900 OHP members in Medicaid funded LTC as well as over 8,000 OHP members in financial and medical programs who do not currently need a Medicaid funded support system to live in the community. The IHN-CCO has a long history of a successful partnership with the AAA in our region, and the development of a CCO will only serve to enhance the relationships and work on behalf of the OHP members that are in both systems.

Working together with the LTC providers in the region to enhance the coordination and transitions that members experience as health issues arise will help to further the goals of health transformation in our region. There will be many opportunities in the future to create pathways that allow for better coordination of specialized services, durable medical equipment and service plans that engage the member as a valuable member of the health care team. Creating greater access to evidence based healthy aging programs that fit the needs of those living on limited incomes with multiple chronic conditions and additional social barriers such as lack of transportation can be effectively addressed by working closely as partners in system reform. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation Additional information is available upon request at readiness review.

A.3.8. Utilization management

a. IHN-CCO medical director and Clinical Advisory Committee Provides provide oversight of clinical functions, including case management and utilization management, review and development of evidence-based clinical practice guidelines and review and development of clinical authorization criteria. The Medical Director reviews encounter data for appropriateness, works with the clinical advisory panel and ensures use of clinical practice guidelines within provider community.

- The IHN-CCO will work toward a unified approach regarding acute authorization processes using processes historically developed as a Fully Capitated Health Plan and Mental Health Organizations. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation given all of our affiliates and stakeholders.
- IHN-CCO works closely with hospital and skilled nursing facilities to monitor all acute services on a concurrent basis. In this way, we both manage length of stay and

facilitate appropriate transitions, particularly for members with special needs, disabilities and mental illness. For ambulatory care, the IHN UM team works closely with ENCC and Case Managers to ensure appropriate services are utilized.

IHN utilizes multiple avenues for identification of over and under utilization, including monitoring of HEDIS reporting, plan developed data analysis and a special committee designated to analysis and make improvement recommendations. Services specifically targeted include: Primary Care and preventive services, ER, urgent care, services provided to aged, blind or disabled members, mental health and chemical dependency services, hospital stays, transplant and high cost services. Additional information is available upon request at readiness review.

Section 4- Health Equity and Eliminating Health Disparities

A.4.1. There are currently many best practices in place to ensure culturally appropriate care and to reduce health disparities while improving the health and well-being of members. Historically IHN and the mental health organizations have contracted with providers or employ staff that can bridge cultural gaps for members. For example members can be assigned to providers who are either from the same culture or at least speak the same language as the member (for example Spanish). An example related to reducing health disparities is a current collaborative Performance Improvement Project between IHN and MVBCN for members with severe persistent mental illness and diabetes. IHN reviews and analyzes its HEDIS data yearly related to health screenings for the Special Needs Plan members to identify any potential issues. The IHN-CCO will work toward a unified approach using processes historically developed as a Fully Capitated Health Plan and Mental Health Organizations. The CCO will continue to develop other best practices as the need is identified such as through the Community Needs Assessment. See also A.I.p (3). Additional information is available upon request at readiness review.

A.4.2. The IHN-CCO employees several programming, report writing and systems analyst staff to assist with data extraction, reporting and validating. In addition to our internal reporting, IHN-CCO currently contracts with an NCQA certified HEDIS vendor to collect and calculate HEDIS measures.

The IHN-CCO will use current reporting processes developed as a FCHP and MHO as it works toward a unified approach to address specifically performing this requirement. The IHN-CCO will develop strategies to achieve trackable quality measures based off demographic factors As the CCO, all partners will work together to obtain this information for tracking and reporting purposes. Additional information is available upon request at readiness review.

Section 5- Payment Methodologies that Support the Triple Aim

A.5.1. The IHN-CCO will implement payment methodologies that support the Triple Aim. This includes a thorough evaluation of system capabilities within the CCO, an evaluation of possible solutions and a foundational understanding by all the stakeholders of the requirements, process and goals. The ultimate resultant strategy will be a powerful mechanism to control costs by lowering medical spending while improving the quality of patient care. Currently the Business Operations Workgroup within the IHN-CCO is leading the charge regarding how to best proceed and will have a strategy and timeline in place within the first year of operations. Additional information is available upon request at readiness review.

Section 6- Health Information Technology

A.6.1 Health Information Technology (HIT), Electronic Health Record Systems (EHRs) and Health Information Exchange (HIE)

a. The CCO has sufficient capacity to support and implement Health Information Technology that will:

• Enhance and improve quality care coordination leading to improvement in the health of the population

• Improve the patient experience of care (including quality, access, and reliability)

• Reduce the cost of care by eliminating errors, improving communications between providers, labs, hospitals, health departments and other regional organizations

In early 2012, we performed a regional survey of providers planning to participate in the IHN COO which indicated that providers were equally distributed on a continuum between early, middle and advanced stages of HIT.

Although we already have planning in place to further facilitate HIT improvements, and in particular the areas of data analytics, quality improvement, and patient engagement, we will go live utilizing our current capabilities. IHN CCO already has two HIT planning groups formed and operational. It is our intention to continue utilizing these workgroups to develop and implement data analytics, quality improvements, and patient engagement in our region. The charters for these two workgroups are defined below:

EHR Baseline Standards Workgroup: Tasked with determining baseline expectation for all participating providers and a timeline for CCO providers to meet the standards. This will include an EHR minimum data set for interoperable communication and a strategic plan for adoption.

Technical Workgroup: Will work closely with Baseline Standard Workgroup to ensure we have the technology to meet timelines. Work on architecture and design of CCO infrastructure and connectivity overall. Propose technical solutions. Group will set standards for technical support of reporting and patient portal and improvement of processes to ensure validation of reports.

We also have an educational plan to allow participating practices a way to access what patient data is currently available to improve clinical decision making. This plan includes the following:

1. Educate provider community on current data available and how to access

2. Seek out opportunities for data sharing that include behavioral health, public health and long term care providers. Additional information is available upon request at readiness review.

b. The two workgroups identified in answer A.6.1.a (above) report up to the IHN CCO IT Workgroup who is tasked with managing the strategies to track and increase adoption rates of certified EHRs as defined by the Office of the National Coordinator (ONC). Initial strategies of the IHN CCO IT Workgroup will focus on communication and education. Our Communication Strategy Approach is critical for a comprehensive and successful coordinated community effort around the issues of health information technology to ensure that all provider messaging from IHN CCO, as well as other key state and commercial partners, complements and builds on the work already being performed in our communities.

The workgroup realizes separate and distinct communications may be required since partners have different focuses, timing and requirements from federal funding entities; however providers need to see and hear consistent, clear messages related to health information technology coming from the CCO.

The Workgroup strategy follows the following stages:

1. Definition of Audience

2. Education of Audience to assist providers in understanding current opportunities already available to help facilitate HIT adoption such as the Medicaid/Medicare EHR Incentive Program.

3. Definition of Current Status to include initial messaging and outreach to key stakeholders focused on core constituencies to raise awareness on where we are as a CCO and what the vision and expectation is

4. Message Development of current status and expectation

The priority under messaging will be to develop a clean, consistent message on the "nuts and bolts" of the expectations of the IHN COO.

Communication Tools and Delivery Methods identified

- Web strategies

- Mailings

- Electronic notices etc

Timeline and Deliverables

Below is a preliminary timeline. As more information is gathered on outreach opportunities, especially the timing of key meetings, as well as the timing of decision points for Oregon specific program decisions, the timeline will be expanded to include that information.

Now	Definition of Audience
July – Dec	Education of Audience (i.e., Provider Outreach)
Aug – Oct	Definition of Current Status and Message Development

Additional information is available upon request at readiness review.

c. The IHN CCO IT Workgroup proposed plan is to wait for the Oregon State HISP and educate providers to register and become a member of the state's HIO according to the plan stated in A.6.1.b(above). As stated previously, the Workgroup is also developing a strategic plan to ensure a CCO wide expectation for base line standards and progress toward advanced meaningful use. Additional information is available upon request at readiness review.

Linn County

Healthy Communities-Building Capacity: Community Action Plan

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COMMITMENT

LINN COUNTY HEALTHY COMMUNITIES COALITION MEMBERSHIP

CHART Member Name	Organization Name	Organization Role	Organization Type	Sector
Anne Peltier	Community Member	An Individual	An Individual	Community-At-Large
Carissa Deethardt	Linn County Health Services	VISTA Volunteer	Public Health Organization	Community-At-Large
Carole Kment	Samaritan Health Services	Living Well Coordinator	Health Care Organization	Health Care
Cecilia Easdale	Community Member	An Individual	An Individual	School
Christina Spicher	Linn County Health Services	Intern	Government Organization	Worksite
Dar Merrill	Commission on Children and Families	Coordinator	Government Organization	School
Deb Fell-Carlson	SAIF	Loss Control Program Adviser	Business/For Profit/Consultant	Work Site
Ellen Nordal	Community Member	An Individual	An Individual	Work Site
Fabiola Sandoval	East Linn Community Health Center	Community Health Navigator	Community Health Center	Health Care
Frank Moore	Linn County Health Services	Health Administrator	Government Organization	Worksite
Janice Gregg	OSU Extension	Extension Agent	Academia/Education	School/Worksite

Joann Miller	Samaritan Health Services	Director of Community Benefit	Health Care Organization	Health Care
Joy Gilliland	Albany Senior Center	Recreation Coordinator	Government Organization	Community Organization
Kaija Daniel	Linn County Health Services	VISTA Volunteer	Public Health Organization	Community-At-Large
Karen Elliot	Oregon State University	Undergraduate Internship Coordinator	Academia/Education	Community-at-Large
Lawrence Eby	Health Advisory Council	Member	Public Health Organization	Health Care
Mollie Kerins	Willamette Valley Rehabilitation Center	Deputy Director	Nonprofit organization	Work Site
Nancy Kirks	Samaritan Health Services	Community Health Improvement Partnership Coordinator	Health Care Organization	Health Care
Pamela Lunsford	Council of Governments	Living Well Regional Coordinator	Government Organization	Community Organization
Pat Crozier	Linn County Health Services	Public Health Program Manager	Government Organization	Work Site
Pat Marion	Community Member	An Individual	An Individual	Health Care

Rachel Fuss	Samaritan Cancer Resource Center	Director	Health Care Organization	Health Care
Rod Sell	Build Lebanon Trails	Member	Community Based Organization	Community-at-Large
Scott Bond	Senior and Disability Services	Director	Government	Organization
Scott Wilson	Council of Governments	Planner	Government Organization	Community-at-Large
Shawna Wolfe	Samaritan Health Services	RN, Program Coordinator	Health Care Organization	Health Care
Spencer Masterson	Ten Rivers Food Web	Americore RARE Volunteer	Nonprofit organization	Community-at-Large
Steven Ranzoni	Linn County Health Services	Health Educator	Public Health Organization	Work Site
Tina Dodge	OSU Extension	Las Comidas Latinas, Nutrition Education Program	Academia/Education	School
Tonja Everest	Oak Elementary School	Principal	Academia/Education	School
Tove Gilbert Morgan	Greater Albany Public Schools	Safe Routes to School Coordinator	Academia/Education	School

VISION

Your vision statement is your inspiration, the framework that describes your strategic planning. It highlights what will be achieved when the activity is successful. It describes a healthier future and answers the question, "Where do we want to be in a few years?" Example: "All citizens of Any Town, USA will, on a daily basis, consume a nutritionally-balanced diet, acquire the minimum recommended daily physical activity, and refrain from using tobacco products." The vision is what will be achieved by your efforts.

"The Linn County Healthy Communities Coalition will work toward developing, implementing and enhancing policies, systems and environments which affect the health of our community; we will continue to identify areas for improvements so that all residents have equal access to a healthy community."

MISSION

The mission statement informs what impact your CHART will make and describes why it is important to achieve the vision. Example: "The CHART of Any Town, USA will work with top-level leaders in all community sectors to implement policy and environmental strategies to facilitate for residents better diets, increased physical activity, and the cessation and abstinence of tobacco products." The mission includes efforts your CHART will undertake to achieve the vision.

"The Linn County Healthy Communities Coalition will work with all community sectors to advocate and facilitate policy and environmental strategies to improve nutrition, increase physical activity, and encourage cessation and abstinence of tobacco products for all residents."

COMMUNITY DESCRIPTION

Demographic information, target population, socio-economic and health data, community size.

Linn County, Oregon, is in the center of the Willamette Valley, with the Willamette River as its western boundary and the crest of the Cascades as its eastern boundary. The climate and soil conditions provide one of Oregon's most diversified agriculture areas, allowing a wide variety of specialty crops and leading the nation in the production of common and perennial ryegrass. Linn County is also home to major producers of rare and primary metals, processed food, manufactured homes and motor homes as well as the traditional logging and wood products industries.

Linn County consists of multiple incorporated cities Albany (pop. 49,165), Brownsville (pop. 1,780), Halsey (pop. 840), Harrisburg (pop. 3,455), Idanha (pop. 230), Lebanon (pop. 15,580), Lyons (pop. 1,135), Mill City (pop. 1,660), Millersburg (pop. 1,170), Scio (pop. 790), Sodaville (pop. 295), Sweet Home (pop. 9,050), Tangent (pop.985), and Waterloo (pop. 215) (Oregon State Archives, 2011). Linn County has a population of 116,584 and 15% percent of the population lives below the poverty level. In 2009, the median household income was $45,700, below that of the state $49,033 and the national median income $51,420 (Oregon Housing and Community Services, 2010).

The prevalence of chronic conditions among adults in Linn County is consistently higher than that of the states: 33% arthritis, 4% stroke (a statistically significant difference compared to Oregon at 2%), 6% coronary heart disease, 8% diabetes, 28% high blood pressure 31% high blood cholesterol. In Linn County, 66% of adults are overweight or obese and 12% of eighth graders are overweight with another 18% being at risk of being overweight. Among Linn County adults, 55% meet CDC requirements (moderate activity for 30+ minutes 5 days a week or 20+ minutes of vigorous activities 3 days a week) for physical activity 53% of 11th graders and 64% of 8th graders meet the requirements. Of Linn County residents 23% of adults, 16% of 11th graders and 23% of 8th graders consume 5 servings of fruits and vegetables a day (Oregon Department of Human Services, 2008).

Among Linn County adults, 25% currently smoke compared to the state at 20%. Tobacco use accounts for 23% of all deaths in Linn County. These are preventable deaths. 21% of 11th grade males and 9% of adult males use smokeless tobacco compared to the state (14% and 6% respectively). Pre-natal tobacco use rates for Linn County are 20% compared to the state at 12% (Oregon Department of Human Services, 2008).

EXISTING EFFORTS

Build Lebanon Trail (BLT): Build Lebanon Trails is committed to improving the communities overall quality of life through better health, events, safer transportation and improved property values. With community support and a dedicated staff, they work closely to support the city government in building/maintaining trail systems throughout the Lebanon community. Current efforts include building 50 miles of multi-use, paved trails connecting the entire community and beyond the city's limits.

Community Health Improvement Project (CHIP): The Community Health Improvement Project works from East Linn County to offer prevention based opportunities to improve the health status of the rural community. CHIP is a community development process that engages rural communities to make local decisions. CHIP develops ways for rural communities to improve local health care systems and improve health status of area residents. CHIP is a unique process because the solutions are created by local residents who know what will work best for their community. CHIP helps diverse groups and individuals seek a common sense of loyalty and identification with health system goals, projects and programs. It builds a shared commitment for the future.

Healthy Aging Coalition: The vision of the Health Aging Coalition is "To promote healthy aging in Linn and Benton counties", while their mission is "to improve and promote health, wellness, and education on issues connected to healthy aging for all, in the region, regardless of age." The Healthy Aging Coalition has an interest in working to impact the health of our communities and develop opportunities to support policy and systems changes that support our mission and work with a wide variety of partners, both public and private, to improve the communities in our region.

Linn County Commission on Children & Families (CCF): The Linn County CCF role is to lead, coordinate and facilitate the development and preparation of a single county plan for coordinating community programs, strategies and services for children ages 0 through 18 and their families with the major focus on prevention. The commission also prioritizes activities identified in the local plan and mobilizes communities to take action by informing and involving citizens, while prioritizing the use of state and federal funding resources allocated through the State Commission on Children & Families. Funds are used to support research-based initiatives for children and their families. The Linn County Commission is also responsible for monitoring the progress of and evaluating the County's Healthy Start and the Juvenile Crime Prevention Programs.

Linn County Childhood Obesity Partnership (LCCOP): LCCOP is the Linn County coalition which is part of Coast to the Cascades

Community Wellness Network (CCCWN). The LCCOP is designed to provide guidance and direction on issues that impact the health of the community. The CCCWN is the formal coalition that resulted from the Coast to the Cascades Childhood Obesity Project and the Rural Health Network Development Planning grant. With a mission to provide leadership to enhance the health of communities through development and support for collaborative regional partnerships in Benton, Lincoln and Linn Counties, the CCCWN membership consists of key leaders and decision-makers from health care, schools, government agencies, non-profit organizations and tribal councils representing these counties.

A growing concern about the incidence of childhood obesity across the region prompted an informal group of health care professionals to host the Coast to the Cascades Childhood Obesity Key Leaders Summit in June 2009. Overwhelmingly, the 55 health care, education, and community leaders who attended the summit agreed that formal community health networks were critical to strengthening regional efforts to address childhood obesity. It was also agreed to broaden the scope of the childhood obesity network to encompass a wide range of health concerns that would benefit from the regional approach. This re-conceptualization led to the development of the CCCWN. The following unmet regional health needs were identified as priority areas for the CCCWN: childhood obesity, behavioral health, oral health, pregnancy/prenatal care, tobacco prevention, chronic care, and access to care. Childhood obesity has been identified as the network's *first* priority area.

Linn County Health Advisory Council: The Linn County Health Advisory Council's role is to advise the Linn County Department of Health Services regarding activities, programs and policies of the Public Health programs. The council is comprised of lay representatives and other agency staff. The work of the Healthy Community's assessment has been presented to the Council through all steps of the process. Some council members have actively participated on the assessment committees. High tobacco rates of usage in Linn County have been a focus of this group over the past year. They support the work of the tobacco program. There has been discussion about of forming a subcommittee to work on tobacco issues, but it is not currently in place. This will continue to be an area of focus in the coming year. The council helped choose a Best Practice Objective (BPO) for the 2011-2012 Tobacco Work Plan that focuses on school policies for tobacco use.

Linn County Wellness Team: The Linn County Wellness Team's mission is to provide opportunities for employees to develop healthier lifestyles through supporting the adoption of positive habits and attitudes that contribute to their physical and behavioral well-being, thereby promoting a productive, compassionate and active workforce.

Living Well: Living Well is a chronic disease self-management program, which offers free 6-week workshops for residents of Linn

County and has since 2007. The classes are being strategically offered to outreach to a diversity of populations, including offerings of Tomando Control de su Salud in Spanish. Forty workshops, at which 499 residents registered for, have been conducted since 2007 in various cities across Linn County: Albany, Lebanon, Sweet Home, and Brownsville. Classes are offered at various locations, including Linn Benton Community College, Helping Hands Homeless Shelter, Senior Centers, Samaritan Hospitals and Cancer center, Senior and Disability Services, etc. Samaritan Health Services and Oregon Cascade Council of Governments are committed to continue to bring Living Well to residents of Linn County helping to reduce ER visits, hospitalizations, unnecessary visits and calls to their physicians, improved self-management skills, decreased levels of depression and feelings of hopelessness, as well as increased fitness levels. Since March of 2009, Living Well has included a tobacco use question for tracking purposes.

Oregon State University Extension Service: Oregon State University Extension Service, and in particular the Family and Community Health program, provides education for communities and families in Linn County. We provide educational programming that will increase, within a limited budget, the likelihood that all SNAP recipients and those eligible for SNAP are making healthy food choices and choosing active lifestyles consistent with the most recent Dietary Guidelines for Americans. Programming covers the lifespan. We accomplish this through community based nutrition education, of which community partnerships are a key component. Participants learn practical skills in the following areas: Healthy Eating and Activity, Increasing Household Food Security, and Reducing Foodborne Illness. We also have a grant based program that is working with Hispanic Families to advocate for their children in the community and schools. Healthy lifestyles and healthy eating is a significant part of the program.

Safe Routes to School (SR2S): The Greater Albany School District (GAPS) has a Safe Routes to School Coordinator who collects data twice a year and supports students walking and biking to school at three of the area schools; Lafayette, Timber Ridge and Oak Elementary. Activities included, but are not limited to; family socials, coordination of walking school buses, creation of walking zone maps, helmet safety promotion, pedestrian safety, bike safety, walk to school days/month, and community health forums.

Samaritan Health Services: Samaritan Health Services serves the close-knit Oregon communities of the mid-Willamette Valley and central Oregon Coast. Samaritan Health Services has provided the meeting space for coalition meetings and has encouraged staff members to be actively involved in the coalition. They will continue to support the work of Healthy Communities through providing a meeting space, encouraging coalition participation, and supporting the implementation of the community action plan in whatever way they can.

Ten Rivers Food Web: The Ten Rivers Food Web's role is to foster an informed and educated network of farmers, processors, institutional buyers, restaurateurs and individuals to accelerate the process of local reinvestment in our three-county food system. We will accomplish our mission through targeted programs to educate and organize individual, community and institutional food buyers and promote grower-direct purchasing relationships; foster creative new investment in local food processing and distribution capacity, as well as land access for new and non-traditional farmers; continue to promote food literacy through periodic food summits and regular lectures, discussions, website and listserve; foster programs that increase access to fresh, local food by low-income people, and connect farmer-innovators with one another and with other sources of expertise, and support their on-farm research.

CHART

Summarize the structures and processes developed for decision making within the CHART.

The CHART is lead by the Healthy Communities Coordinator and the TPEP Coordinator. The coordinators have provided leader support, order, organization, and structure to the coalition throughout the Healthy Communities process. The formal structure of the coalition includes CHART members gathering at monthly meetings with set agendas, timelines, and regular reminders of the purpose, goals, and roles of all involved. There is an attempt to keep discussion open, free-flowing, and idea-based while maintaining structure. Meetings always include an educational piece that guides discussion and the decision making process. Regular debriefing sessions occur. All CHART members are encouraged to participate in the decision making process individually and/or in small groups. Large group consensus must occur for a final decision to be made. All members of the CHART were asked to play an active role in the assessment process. Site selection was determined by the CHART breaking up into sector groups that they were most interested in; school, worksites, community organizations, healthcare, and community-at-large. The small sector groups then brainstormed and identified 5 specific sites across Linn County as possible assessment sites. Colored dots identifying specific sites were then placed on a large map of Linn County, in order to make sure there was representation from rural and "urban" areas. Group consensus was reached regarding the site selection. Five sites were identified in each sector and 3 interested sites within each sector participated in the assessment.

CHART members formed individual assessment teams of 3-5 members to conduct site assessments. Once sites were engaged in the process the data-collection methods to be used at each site were identified by the sites and team members. Consensus among assessment team members occurred during the assessment scoring process, which took place after each site assessment.

Assessment results were presented to the CHART and multiple priority areas within nutrition, physical activity, and tobacco were identified by the group, through large group brainstorming. Priority areas chosen were based upon the assessment results and specific criteria for choosing community issues that was provided to the CHART by the Healthy Communities Coordinator. Further narrowing of priority areas occurred when the CHART selected the 4 most feasible options. CHART member consensus was reached when we identified the priority areas with the most dots; Tobacco/Smoke Free Outdoor Areas, Worksite Wellness, School Wellness, Health Care System Change. CHART members were asked to sign up for one of these priority areas if they were interested in working on the Community-Action-Plan (CAP). Four workgroups were formed and each group met twice to do research and create the goals, objectives, and action steps for the CAP. The workgroups were guided by the HC and TPEP Coordinators through a brainstorming process at each meeting. Consensus was reached about the CAP among participating members at each group. The CAP was presented to the large coalition for review and input. All attending members brainstormed and created the vision and mission statement and agreed upon the content of the CAP.

Describe the structures and processes that have been put in place to ensure that CHART member involvement matches their skills, interests, and resources.

CHART member selection involved identifying those in the community who represent each sector area, can influence policy and/or environmental change, have contacts in the community, have the ability to mobilize others, are knowledgeable about nutrition, food insecurity, and food access issues, and are knowledgeable about physical activity and active community environments. The involvement of CHART members was based upon each CHART member's ability to commit to the time and effort of the process. CHART members always have the opportunity to be involved in the areas that they feel are the best fit.

Summarize structures and processes for communication within the CHART.

Communication within CHART included individual and group emails along with small and large group discussion at monthly meetings.

Describe how the CHART prioritized strategies within the CAP.

Assessment results were presented to the CHART in the form of percentages for sectors, percentages for target areas, target areas by sector, and lowest scoring assessment questions (please see Assessment Results Summary in the appendix). Multiple priority

areas were determined through large coalition brainstorming. Priority areas chosen were based upon the assessment results, specific criteria for choosing community issues that were provided to the CHART by HC Coordinator, and looking at policy and environmental change strategies. Priority areas identified in nutrition were; mandatory labeling, workplace healthy food options and meeting policies, school wellness (specifically nutrition and school gardens), access to healthy foods in rural populations, and nutrition counseling in healthcare settings. Physical activity priorities included; school policies to increase physical activity, access to extracurricular activity, Safe Routes to School, walking paths, bike parking, sidewalk development and connectivity, and worksite policies to increase physical activity. Tobacco priorities identified by the group were tobacco/smoke free outdoor areas, current tobacco policy enforcement, increase anti-tobacco efforts in schools, no smoking policy in cars, and addressing tobacco use in healthcare setting. Further narrowing of priority areas occurred when the CHART voted on the top 4 most feasible priority areas using dots placed by each CHART member next to the area that they believed was a top priority. CHART member consensus was reached when we identified the priority areas with the most dots; Tobacco/Smoke Free Outdoor Areas, Worksite Wellness, School Wellness, Health Care System Change.

ASSESSMENT

CHANGE Tool Information

Describe key findings of CHANGE and how the data will be used to inform the CAP.

Summary of Results From CHANGE Tool

	Low 0-20%	21-40%	Medium 41-60%	61-80%	High 81-100%
Leadership		**37.43**			
Chronic Disease Mgt		**39.63**			
Physical Activity			**41.36**		
Nutrition			**41.57**		
Tobacco				**63.39**	

After reviewing the different excel files from each assessment site, the key finding was the lack of policies that support a healthy environment in Linn County. The table above shows the average percentage for all of the sectors combined. A low score (0-20%) is the equivalent of a 1 on the change tool, where a high score (81-100%) is the equivalent of a 5. The assessment results as well as the lowest scoring questions were used to determine the priority areas for the Community Action Plan. Please see the Assessment Results Summary in the appendix.

COMMUNITY ASSESSMENT INFORMATION

Enter any assessments conducted in addition to CHANGE. If no other assessments have been conducted, leave this section blank. Add additional rows as needed.

Name of Assessment	Date Assessment Completed	Description of Assessment	How Assessment Data Informed the CAP

PLANNING, IMPLEMENTATION, AND EVALUATION

LINN COUNTY HEALTHY COMMUNITIES WORK PLAN

Project Goal 1.0

Goal:

By June 2014, the number of tobacco free outdoor events and/or areas will increase in Linn County.

Priority area(s) the goal addresses:

Chronic diseases: ☑ arthritis ☑ asthma ☑ cancer ☑cardiovascular disease ☑ diabetes ☑ obesity

Related risk factors: ☐ nutrition ☐ physical activity ☑ tobacco

How the goal impacts the priority area(s):

The assessment highlighted the need for an increase in the amount tobacco free outdoor areas, making this goal a priority. By achieving this goal, we will help to eliminate hazardous secondhand smoke exposure and support a tobacco-free norm, which can in turn reduce tobacco initiation among youth and young adults who frequent the venues and events and help tobacco users quit. Additionally, we will reduce youth's exposure to tobacco messages and improve the environmental health of our community by reducing cigarette butt litter and the negative and dangerous effects cigarette butt litter has on our soil, waterways, and wildlife. Achieving this goal will improve the results of the CHANGE tool by increasing the number of tobacco- and smoke-free areas in our community, which could in turn improve the results for the Community at Large, Community Organizations, and Worksites sectors that scored low in tobacco-and smoke-free outdoor policies. It may also indirectly improve the leadership, chronic disease management and tobacco categories.

Measuring progress:

Primary Data Source	Secondary Data Source
Policy Reviews	Observation
Describe the progress	
Describe barriers or issues and plans to overcome them	

Annual Objective 1.1

Setting/Sector:

☑ Community at large ☑ Community institution/organization ☐ Health care ☐ School ☐ Work site

Policy/environmental change strategy to achieve this objective:

Tobacco-free policy 24/7 for outdoor public places.

Evidence/practice base for the strategy:

"Scientific evidence has firmly established that there is no safe level of exposure to secondhand tobacco smoke (SHS), a pollutant that causes serious illnesses in adults and children. There is also indisputable evidence that implementing 100% smoke-free environments is the only effective way to protect the population from the harmful effects of exposure to SHS."[1] By creating a tobacco-free environment at outdoor areas/events, as multiple other municipalities across the world have, the health of our

[1] http://www.globalsmokefreepartnership.org/resources/ficheiros/SF_Outdoors.pdf

community will be improved. By discouraging the use of tobacco and creating a social norm of a tobacco-free environment, we will be fighting litter, setting a tobacco-free example for youth and adults, reducing opportunities for youth and adults to smoke and use smokeless tobacco, as well as reduce secondhand smoke exposure.

Target number of people that will be reached: 35,000

How the objective impacts the problem:

This objective impacts the overall problem by reducing exposure to secondhand smoke which has been deemed harmful to health by the Center for Disease Control and the World Health Organization. Additionally, it supports a community norm of a tobacco-free environment which reduces youth tobacco exposure and initiation in youth and young adults and encourages tobacco users to quit smoking or using tobacco.

Objective:

By June 2012, River Rhythms will adopt and implement a tobacco free policy for all of their events.

Measuring progress:

Primary Data Source	**Secondary Data Source**
River Rhythms Tobacco Policy	Observation at River Rhythms
Describe the progress	
Describe barriers or issues and plans to overcome them	

Action Steps:

Action Steps	Specific Person(s)/ Organization(s) Responsible	Timeframe
1. Research outdoor events with successful tobacco free policies.	TPEP	July 2011
2. Engage stakeholders. Share information from the Healthy Communities project and seek out champions.	Linn County Tobacco Workgroup	July 2011
3. Conduct an assessment of community. Is this goal supported by the Linn County River Rhythms concert goers?	Linn County Tobacco Workgroup	July-Aug 2011
4. Share community and CHANGE assessment results with stakeholders and discuss feasibility of policy.	Linn County Tobacco Workgroup	Sept-Nov 2011
5. Assess barriers to policy change.	Linn County Tobacco Workgroup	Oct-Nov 2011
6. Create a draft policy.	TPEP	Dec 2011-Jan 2012
7. Present policy to stakeholders and revise as necessary.	Linn County Tobacco Workgroup	Feb 2012
8. Policy adoption and creation of the implementation plan (including signage, enforcement and communication plans).	Linn County Tobacco Workgroup	March-June2012
9. Celebrate success of the policy with champions and stakeholders.	Linn County Tobacco Workgroup	June 2012

LINN COUNTY HEALTHY COMMUNITIES WORK PLAN

Project Goal 2.0

Goal:

By June 2014, school district wellness council(s) will have successfully implemented wellness policies.

Priority area(s) the goal addresses:

Chronic diseases: ☑ arthritis ☑ asthma ☑ cancer ☑cardiovascular disease ☑ diabetes ☑ obesity

Related risk factors: ☑ nutrition ☑ physical activity ☑ tobacco

How the goal impacts the priority area(s):

This goal was selected because none of the districts assessed in the CHANGE tool demonstrated having a school district wellness council comprised of school personnel, parents, students, community partners that help plan and implement district health activities. This goal will positively impact the health of Linn County students, being that school wellness councils are key in effectively implementing, monitoring, and evaluating school wellness policies and that wellness policies are a key component to increased physical activity and nutrition, resulting in the prevention of childhood obesity. Polices are also key to reducing tobacco use among students. Achieving this goal will improve the results of the CHANGE tool by increasing the number of school district wellness councils, which could in turn improve the results for the School District sector. There is great potential for the school wellness council to influence the policies and environments around nutrition, physical activity, and tobacco within the schools in their district resulting in improved scores for individual schools within the CHANGE tool. It will take leadership to achieve this goal, resulting in possible improved leadership scores as well.

Measuring progress:

Primary Data Source	Secondary Data Source
Success of the goal will be measured by the development of a school district wellness council.	
Describe the progress	
Describe barriers or issues and plans to overcome them	

Annual Objective 2.1

Setting/Sector:

☐ Community at large ☐ Community institution/organization ☐ Health care ☑ School ☐ Work site

Policy/environmental change strategy to achieve this objective:

District Health Group

Evidence/practice base for the strategy:

A child's ability to learn is directly affected by their health status. Because proper eating and physical activity habits as well as tobacco avoidance skills are a set of complex behaviors there is a need for schools to work with their surrounding communities to help students establish health habits from an early age. According to the American School Board Journal, it is important for schools to make connections with community partners because they bring resources and expertise that the district may not have. These councils can spread the responsibility of child wellness throughout the community, relieving school administrators and staff of

shouldering burden alone. Collaboration between schools, family and their surrounding communities is considered to be on of the most effective ways to both prevent and intervene against negative health outcomes. Community involvement can also lead to successful implementation of health policies and programs in schools, while keeping true to that communities own unique values. The use of school health advisory councils can lead to schools within the district becoming places where children can not only learn about health but also engage in healthy behaviors.

The Center for Disease Control and Prevention, the national Let's Move campaign, the American Cancer Society and many other entities recommend the use of a school health advisory council to guide collaboration between schools and community. In fact, many states, including North Carolina and Texas, require the formation and maintenance of school health councils. School health advisory councils are proven an effective tool in helping sustain a school districts focus on student wellness.

Target number of people that will be reached: Will vary depending on the district selected.

How the objective impacts the problem:

Creation of district wide wellness councils addresses the problem by mobilizing the community to solve issues uncovered in the Healthy Communities assessment. A council made up of school administration, teachers and parents is best qualified to address policy and environment as it pertains to the schools. Issues such as physical activity requirements, food for celebration and reward, and healthy cafeteria options vary from school to school and need to have the flexibility to be addressed in the manner that is best for each school. One size fits all approaches does not account for the demographic and socioeconomic differences from school to school and district to district. Our objective of piloting a single district wellness council by 2012 works to identify initial successes, barriers to success and establishes a model for other councils to follow. Experiences learned and information gathered during a pilot program can then be applied to follow up councils as a roadmap to greater success and smoother rollout.

Objective:

By June 2012, create one model pilot school district wellness council.

Measuring progress:

Primary Data Source	Secondary Data Source
Success of the goal will be measured by the development of a school district wellness council	
Describe the progress	
Describe barriers or issues and plans to overcome them	

Action Steps:

Action Steps	Specific Person(s)/ Organization(s) Responsible	Timeframe
1. Research: School districts wellness policies, wellness councils and key contact within each district.	TPEP	July-Aug 2011
2. Identify district interested in developing a school wellness council.	TPEP	Aug 2011
3. Identify possible steering committee members including nurses, parents with different SES, students, physical education specialist, administrators, school nutrition, OSU Extension, Linn County Health Department, Linn County Childhood Obesity Partnership,	TPEP/Tonja (Seven Oaks Elementary School principal)	Aug-Sept 2011
4. Hold steering committee meeting(s). Present Healthy Communities assessment, discuss possible easy wins, discuss how to identify needs within district and look into doing an assessment, get buy in from the steering committee.	TPEP/Steering Committee	Sept 2011-Jan 2012
5. Assess barriers.	Steering Committee	January 2012
6. Use different methods (email, in person, phone calls) to invite potential council members to the table.	Steering Committee	Jan-Feb 2012

7. Determine implementation plan for School District Wellness Council.	Steering Committee	March-June 2012

LINN COUNTY HEALTHY COMMUNITIES WORK PLAN

Project Goal 3.0

Goal:

By June 2014, increase the strategic referrals to self-management programs in the Linn County health care systems.

Priority area(s) the goal addresses:

Chronic diseases: ☑ arthritis ☑ asthma ☑ cancer ☑cardiovascular disease ☑ diabetes ☑ obesity

Related risk factors: ☑ nutrition ☑ physical activity ☑ tobacco

How the goal impacts the priority area(s):

The results of the CHANGE tool indicated a need for the implementation of a referral system with in the health care systems to help patients access community-based resources or services for chronic disease management. Streamlining the referral process for Living Well directly from Health care providers to workshops will increase overall community wellness by strategically increasing participation in the program and by integrating the medical system more fully into Living Well, a self management program. Living Well has been shown to help people living with chronic conditions better manage their health, resulting in fewer hospital stays, reduced health care expenditures, and improved energy levels and overall health.

Measuring progress:

Primary Data Source	Secondary Data Source
Linn County Referrals to Living Well	Clinic Referrals to Living Well
Describe the progress	
Describe barriers or issues and plans to overcome them	

Annual Objective 3.1

Setting/Sector:

☐ Community at large ☐ Community institution/organization ☑ Health care ☐ School ☐ Work site

Policy/environmental change strategy to achieve this objective:

Chronic disease referral system.

Evidence/practice base for the strategy:

Targeted and strategic provider referrals to self management programs (SMP) reinforce public health efforts aimed at prevention and health promotion, specifically for older adults. Nationally, over 80% of adults in the US age 65 and older are living with at least one chronic condition, and half live with two or more. Chronic conditions such as arthritis, heart disease, diabetes, depression and stroke are more common with increasing age. These conditions account for over 75% of the nation's healthcare costs. In 2007 alone, the hospitalization costs for arthritis, cancer, lung disease, diabetes, heart disease and stroke together cost nearly $2 billion

for adults 45 years and older in Oregon.

Previous studies of SMP participants consistently show improvements in health status, greater vitality, reduced fatigue, improved psychological well-being, increased physical activity and improved ability to manage their chronic illness (i.e. self-efficacy and improved communication with physicians). These individual patient benefits, in tern, translate to more effective utilization of healthcare, decreased hospitalization, and provides savings to public and private insurance programs.

Target number of people that will be reached: Will vary depending on the clinic selected.

How the objective impacts the problem:

- Increase participation and successful completion of Chronic Disease Self Management Programs.
- Improve individual participant health status and self-efficacy.
- Improve the effective utilization of health care, which will in turn decrease ER and hospital visits, and overall reduce healthcare expenditures/cost.

Objective:

By June 2012, at least one clinic will have developed a strategic referral process in Linn County.

Measuring progress:

Primary Data Source	Secondary Data Source
Identified clinic referrals to Living Well.	Linn County referrals to Living Well.
Describe the progress	

Describe barriers or issues and plans to overcome them	

Action Steps:

Action Steps	Specific Person(s)/ Organization(s) Responsible	Timeframe
1. Assess current pilot and referral pathway at East Linn Community Health Center (ELCHC).	OPCA: Community Health Center Patient Self-Management Collaborative	Sept 2011
2. Refine and improve a final referral pathway for ELCHC.	OPCA: CHC Patient Self-Mgmt Collaborative	Nov 2011
3. Identify liaison between Living Well, OPCA, and clinics to see process through.	OPCA: CHC Patient Self-Mgmt Collaborative	Nov 2011
4. Identify possible clinics: Samaritan Albany Internal Medicine Group, Heart Spring Wellness Center (Dr. Chapin via Rachel Fuss), In-Reach, Out-Reach, family practice.	Liaison/Living Well Group	Nov 2011
5. Develop talking points: medical home, health care reform, meaningful use	Liaison/State (Laura Saddler)	Nov-Dec 2011
6. Present and promote model plan to interested clinics.	Liaison/Fabiola (ELCHC)	Jan-Feb 2011
7. Assist clinic in adapting and adopting customized plan.	Liaison	March-June 2012

LINN COUNTY HEALTHY COMMUNITIES WORK PLAN

Project Goal 4.0

Goal:

By June 2014, Linn County will see an increase in worksites who have adopted wellness policies.

Priority area(s) the goal addresses:

Chronic diseases: ☑ arthritis ☑ asthma ☑ cancer ☑cardiovascular disease ☑ diabetes ☑ obesity

Related risk factors: ☑ nutrition ☑ physical activity ☑ tobacco

How the goal impacts the priority area(s):

The CHANGE tool identified multiple areas within nutrition, physical activity, and tobacco in which policy creation with in worksites may have a positive impact, therefore the goal of worksites adopting wellness policies was chosen. Effective workplace programs and policies can reduce health risks and improve the quality of life for employees in Linn County. Policy change supported by an environmental change may improve multiple results of the CHANGE tool assessment. Improved nutrition results may be seen through policies around enhancing access to healthy foods. Physical activity results may improve with policy change around using break and lunch time for physical activity and tobacco results may improve with policies around tobacco-free outdoor areas. Evidence from naturally occurring experiments on policy changes supports that changes in smoking behaviors, in part, result from changes made in the workplace. The thought is that policy change will also improve physical activity, nutrition, and chronic disease management. These improvements may be seen in employees, as well as in employees' families being that work habits are often duplicated at home. It was determined by the coalition that worksite wellness coordinators and/or committees would be the best at encouraging and creating policy change within worksites.

Measuring progress:

Primary Data Source	Secondary Data Source
Worksite Wellness Policies	Surveys
Describe the progress	
Describe barriers or issues and plans to overcome them	

Annual Objective 4.1

Setting/Sector:

☐ Community at large ☐ Community institution/organization ☐ Health care ☐ School ☑ Work site

Policy/environmental change strategy to achieve this objective:

Leadership: Wellness Committee

Evidence/practice base for the strategy:

The workplace and the health of the workers within it are inextricably linked. Ideally, workplaces should not only protect the safety and wellbeing of employees but also provide them opportunities for better long-term health and enhanced quality of life. Effective workplace programs, policies, and environments that are health-focused and worker-centered have the potential to significantly benefit employers, employees, their families, and communities. Well-constructed and well-run programs can reduce costs to the employer and improve employee health and morale. At its best, worksite health promotion creates an organizational climate that fosters vitality and motivation, and leverages the potential for increased workforce productivity that creates a worksite wellness environment. Defined, worksite wellness refers to the policies and practices that support profitability for the organization and employability for the individual.

Numerous studies have found that investment in a worksite wellness program can be worth the employer's initial cost. In 2009, *Preventing Chronic Disease* published a case study of a worksite wellness program in Austin, Texas which found that employees who engaged in more physical activity, had better knowledge of disease management (diabetes and asthma), had better eating habits, and smoked less than they did before the program was implemented. (National Center for Chronic Disease Prevention and Health Promotion, 2010)

Target number of people that will be reached: Will vary depending on the worksite selected.

How the objective impacts the problem:

The objective of developing a single wellness coordinator/committee by 2012 works to identify initial successes, barriers to success and establishes a model for other worksites to follow. It was decide that a diverse wellness committee that includes top-level management is best qualified to develop and implement wellness policies that create a healthier environment. Once management commitment is conveyed and a wellness committee established at this "model" company and the committee begins the wellness work tailored to that employee demographic and workplace exposures, the coalition can use that same model to educate and assist other employers as they recruit and equip wellness committees to move workplace wellness forward in Linn County. Once established, the worksite wellness committees will have the ability to implement policies, systems and environmental changes within their worksites to increase physical activity, provide healthy food options, and decrease smoking, which can improve the overall health of employers

and employees.

Objective:

By June 2012, one worksite in Linn County will have established a wellness committee.

Measuring progress:

Primary Data Source	Secondary Data Source
Worksite Wellness Committees	Surveys
Describe the progress	
Describe barriers or issues and plans to overcome them	

Action Steps (list up to 10):

Action Steps	Specific Person(s)/ Organization(s) Responsible	Timeframe
1. Identify a worksite wellness community champion.	Healthy Communities Coalition	May-June 2011
2. Develop a steering committee.	Champion	July
3. Research best practices, ROI, development of wellness committee, talking points, create education and marketing materials, and connect with SAIF and look to their resources.	Champion/Steering Committee	August-Sept 20011
4. Approach chambers of commerce to champion and find interested worksites.	Champion/Steering Committee	October 2011
5. Communication with interested worksites (discuss ROI, benefits, resources, easy wins, policy change, reinforce the importance)	Champion/Steering Committee	Nov 2011-Feb 2012
6. Develop action plan with employer.	Champion	Feb-June 2012

	Steering Committee/Worksite	

SUSTAINABILITY PLAN

Describe the plan to maintain the CHART and/or associated activities beyond the national funding commitments. Elements of sustainability include CHART infrastructure, maintenance, and development of local capacity, identification of additional funding sources, or policy implementation that may continue beyond the life of this funding.

Sustainability is an ongoing topic for the CHART. Currently, Linn County Health Services is looking into other funding options. Linn County Tobacco Prevention Program has committed to hosting quarterly coalition meetings in order to continue building capacity for chronic disease prevention and self-management programs. CHART member Dar Merrill has suggested that there may be a possibility for the Commission on Children and Families to work on school wellness goal/objective in congruence with the governor's initiatives on early childhood, etc. Other ideas for continued work towards schools include connecting with Safe Kids, Healthy Schools, and the Linn County Council on Schools. Janice Gregg with the OSU Extension brought forth the idea of integrating some of Healthy Communities priorities with the extension's current work. Samaritan Health Services will continue to encourage staff to be involved with the coalition, will continue to work towards submitting proposals together and are on board for further discussing how they can be involved in the community action plan, which may include the healthcare goal and objective. Sustainability and resources will be the focus of our June Healthy Communities meeting and we have asked the coalition to bring additional ideas to the table at that time.

COMMUNICATIONS PLAN

Describe any plans your CHART has to communicate this plan or your work to your greater community or stakeholders.

The CHART is currently communicating the community action plan to those who may be interested in assisting with the plan and assuring the likelihood of its success over the next year. This includes communicating with the Linn County Wellness team to begin work on policy change within Linn County Health Services, presenting to the Health Advisory Council, communicating with Living Well to encourage a strategic referral process with in health care systems, and sharing with representatives of the Linn County Childhood Obesity Partnership for possible collaboration efforts specific to schools. The CHART will continue to share with community, as it is our mission to work with all community sectors to advocate and facilitate policy and environmental strategies to improve nutrition, increase physical activity, and encourage cessation and abstinence of tobacco products for all residents. Developing communication strategies is on going and whenever the opportunity presents itself Healthy Communities Coalition members are encouraged to share and engage the community and stakeholders.

RESOURCES

Describe what additional resources (e.g., funding, equipment, media, human resources, in-kind) that have been committed, and by whom, to leverage resources.

The Linn County Tobacco Prevention Program is committed to coordinating quarterly coalition meetings. Samaritan Health Services is committed to provide the meeting space and equipment as well as encouraging relevant staff members to be involved with coalition.

Date completed	May 26, 2011
Date revised	
Date revised	

Healthy Communities-Building Capacity: Appendix

A.I.p(3)_LinnCountyCAP.pdf

Linn County Healthy Communities Coalition

2010-2011 Results Summary Snapshot

Community Health Assessment aNd Group Evaluation (CHANGE)

Sector	Average Score
Community At Large	**41.29%**
Worksites	**42.92%**
Community Organizations	**44.08%**
Health Care	**45.17%**
Schools	**49.91%**

	Low 0-20%	21-40%	Medium 41-60%	61-80%	High 81-100%
Community at Large			**41.29**		
Worksites			**42.92**		
Community Organizations			**44.08**		
Health Care			**45.17**		
Schools			**49.91**		

Target Areas	Average Score
Leadership	**37.43%**
Chronic Disease Management	**39.63%**
Physical Activity	**41.36%**
Nutrition	**41.57%**
Tobacco	**63.39%**

	Low 0-20%	21-40%	Medium 41-60%	61-80%	High 81-100%
Leadership		**37.43**			
Chronic Disease Mgt		**39.63**			
Physical Activity			**41.36**		
Nutrition			**41.57**		
Tobacco				**63.39**	

Target Areas by Sector	Average Score
Community At Large	**41.29%**
Leadership	32.42%
Nutrition	33.83%
Chronic Disease Management	34.81%
Physical Activity	50.53%
Tobacco	54.85%
Worksites	**42.92%**
Physical Activity	29.83%
Leadership	31.54%
Nutrition	41.29%
Chronic Disease Management	43.64%
Tobacco	68.33%
Community Organizations	**44.08%**
Chronic Disease Management	32.92%
Nutrition	43.33%
Leadership	44.33%
Physical Activity	44.38%
Tobacco	55.42%
Health Care	**45.17%**
Physical Activity	34.72%
Leadership	39.72%
Nutrition	42.40%
Chronic Disease Management	44.00%
Tobacco	65.00%
Schools	**49.91%**
Leadership	39.12%
Chronic Disease Management	42.78%
Nutrition	47.00%
Physical Activity	47.33%
Tobacco	73.33%

A.I.p(3)_LinnCountyCAP.pdf

Community At Large	Health Care	Organizations	Schools	Worksites	Lowest Scoring Questions To what extent does the community...
					Nutrition
					Adopt strategies to encourage food retailers to provide healthy food and beverage options in underserved areas?
					Encourage community gardens?
					Connect locally grown foods to local restaurants and food venues and promote the purchase of these foods?
					Provide smaller portion sizes at local restaurants and food venues?
					Ban local restaurants and retail food establishments from cooking with trans fats?
					Implement breastfeeding initiative for future or current moms?
					Assess patients' nutrition as part of a written checklist or screening used in all routine office visits?
					Provide regular counseling about the health value of good nutrition during all routine office visits?
					Provide free or low cost weight management or nutrition programs?
					Implement a referral system to help patients access community-based resources or services for nutrition?
					Institute nutritional labeling at onsite cafeteria and food venues?
					Institute healthy food preparation practices in onsite cafeteria and food venues?
					Ban marketing of less than healthy foods and beverages onsite?
					Provide smaller portion sizes in onsite cafeteria and food venues?
					Ban using food as a reward or punishment for academic performance or behavior?
					Ensure that students are provided only healthy food and beverage options beyond the school food services?
					Ensure that multiple channels, including classroom, cafeteria and communications with parents, are used to promote healthy eating behaviors?
					Provide school garden and related resources?
					Institute pricing strategies that encourage the purchase of healthy food and beverage options?
					Provide direct support for community-wide nutrition opportunities ?
					Institute healthy food and beverage options at company-sponsored meetings and events?
					Physical Activity
					Encourage non-motorized commutes to the facility/school?
					Enhance access to public transportation within reasonable walking distance?
					Provide street traffic calming measures to make areas where people are or could be physically active safer?
					Maintain a network of parks?
					Provide regular counseling about the health value of physical activity during all routine office visits?
					Implement a referral system to help patients access community-based resources or services for physical activity?
					Assess patients' physical activity as part of a written checklist or screening used in all routine office visits?
					Provide bicycle parking for patrons?
					Restrict screen time to less than 2 hours per day for children over 2 years of age?
					Ban using or withholding physical activity as a punishment?
					Ensure the availability of proper equipment and facilities that meet safety standards?
					Require 225 minutes per week of physical education for all middle school and high school students?
					Require 150 minutes per week of physical education for all elementary school students?
					Ensure that students are not provided waivers or exemptions from participation in physical education for other school and community activities, such as band, chorus, ROTC, sports participation, or community volunteering?
					Provide a changing room or locker room with showers?
					Designate a walking path on or near building property?
					Provide access to offsite workout facility or subsidized membership to local fitness facility?

Tobacco					
					Institute a tobacco-free policy 24/7 for indoor public places?
					Institute a tobacco-free policy 24/7 for outdoor public places?
					Implement a referral system to help students/employees/patrons access tobacco cessation resources or services?
					Ban tobacco advertisement tobacco promotions, promotional offers and prizes?
					Regulate the number, location, and density of tobacco retail outlets?
					Implement a provider-reminder system to assess, advise, track, and monitor tobacco use?
					Provide regular counseling about the harm of tobacco use and exposure during all routine office visits?
					Provide access to free or low cost pharmacological quitting aids for their patients?
Leadership					
					Have a health promotion budget?
					Have a wellness coordinator/committee?
					Participate in the public policy process to highlight the need for community changes to address chronic diseases and related risk factors?
					Finance public sports facilities?
					Institute a management program to improve safety within the transportation system?
					Enhance access to childhood overweight prevention and treatment services to reduce health disparities?
					Promote high standards of modifiable risk factor practice to healthcare and provider associations?
					Promote collaboration between health care professionals for managing chronic diseases?
					Provide incentives to patrons participating in chronic disease prevention measures?
					Provide training for all teachers and staff on school physical activity, nutrition, and tobacco prevention policies?
					Adopt organizational or performance objectives pertaining to employee health and well-being?
					Reimburse employees for preventive health or wellness activities?
Chronic Disease					
					Provide access to an onsite nurse?
					Provide an onsite medical clinic to monitor and address chronic diseases and related risk factors?
					Provide routine screening, follow–up counseling and education to patrons/employees to help address chronic diseases and related risk factors?
					Adopt strategies to address chronic disease health disparities?
					Adopt strategies to educate its residents on the importance of obesity prevention, controlling high blood pressure, and controlling blood sugar or insulin levels?
					Implement a referral system to help patient's access community-based resources or services for chronic disease management?
					Provide screening for chronic diseases in adults with risk factors?
					Adopt curricula or training to raise awareness of the signs and symptoms of heart attacks and strokes?
					Provide chronic disease self-management education to individuals identified with chronic conditions or diseases?
					Provide opportunities to raise awareness among students of the signs and symptoms of heart attack and stroke?

			■		Ensure students are aware of the importance of calling 9-1-1 for emergencies?
					Provide paid time off to attend health promotion programs or classes?

KELLEY C. KAISER, MPH
2530 NW Windsor Pl.
Corvallis, OR 97330
(541) 757-6631 (h) ❖ (541) 768-5341 (w)

OBJECTIVE

To obtain a challenging position, which allows me to utilize my knowledge of HealthCare Administration focusing on leadership and operations

WORK EXPERIENCE

Samaritan Health Services ***April 2002 - Present***
Corvallis, Oregon
VICE-PRESIDENT HEALTH PLANS OPERATIONS

RESPONSIBILITIES INCLUDE: SERVE AS THE CHIEF EXECUTIVE OFFICER FOR SAMARITAN HEALTH PLANS AND INTERCOMMUNITY HEALTH PLANS AS DESCRIBED BLEOW.

Samaritan Health Plans ***January 2005 - Present***
Corvallis, Oregon
CHIEF EXECUTIVE OFFICER

RESPONSIBILITIES INCLUDE: LEADERSHIP POSITION FOR A HOSPITAL OWNED PHYSICIAN DRIVEN INSURANCE PLAN FOCUSING IN MEDICARE MANAGED CARE. RESPONSIBLE FOR THE DESIGN AND IMPLEMENTATION OF THE STRATEGIC PLAN WHICH INCLUDES: THE RESEARCH AND DEVELOPMENT OF NEW GROWTH OPPORTUNITIES, DEVELOPMENT AND MONITORING OF HEDIS MEASURES AS THEY RELATE TO NCQA STANDARDS, AND THE IMPLEMENTATION OF FURTHER EXPANSION TO ALL LINES OF BUSINESS. ADDITIONAL RESPONSIBILITIES INCLUDE COORDINATION WITH THE OWNER PHYSICIAN HOSPITAL ORGANIZATIONS (PHOS) TO INCREASE THE EFFECTIVENESS OF THE MANAGED CARE DELIVERY SYSTEM WITHIN OUR COMMUNITY.

InterCommunity Health Plans ***March 1999 - Present***
Corvallis, Oregon
CHIEF EXECUTIVE OFFICER

RESPONSIBILITIES INCLUDE: LEADERSHIP POSITION FOR A HOSPITAL OWNED PHYSICIAN DRIVEN MEDICAID MANAGED CARE PLAN. RESPONSIBLE FOR THE DESIGN AND IMPLEMENTATION OF THE STRATEGIC PLAN WHICH INCLUDES: THE RESEARCH AND DEVELOPMENT OF A MEDICARE PSO PLAN, DEVELOPMENT AND MONITORING OF HEDIS MEASURES AS THEY RELATE TO NCQA STANDARDS, AND THE IMPLEMENTATION OF FURTHER EXPANSION TO THE OREGON HEALTH PLAN. ADDITIONAL RESPONSIBILITIES INCLUDE COORDINATION WITH THE OWNER PHYSICIAN HOSPITAL ORGANIZATIONS (PHOS) TO INCREASE THE EFFECTIVENESS OF THE MANAGED CARE DELIVERY SYSTEM WITHIN OUR COMMUNITY.

InterCommunity Health Plans ***May 1998 – March 1999***
Corvallis, Oregon
CHIEF OPERATING OFFICER

RESPONSIBILITIES INCLUDE: THE OPERATION OF IHP AS IT ACCOMPLISHES ITS MISSION GOALS AND OBJECTIVES. RESPONSIBLE FOR THE OVERALL SUCCESS AND FUNCTION OF IHP, AND THE DAILY OPERATIONS THROUGH THE (1) PROPER AND TIMELY ADMINISTRATION OF POLICIES, PROCEDURES, AND BENEFITS, (2) SUPERVISION OF STAFF, (3) REPRESENTATION OF IHP TO THE STATE AND PROVIDERS AND (4) DEVELOPMENT OF PLANS TO MEET REGULATORY AND CONTRACTUAL COMPLIANCE FOR THE STATE OF OREGON AS THEY RELATE TO PROVIDER AND MEMBER SERVICES.

InterCommunity Health Network ***September 1995 - May 1998***
Corvallis, Oregon
GOVERNMENT PROGRAMS MANAGER

RESPONSIBILITIES INCLUDE: PERSONNEL AND DAILY OPERATIONS ENSURING THAT PROCEDURES AND BENEFITS ARE ADMINISTERED ON A TIMELY AND ACURATE BASIS. PROVIDER SERVICES, CONTRACTING, FINANCIAL AND STATISTICAL ANALYSIS, CLAIMS ADMINISTRATION ISSUES, AND GENERAL OPERATIONAL MANAGEMENT FUNCTIONS FOR PROVIDER AND MEMBER SERVICES.

Women's Care, PC ***June 1990 - September 1995***
Eugene, Oregon
ASSISTANT ADMINISTRATOR

ASSISTED IN OVERSEEING THE DAILY OPERATIONS OF THIS FOURTEEN-PHYSICIAN THREE COST CENTER PRACTICE.

RESPONSIBILITIES INCLUDE: ANALYSIS OF CPT CODES AND REIMBURSEMENT RATES, MAINTAINING MAL-PRACTICE AND GENERAL INSURANCE COVERAGE, AND SUPERVISION OF INTERNS. ASSISTED IN ALL ADMINISTRATIVE OPERATIONS OF THE CORPORATION INCLUDING, PAYROLL, EMPLOYEE BENEFIT PACKAGES, CORPORATE/PENSION PLAN RECORDS, AND GENERAL ACCOUNTING FUNCTIONS.

EDUCATION

Oregon State University ***Graduated June 1993***
Corvallis, Oregon
BACHELORS OF SCIENCE IN HEALTH CARE ADMINISTRATION

Oregon State University ***Graduated June 1999***
Corvallis, Oregon
MASTERS OF PUBLIC HEALTH IN HEALTH POLICY AND MANAGEMENT

COMMUNITY ACTIVITIES

OSU FEDERAL COMMUNITY CREDIT UNION – SUPERVISORY COMMITTEE SINCE 2009

ROTARY CLUB – MEMBER OF THE CORVALLIS ROTARY CLUB (CURRENT BOARD MEMBER) MEMBER SINCE 2005

CORVALLIS-BENTON CHAMBER COALITION – PAST BOARD CHAIR, MEMBER SINCE 2002 – MEMBER OF THE GOVERNMENT AFFAIRS COMMITTEE

OSU ALUMNI ASSOCIATION – ADVISORY COUNCIL MEMBER 2010 – CURRENT

2008 JUNIOR FIRST CITIZEN – CELEBRATE CORVALLIS

PROFESSIONAL ORGANIZATIONS/ASSOCIATIONS

AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES – ACTIVE MEMBER

AMERICAN ACADEMY OF MEDICAL ADMINISTRATORS – ACTIVE MEMBER

AMERICAS HEALTH INSURANCE PLANS MEMBER – ACTIVE MEMBER

MEDICAID ADVISORY COMMITTEE – OREGON, BOARD MEMBER (2001 – 2010) PAST CHAIR

CHAIR, OHP CONTRACTORS COMMITTEE (2001 – 2002)

VICE-CHAIR, OHP CONTRACTORS COMMITTEE (2000 – 2001)

RONALD S. STEVENS

1327 N.W. Souza Place
Corvallis, OR 97330
(541) 753-0996

EDUCATION:

Master of Business Administration, Accounting
University of Oregon
Graduated, December, 1978

Bachelor of Science, Agriculture
Oregon State University
Graduated, June, 1971

PROFESSIONAL:

Certified Public Accountant, Oregon
Fellow, Healthcare Financial Management Association
Certified Manager of Patient Accounts

EXPERIENCE:

Vice President Financial Services/Treasurer for Samaritan Health Services, Inc June 2003 to Present; Samaritan Health Plans Finance Officer August 2004 to Present; InterCommunity Health Plans Finance Officer February 1994 to Present; and Paradigm Indemnity Corporation Treasurer 1997 to Present.

Responsibilities: Financial operations of the health plans and captive insurance company; Direct the annual budget process, annual financial audit, and financial reporting systems; Direct the financial operations of the health plans, including monthly financial statements, estimation of claims IBNR, annual audit, and annual/quarterly filings to NAIC (National Association of Insurance Commissioners) and State of Oregon.

Vice President Financial Services/CFO, Samaritan Health Services, Inc. January 1998 to June 2003.

Vice President Financial Services/CFO, Good Samaritan Hospital, Corvallis, Oregon December, 1989 to June 2003.

Responsibilities: All aspects of the financial operations of the hospital including management authority for Accounting, Patient Accounts, Admitting, Information Systems, Medical Records, Materials Management, and Volunteer Services; Directed the annual budget process, annual financial audit, and financial reporting systems;

Completed the successful financing for the 1992 Revenue Bonds in the amount of $11.5 million and 1998 Revenue Bonds in the amount of $40 million, including a Standard & Poor's A Ratings utilizing the Hospital Facilities Authority of Benton County; Obtained approval to maintain interest rate subsidy and loan guarantee from Department of Health and Human Services on May 1, 1973 Hill-Burton loan.

Controller/Accounting Manager, Good Samaritan Hospital, Corvallis, Oregon
May, 1985 to November, 1989.

Responsibilities: The Accounting functions related to monthly financial statement reporting, budget preparation, annual financial reporting, Medicare cost report work-up, strategic financial planning, and tax return preparation; Supervised the functions of general ledger accounting, accounts payable, payroll, cost accounting, fixed assets, and financial analysis projects; Project Manager for selection and implementation of hospital information system modules for general ledger, payroll, accounts payable, admitting, medical records, patient accounts, and order entry.

Senior Accountant, Kohnen, Larson & Company CPAs, Corvallis, Oregon
January, 1979 to May, 1985

Responsibilities: Tax return preparation and review, monthly financial statement preparation, auditing and financial management consulting; Regional accounting firm responsible for performance of Good Samaritan Hospital audit until 1987.

COMMUNITY SERVICE:

Samaritan Village Board of Directors, June 2008 to January 2012.
OSU Federal Credit Union, Board of Directors, 1998 to present.
Rotary Club of Greater Corvallis, 1995 to 2000, Treasurer 96-97 & 97-98.
OSU Federal Credit Union, Supervisory Committee, 1995 to 1998.
United Way of Benton County, Board of Directors, 1989-1995.
Corvallis Boys & Girls Club, Board of Directors, 1982-1992.
Kiwanis Club of Corvallis, 1982-1985.
Corvallis Jaycees, 1979-1982, Treasurer 80-82.

Alissa P. Craft, DO, MBA
CURRICULUM VITAE

I. Personal Data

Name	Alissa Paula Craft
Address	Samaritan Health Plans 815 NW 9th Street, Suite 103 Corvallis, OR 97330
Phone	541-768-4889
Email	acraft@samhealth.org

II. Education

Master of Business Administration (MBA), 1999
University of Phoenix, San Diego, CA

Doctor of Osteopathic Medicine (DO), 1992
Kirksville College of Osteopathic Medicine,
Kirksville, MO

Bachelor of Science, Biology, 1987
Arizona State University, Tempe, AZ

III. Postgraduate Training

07/01/97-06/30/00	Fellowship, Neonatal-Perinatal Medicine University of California, San Diego San Diego, CA
07/01/96-03/31/97	Fellowship, Pediatric Intensive Care University of California, San Diego San Diego, CA
10/01/92-06/30/96	Internship and Residency Phoenix Children's Hospital/ Maricopa Medical Center Phoenix, AZ

IV. Professional Experience

2011-	Medical Director, Samaritan Health Plans Corvallis, OR
2009 – 2010	Director of Medical Education Samaritan Health Services, Corvallis, OR
2007 - 2008	Department Chair, Pediatrics Midwestern University Arizona College of Osteopathic Medicine

2006- 2007	Unit Director, Phoenix Children's Hospital Phoenix Perinatal Associates, Division of Neonatal Medicine
2005 - 2008	Associate Director, Department of Continuous Quality Improvement Pediatrix Medical Group Sunrise, FL
2002-2003	Children's Specialists – San Diego Division of Neonatal Medicine San Diego, CA
2000- 2002	Phoenix Perinatal Associates, Division of Neonatal Medicine Attending Neonatologist Phoenix, AZ

V. Certification

National Board of Osteopathic Medical Examiners
November 1, 1993
Certificate No. 21203

American Board of Pediatrics
October 11, 1995/ December 6, 2001
Certificate No. 055643

American Board of Pediatrics
SubBoard in Neonatal Perinatal Medicine
November 12, 2001/ March 2008
Certificate No. 003747

American Osteopathic Board of Pediatrics
June 2010

VI. Licensure

Arizona Board of Osteopathic Examiners in
Medicine & Surgery
Date February 14, 1994
Certificate No. 2879

Osteopathic Medical Board of California
Date February 13, 1996
Certificate No. 20A6810
Inactive

Kansas Board of Healing Arts
Certificate No. 05-33188
Inactive

Oregon Medical Board
Certificate No. DO125776

VII. Honors and Awards

2011	Scholar in Residence American Association of Colleges of Osteopathic Medicine
2010 – 2011	AOA Health Policy Fellow
2007-2008	Costin Scholar Costin Faculty Development Program Midwestern University
2002-2003	Michael Allshouse Award Outstanding Teacher, Pediatric Residency Program Naval Medical Center San Diego
1992	F.M. Walter Living Tribute Award Kirksville College of Osteopathic Medicine
1992	Who's Who Among Colleges and Universities
1988-89	President's Scholar Award Kirksville College of Osteopathic Medicine
1988-92	US Navy Health Professions Scholarship

VIII. Professional Affiliations

American Academy of Pediatrics
American Osteopathic Association
Northwest Osteopathic Medical Foundation, Board Member
Old Mill Center for Children and Families, Board Member and Officer
Osteopathic Physicians and Surgeons of Oregon, Board Member
Phi Delta Epsilon International Medical Fraternity, Past President

IX. Invited Presentations

March 2011	Adverse Medication Events in the NICU TxANNP Conference San Antonio, TX
March 2011	Medical Errors, 10 Years After the IOM Report

Babysteps Conference
Pensacola, FL

April 2010 — Antibiotic Usage in the NICU
TxANNP Conference
Galveston, TX

March 2010 — Pharmacology for Neonatal Nurses
Babysteps Conference
Pensacola, FL

X. Academic Appointments

2009 - Associate Professor
Department of Pediatrics
Western University of Health Sciences

2007 - Clinical Assistant Professor
Department of Pediatrics
AZ College of Osteopathic Medicine

2002-2003 — Clinical Instructor, Department of Pediatrics
University of California, San Diego

1998-2000 — Clinical Instructor, Department of Pediatrics
University of California, San Diego

XI. Committee Memberships

2009 - Institutional Review Board
Samaritan Health Services
Chair, 2010 –

2005-2008 — Institutional Review Board
Phoenix Children's Hospital

2004 — Bioethics Committee
Banner Good Samaritan Regional Medical Center

1998-2000 — Medical Risk Management Committee
University of California, San Diego

1994-96 — Editorial Board
Pediatric Review, Phoenix Children's Hospital

XII. Bibliography

A. Original Reports

Craft A, Bhandari V, Finer N. The Sy-Fi Study. *Journal of Perinatology*, 2003; 23(1): 14-19.

Finer NN, Rich W, **Craft A**, Henderson C. Comparison of methods of bag and mask ventilation for neonatal resuscitation. *Resuscitation.* 2001; 49: 299-305.

Salerno CC, Pretorius DH, Hilton SW, O'Boyle MK, Hull AD, James GM, Riccabona M, Mannino F, **Craft A**, Nelson TR. Three dimensional ultrasonographic imaging of the neonatal brain in high risk neonates: preliminary study. *J Ultrasound Med.* 2000; 19: 549-55.

Finer NN, Vaucher Y, **Craft AP**, Clark R. Postnatal Steroids: Short Term Gain, Long Term Pain?. *J Pediatr* 2000; 137:9-13.

Craft AP, Ludwig D, Dudell G. Radiology Casebook: Gastric Perforation. *J Perinatol* 1999; 19 (3): 242-3.

Craft AP and Etzl M. Clinical Case: Cystic Lesions of the Lung. *Pediatric Review* 1995.

B. Reviews

Craft AP and Finer NN. Nosocomial CoNS Sepsis in Preterm Infants: Definition, Diagnosis, Prophylaxis, and Prevention. *J Perinatol.* 2001; 21: 186-92.

Coughlin C and **Craft A**. Hepatitis C- the silent epidemic. *J Emerg Med Serv.* 2000; 25: 114-29.

Craft AP, Finer NN, Barrington KJ. Vancomycin for prophylaxis against sepsis in the preterm neonate. *Cochrane Database of Systematic Reviews* 2000, Issue 1.

C. Book Chapters

Craft AP and Finer NN. Respiratory Distress Syndrome in Eds. Burg FD and Gershon A. Current Pediatric Therapy 17. 2002.

D. Abstracts

Craft AP and Bloom BT for PediQuIC (The Pediatrix Quality Improvement Collaborative). Improving Prophylactic Surfactant Administration in the NICU. Hot Topics in Neonatology 2004, Washington, DC.

Craft AP and Bloom BT for PediQuIC (The Pediatrix Quality Improvement Collaborative). Reducing Antibiotic Use in the NICU. The Improvement Opportunities? Hot Topics in Neonatology 2003, Washington, DC.

Craft AP, Bhandari V, Finer NN. The Sy-Fi Study. Society for Pediatric Research 2001, Baltimore, MD

Finer NN, Rich W, **Craft AP**, Henderson C. Comparisons of methods of bag and mask ventilation for neonatal resuscitation. Society for Pediatric Research 2001, Baltimore, MD.

Craft AP and Finer NN. A prospective analysis of premedication for endotracheal intubation in the NICU. Mead Johnson Nutritionals Western Perinatal Research Conference 2000, Palm Springs, CA.

Craft AP, Finer NN, Barrington KJ. The use of vancomycin for prophylaxis against sepsis in the preterm neonate. Hot Topics in Neonatology 1999, Washington DC.

Craft AP and Finer NN. Nosocomial sepsis in the neonatal intensive care unit: Are we speaking the same language? Hot Topics in Neonatology 1999, Washington DC.

Craft AP, Tellez D, Liu P and Bakerman P. Ketamine sedation in nonintubated children with severe asthma. Western Society for Pediatric Research 1999, Carmel, CA.

Craft AP, Barrington K, Henderson C, and Cochrane C. Bronchial lavage with KL4 surfactant: The value of PEEP in a model of MAS. Mead Johnson Nutritionals Western Perinatal Research Conference 1999, Palm Springs, CA.

Craft AP, Tellez D, Liu P and Bakerman P. Ketamine sedation in nonintubated children with severe asthma. Pediatric Critical Care Colloquium 1995, Sea Island, GA.

Robert J. Power

3850 SW Fairhaven Dr, Corvallis, OR 97333 541-768-4403 RPower@samhealth.org

Healthcare Chief Information Officer - expert in the delivery of technology required to support rapid and effective clinical and business decision making in the expanding healthcare environment. Skilled in all aspects of project management and delivery, from initial discovery and systems analysis to product implementation and enhancement to legacy management. Effective at identifying and nurturing IT talent, building strong, results-oriented teams needed to deliver quality driven care within a multi-facility organization. Key qualifications include:

- Strategic and Operational Planning
- HIPAA Privacy and Security Management
- JCAHO Patient Safety and Quality Planning
- Enterprise and community EMR/EHR delivery
- Physician Relations Management
- Healthcare IT Design and Implementation
- Integrated Delivery Systems Operations
- Emerging Technologies and Architectural Delivery Systems

PROFESSIONAL EXPERIENCE

Samaritan Health Services (SHS), Corvallis, OR
SHS – SHS operates five hospitals and 70 clinics located throughout Linn, Benton and Lincoln counties. The not-for-profit system employs approximately 5000 personnel.

Chief Information Officer – Samaritan Health Services (2010 to present)
Responsible for IT tactical operations, strategic planning, resource management, budgeting, and project management at SHS. Highlights:

- Oversight of 13 direct reports and 117 IT and Project Management employees.
- Managing the organization's strategy for meeting the objectives of meaningful use of clinical systems set forth in the American Recovery and Reinvestment ACT (ARRA) and HITECH.
- Activation of a Clinical Transformation Team to prepare the organization for implementation of advance clinical decision making tools utilizing evidenced-based medicine.
- Participation in state-wide initiatives related to Rural Tele-health TAO and OHN and Health Information Technology Oversight Council (HITOC).

HCA – Hospital Corporation of America, Nashville, TN 1995 to 2010
HCA – The Hospital Corporation of America operates 168 hospitals and approximately 119 freestanding surgery centers in 20 states and London, England. The for-profit, privately owned corporation has approximately 178,000 personnel across the enterprise. The organization is divided into thirteen regional Divisions reporting into a corporate operation in Nashville, Tennessee. I am currently the Chief Information Officer for the HCA - Continental Division, which has operations in Denver, CO, Oklahoma City, OK, and Wichita, KS.

Chief Information Officer – Continental Division (2005 to 2010)
Responsible for IT tactical operations, strategic planning, resource management, budgeting, and project management for HCA's Continental Division, a ten hospital, 13,000+ employee system within HCA. The division includes HealthONE, a seven hospital Joint Venture in Denver, CO, Oklahoma University Medical Center, a separate Joint Venture with the State of Oklahoma, as well as two wholly owned HCA facilities in Kansas and Oklahoma. Reporting to the Division CEO and CFO, manages 18 direct reports and 127 indirect report IT professionals in 11 locations in 3 states. Highlights include:

- Partnered with division leadership and the HealthONE Board of Directors to secure $23 million in funding to implement a technology refresh program to upgrade facilities infrastructure to

accommodate new advances in technology, including wireless infrastructure, guest networking for Internet access for physicians and families, delivery of PACS images to all care locations, and equipment upgrades to replace aging technology.

- Successful enterprise-wide implementation of T-EV Emergency Department Information System, including automation of clinician documentation and integration to Meditech patient care system. The consolidated enterprise model effectively eliminating $700,000 in equipment and maintenance costs incurred in the initial facility-based model.
- Drove implementation of GE Radiology and CV PACS in hub and spoke design for HCA's Oklahoma hospitals. The hub and spoke design allowed for true offsite disaster recovery/business continuity while minimizing cost.
- Participated in company-wide Ambulatory EMR selection process, including clinician surveying, RFP creation, vendor product review, and contract negotiations.
- Advisory participant of Colorado Regional Health Information Organization (CORHIO), including governance committee created to steer movement from volunteer organization into 501(c)(3) development, and initial seating of the first Board of Directors.
- Initiated HealthONE Executive IT Steering Committee to drive strategic Health Information Technology decisions.
- Facilitated team of HIM Directors and records managers to design and build a centralized, 90,000 square foot records center located in Stapleton Business Park – Denver. Operation includes records management and release of information (ROI).
- Oversight of Centralized Physician Order Entry in three hospitals within the organization.
- Directed testing and implementation of Meditech Patient Care Systems version upgrades within the organization.
- Implemented Telemedicine technology for remote stroke care program.
- Leveraged EMC storage technology to save $2.6 million in potential costs related to growth by creating an enterprise-wide storage solution, successfully reducing the cost of individual hospital storage.

Project Manager – HCA Regional Patient Account Services (2004 -2005)
Responsible for analysis, timeline development, task assignment and overall project plan for all projects at HCA's Consolidated Patient Account Services in Denver. Responsible for concurrent management and implementation of all back-office projects, including:

- Design and implementation of Centralized patient scheduling,
- Implementation of ABN/LMRP software,
- Sarbanes-Oxley policy and procedure development.
- Research and preparation of business case development for Patient Account Services strategic directives.
- Drove business plan development for converting HealthONE Legacy A/R systems to HCA's current billing and A/R systems.

Market Director of Information Technology HealthONE/HCA (1996 – 2004)
Directed IT operations within HealthONE facilities including Patient Accounting, Supply Chain, and acted as liaison to the Denver market for all HCA corporate initiated IT projects. Highlights include:

- Effectively reduced the IT operational budget by $1.2 million by consolidating redundant services, implementing strong software license management processes, and implementing key technology used for remote desktop troubleshooting.
- Implemented SSL/VPN solution and Metropolitan Area Network (MAN) to connect all HealthONE hospitals to successfully share information and imaging data, and to implement enterprise-wide software solutions.
- Provide guidance for centralized technical staff, business analysts and facility-based IT employees to ensure optimal employee performance and personal growth.
- As part of the newly formed HealthONE – HCA Joint Venture partnership, successfully implemented the Meditech Patient Care System and transitioned from HealthONE's legacy systems. Transition responsibilities included data center closure, elimination of legacy systems,

termination and transition of programming staff, negotiation of vendor shutdown contracts and removal of legacy mainframe equipment.

HealthONE Hospitals,
dba: American Medical International. A for-profit healthcare system 1980 to 1996
dba: P/SL HealthCare System, a Denver-based, not-for-profit system.

Various positions - Increasingly advanced positions within the organization, including:

- **Market Business Analyst** (1990 to 1996)
  Provided strong business analysis, design, testing, training and implementation of McKesson's suite of mainframe patient care products with an emphasis on registration and billing. Directed team that designed and performed data conversion of legacy systems as additional healthcare facilities were acquired.

Information Systems Instructor (1985 to 1990)

- Delivered centralized standardized training and education in a three-hospital system. Effectively increasing productivity in new employees by creating easily understood coursework that was used to train users as new technology was deployed or new employees joined the organization.

- **Patient Access Manager** (1980 to 1985)
  Hired as an entry-level combination mailroom/patient access role, mastered all aspects of patient access and within three years became the manager, overseeing all aspects of In-patient, Outpatient and ED registration at Presbyterian/St. Luke's Medical Center.

Education

Bachelor of Science, Business Management, summa cum laude Regis Jesuit College Denver, CO

Kim R. Whitley

3530 NW Mariposa
Albany, OR 97321

Mobile: 541-913-5950
kwhitley@samhealth.org

STRATEGIC MANAGEMENT EXECUTIVE
Cross-Functional Experience & Cross-Industry Expertise

My healthcare interests include prevention services, provider reimbursement models, regulatory compliance, healthcare EDI, and seeking solutions to the rising cost of healthcare. I have managed a variety of healthcare functions and developed and implemented several programs in various healthcare related fields. My unique experience allows me the opportunity to present on topics of cost containment, integrated healthcare management, EDI and various health access, insurance and administration issues.

- Budget /Expense Planning/Control & Margin Improvement
- Product Commercialization & Expansion Strategies
- Competitive Bidding Processes
- Contract Negotiations
- Quality Assurance
- Regulatory Compliance
- Sales & Marketing
- Business Development/Opportunity Identification
- Corporate Restructuring & Performance Enhancement
- Leading with a clear vision

Professional Experience

Samaritan Health Services, Corvallis, OR **3/01 - present**

CHIEF OPERATING OFFICER – SAMARITAN HEALTH PLAN OPERATIONS (8/05 – PRESENT)
DIRECTOR OF OPERATIONS – (2/03-8/05)
OPERATIONS MANAGER – (3/01 – 2/03)

Currently direct all operations for multiple lines of business within three corporations. Provide leadership for a 100+ person workforce and hold P & L responsibility. Oversee financial processes, all functional areas including: claims production, customer service, sales, business development, revenue enhancement, accounts receivable, professional development and health information management to maintain the provision of healthcare services for 40,000 + and over $150,000,000 in annual revenue.

Selected Results:

- Over the past five years successfully developed and implemented procedures to standardize processes for managed care organization enabling it to grow successfully. Elevated standards of quality by establishing procedures for quality assurance and continuity of services.
- Initiated and facilitated the successful implementation of a business intelligence solution to leverage information assets to allowing the organization to make high-value decisions for faster revenue growth, reduction of operational expense and delivery of a sustainable competitive advantage.
- Strategically planned and initiated the introduction of new lines of business to stabilize the healthcare delivery system while simultaneously managing and directing the operations of current Third Party Administrator and risk contracts including Medicaid and Medicare.

- Developed "Balanced Scorecard" corporate culture that has lead to strategic approach to annual goals resulting in greater collective understanding of vision and greater ability to make well informed business decisions at all levels of the organization.
- Implemented consistently successful strategic marketing plans to meet and exceed budget.
- Strategically negotiated financially beneficial contracts and successfully managed oversight of all outsourcing.
- Demonstrated profitability improvement through financial analysis, strategic planning and financial compliance within NAIC, DCBS, ERISA, DMAP and CMS rules and regulations.

Pointshare, Portland, OR/Bellevue WA

TECHNICAL ACCOUNT MANAGER 1/00 – 03/01

- Analyzed market and identified opportunities.
- Sold IT solutions to physician practices and hospitals
- Assessed customers' ongoing needs, suggested solutions, and managed contract negotiations.
- Analyzed, planned, implemented products, including budget, scope, resource allocation, and deadlines.
- Resolved customer product complaints of a technical nature, which required cross-department communication and negotiations to facilitate a solution.
- Organized and assessed Customer Feedback Sessions.

First Resort Clinic, San Leandro, CA

MARKETING/DEVELOPMENT ASSOCIATE 8/98 – 1/00

- Developed direct marketing strategies and fiscal marketing plan.
- Managed and organized marketing projects and events.
- Created, developed and edited all collateral materials.
- Wrote all grants and proposals.
- Cultivated relationships with major donors.
- Database management and integrity.
- Assisted with IT issues.

Catholic Charities, Pullman WA

CASE MANAGER 8/96-7/98

- Managed satellite agency.
- Developed programs and written guidelines
- Marketed services to target population and positioned organization to outside agencies.
- Organized, managed and evaluated volunteers.

Beverly Corporation, Payette Lakes Care Center, McCall, ID

DIRECTOR OF SOCIAL SERVICES, ADMISSIONS AND ACTIVITIES 5/94 - 8/95

- Managed personnel, budget and activities of three departments.
- Assured the adherence of staff to State/Federal rules and regulations.
- Developed programs and written guidelines.
- Directed all marketing and sales efforts including editing monthly newsletters, the development of collateral, grants and written proposals.

Council Hospital, Council ID

CONSULTANT **(simultaneously with Payette Lakes)** 10/94 - 8/95

- Brought the hospital "in line" with State/Federal rules and regulations.
- Developed quality assurance protocol and programs to improve quality.

Education

Master of Public Administration (MPA)
University of Idaho, Moscow ID
Bachelor of Science, Biology (BS)
Gonzaga University, Spokane WA
Bachelor of Arts, Psychology (BA)
Gonzaga University, Spokane WA

Professional Affiliations

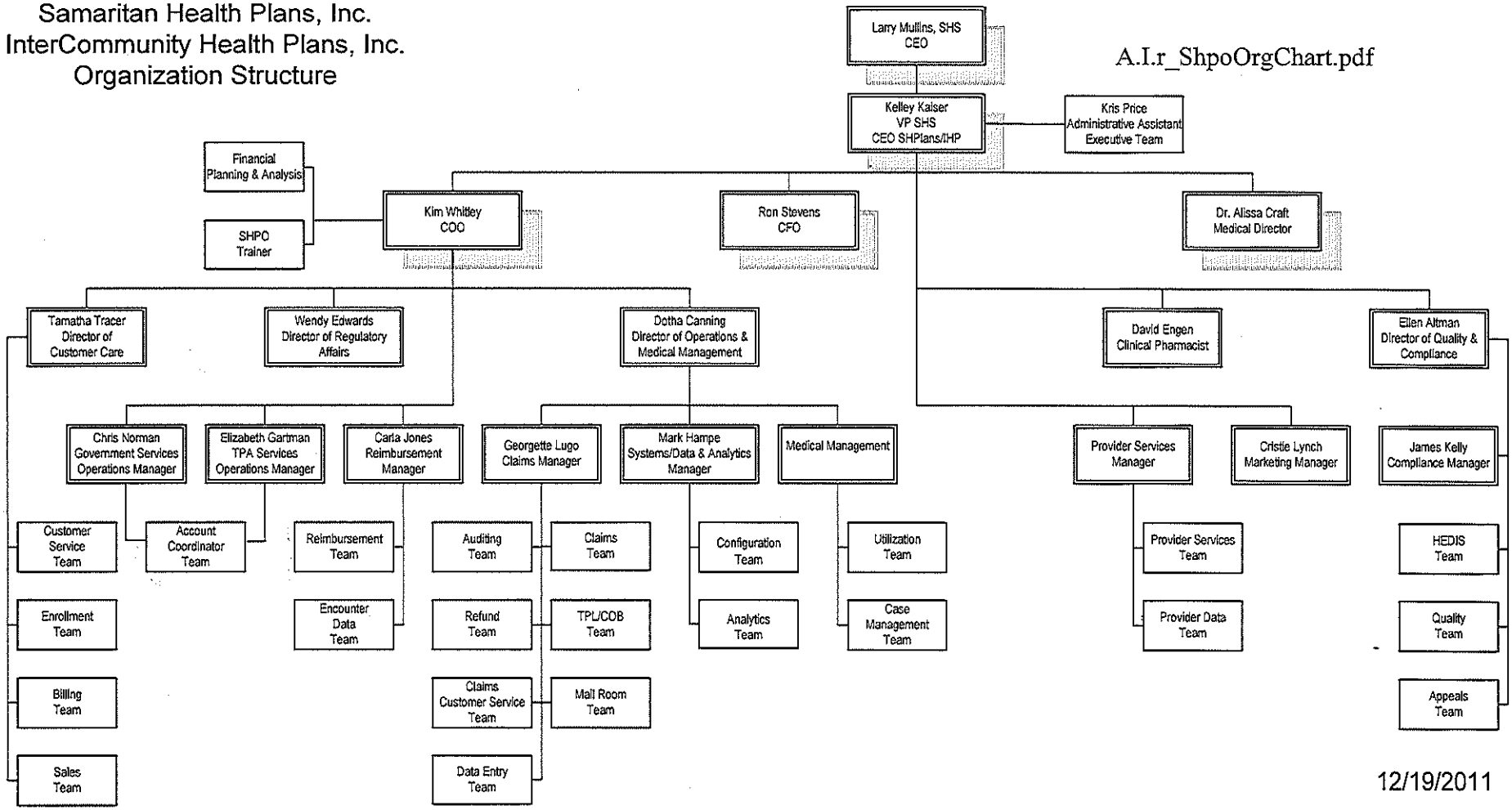
AHIP, America's Health Insurance Plans
Advisory Board Member

Outside Activities

Volunteer: Community Outreach, Inc.
Vice Chair, Albany Human Relations Commission

Samaritan Health Plans, Inc.
InterCommunity Health Plans, Inc.
Organization Structure

A.I.r_ShpoOrgChart.pdf



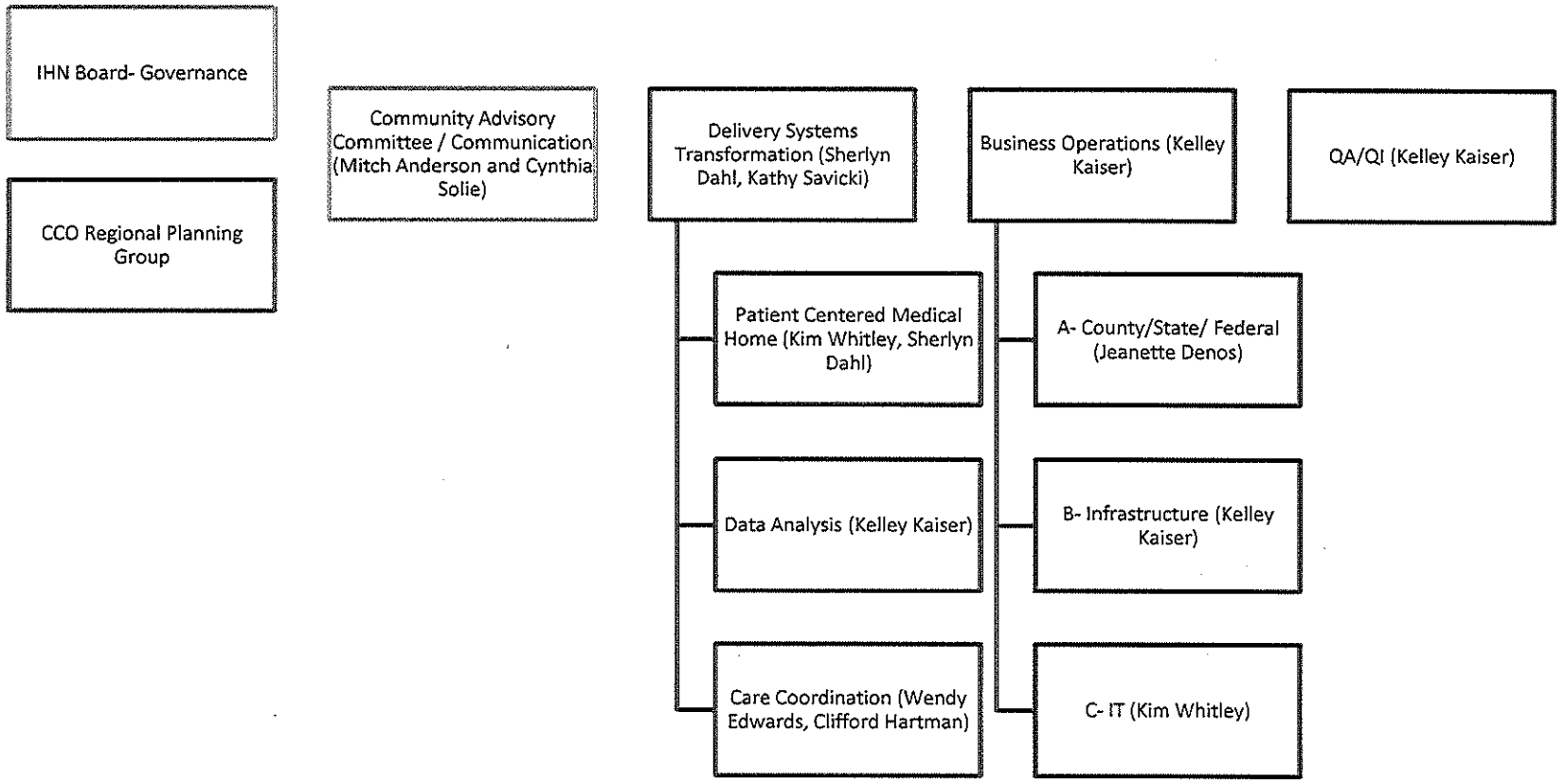
12/19/2011

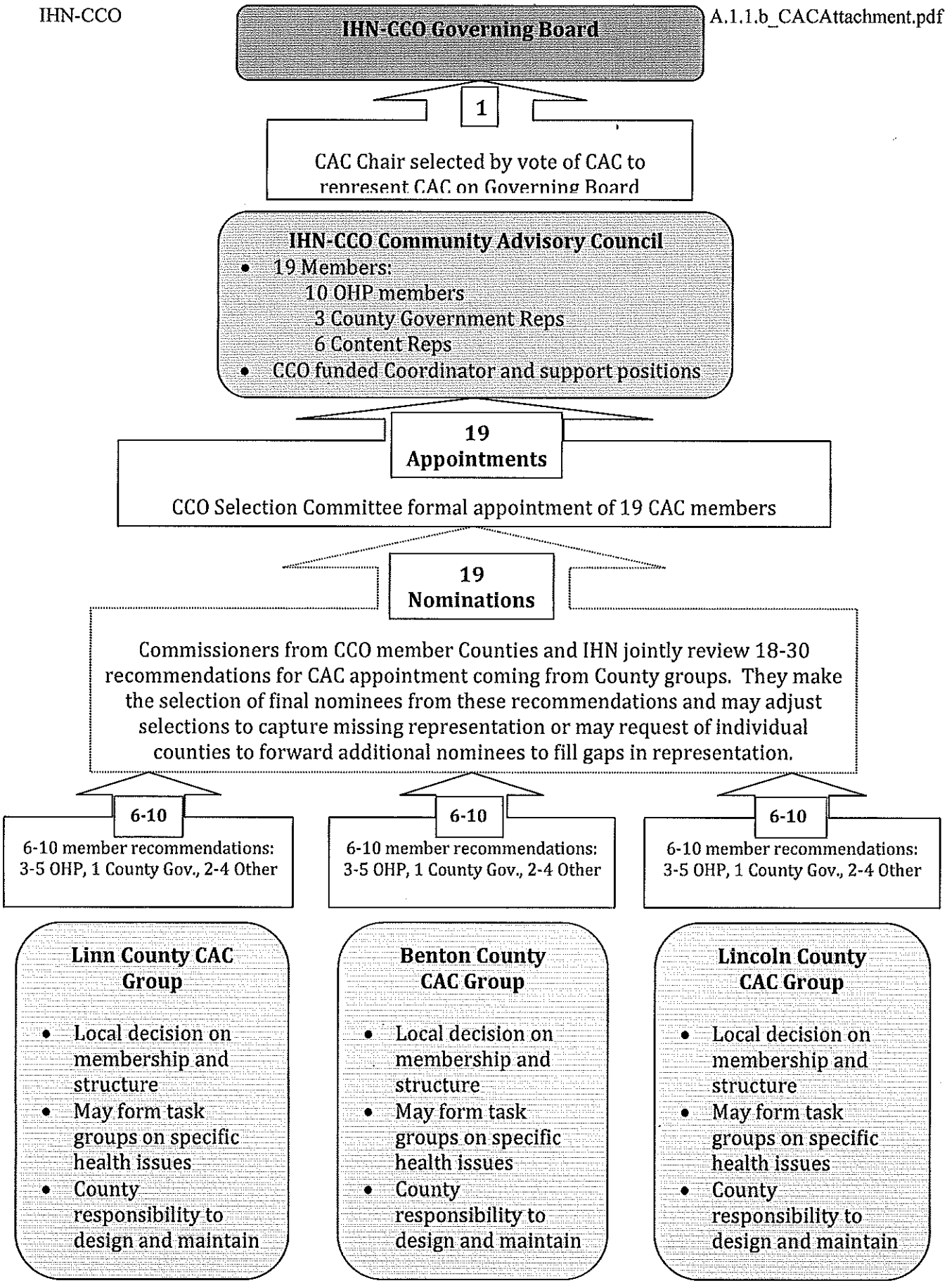
IHN-CCO

RFA Attachment

Response to Appendix A

IHN-CCO Workgroup Structure




IHN-CCO Governing Board
1
CAC Chair selected by vote of CAC to represent CAC on Governing Board
IHN-CCO Community Advisory Council
• 19 Members:
10 OHP members
3 County Government Reps
6 Content Reps
• CCO funded Coordinator and support positions
19 Appointments
CCO Selection Committee formal appointment of 19 CAC members
19 Nominations
Commissioners from CCO member Counties and IHN jointly review 18-30 recommendations for CAC appointment coming from County groups. They make the selection of final nominees from these recommendations and may adjust selections to capture missing representation or may request of individual counties to forward additional nominees to fill gaps in representation.
6-10
6-10 member recommendations: 3-5 OHP, 1 County Gov., 2-4 Other
6-10
6-10 member recommendations: 3-5 OHP, 1 County Gov., 2-4 Other
6-10
6-10 member recommendations: 3-5 OHP, 1 County Gov., 2-4 Other
Linn County CAC Group
• Local decision on membership and structure
• May form task groups on specific health issues
• County responsibility to design and maintain
Benton County CAC Group
• Local decision on membership and structure
• May form task groups on specific health issues
• County responsibility to design and maintain
Lincoln County CAC Group
• Local decision on membership and structure
• May form task groups on specific health issues
• County responsibility to design and maintain

IHN-CCO
RFA Attachment
Response to Appendix A

A.1.5 Social and Support Services in the Service Area

Team or Activity	A&D	Mental Health	Public Health	Health Admin
Linn Co. Council for Integrated Services to Children & Families	x*	x		x
Commission on Children & Families			x	x
Youth Services Teams (in 7 school districts)	x	x		
Adult Services Team (homeless adults)	x	x		
Linn Co. Homelessness Committee	x			x
Homelessness Committee Detox Planning Subcommittee	x			
Family Treatment Court	x	x*		
Family Treatment Court Advisory Committee	x			
Juvenile Dependency Work Group	x			x
Linn Together (A&D prevention coalition)	x		x	
STAND (Linn Underage Drinking Youth Council)	x			
Child Welfare Multi-disciplinary teams	X	X	x	
Adult Drug Court / M57 Drug Court	x	x*		
Adult Drug Court / M57 Drug Court Steering Committee	x			x
Local Public Safety Coordinating Council	x	x		x
Teen Parent Task Force	x		x	

DHS Self-Sufficiency Program staffings	x			
Linn Co. Parole & Probation Accountability Panel	x	x*		
MVBCN regional partners committee (Children metal health continuum of care)		X		
Oregon Health Authority/Dept. of Human Services Local Government Advisory Committee	x			

* On as-needed basis

Benton County, Oregon

Population 87,000

Not everyone in Oregon has the same *opportunities* to be healthy

Persons with **substance abuse** and/or **mental health conditions die 34.5 years earlier** than the general population.

Nearly **1/3 of Latina women do not receive prenatal care** during their first trimester.

High school **dropout rate for minority youth is 30%** compared to 7% for all youth.

LBGTQ persons face health disparities with high rates of tobacco, alcohol and other drug use linked to societal stigma and discrimination.

52% adults manage one or more **chronic diseases.**

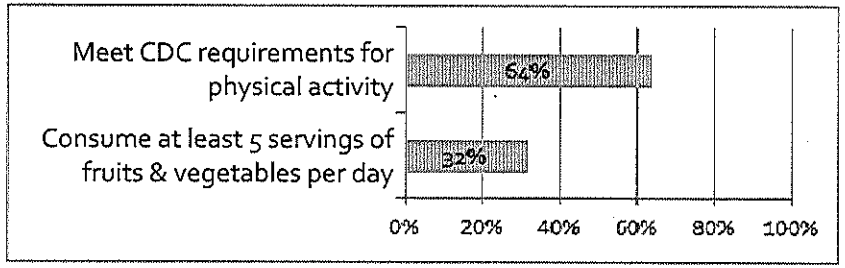
Percent of children receiving free or reduced lunches varies among school districts.

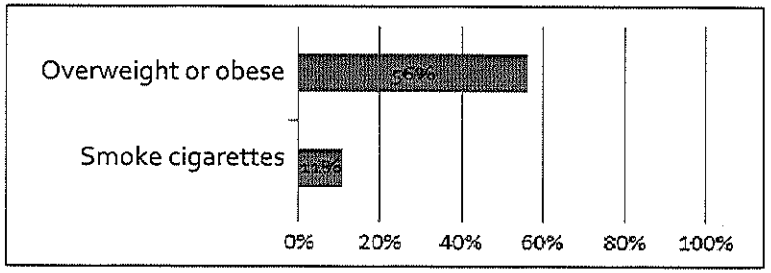
Alsea	76%
Monroe	57%
Philomath	38%
Corvallis	35%

We strive to make sure everyone in our area has an equal opportunity to be healthy.

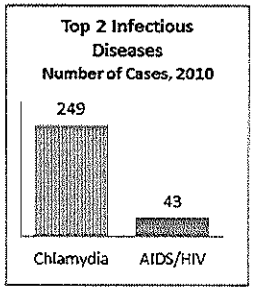
Specific Populations
(not a comprehensive list)

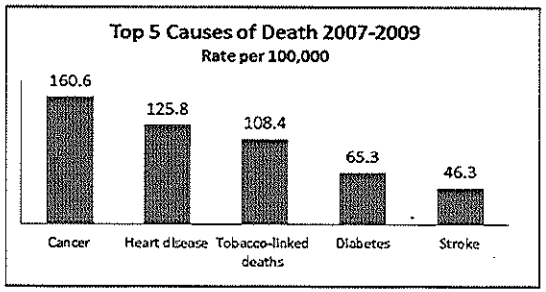
Hispanic/Latino	6%
Children under 18	19%
Rural Residents	19%
Adults over 65	11%
Uninsured	15%





The health of the community relies on people making healthy choices and people having access to opportunities for healthy choices.





Health begins in our neighborhoods– in places we live, work, learn, and play

Places We Live

Households with housing costs ≥ 30% of household income	**39%**
% of all restaurants that are fast food establishments	**49%**
Annual number of unhealthy air quality days	**21 days**

Places We Work

% of earnings a minimum-wage family must pay for childcare	**59%**
Travel time to work	**20 minutes**

Places We Learn

High school graduation rate	**78%**

Places We Play

Miles of bicycle pathway thru parks, within the city and along the Willamette	**>60 miles**

Benton County Health Services
530 NW 27th Street • P.O. Box 579 • Corvallis, OR 97339-0579 • Phone: 541-766-6835 • FAX: 541-766-6186
PHF-0126b JS 04/12

Samaritan Health Plans

Samaritan Advantage Health Plan HMO

815 NW Ninth Street, Suite 101
Corvallis, Oregon 97330
(541) 768-4550
1-800-832-4580

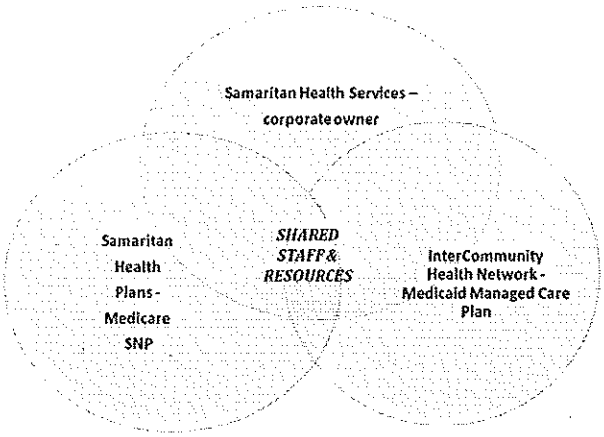
2013 SNP Model of Care Written Narrative

CMS Contract Number: H3811

February 14, 2012

Introduction

Samaritan Health Plans operates a Medicare Advantage Special Needs Plan through its corporation Samaritan Health Plans d.b.a. Samaritan Advantage Health Plan HMO for the dual-eligible population residing in Linn, Benton and Lincoln Counties of Oregon. Samaritan Health Plans is affiliated with Samaritan InterCommunity Health Network, a Medicaid managed care plan, through its parent company, Samaritan Health Services. Samaritan InterCommunity Health Network functions under a contract with the State of Oregon for Oregon Health Plan members living in Linn, Benton, Lincoln and Tillamook Counties.



The Samaritan Health Plans Model of Care is designed to meet the needs of the members covered on both our Medicare Advantage Special Needs Plan and our Samaritan InterCommunity Health Network Plan. This is our dual-eligible population (D-SNP). Our SNP Model of Care includes our care management protocols, nationally recognized clinical practice guidelines and information on our specialized provider network. As part of our Model of Care, we conduct health risk assessments to identify target populations and develop evidenced-based individualized care plans.

Samaritan Health Plans

The Samaritan Health Plans Model of Care includes the following components:

- Description of the SNP-specific Target Population
- Measurable Goals
- Staff Structure and Care Management Roles
- Interdisciplinary Care Team (ICT)
- Provider Network with Specialized Expertise and Use of Clinical Practice Guidelines and Protocols
- Model of Care Training for Personnel and Provider Network
- Health Risk Assessment
- Individualized Care Plan
- Communication Network
- Care Management for the Most Vulnerable Subpopulations
- Performance and Health Outcome Measurement

1 Description of the SNP-specific Target Population

Samaritan Advantage Health Plan HMO Special Needs Plan currently has approximately 2,000 eligible members on both Medicare and Medicaid who are also eligible on the Samaritan InterCommunity Health Network, Oregon Medicaid managed care plan for Linn, Benton and Lincoln Counties.

Samaritan Health Plans d.b.a. Samaritan Advantage Health Plan HMO (SAHP) currently serves a full dual-eligible (D-SNP) population of approximately 2,000 very vulnerable members living in Linn, Benton or Lincoln Counties in the State of Oregon. Of these 2,000 members, approximately 1,100 live in mostly rural Linn County, 420 live in Benton County and 450 live in Lincoln County.

To ensure coordinated services are effective and promote optimal health outcomes for our target population, we work very closely with the Oregon State Division of Medical Assistance Programs (DMAP) and social services providers, including Oregon Department of Human Services (DHS) case workers and community-based resources such as transportation, housing and educational providers.

Our target population includes all dual-eligible SNP members. There are a wide-range of age groups, levels of disability and frailty characteristics amongst our duals. Some of which include:

- approximately 70% of the full dual-eligible members are under the age of 65
- 20% of those under the age of 65 are under the age of 34
- 75% of our target population are disabled
- currently 20 full dual-eligible SNP members have End Stage Renal Disease (ESRD)

Samaritan Health Plans

2 Measurable Goals

a. The specific goals of the Samaritan Advantage SNP Model of Care include:

- Improving access to essential services such as medical, mental health and social health services by maintaining and monitoring an adequate contracted provider network. We maintain an adequate provider network through thorough contracting. For any services where contracting is not an option the care manager works with the member and primary care provider to obtain needed services outside of our network. We monitor for network adequacy through methods such as our prior authorization process and through our complaint/grievance process.
- Improving access to affordable care by maintaining and monitoring an adequate contracted provider network. Having an adequate contracted provider network allows for timely access to care at the lowest cost to our members.
- Improving coordination of care through an identified point of contact. Our care managers act as a point of contact for all our SNP members. They work with the member, the member's primary care provider and all other professionals of the Interdisciplinary Care Team as needed to coordinate care for each member.
- Improving seamless transitions of care across healthcare settings, providers and health services by developing policies & procedures and processes for transitions which include training providers and monitoring all types of transitions by the case manager for each member.
- Improving access to preventive health services by reducing or eliminating barriers to obtaining preventive health services such as not requiring referrals for routine women's health care, mammograms, flu shots or pneumonia shots. We also monitor the use of these services by internal reports and Healthcare Effectiveness and Data Information Set (HEDIS), Medicare Health Outcomes Survey (HOS) or Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) measures.
- Assuring appropriate utilization of services by monitoring data on primary care physician (PCP) visits, Emergency Department (ED) visits, inpatient visits, and educating each member and/or the provider on the appropriate utilization of services. Utilization data is routinely reviewed by our Healthcare Assessment Committee and our Physician Advisory Committee.
- Improving member health outcomes including member functional status by monitoring Healthcare Effectiveness and Data Information Set (HEDIS), Medicare Health Outcomes Survey (HOS) and other data sources. We also implement quality improvement projects when necessary for improving overall member health outcomes.

b. The following table lists specific goals as measureable outcomes and indicates how we will know when the goals are met:

Samaritan Health Plans

SNP Goal	SAHP Related Goal Example	Measurable Outcome Example	Goal expected completion date	We will know we have met the example goal when
Improve access to essential services such as medical, mental health and social health services	Maintain and monitor adequate and appropriate contracted provider network.	Percent of care received out of network is less than 20% of all care received.	Annual evaluation of network vs. non-network services data	1) 80 % of services are obtained at in network providers 2) Access Grievances rate is declining on a PMPM basis
Improve access to affordable care	Maintain PCP panel adequate for our members and ensure members are assigned or choose a PCP upon enrollment	All members are assigned a PCP in our system within 7 days of enrollment	Annual evaluation of PCP assignment data	100% of members are assigned a PCP within 7 days of enrollment
Improve coordination of care through an identified point of contact	Our Care Managers monitor and assist as needed to ensure members received follow up care with their PCP after a hospital discharge	All SNP members receive follow up care from their PCP within 5 days following discharge from a hospital	Monthly evaluation	95% of our members have a PCP follow up visit within 5 days of discharge from a hospital
Improve seamless transitions of care across healthcare settings, provider and health services	Facilitate improved transitions of care through evaluation of health plan claims data such as acute readmission rates	Hospital readmission rate is at or better than NCQA's national benchmarks (HEDIS "Plan All Cause Readmission" measure)	Annual evaluation of our HEDIS data on "Plan All Cause Readmission" measure	HEDIS Readmission data demonstrates rates at or better than NCQA's National benchmarks
Improve access to preventive health services	Maintain reports measuring use of CMS recommended preventive health services including flu vaccine, mammography and colonoscopy	All SNP members receive preventive health services per CMS recommended guidelines	Annual evaluation of preventive health services data from our claims system, HEDIS data, etc	Annual increase in the percentage of members that received preventive health services per CMS recommended guidelines

Samaritan Health Plans

SNP Goal	SAHP Related Goal Example	Measurable Outcome Example	Goal expected completion date	We will know we have met the example goal when
Assuring cost effective and appropriate utilization of services	Monitor data on members with diabetes	Members with diabetes receive care in an outpatient setting (PCP or specialist office) and not ED or Inpatient visits	Monthly evaluation of our claims data.	90% of members receive their diabetes care in an outpatient setting (PCP or specialist office)
Improve member health outcomes	HEDIS data supports health outcome improvement	HEDIS measures for DDE* and DAE* meet or exceed benchmarks in 2012	Annual evaluation of HEDIS results.	HEDIS measures for DDE and DAE* meet or exceed benchmarks in 2012

* *DDE = Potentially Harmful Drug-Disease Interactions in the Elderly*

* *DAE = Use of High-Risk Medications in the Elderly*

c. The following table lists specific actions we will take if goals are not met in the expected time frame:

SNP Goal	Actions we will take if goals are not met
Improve access to essential services such as medical, mental health and social health services	One action if indicated may include immediately pursuing contracting with additional specialty, primary, ancillary, social services or mental health providers or facilities. Have additional contracts in place within 3 months of the unmet goal.
Improve access to affordable care	One action if indicated may include immediately implementing an improvement project to increase number of members assigned a PCP within 7 days of enrollment. Monitor the project monthly until data shows all members are being assigned a PCP within 7 days of enrollment for at least 3 months, return to annual monitoring.
Improve coordination of care through an identified point of contact	One action if indicated may include immediately implementing new Care Management processes as needed to accommodate any issues found. Have any new processes in place within 3 months.
Improve seamless transitions of care across healthcare settings, provider and health services	One action if indicated may include immediately implementing new Care management processes as needed to accommodate any issues found. Have any new policies and procedures or processes in place within 3 months.

Samaritan Health Plans

SNP Goal	Actions we will take if goals are not met
Improve access to preventive health services	One action if indicated may include immediately implementing a quality improvement project to increase number of members receiving flu vaccine, mammography and/or colonoscopy per recommended guidelines. Project to include notification to members and providers of missed services.
Assuring appropriate utilization of services	One action if indicated may include immediately upon identification, educating the member and/or provider on the appropriate utilization of services. Possibly implement member and/or provider incentives as appropriate.
Improve member health outcomes including functional status	DDE = potentially harmful drug disease interactions in elderly High risk patients will be identified using HEDIS criteria and related Rx adherence data/possession ratio. One action if indicated may include immediately upon identification, communicating verbally or in writing with the member stating risks and encouraging follow-up with the provider. Provider copied on communication. Or immediately upon identification, Clinical Pharmacist intervention with the provider as appropriate. DAE = Use of high risk medications in the elderly Patients with high-risk medications will be identified using HEDIS criteria and Rx adherence data/possession ratio over the previous 6 months. One action if indicated may include immediately upon identification, sending written educational letters to the member regarding safety hazards involved with the prescribed high-risk medication. Or immediately upon identification, Clinical Pharmacist intervention with the provider as appropriate.

3 Staff Structure and Care Management Roles

There are three essential care management roles within Samaritan Health Plans' Model of Care:

a. Employed or contracted staff to perform **Administrative Roles** – These roles involve the day-to-day operations of the plan such as:

- Enrollment
- Eligibility
- Claims
- Grievances and provider complaints
- Plan information communication
- Collect, analyze and report on performance and health outcome data
- Provider services

Samaritan Health Plans

The staff in our Customer Care Department, Claims Department and Provider Department process and manage enrollment, eligibility, claims, grievances and provider services. As such, our Customer Care Department holds a very prominent role in our care management model. Samaritan's Customer Care Department staff is the frontline of the health plan. They answer members' phone calls, e-mails correspondence and face-to-face questions in order to expediently respond to member concerns. This department is available by phone Monday through Friday 8:00 am to 8:00 pm and available for walk-in consultations Monday through Friday 8:30 am – 5:00 pm. We communicate to members through advertising, newsletters and new member packets upon enrollment as part of our community approach and availability. Each member of the Customer Care team logs information about members in our core system, Facets, which creates an electronic record that is accessible across the organization. All Interdisciplinary Care Team members have access to this information in addition to information systems from other sources to obtain additional information about a member and support our care team activities.

All Customer Service Department staff is trained to take multiple types of requests from members and triage to the appropriate resource if they are unable to resolve an issue themselves. These include requests for additional services, education and support, questions about specific providers, pharmacy issues, and complaints. We have developed standard protocols so that our customer service representatives consistently answer and/or triage appropriately to ensure a positive member experience. Each Customer Service Representative has access to member records in our core software system, Facets, and logs all contacts with members in the system. The customer service staff work closely with each member's designated care manager. Because the Customer Service Representative is considered an integral member of the care management team, the Customer Service Representative often serves as the main point of contact with the member in addressing the member's concerns. Within the Customer Care Department are the following specific positions and duties of team members:

- Director of Customer Care: Responsible for oversight of Customer Care Department, ensuring compliance requirements, customer service protocols are met and oversight of Model of Care for that team.
- Training Coordinator : Manages and implements all internal training requirements
- Supervisor - Customer Service: Manages information flow to members including benefits and plan information, and ensures compliance with rules and regulations.
- Supervisor – Enrollment: Manages enrollment process from initial application to termination, ensures compliance with rules and regulations.
- Customer Care Coordinator: Coordinates cross-functional processes to ensure seamless service delivery to members and critical information is shared with the Interdisciplinary Care Team.
- Enrollment Coordinator: Coordinates cross functional enrollment processes, ensures critical member information is relayed to appropriate individuals on the Interdisciplinary Care Team.
- Member/Pharmacy Coordinator: Coordinates information about pharmacy benefits, shares utilization information with the Interdisciplinary Care Team.

Samaritan Health Plans

Below are additional positions that support the work of the Customer Care team and perform the details of day-to-day operations:

- Enrollment Specialist II
- Enrollment Specialist I
- Customer Service Representative II
- Customer Service Representative I
- Enrollment Representative
- Health Plan Office Rep II
- Health Plan Office Rep I

Calls and issues about a claim that cannot be answered by a customer service representative are triaged to the Customer Service Claims Analyst within the Claims Department. This position is specifically trained to address and resolve member and provider issues. The Claims Department ensures accurate claim adjudication and important payment information is shared with providers and members on a timely basis. This team consists of the following:

- Manager
- Supervisor - Claims
- Claims Audit Coordinator
- Claims Analyst - Senior
- Third Party Recovery Coordinator
- Claims Analyst II
- Claims Audit Analyst
- Customer Service Claims Analyst
- Claims Tech
- Data Entry Clerk
- Health Plans Clerk I

Plan information communication and data reporting is performed throughout our organization but primarily supported through our Provider Services Department and Analytics Department and through our centralized electronic record in our core system, Facets, that contains shared information on each health plan member. Our Provider Department staff monitors contracts and access to services, disseminates written plan information to network providers, provide provider education and training and answer provider questions and concerns.

- Manager
- Provider Relations Coordinator

Samaritan Health Plans

- Provider Technical Specialist I
- Contract & Credentialing Specialist

Samaritan has an Analytics Department that focuses on collecting, analyzing and reporting data to appropriate staff for evaluating the effectiveness of the Model of Care. Each staff member supports a different focus area within the plan. Two are assigned to the care management team. All processes are done according to HIPAA regulations in compliance with health plan policies.

- Manager
- Business Systems Analyst - Senior
- Business Systems Analyst II
- Senior Report Development Analyst
- Report Development Analyst
- Business Systems Analyst I
- Report Development Analyst I
- Web Support Analyst II

Reports are disseminated and analyzed at an executive, management and operational levels through Standard and ad hoc reports as well as monthly staff meetings, weekly and monthly staff dashboards, bi-monthly utilization and quality management meetings, and through external reporting to the State and Federal oversight bodies. The Analytics Department works closely with the Director of Quality and Compliance to conduct our quality improvement projects and program.

b. Specific employed or contracted staff to perform **Clinical Service Delivery Roles** – These roles involve coordinating care for each member, such as:

- Advocate for, inform and educate members
- Identify and facilitate access to community resources
- Provide coordination of care
- Educate members on health risks and management of illnesses
- Empower members to be advocates of their healthcare
- Maintain and share records and reports
- Ensure HIPAA compliance

Staff who coordinate Clinical Service Delivery include the following:

- Samaritan Care Managers: Provide care management services, facilitate use of applicable providers and community resources, collaborate with member's primary care provider, collaborate with specialty and ancillary medical providers, facilitate member participation for optimal health outcomes, and coordinate and conduct Interdisciplinary Care Team

Samaritan Health Plans

(ICT) communication. The care managers facilitate the implementation of the individualized care plan, retrieve consultation and diagnostic reports and facilitate scheduling appointments and follow–up services ensuring care and prescriptions are delivered as planned. They also provide utilization management services, review and coordinate authorization requests, work in collaboration with ICT, Medical Director, Durable Medical Equipment (DME) coordinator, providers and members to optimize health outcomes. Care Managers have training and certification in medical and/or mental health.

- Exceptional Needs Care Coordinators: Ensures focused coordination for dual-eligible Oregon Health Plan members, facilitates use of community and civic based providers and the State of Oregon Division of Medical Assistance Program Case Workers. A Care Management Nurse, the Exceptional Needs Care Coordinator focuses on the plan's most vulnerable members per OAR 410-141-0405 (focus on members identified as aged, blind or disabled who have complex medical needs).
- DME Coordinators: Focused coordination and optimization of DME service for special needs population. These coordinators serve as a referral source for care management services and assist in locating add-on services needed for SNP population.
- Health Care Coach: Conducts member surveys under the direction of licensed Registered Nurse (RN) Care Managers. The Health Care Coach assists in member outreach efforts, screens members to identify risks, supports healthy behavior and suggested lifestyle changes as directed by RN Care Manager. The Health Care Coach also facilitates translation services, schedules appointments and follow-up services, and facilitates transportation and other community-based services for members.
- Clinical Pharmacist: Reviews medication authorization requests, monitors appropriate use of medications, medication adherence, and performance measure outcomes. The Clinical Pharmacist serves as a resource to providers, Care Managers and members.
- Medical Director: Directs the clinical components of Samaritan Health Plans in conjunction with the Director of Medical Management and Operations and the Director of Quality and Compliance. Provides guidance and facilitation for collaboration within the ICT and provider community, ensuring optimal resource availability and coordination. The Medical Director reviews claims/encounter data for appropriateness, works with the Physician Advisory & Quality Committee and ensures use of clinical practice guidelines within the provider community.

c. Specific employed or contracted staff to perform **Administrative and Clinical Oversight Roles**

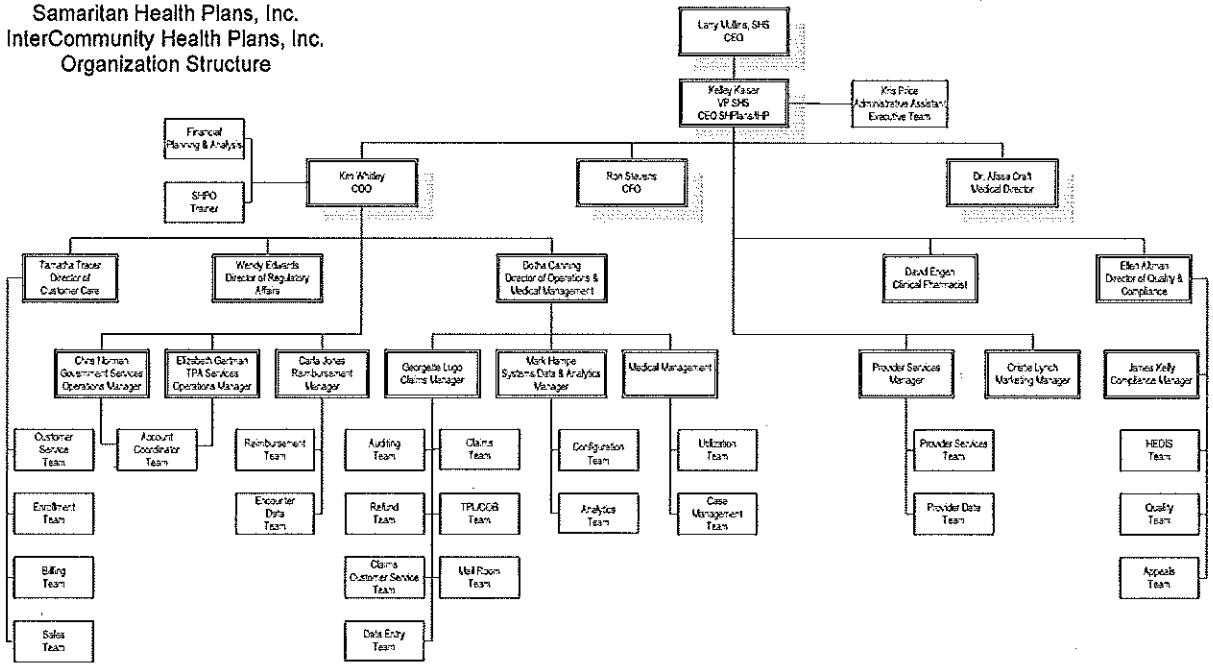
Oversight Roles within Samaritan Health Plans provide oversight for both Administrative and Clinical functions. Some examples of oversight functions related to the Model of Care include:

- Monitoring Model of Care compliance
- Assuring statutory and regulatory compliance
- Evaluating the Model of Care effectiveness

Samaritan Health Plans

- Monitoring the Interdisciplinary Care Team
- Assuring timely and appropriate delivery of services
- Assuring seamless transitions and timely follow-up to care
- Conduct chart reviews and oversight of encounter data

Samaritan staff providing oversight includes the following from the below organizational chart:



- Medical Director: Provides daily oversight of clinical functions, including care management and utilization management, review and development of evidence-based clinical practice guidelines and review and development of clinical authorization criteria. Also provides guidance and facilitation for collaboration within the ICT and provider community, ensuring optimal resource availability and coordination. The Medical Director reviews claims/encounter data for appropriateness, works with the Physician Advisory & Quality Committee and ensures use of clinical practice guidelines within the provider community. In addition, the Medical Director directs the clinical components of Samaritan Health Plans in conjunction with the Director of Medical Management and Operations and the Director of Quality and Compliance.
- Director of Medical Management and Operations: Provides daily oversight of health plans' utilization and care management operations, facilitates process development and improvement, is responsible for policy development and compliance and initiates team

Samaritan Health Plans

orientation and education. The accountability for the daily operations of the Medical Management Department is delegated to the Director of Medical Management and Operations who reports directly to the Chief Operations Officer.

- Assistant Care Coordination Manager: The Assistant Care Coordination Manager is a licensed Registered Nurse (RN) who assists the Director of Medical Management and Operations in overseeing the clinical operations of the Medical Management Department for utilization management, care management, pharmacy and clinical support staff.
- Chief Executive Officer: The Chief Executive Officer has the senior level executive responsibility and reports directly to the governing boards.
- Chief Operating Officer: The Chief Operating Officer reports directly to the CEO and participates at a Board level. This position provides oversight of all operations within the plan including ensuring information related to licensing, encounter data, providers communication and utilization is validated and disseminated to the appropriate oversight individuals for consideration and evaluation of plan operations.
- Director of Quality and Compliance: Manages and conducts our quality improvement program. Surveys members, plan personnel and network providers to assess performance and health outcome data. As part of the quality program, the director ensures medical charts reviews are conducted. In conjunction with the Provider Network team, this position ensures monitoring of current licensure and competency of providers and contractor compliance.
- Physician Advisory & Quality Committee: Provides assistance in developing the most comprehensive resource for clinical plan management. The committee is comprised of physicians and health specialists from around the service area and interacts regularly with our network providers. In general, their role is to support our mission of delivering better health, at the appropriate time and the lowest cost. They provide oversight for health information and clinical guidelines and serve as spokespersons to educate and advocate the health care community and public about our services. This team ensures evidence based research supported systems and practices are integrated into the care management model.

4 Interdisciplinary Care Team (ICT)

a. Composition of the ICT and how we determine the membership:

To ensure coordinated care for our special needs members and to facilitate participation of the member in all aspects of health care, we use an Interdisciplinary Care Team (ICT) to develop an individualized care plan and communicate it across all healthcare settings and providers.

Special Needs Plan members are assigned to an ICT designed to specifically meet the individual member's needs. The Care Manager works with the ICT to coordinate member care with a flexible and coordinated team approach. The membership of this team is modified, depending on the condition and needs of each individual member. Interdisciplinary Care Team membership is comprised of any or all of the following:

Samaritan Health Plans

- The Member and/or the Member's Care Giver
- The Primary Care Provider (PCP)
- Board-certified physicians (including primary, ancillary and specialty care providers)
- Social Workers (and other qualified and clinically appropriate mental health and chemical dependency treatment providers)
- Home Health Care staff
- Physical and Occupational Therapy providers
- Hospital and Skilled Nursing Home physician and care management staff, including hospitalists who provide 24 hour physician coverage in our acute care hospitals
- Dietician/Nutritionist
- RN, ARNP, PA-C or other non-physician providers
- Care Manager
- Exceptional Needs Care Coordinator
- DME Coordinator
- Medical Director
- Health Care Guide
- Clinical Pharmacist
- Pastoral Specialist
- Health/Disease Education Specialist
- Disease Management Specialist
- Preventive Health Promotion Specialist
- Community Resource Specialist
- Other providers and services as warranted

Each SNP member will be initially assigned to an ICT comprised of the member's Primary Care Provider and a Care Manager. The Care Manager will contact the member to explain the program, initiate their participation. With this information, the Care Manager assesses the members' health and psycho/social indicators, incorporating the member's input, electronic and other medical records, Health Risk Assessment, claims and pharmacy data as available. Following plan process, an expanded ICT is assigned, addressing needs for services of other team members such as the DME coordinator (e.g., member has mobility issues), Clinical Pharmacist (e.g., member has multiple prescriptions), Home Health (e.g., member needs a home assessment for fall hazards).

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b. How we facilitate the participation of the member whenever feasible:

Care Managers make multiple efforts if necessary to contact and involve members in participation. Follow-up assignments are tracked through Facets and members are contacted according to these assignments. Members thus receive additional individual communication through the efforts of our ICT team.

In addition to these contacts and our initial contact mentioned above, members receive education about benefits, and disease management education through letters, periodic mailings, and periodic newsletters.

In addition, we ensure that all health plan services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Interpreter services are available as needed.

c. How the ICT operates and communicates:

Documentation of all health plan/ member interactions is recorded in our core system, Facets. This documentation meets HIPAA standards for privacy and security.

Following is a case study presented as an example of how the ICT facilitates care for SNP members. This case study illustrates the ICT composition, participation of the member, ICT operations and communications. It also illustrates the coordination of the Plan of Care:

Case Study Example

Member Description, Medical:

Member is a 75 year-old married female who became eligible for the Special Needs Plan with dual eligibility in January of the current year. Diagnoses identified on first Care management assessment included chronic renal disease, Diabetes Type II, hypertension, peripheral vascular disease and Congestive Heart Failure. Primary Care provider oversight is in place with follow-up visits completed as recommended. Specialty care is in place with Nephrology ongoing via scheduled evaluations. Recent discussion about potential need for hemodialysis is noted in the medical record. Consultations have been completed as recommended and as warranted, including Nutrition, Cardiology, and Orthopedics. Current Home Health Services include Physical Therapy.

Member Description, Psychosocial:

The member is married and spouse has been in an intermediate care facility for two years with diagnosis of dementia. She has one child, a daughter, who resides in Sweden, has legal Power of Attorney (POA) and who is active in communications with providers and services. Full-time caregivers are supported by State eligibility and family supplement. A Physician Orders for Life-Sustaining Treatment (POLST) is in place for Do Not Resuscitate (DNR).

Member Description, Functional:

The member is partially ambulatory due to a right side below the knee amputation, with post operative status following her eligibility date. She is participating in rehabilitation therapy focused on strengthening and transfer ability. She is partially independent for Activities of Daily

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Living (ADL). Assessment for adaptive and assistive equipment in the home has been initiated with equipment in place. The member's cognitive and sensory functioning is intact, with hearing aid use.

Interdisciplinary Care Team Formation:

Care Management Assessment: Care management assessment of risk identification was initiated at time of enrollment. The member was individually assessed for level of need for ongoing, outreach support and entrance to an Interdisciplinary Care Team (ICT) assignment. An initial Health Risk Assessment was reviewed, which was positive for a need for disease management for Congestive Heart Failure (CHF) with other major co-morbidities, functional risks in home environment and recent readmissions between acute and Skilled Nursing Facility (SNF) settings. A Care Manager review of available medical records indicated additional risk factors, including a recent extended inpatient Length of Stay (LOS), and a current treatment regimen requiring primary and specialty care coordination. Laboratory data was reviewed with abnormal values for kidney and endocrine panels.

Member Participation: Care Manager contact was made directly with the member, caregiver and daughter with Power of Attorney (POA). Ongoing care management support, assessment and resource to facilitate care coordination were initiated. The member's and family/caregiver perspective on functional and medical needs was obtained. The ICT was described to offer the member and POA participation. Methods to access the Care Manager and to the ICT were outlined and current components of the treatment plan were reviewed. A Plan of Care was initiated, using all available data assessed and expanded to include member preferences.

ICT Composition:

Initial membership of the member's ICT was determined by an integrated risk assessment completed by the Care Manager. Team composition was determined by medical circumstances, input from providers and ancillary involved professionals, and the member/POA. Initial ICT membership included:

- Health Plan Care Manager
- Member and representative/POA and caregiver
- Primary Care Provider (PCP) and office nurse
- Specialty Care Provider(s), Nephrology, Cardiology, Orthopedics
- State Caseworker
- Home Health Physical Therapist
- Nutritionist
- Pastoral representative
- Utilization Nurse
- Medical Director

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- Exceptional Needs Care Coordinator
- DME Coordinator

The ICT members were contacted to meet and develop an individualized plan of care.

ICT meeting/communications:

An ICT meeting was scheduled with the members with the goal of development and communication of treatment plans across providers, prevention of disease complications and readmissions and further deterioration in functional status. Recommendations were discussed for integrated clinical decision-making. The Plan of Care now serves as the documented guide for updating provider recommendations and member preferences. Later, the member's POA contacted the member's spiritual pastor to request home contacts and to discuss decision making regarding hemodialysis options.

ICT meeting outcomes included addition of a Clinical Pharmacist to the team to assist with medication verifications across providers. Pharmacy and Nutrition recommendations were jointly reviewed for best renal and endocrine management. Physical Therapist was advised of equipment benefits with a plan established for wheelchair re-evaluation. Functional suggestions were conveyed to the member and caregiver.

An ICT meeting summary and the Plan of Care were documented with the ability to import to the medical record and to be available to the member/POA. The member/POA was provided a copy of the Plan of Care at the completion of the meeting.

Monitoring of the Plan of Care:

Individualized care management contact with the member will continue for recurrent assessment of needs, completion of treatment plan recommendations, ongoing coordination and communication with providers and services agencies and updating the Plan of Care, as warranted. Next review date was established to assure follow up on changes based on the individual member's care needs as recommended by the ICT. Additional ICT meetings and/or contacts can be initiated as needed by any members of the ICT (especially the member) if barriers to the evolving Plan of Care occur.

Plan of Care Example: see Attachment A

5 Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols

a. Specialized expertise in our provider network that corresponds to our target population including facilities and providers:

Samaritan Health Plans maintains and monitors a network of providers who use Evidence Based Practice guidelines and Clinical Protocols to serve our members. These providers consist of both primary care providers and specialty physicians who participate in both the Medicare and Medicaid programs and can provide seamless care to the dual-eligible SNP population. Samaritan Health Plans places a priority on ensuring that the majority of providers in our

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network are Board Certified. All non-Physician providers also participate in both Medicare and Medicaid ensuring that our member's care coordination is seamless.

The existing provider network includes contracted providers with specialists in all areas to meet the needs of our dual-eligible SNP members and provides 24 hour access to clinical consultation. In the rare case where the plan does not have a contract with a particular specialist requested due to a unique situation, the primary care provider and the Medical Director collaborate to identify the nearest qualified provider.

An online Network Provider listing is updated regularly and contains a complete directory of the contracted providers in the Samaritan Health Plans provider network.

The Samaritan Health Plans provider network includes:

- Hospitals (acute inpatient care, outpatient care, laboratory, speech therapy, occupational and physical therapy, radiology and imaging care),
- Skilled nursing facilities/ long-term care facilities
- Kidney dialysis centers
- Rehabilitation facilities
- Specialty providers (cardiology, nephrology, psychiatry, gerontology, neurologists, endocrinologists, obstetricians, gynecologists, pulmonologists, surgeons, etc.)
- Primary care providers (family practice, internal medicine, gerontologists, general practitioners, etc.)
- Ancillary providers (including stand alone laboratories, radiography/imaging facilities and other provider specialties/clinics)
- Durable Medical Equipment providers (prosthetics, orthotic devices and equipment or supplies)
- Home health services (in-home nursing and therapy)
- Chemical dependency and mental health services (outpatient chemical dependency services provided by Certified Alcohol and Drug Counselors, mental health services provided in the outpatient setting, inpatient services and facilities)

b. How we determine that our network facilities and providers are actively licensed and competent:

Samaritan Health Plans ensures that all physicians and providers permitted to practice independently under state law are properly credentialed per the Centers for Medicare and Medicaid Services (CMS), the Oregon Medicaid program, and Samaritan Health Plan Operations (SHPO) policies prior to providing health care services to our SNP members.

- Initial Credentialing of **practitioners** is as follows:
  - SHPO requires all network practitioners to fill out an Oregon Practitioners Credentialing Application (OPCA) form and/or Re-credentialing form. This application includes all

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information necessary for Primary Source Verification. Form can be found at: http://www.oregon.gov/OHA/OHPR/ACPCI/docs/2009CredApp.pdf?ga=t

- In addition to this form SHPO requires the following information be included:
  (a) Completed and signed Attestation & Release
  (b) Completed and signed Attachment A
  (c) Copy of Oregon State License
  (d) Current DEA and/or CDS certificate (if applicable)
  (e) List of Medical Malpractice carriers for the past 5 years
  (f) Copy of Board Certificates (if applicable)
  (g) Copy of Physician Assistant (PA) Practice Description, and OMB (Oregon Medical Board) Supervising Physician Approval Letter (if applicable)
  (h) Copy of Medical School diploma and/or completion certificates from medical training (preferred)

- Initial Credentialing of **facilities** is as follows:
  - SHPO requires all network facilities to fill out an Organizational Provider Credentialing Application form. Form can be found at: http://www.oregon.gov/OHA/OHPR/ACPCI/docs/2009CredApp.pdf?ga=t
  - In addition to this form SHPO requires the following information be included:
    (a) Completed and signed Authorization & Release of Information form page 8 of the Organizational Provider Credentialing Application.
    (b) Copy of Current State License
    (c) Copy of current Liability Certificate
    (d) Disclosure of Ownership form (DHS 3973)

- Once all appropriate paper work is submitted, all information is verified by the specialized credentialing department as follows:
  - License is still current and active
  - Liability/Malpractice insurance is still active
  - Board information is verified
  - Clinical Privileges are verified if applicable
  - Quality of Care issues are reviewed (for re-credentialing if applicable)
- Along with the information supplied, SHPO also requires that the following be verified:
  - Ensure provider is not sanctioned - http://exclusions.oig.hhs.gov/
  - Ensure provider has not opted out of Medicare - Medicare Opt out List
  - NPDB

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- Determination of Plan Participation is conducted by the Credentialing Committee. The Credentialing committee is comprised of 6 physicians representing various specialties.
- Providers are re-credentialed every three years according to Samaritan Health Plan's policy, using the OPRA (Oregon Practitioners Re-credentialing Application).

Board certification is monitored via the credentialing and re-credentialing process to ensure boarded providers are still active and/or newly boarded providers are updated. Those providers that are no longer active will be updated and reflected as no longer being board certified. Board information is audited yearly.

Quality of care issues are investigated and reviewed by the Medical Director. The Medical Director in turn submits this information along with their findings to the Provider Services Department who in turn presents negative outcomes to the Provider Contracting Committee. The Provider Contracting Committee will determine if additional action is needed and what kind of action is needed. A summary of negative quality of care issues are submitted to the Credentialing department for re-credentialing purposes. The Credentialing Committee, which meets every other month, will determine if the provider will stay on as an active provider or deny credentialing.

c. Who determines which services members will receive:

The member's primary care provider determines which services each member will receive based on their diagnoses and treatment plan, in coordination with the ICT and care manager. Each member chooses or is assigned a primary care provider upon enrollment into our SNP plan. The primary care provider serves as the center of care available to dual-eligible members with no visit limit. Samaritan Advantage Health Plan HMO and Samaritan InterCommunity Health Network maintain the same network of primary care providers and members are assigned the same primary care provider for both plans.

The role of the member's primary care provider is to direct and oversee all care for the member including the preventive and disease specific care of the individual, in consultation with the ICT. When the provider's expertise does not meet the specific needs of the member, the primary care provider may refer the member to a contracted specialist to meet the special needs of the dual-eligible member.

d. How the provider network coordinates with the ICT and the member to deliver specialized services:

As noted above, the primary care provider oversees all member care. If it is necessary for the provider to refer the member to another provider, they work with the ICT to coordinate the referral, provide any necessary chart notes for that referral, obtain information back from the referring provider and/or interdisciplinary care team member and provide follow up as necessary. The primary care provider, referring provider and the interdisciplinary care team member communicate by phone, fax, and letter or directly through the electronic medical record (EMR).

Care Managers play a key role in assuring that care is coordinated between our provider network and members. The Care Managers facilitate communication between the primary care provider and other members of the Interdisciplinary Care Team (ICT). They also assist and support the

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individual member in reducing barriers and assuring that needed care is received. To facilitate the ICT process, the Care Managers utilize our internal care management tracking system specifically designed to capture and track data. The Care Managers communicate with the provider, the member and other team members via various methods depending on the situation. These methods include but are not limited to phone, fax, face-to-face contact and letters. The frequency of these communications also depends on the situation but all communication is documented and tracked in our internal care management tracking system, which is a fully-integrated module of our core system, Facets.

e. How we assure that providers use evidence-based clinical practice guidelines and nationally recognized protocols:

Our Physician Advisory & Quality Committee approves evidence-based clinical practice guidelines. These guidelines are used to assist providers and members in making decisions about appropriate health care for specific clinical circumstances including "self-management" of chronic diseases. The guidelines are intended to improve the quality and consistency of care provided to our members.

Our guidelines are reviewed and updated periodically and presented to our Physician Advisory & Quality Committee for re-approval as appropriate but at least every two years. Numerous evidence-based clinical practice guidelines have been approved and are currently in place. Some examples appropriate to the SNP population include: Asthma; Coronary Artery Disease; Congestive Heart Failure; Diabetes; Obesity Assessment and Treatment; Osteopenia/Osteoporosis Screening and Treatment; Recommended Adult Preventive Screening and Immunization and Tobacco Cessation.

Our evidence-based clinical practice guidelines are shared with providers as part of our provider education and communication processes. Methods for this communication may include distributing the guidelines as part of our provider newsletter, placing them on our website and medical director presentation to providers.

We ensure that network providers use evidence-based clinical practice guidelines and nationally recognized protocols through methods such as:

- Internal review of outcome data such as HEDIS per provider per clinic on such things as Diabetes Care, Colorectal Cancer Screening and Breast Cancer Screening
- Analysis of provider reports that show the HEDIS results. This information is distributed to providers and/or discussed with individual providers by our medical director
- Through our Clinical Record Review Process in which random chart audits are conducted
- Contract language stipulating delivery of services in accordance with evidence-based clinical practice guidelines and nationally recognized protocols

Samaritan Health Plan's Evidence of Coverage documents, as well as federal and state guidelines, are used to interpret benefits. Nationally recognized criteria, federal, state, internal practice guidelines and company developed clinical standards are used to determine clinical appropriateness and medical necessity of services.

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Complete clinical criteria sets are maintained in the Medical Management Department, and are available for reference to authorized entities, providers and members upon request. The criteria utilized are:

- McKesson Corporation's Care Enhance Review Manager – Interqual criteria
- Milliman Corporation's CareWebQI – Inpatient, Procedures and Behavioral Health Care, and Length of Stay statistics.
- Centers for Medicaid and Medicare Services – Coverage guidelines, Local and National Coverage Determinations, a compendium of regulations, operation policy letters and manuals that are based on medical appropriateness criteria and clinical status of the patient to support decision-making.
- The Oregon Health Plan Oregon Administrative Rules (OARs) and Oregon Revised Statues (ORS) provide guidance for interpreting Medicaid benefits.

6 Model of Care Training for Personnel and Provider Network

a. How we conduct initial and annual model of care training including training strategies and content:

For Personnel:

All Samaritan Health Plans staff receives initial and annual training about our Special Needs Plan and our Special Needs Plan Model of Care.

Training detail content is identified by our Medical Director, the Director of Medical Management and the Director of Quality & Compliance. Our Training Coordinator then prepares all the training materials such as the PowerPoint presentation and the handouts. Content for trainings include information about the history of SNP plans, how our SNP plan is structured and information about our SNP Model of Care. When providing training about our SNP Model of Care, information about all the 11 elements (Description of the SNP-specific Target Population, Measurable Goals, Staff Structure and Care Management Roles, Interdisciplinary Care Team (ICT), Provider Network with Specialized Expertise and Use of Clinical Practice Guidelines and Protocols, Model of Care Training for Personnel and Provider Network, Health Risk Assessment, Individualized Care Plan, Communication Network, Care Management for the Most Vulnerable Subpopulations, Performance and Health Outcome Measurement) are included.

Training is currently done in small group trainings for initial (new Samaritan Health Plans employees) and annually (for all Samaritan Health Plans employees) using a PowerPoint slideshow with handouts. Staff has the opportunity to ask questions during the training. There is a sign in sheet for each training session to track and monitor who attends the trainings. All sign in sheets are maintained by our Training Coordinator. Employees have several opportunities to attend a training session within a specific timeframe. If employees do not attend either the initial or annual training during the specific timeframe, the Training Coordinator notifies each employee's manager/supervisor who discusses options with the employee on how to complete the appropriate MOC training and, if necessary, take any appropriate disciplinary action.

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Disciplinary action starts within 90 days of failure to comply and begins with a verbal warning then proceeds to a written warning (which goes in the employee's file) if compliance is not met.

Samaritan Health Plans is working towards a web-based training program that will require, within 90 days of employment, each new employee complete the SNP MOC web training. Each employee will then also be required to attend this web based training on an annual basis. At the completion of training, all employees will sign an attestation of completion. Completion of the web-based training would be documented for each staff person and records of training maintained through our Training Department. If employees do not complete either the initial or annual web based training during the specific timeframe, the Training Coordinator will notify each employee's manager/supervisor who will discuss options with the employee on how to complete the appropriate MOC training and, if necessary, take any appropriate disciplinary action. Disciplinary action will start within 90 days of failure to comply and begin with a verbal warning then proceed to a written warning (which will go in the employee's file) if compliance is not met.

As new information becomes available and in order to ensure timely updates to our staff on our Special Needs Plan or our Special Needs Plan Model of Care, additional training methods are used throughout the year including:

- Verbally at monthly staff meetings
- Electronically via email

For Providers:

Contracted network providers receive initial and annual training about our Special Needs Plan and our Special Needs Plan Model of Care.

Training detail content is identified by the Medical Director, the Director of Medical Management and the Director of Quality & Compliance. The Provider Relations Coordinator then prepares all the training materials such as the PowerPoint presentation and the handouts. This training focuses on a description of our dual-eligible SNP plan (D-SNP) and the definition and requirements surrounding this plan, with a specific focus on the integration of Medicare and Medicaid services. Content for the initial and annual trainings include information about the history of SNP plans, how our SNP plan is structured and information about our SNP Model of Care. When giving information about our SNP Model of Care we include information about all the 11 MOC elements (Description of the SNP-specific Target Population, Measurable Goals, Staff Structure and Care Management Roles, Interdisciplinary Care Team (ICT), Provider Network with Specialized Expertise and Use of Clinical Practice Guidelines and Protocols, Model of Care Training for Personnel and Provider Network, Health Risk Assessment, Individualized Care Plan, Communication Network, Care Management for the Most Vulnerable Subpopulations, Performance and Health Outcome Measurement). Provider training is done through either:

- PowerPoint slide set given to the provider as a self learning module or

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- Face-to-face training by the Medical Director given at our on-site annual training via PowerPoint presentations and verbal discussions (training is done for providers either at individual provider clinics or designated location for several clinics at one time)

The Provider Relations Coordinator is responsible for sending the PowerPoint self learning module to all newly contracted providers along with an attestation sheet that the provider returns as proof of completion of the training. The Provider Relations Coordinator tracks this information and contacts the provider if the attestation is not returned within 60 days. After the 60 days if the provider still hasn't returned the attestation the Provider Relations Coordinator notifies the Medical Director who discusses options with the provider on how to complete the appropriate MOC training. Disciplinary action by the Medical Director starts within 90 days of failure to comply and begins with a verbal warning then proceeds to a written warning (which goes in the provider's credentialing file) if compliance is not met. This information is taken into account when re-credentialing this provider.

Training is done on an ongoing basis as new providers are contracted, plus there is an annually training for all established providers. All providers are sent notification as to when the annual training will take place. Annual training is a face-to-face training by the Medical Director via a PowerPoint presentation and verbal discussions. Training is done for providers either at individual provider clinics or designated location for several clinics at one time. Attendance for all trainings is documented and maintained by the Provider Relations Coordinator. Those providers that do not attend are contacted by the Provider Relations Coordinator and required to complete a self learning module along with an attestation document which they sign and return to the Provider Relations Coordinator. If the provider doesn't return the attestation within 60 days the Provider Relations Coordinator contacts the Medical Director. Any providers that do not complete the annual training are contacted by the Medical Director who discusses options with the provider on how to complete the appropriate MOC training. Disciplinary action by the Medical Director starts within 90 days of failure to comply and begins with a verbal warning then proceeds to a written warning (which goes in the provider's credentialing file) if compliance is not met. This information is taken into account when re-credentialing this provider.

Throughout the year as new information becomes available and in order to ensure timely updates to our providers on our Special Needs Plan or our Special Needs Plan Model of Care additional methods may be used including:

- Written information in our provider newsletter, *The Navigator* (which is available in paper copy, electronic copy and on our website)
- Web-based information on our website
- Written news bulletins by the Medical Director
- Written information in our Provider Manual (which is available in paper copy, electronic copy and on our website)

Please see Attachment B for an example of slides used in provider training

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Please see Attachment C for an example of Attestation for Providers on MOC training

Please see Attachment D for an example of slides used in training staff in our Medical Management Department

Please see Attachment E for example of employee sign in sheet for trainings

b. How we assure and document completion of training by employed and contracted personnel:

Training for staff is currently done in small group trainings for initial (new Samaritan Health Plans employees) and annually (all Samaritan Health Plans employees) using a PowerPoint slideshow with handouts. There is a sign in sheet for each training session to track who attends the trainings. All sign in sheets are maintained by our Training Coordinator. Employees have several opportunities to attend a training session within a specific timeframe. For those employees that don't attend either the initial or annual training during the specific timeframe the Training Coordinator notifies that employee's manager/supervisor who discusses options with the employee on how to complete the appropriate MOC training and if necessary take the appropriate disciplinary action. Disciplinary action starts within 90 days of failure to comply and begins with a verbal warning then proceeds to a written warning (which goes in the employee's file) if compliance is not met.

The Provider Relations Coordinator is responsible for sending the PowerPoint self learning module to all newly contracted providers along with an attestation sheet that the provider returns as proof of completion of the training. The Provider Relations Coordinator tracks this information and contacts the provider if the attestation is not returned within 60 days. After the 60 days if the provider still hasn't returned the attestation the Provider Relations Coordinator notifies the Medical Director who discusses options with the provider on how to complete the appropriate MOC training. Disciplinary action by the Medical Director starts within 90 days of failure to comply and begins with a verbal warning then proceeds to a written warning (which goes in the provider's credentialing file) if compliance is not met. This information is taken into account when re-credentialing this provider.

Training is done on an ongoing basis as new providers are contracted plus there is an annually training for all established providers. All providers are sent notification as to when the annual training will take place. Annual training will be a face-to-face training by the Medical Director via a PowerPoint presentation and verbal discussions. Training is done for providers either at individual provider clinics or designated location for several clinics at one time. Attendance for all trainings is documented and maintained by the Provider Relations Coordinator. Those providers that do not attend are contacted by the Provider Relations Coordinator and required to complete a self learning module along with an attestation document which they sign and return to the Provider Relations Coordinator. If the provider doesn't return the attestation within 60 days the Provider Relations Coordinator contacts the Medical Director. Any providers that don't complete the annual training are contacted by the Medical Director who discusses options with the provider on how to complete the appropriate MOC training. Disciplinary action by the Medical Director starts within 90 days of failure to comply and begins with a verbal warning

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then proceeds to a written warning (which goes in the provider's credentialing file) if compliance is not met. This information is taken into account when re-credentialing this provider.

Please see Attachment E for example of employee sign in sheet for training

Please see Attachment C for example of Attestation for Providers

Please see Attachment F for example of tracking log for provider attestations

c. Who we identify as personnel responsible for oversight of the model of care training:

All Samaritan Health Plans staff receives initial and annual training about our Special Needs Plan and our Special Needs Plan Model of Care. Training detail content is identified by our Medical Director, the Director of Medical Management and the Director of Quality & Compliance. Our Training Coordinator then prepares all the training materials such as the PowerPoint presentation and the handouts. The Training Coordinator conducts the initial and annual trainings and tracks whether staff has completed the appropriate training. For those employees that don't attend either the initial or annual training during the specific timeframe the Training Coordinator notifies that employee's manager/supervisor who discusses options with the employee on how to complete the appropriate MOC training and if necessary take the appropriate disciplinary action. Disciplinary action starts within 90 days of failure to comply and begins with a verbal warning then proceeds to a written warning, which goes in the employee's file if compliance is not met.

Contracted network providers receive initial and annual training about our Special Needs Plan and our Special Needs Plan Model of Care. Training detail content is identified by the Medical Director, the Director of Medical Management and the Director of Quality & Compliance. The Provider Relations Coordinator then prepares all the training materials such as the PowerPoint presentation and the handouts. The Training Coordinator is responsible for tracking provider training. For providers that don't complete the initial or annual training the Training Coordinator notifies the Medical Director who takes appropriate action. Disciplinary action by the Medical Director starts within 90 days of failure to comply and begins with a verbal warning then proceeds to a written warning (which goes in the provider's credentialing file) if compliance is not met. This information is taken into account when re-credentialing this provider.

d. Actions we will take when the required model of care training has not been completed:

There is a sign in sheet for each employee training session to track who attends the trainings. All sign in sheets are maintained by our Training Coordinator. Employees have several opportunities to attend a training session within a specific timeframe. For those employees that don't attend either the initial or annual training during the specific timeframe the Training Coordinator notifies that employee's manager/supervisor who discusses options with the employee on how to complete the appropriate MOC training and if necessary take the appropriate disciplinary action.

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Disciplinary action starts within 90 days of failure to comply and begins with a verbal warning then proceeds to a written warning, which goes in the employee's file if compliance is not met.

The Provider Relations Coordinator is responsible for sending the PowerPoint self learning module to all newly contracted providers along with an attestation sheet that the provider returns as proof of completion of the training. The Provider Relations Coordinator tracks this information and contacts the provider if the attestation is not returned within 60 days. After the 60 days if the provider still hasn't returned the attestation the Provider Relations Coordinator notifies the Medical Director who discusses options with the provider on how to complete the appropriate MOC training. Disciplinary action by the Medical Director starts within 90 days of failure to comply and begins with a verbal warning then proceeds to a written warning (which goes in the provider's credentialing file) if compliance is not met. This information is taken into account when re-credentialing this provider.

Those providers that do not attend annual training are contacted by the Provider Relations Coordinator and required to complete a self learning module along with an attestation document which they sign and return to the Provider Relations Coordinator. If the provider doesn't return the attestation within 60 days the Provider Relations Coordinator contacts the Medical Director. Any providers that don't complete the annual training are contacted by the Medical Director who discusses options with the provider on how to complete the appropriate MOC training. Disciplinary action by the Medical Director starts within 90 days of failure to comply and begins with a verbal warning then proceeds to a written warning (which goes in the provider's credentialing file) if compliance is not met. This information is taken into account when re-credentialing this provider.

Please see Attachment C for example of Attestation for Providers

Please see Attachment E for example of employee sign in sheet for training

Please see Attachment F for example of tracking log for provider attestations

7 Health Risk Assessment

a. Health risk assessment tool we use to identify the specialized needs of our members:

Samaritan Health Plans conducts a comprehensive initial Health Risk Assessment within 90 days of enrollment, and an annual Health Risk Assessment for its full dual-eligible SNP population. The tool we utilize is a paper-based tool which is a plan-developed tool using the methodology behind the SF- 36 document. Our Health Risk Assessment tool identifies the specialized needs of our member's medical, psychosocial, functional, and cognitive needs.

Medical questions include questions about their health compared to one year ago, what type of medical services they have needed recently and whether they have had any difficulty receiving these services, medications they are taking and types of conditions/diseases that they currently have or have had in the past. Psychosocial and cognitive needs questions include living conditions and environment, as well as questions about depression and limited social activities due to their physical health. Functional questions include activities of daily living and whether or

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not they need assistance with them. The assessment helps us focus not only on preventing deterioration of each individual's current health state, but also on improving the overall health and wellness of our members.

The Health Risk Assessment tool is mailed to members at the time of enrollment along with a pre-paid postage envelope so they can return the completed form to us. If required the assessment can be done in person or by phone by our Health Coach if the member requests one of these options. At the end of the Health Risk Assessment form is a place for the member to sign giving us permission to share the information with their primary care provider and the Interdisciplinary Care Team.

Please see Attachment G for a copy of our current Health Risk Assessment tool

b. When and how the initial health risk assessment and annual reassessment is conducted for each member:

Samaritan Health Plans Special Needs Plan members receive an initial plan-developed comprehensive Health Risk Assessment form via mail at the same time enrollment documents are sent to the member (within 90 days of enrollment). They also receive pre-paid postage envelope in which to return the completed form to us. Per monthly generated reports, if the member doesn't return a completed initial Health Risk Assessment form within 60 days, another one is mailed to them. If required the assessment can be done in person or by phone by our Health Coach if the member requests one of these options. Members can return the completed form in person or through the mail.

If the member doesn't return a completed Health Risk Assessment form after the second mailing a Health Coach contacts the member by phone. They will assist the member in completing the form over the phone or in a face-to-face visit if the member requests.

Once the completed Health Risk Assessment form is completed all the data is entered into our Health Risk Assessment module of our core system, Facets. From this module stratification reports are generated on at least a monthly basis for development of each member's Individualized Care Plan by our Care Managers. Reports are also generated monthly by our Quality Department for our Chronic Care Improvement Program educational interventions.

Annually (per generated reports), within one year of when the initial health risk assessment was received or the last annual health risk assessment was received), the Health Risk Assessment form is mailed to each SNP member. The Health Coach is responsible for ensuring that an annual health risk assessment is received. The Health Coach will follow up on any outstanding annual health risk assessments if not received within 60 days. This is done by phone or by a face-to-face visit if the members requests.

From this data stratified and comparative reports are generated on at least a monthly basis for reviewing/updating as required each member's Individualized Care Plan by our Care Managers.

The same Health Risk Assessment form is utilized for both the initial and annual assessments. The form is reviewed at least yearly by the Medical Director, the Care Managers, the Assistant Care Coordination Manager and the Director of Quality & Compliance and is revised as needed. The Health Risk Assessment is currently under revision for Plan Year 2013.

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c. Personnel who review, analyze and stratify health care needs:

All data from the Health Risk Assessment is entered into the Health Plan core system, Facets, for developing and/or updating the individualized care plan for each member, and for reporting purposes.

The Plan Medical Director, the Director of Medical Management and Operations, and the Director of Quality & Compliance, review and analyze reports to stratify the data using risk factors and diseases (see information below regarding stratification). Reports are generated and reviewed at least monthly by the Care Managers. The stratification methods are reviewed and adjusted as necessary by the Healthcare Assessment Committee, a subcommittee of the Physician Advisory & Quality Committee.

Examples of the current stratification of members from Health Risk Assessments include:

- Stratification:
  Healthy = 0 targeted diseases and 0 risk factors
  At Risk = 0 targeted diseases and 1-7 risk factors
  Low Risk = At least 1 targeted disease and 0-3 risk factors
  High Risk = At least 1 targeted disease and 4-7 risk factors
- Risk Factors:
  ADL = Activities of Daily Living (ADLs)
  Smoke = Smokes or lives in smoky environment
  Fall = Falls in the past 6 months
  CLS = Concerns about current living situation
  Dep = Depression
  ER = Visit to ER in the past year
  IP = Admitted to hospital in past year
- Targeted Diseases:
  Diabetes
  Asthma
  CAD (Coronary Artery Disease)
  CHF (Congestive Heart Failure)
  COPD (Chronic Obstructive Pulmonary Disease)
  Hypertension

As we look to the future, we are working to incorporate stratification levels based on the CMS definitions as below:

- Frail
- Disabled
- Members developing end-stage renal disease after enrollment
- Members near the end of life

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- Members having multiple and complex chronic conditions

d. Communication mechanism we institute to notify the ICT, provider network, members, and others about the health risk assessment and stratification results:

The individualized care plans are developed by the Care Manager in collaboration with the ICT based on results from the initial Health Risk Assessment (and modified as needed based on annual assessments), chart reviews, provider communication, claims data, and other data as appropriate. Results from the stratification of the Health Risk Assessment data are communicated to the ICT (which initially includes the member and the member's primary care provider) to ensure that those members at highest risk receive top prioritization. This communication, of both the Health Risk Assessment and stratification results, is done via phone, mail, fax or email. The Health Plan Medical Director participates in most ICT meetings to assist in direct communication of care plan goals.

Case Study:

When Mrs. Jones, a 75 year old married female enrolled in our Special Needs Plan with dual eligibility in January of the current year, she received a HRA to complete along with her enrollment documents. She was unable to complete this independently and called the Health Plan office, where a Health Coach assisted her in documentation completion.

Mrs. Jones chart review notes diagnoses including chronic renal disease, Diabetes Type II, hypertension, peripheral vascular disease and congestive heart failure. Claims data demonstrate that she takes over 17 differing medications, has had 8 ED visits in the past year, and 2 hospitalizations. A discussion with her primary care provider reveals additional information about her complex medical history plus a stressful home situation. Her completed Health Risk Assessment identifies the targeted diseases noted above, difficulty with ADLs, concerns about living situation, and multiple ED visits plus an inpatient hospitalization in the past year. She is assigned a risk stratification of High Risk. For this reason, her case is scheduled to come to the ICT within 60 days. The Care Manager compiles all available information on Mrs. Jones and she, along with her caregiver and primary care provider, are invited to the ICT meeting to participate in the development of her Individualized Care Plan. A plan is created to repeat the Health Risk Assessment within 1 year and re-convene the ICT at that time to make needed adjustments to both the risk stratification and Individualized Care Plan.

8 Individualized Care Plan

a. Which personnel develop the individualized plan of care and how the member is involved in its development as feasible:

SNP members have an Individualized Care Plan (Plan of Care) that is developed by the Care Manager in collaboration with the ICT, and in cooperation with the member or with the member's caregiver if the member is unable to assist. The ICT meets following receipt of the member's Health Risk Assessment and compilation of other heath data, including chart notes and claims records. The timing of the ICT meeting for developing the plan of care is adjusted based

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on the risk stratification category for the member, with the highest risk member's plan ICT meetings scheduled within 30 days of compilation of the needed data. The Care Manager is responsible for maintaining the plan of care, which is based on the member's current needs and is reviewed and modified as those needs change. The member or the member's caregiver receives a copy of the care plan, as does the primary care provider.

Every effort is made to have the member, and/or their caregiver, attend the ICT meeting. Each ICT meeting is individualized so the team is designed to meet the member's needs. Participation includes the member's specific Care Manager, primary care provider, and specialist physicians, or their representatives. We are working towards consistency across ICTs and care plan development by developing a process whereby the Health Plans' Medical Director provides oversight.

Members are regularly contacted telephonically by the Care Manager as part of the ongoing care management process. In addition, members may meet with their Care Manager, Clinical Pharmacist, or other members of their ICT face-to-face in our storefront during normal business hours.

b. The essential elements incorporated in the plan of care:

The Individualized Care Plan includes a collection of information to assist in directing the care and improving the health of the member. The Individualized Care Plan also provides consistency in communication on behalf of the member, with all participants in the care team. As the ICT coordinator, the Care Manager assures that the Individualized Care Plan incorporates the following essential elements (see also the case study example provided in Element 4, ICT for a specific Individualized Care Plan example):

- Health Risk Assessment (both initial and annual)
- Member specific goals and objectives
- Documentation of the specific services and benefits
- Applicable outcome measures
- Member preferences for care
- Add-on benefits available or recommended
- Special services needed to accommodate disability or special circumstances such as end-of-life care

The Individualized Care Plan is individualized and disease specific, with both functional and psychosocial components. The member receives a copy of the Individualized Care Plan and a copy each time it is updated.

c. Personnel who review the care plan and how frequently the plan of care is reviewed and revised:

The Individualized Care Plan is reviewed and revised as needed for health status changes, but at reviewed at least annually by the member's ICT. Annual Health Risk Assessment updates are reviewed and incorporated into the Individualized Care Plan. The member, or the member's

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caregiver if the member is unable able to assist, is involved in any updates to their care plan and is invited to attend their ICT meetings. For example, in the case study example provided in Element 4, the member's Individualized Care Plan incorporated a follow-up review timeline to meet the individual member's needs.

The Individualized Care Plan is also reviewed and updated whenever there are Skilled Nursing, ED or inpatient hospital admissions. Automated reporting provides timely information to Health Plan Care Managers so that they may adjust the Individualized Care Plan for any transitions.

d. How the plan of care is documented and where the documentation is maintained:

The Individualized Care Plan is documented electronically in the health plan core system, Facets, in the Care Management Module. Documentation is accessible to the ICT members through various methods as noted below:

- Electronically – health plan staff on the Care Management team have access to Facets Care Management module in which the Care Manager documents information on each member.
- Electronically – all health plan staff have access to the Facets Customer Service module in which Customer Service staff document all member interactions, including telephonic and face-to-face.
- Fax – members of the ICT (outside of the health plan staff) are sent copies of the Individualized Care Plan via fax for each member.
- Mail – All ICT members are sent copies of the Individualized Care Plan for each member through the mail with a letter from their Care Manager.

The Facets system is maintained by the Samaritan Health Services IS department according to industry standard requirements for HIPAA security, privacy and confidentiality (see Element 9 for details).

e. How the plan of care and any care plan revisions are communicated to the member, ICT, MAO and pertinent network:

Communication about the initial Individualized Care Plan and any revised Individualized Care Plans is communicated through various methods.

- Electronically – health plan staff on the Care Management team have access to Facets Care Management module in which the Care Manager documents information on each member.
- Electronically – all health plan staff have access to the Facets Customer Service module in which Customer Service staff document all member interactions, including telephonic and face-to-face,
- Fax – members of the ICT (outside of the health plan staff) are sent copies of the Individualized Care Plan via fax for each member.
- Mail – All ICT members are sent copies of the Individualized Care Plan for each member through the mail with a letter from their Care Manager.

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9 Communication Network

a. Structure for a communication network:

Samaritan Health Plans uses a multi-faceted approach to communication in order to ensure that we connect effectively with our members, their providers, and all potential stakeholders involved in a particular members care. Samaritan Health Plans' communication network utilizes the provider's Electronic Medical Record, the Health Plans' Core system, Facets, and face-to-face meetings as well as e-mails, faxes, and written correspondence.

We have a call-in line for both members and providers to ensure access to the Interdisciplinary Care Team. This multi-faceted approach accommodates the plan's widespread geographical area (including many rural areas) and a variety of provider Electronic Medical Record systems. In addition, we have a solid tradition going back to the beginning of our Medicaid plan in 1995 of established regional face-to-face meetings with various stakeholders to ensure ongoing collaboration and communication. We have mechanisms in place to target audiences for a particular reason. Current examples include, marketing focus groups, monthly member newsletters and disease management information sent to a subset of our population.

b. How the communication network connects the plan, providers, members, public and regulatory agencies:

The communication network is a multi-faceted approach that includes maintaining a website, storefront, well-trained Customer Care and Care Management staff and a sophisticated documentation system. The Samaritan Health Plans' internal computer systems are designed to facilitate and enhance communication, while ensuring regulatory compliance. Examples of current communication networks include:

- Our local storefront welcomes both members and providers to connect with us face-to-face.
- Our website is updated weekly with information on changes to our Provider Directory. We have a Provider Relations Coordinator who regularly visits with providers and coordinates a regular newsletter to the provider community. We use this model as one method to inform our provider community about our MOC.
- Members are notified of the various options for communication through introductory material sent out upon enrollment and in our marketing to the public. We also inform members of these options when they call our customer services department.

Communication from a care plan perspective is done through the ICT, with the Care Manager holding the key position. The Care Manager contacts all external members in the team directly to determine the necessary mode of communication. This is then documented in the member's care plan and our core system, Facets. An example of how this would work involves one of our members in a rural area. They do not have electricity or landline but do have a cell phone. To arrange a meeting with the member and other stakeholders, the Care Manager contacts the parties to arrange a date and determines the best way for all to participate.

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c. How we preserve aspects of communication as evidence of care:

We currently utilize multiple ways to preserve evidence of care including recordings, written minutes, newsletters, and written correspondence. Each area within the health plan has policies describing how, when and for how long they preserve different types of documentation.. We facilitate preserving evidence of care through policy and train staff frequently on the importance of all documentation residing in this one location. Our goal is to merge this data into our core software, Facets, in the near future. Additionally, we are implementing strategies to integrate other documentation into Facets such as chart information from providers, phone recordings, newsletters and written minutes so that everything the care team has done or the member has experienced is in their Facets record.

Facets is an enterprise-wide system specifically designed for health plan administration. Facets enables seamless transactions between our providers, members and within the Health Plan through a sophisticated security solution in addition to a web-portal specifically designed for members and providers. In addition, it allows for detailed documentation and reporting, as needed for regulatory agencies.

Facets database transaction logs are backed up every 15 minutes and a full backup is performed nightly of the database. The Facets servers, including the destination of the Facets transaction log backups and full database backup have nightly incremental backups on tape. The tape backups are kept onsite at SHS and copies are sent offsite to Iron Mountain on a daily basis.

- Reference: SHS IS, Samaritan Health Plans Disaster Recovery Policy

d. Personnel having oversight responsibility for monitoring and evaluating communication effectiveness:

Communication oversight is assured through a series of written policies and procedures and monitoring to close the loop and ensure processes are followed as expected. Specific policies and procedures identify specific personnel having oversight responsibility. These include the following:

- Marketing Manager, specifically responsible for oversight of member and public communication to ensure compliance with regulatory requirements.
- Director of Customer Care, specifically responsible for oversight of our telephone system and for ensuring compliance with multiple written policies regarding documentation of member contacts in Facets.
- Samaritan Health Plans Government Operations Manager, specifically responsibility for communication with regulatory agencies and overall responsibility for Samaritan Advantage, SNP Health Plan compliance.
- Samaritan Health Services, Information Systems Managed Care Manager, specifically responsible for Facets backup processes as documented in the SHS IS, Samaritan Health Plans Disaster Recovery Policy.
- Director of Medical Management and Operations, specifically responsible for oversight of Care Management communication effectiveness, including evaluating and monitoring of

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processes and policies designed to standardize Facets data entry and ensure care management protocols. The Director of Medical Management and Operations meets regularly with the Care Management staff and reviews Facets reports to monitor and evaluate Care Management communication effectiveness.

- Compliance Manager, specifically responsible for compliance with all HIPPA policies and procedures.

10 Care Management for the Most Vulnerable Subpopulations

a. How we identify our most vulnerable members:

Samaritan Health Plans identifies the most vulnerable beneficiaries through multiple, documented methodologies. A compilation of the Health Risk Assessment results, chart review for diseases, and additional member input is used to stratify risk. Members are currently assigned a risk category as described below:

Healthy = 0 targeted diseases and 0 risk factors

At Risk = 0 targeted diseases and 1-7 risk factors

Low Risk = At least 1 targeted disease and 0-3 risk factors

High Risk = At least 1 targeted disease and 4-7 risk factors

In addition, we utilize a combination of medical and pharmacy claims data, HRA data, chart note analysis, hospital reported data (such as ER and Inpatient admits), Customer and Provider Services inquiries, and other data to further identify members in the following CMS based risk categories:

- Frail
- Disabled
- Members developing end-stage renal disease after enrollment
- Members near the end of life
- Members having multiple and complex chronic conditions

All data is then utilized to determine the timing of ICT meetings, needed updates to Individualized Care Plans and other actions by our clinical team which may lead to the provision of care coordination and/or add on services as needed for our most vulnerable sub-populations.

b. Add-on services and benefits we deliver to our most vulnerable members:

Samaritan Health Plans provides comprehensive Care Management services with priority in delivering specialized services to address the needs of vulnerable members with known complex conditions. Care Management services recognize the multidimensional needs of the following groups and provide targeted additional services including:

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Frail and Disabled Conditions

Members are identified who may have debilitating and/or disabling conditions that impact multiple levels of medical and/or cognitive functioning. Additional services they receive may include:

- Ongoing assessments and reassessments of the member's medical, psychiatric, psychosocial and economic circumstances that impact the member's daily functioning and communication with providers, with goal toward a member-centered plan of care.
- Fostering integrated, interdisciplinary communication focused on member-centered care and avoidance of unplanned transitions to higher levels of care utilization.
- Initiation and review of home environmental assessments to identify barriers, needs and adaptations possible for safety and quality of life, including referrals, equipment and caregivers supports.

Development of End Stage Renal Disease

Members are identified who have developed a new diagnosis of End Stage Renal Disease post-enrollment. Additional services they receive may include:

- Promotion of member education toward managing disease symptoms, in addition to other co-existing disorders, and avoiding preventable complications.
- Reinforcing and facilitating provider expectations in the development of multi-specialty planning and communication with members to meet specialty and primary care needs.
- Facilitating use of available treatment sources/locations, transportation services and caregiver assistance in securing ongoing medical visits, procedures, pharmacy/supplies and other services.

Near End of Life Status

Members are identified who may be near end of life due to medical diagnosis(s) and provider assessment of prognosis. Additional services they receive may include:

- Direct engagement with members and caregivers toward advanced planning, including discussion about treatment choices, palliative and hospice care and resource support per benefit and community sources.
- Assessment of member beliefs and preferences toward diagnosis and potential loss of life, including care setting, spiritual and cultural support.
- Participation with multi-resource team to establish continuity of care for best comfort options, pain control, emotional support and information sharing with the member and family.

Multiple and Complex and /or Chronic Disease States

Members are identified who may have been diagnosed with one or more chronic diseases and known functional health risk factors. Additional services they receive may include:

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- Comprehensive assessment and review of medical evaluations and prescribed recommendations to tailor member communications regarding available benefits and other eligibilities that support the treatment plan toward best outcomes (e.g.: provider visits, scheduled testing procedures, health education, use of community and other support groups and resources).
- Review of member functional status and ability to self-manage disease and medical care needs, with proactive identification, referral and outreach to state and community resources.
- Promotion of symptom surveillance monitoring and reporting by members, caregivers and providers toward prevention of disease complications.

Case Study

Based on the initial Health Risk Assessment, in association with a chart review, Mrs. Jones was identified as a high risk member. She was noted to have two targeted diseases and four risk factors. High risk members are scheduled to meet with the ICT sooner. She participated in the ICT and formulation of her plan of care.

Additionally, due to her high risk status, she was automatically provided with a medication therapy assessment. During that assessment, a clinical pharmacist met with Mrs. Jones and reviewed all medications, including dosing and frequency. A complete review was done looking at drug to drug interactions, needed dosing adjustments for her renal disease, and administration issues. This is documented in Facets and hard copy results are provided to all physicians involved in her care, as well as to Mrs. Jones and her daughter.

As a high risk patient, the Care Manager meets with Mrs. Jones every 30 days, either via phone or in person. Any status change also prompts another meeting. Finally, the health plan medical director also reviews Mrs. Jones plan of care and correlates it to claims data to ensure she is receiving all needed care identified by the care team

11 Performance and Health Outcome Measurement

a. How we collect, analyze, report and act on the evaluation of the model of care:

Samaritan Health Plans collects, analyzes, reports and acts on data regularly to evaluate the Model of Care. The Care Management/Quality & Compliance Analyst works with the Systems and Data Team to develop data reports to analyze and evaluate performance and outcome measures, with report outputs daily, weekly, monthly, quarterly and annually. The Healthcare Assessment Committee (a subcommittee of the Physician Advisory & Quality Committee) includes representation from:

- The Director of Medical Management and Operations
- Government Plans Operations Manager
- Plan Medical Director
- Clinical Pharmacist
- Director of Quality and Compliance

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- Care Management/Quality & Compliance Analyst
- CEO and COO as needed

The committee work closely with the data received from the Analyst to evaluate the ongoing effectiveness of the Model of Care, and performance and outcome measures. The analysis of the data is presented to the Healthcare Assessment Committee to evaluate the specific performance and outcome measures and the infrastructure for the Model of Care.

Methodologies used include the following examples:

- The data is collected using current processes and workflow. Pharmacy data is collected by the Pharmacy Benefits Manager (PBM) and the claims data through claims processing activities in Facets. These are then aggregated in a central data repository.
- Data elements for the evidenced-based individualized care plans are collected by the ICT and stored in the health plan's core Health Information System, Facets.
- Health Risk Assessment data is collected at the time of Enrollment and annually thereafter. This data is collected and stored in the health plan's core information system, Facets. Performance and Outcome Measures are developed to analyze the SNP population outcomes based on utilization of specific services including but not limited to, Preventative Services, Hospital and Skilled Nursing Facilities, Non-emergency transportation, Private Duty Nursing, Home Health Aides, and Inpatient Mental Health Services.
- Other staff within Samaritan Health Plans collect data elements that are analyzed to help evaluate performance and outcome measures and the Model of Care, including but not limited to the HEDIS databank (annually), Hierarchical Condition Categories (HCC) databanks (quarterly), encounter data databank (monthly), provider database (monthly), and the benefits configuration system (annually).

Examples of other types of reports collected, analyzed and actions taken to address issues and evaluate performance and outcome measures and the Model of Care structure and processes include but are not limited to:

- Chronic condition data extracts are reviewed to evaluate the Model of Care, and to identify areas that may need additional attention in an effort to maintain and improve performance and health outcomes and to assist members to optimally manage their medical conditions.
- Emergency, hospital, home health, inpatient mental health & outpatient authorization data is reviewed and analyzed regularly to evaluate improved access to medical, mental health and social services.
- Care management dashboards and production data are reviewed and analyzed for trends in member needs, evaluation of internal staffing levels and evaluation of coordination of care through a single point of care management.
- Utilization management production for facilities, authorizations and Stop Loss data are reviewed and analyzed regularly for analysis of prior authorization effectiveness, member

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barriers and analysis of transitions and care management to evaluate improved access to affordable care.

- Trending by facility type, services and cost data is reviewed and analyzed regularly, and trends are identified. Action plans are created for outliers, by facility and service type. For example, we would trend MRI utilization by provider, by location to identify if certain locations are increasing or decreasing utilization, and if this correlated to trends in patient care and health outcomes. These are also evaluated for improved transitions of care across settings and providers.
- Each year the HealthCare Effectiveness Data & Information Set (HEDIS) performance measures are evaluated. Measures such as the Effectiveness of Care, Access/Availability of Care, and the Use of Services are reviewed to evaluate performance measures, trend results from prior years' data and to identify areas for improvement, including specific areas targeting for future performance improvement or other actions. Certain HEDIS data measures specific to Special Needs Plan members are evaluated and trended against our total Medicare Advantage population.
- Medicare and Medicaid Satisfaction Surveys (CAHPS) and the Medicare Health Outcomes Survey (HOS) are also reviewed annually and utilized to identify areas for improvement. The Healthcare Assessment Committee does an in depth analysis of this data and makes recommendations on areas for improvement which is reported to the Physician Advisory & Quality Committee.

The data collected is analyzed not less than annually by the Healthcare Assessment Committee and evaluated against the goals for the Model of Care. If deficiencies are found, initiatives to address them are implemented.

b. Who collects, analyzes, reports and acts on data to evaluate the model of care:

The Analytics Department is responsible for development of the reports requested for analyzing the Model of Care. The Care Management/Quality & Compliance Analyst has a background in the specific medical and care management functional areas, and is trained on quality data capture and reporting methodologies. The Analyst is responsible for determining what data marts need to be used to ensure appropriate analysis and evaluation. The Analyst is also responsible for validating the data provided through the reports received and storing all versions of each report and evidence of the validation procedures. Oversight of the Analytics Department is the responsibility of the Manager of Systems and Data and Analytics.

The Analyst works with the Director of Quality and Compliance, a licensed RN with certification in CPHQ and 22 years of experience in clinical quality to analyze the performance and outcomes measures data and develop tools and charts to accurately reflect the state of the Model of Care. All data and documentation on the analysis of the data is presented to the Healthcare Assessment Committee on regular reporting intervals. Data is presented to the Healthcare Assessment Committee prior to going to the Physician Advisory & Quality Committee.

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The Medical Director and the Director of Medical Management and Operations review other aspects of the model of care such as the staff structure and care management roles, the ICT and the individual care plans and staff training on the model of care to identify strengths, weaknesses and opportunities for improvement.

The Provider Services department and the Medical Director review provider training on the model of care to identify strengths, weaknesses and opportunities for improvement.

Major findings are acted on immediately with guidance from the Healthcare Assessment Committee and at the direction of the Chief Operations Officer. Other staff within Samaritan Health Plans may have structure and process tasks to complete as a result of the initiatives implemented by the Chief Operations Officer.

The Director of Medical Management and Operations, the Medical Director and the Director of Quality & Compliance are responsible for managing the actionable items as a result of the Healthcare Assessment Committee's recommendations as initiated by the Chief Operating Officer.

c. How we use the analyzed results of the performance measures to improve the model of care:

The Healthcare Assessment Committee has scheduled meetings monthly to review and analyze data reports, and to follow up with results from the performance and outcome measures. These results are trended by timeframe (over prior reporting period and prior year) and compared to enrollment and utilization trends. Based on the analysis the Healthcare Assessment Committee will develop recommendations which could include such things as the development of a quality improvement project to improve access to preventive services as an example.

All recommendations made by the Healthcare Assessment Committee are documented in meeting minutes. The clinical recommendations are presented to the Physician Advisory & Quality Committee, who reviews the information and data presented, gives their input and final approval for quality improvement projects. All operational recommendations from the Healthcare Assessment Committee are presented to the Director of Medical Management and Operations, the Operations Manager or the Provider Services Manager as appropriate. The Director of Medical Management and Operations is responsible for the oversight of the implementation and completion of operational improvement activities.

d. How the evaluation of the model of care is documented and preserved as evidence of the effectiveness of the model of care:

All discussions, analysis, recommendations, decisions and follow up made by both the Healthcare Assessment Committee and the Physician Advisory & Quality Committee are documented in electronic meeting minutes and stored within Samaritan Health Plans' electronic management database.

The Samaritan Advantage SNP Model of Care annual evaluation is documented using the Plan-Do-Study-Act quality improvement cycle. The template provides details and descriptions of the format and examples of mechanisms we use to document the effectiveness of our Model of Care.

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Please see Attachment H for example of the template utilized for documenting the SNP Model of Care annual evaluation

e. Personnel having oversight responsibility for monitoring and evaluating the model of care effectiveness:

Oversight responsibilities for monitoring and ensuring effectiveness of the Model of Care are as follows:

- The Director of Quality and Compliance and the Director of Medical Management and Operations are responsible for the oversight of monitoring and evaluating the effectiveness of the Model of Care on an ongoing basis. The Director of Quality and Compliance is a licensed RN with CPHQ certification and 22 years of quality and health plan management experience. The Director of Medical Management and Operations has 18 years of Health Plan Management background in Claims, Provider Services, Data and Analytics and Medical Management.
- The Care Management/Quality & Compliance Analyst, whose job responsibilities include quality methodologies, data sets and systems and analysis, works with the Analytics Department to develop reports to analyze performance and outcome measures. The Director of Quality & Compliance performs oversight and monitoring of the HEDIS measures and Performance Improvement Projects, and reporting to the Healthcare Assessment Committee.
- The Care Management/Quality & Compliance Analyst works with the Analytics Department to develop reports that analyze structure and process through a wide range of data. They also develop performance and outcome measures based on the individualized Care plans and authorization, claims and utilization data, and identify results for the various vulnerable populations and specific health risks.
- The Director of Quality & Compliance and the Director of Medical Management and Operations present the data and the analyzed results to the Physician Advisory & Quality Committee as needed, but at a minimum annually to evaluate outcomes from the oversight and monitoring activities of the Model of Care.
- The Physician Advisory & Quality Committee is responsible for evaluating the ongoing success of the Model of Care, including any improvements that need to be made on structure, policy and procedures for the ongoing success of the Model of Care. The Physician Advisory & Quality Committee reviews and evaluates performance and outcome measures and determines process improvements, project implementations, and education and training.
- The Director of Medical Management and Operations is responsible for oversight of Model of Care structure and process.
- The Chief Operations Officer is responsible for initiation of initiatives and changes related to improvements in the Model of Care.

f. How we communicate improvements in the model of care to all stakeholders:

Information regarding improvements in the Samaritan Health Plans Model of Care is communicated to stakeholders through several different means. This includes:

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- Annual SNP training for network providers and Samaritan Health Plan staff
- Quarterly newsletters to social service agencies
- Monthly webpage announcements on the Samaritan Health Plans website
- Monthly printed Newsletters to all network providers
- Annual printed program assessment documents to the Board of Directors
- Quarterly webpage announcements on the provider access portal, Healthweb
- Quarterly announcements in our member newsletter, Health Matters
- Ongoing communication with network providers via face-to-face, fax, e-mail and telephone calls and written communication through the main point of contact and other appropriate Samaritan Health Plan staff.

Communication regarding updates is completed no later than 30 days after any change in the Model of Care. For example, if the MOC changes for DME services, requiring a different method of coordination, the MOC change is communicated through internal emails, website updates, and targeting mailings and phone calls to DME providers, physicians, members and health plans staff. Changes are reiterated through the Samaritan Health Plans DME Coordinator in conversations with physicians and DME providers, and provider web portal and newsletters.

Information on Model of Care effectiveness is provided through various communications, such as the quarterly provider newsletter to the community and provider network; internal staff dashboards of Model of Care goal status and progress on those goals.

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ATTACHMENT A: Samaritan Health Plans SNP Plan of Care Example

Member Name: Jane Jones **ID#:** 100000000 **DOB:** 00/00/0000

Risk identification:
_x_ Multiple Providers Managing Treatment __ Need New Provider Access _x_ Multiple/Chronic Disease States ___Readmissions _x_ED visits _x_Multiple Services Needed __x_Frail/Disabling Conditions __ ESRD _x_HRA data__End of Life Status _x_ Functional Decline _x_Clinical/Medical indicators __x_ Safety Risk
Specify/Notes: Recommended hemodialysis, diabetes, renal disease, CHF, ADL assistance required in home environment, fall risk

Specific clinical and support services in place:.
__x_CM __x_PCP _x__ State Caseworker/Social Services__x_ Home Health _x__ Caregivers/Others _x_Pharmacist __x_Rehab Services ____Discharge Planners _x__Disease Management _x__ Nutritionist ___ Nursing Facility staff ___Foster Care _x__Equipment/Supply Vendors _x_ Specialty Providers (list) _____Nephrology, Orthopedics, Cardiology_____
___ Other (list)_daughter POA_____

Add-on benefits and/or services recommended and status:
Clinical Pharmacist, Pastoral Care, Wheelchair Evaluation

Member-specific goals and objectives (including member preferences):
Member prefers home care. POLST in place for DNR with need for information about dialysis options.

Targeted outcome measures and status:
_x_ Maintain home placement as feasible. _x_Include long-distance POA in decision-making.
_x_ Maintain controlled lab values for renal, endocrine and cardiac function _x_ prevent readmissions
_x_Provide disease management information to member and caregiver.

Interdisciplinary Care Team (ICT) Members:
Care Manager(with other health plan personnel as warranted, including Utilization, DME, ENCC, Medical Director), PCP, Member/Caregiver/POA, Nephrologist, Orthopedic Provider, Cardiologist, Physical Therapist, Dietician, Clinical Pharmacist, State Caseworker, Pastor of choice

ICT Communications:
Care Manager contact:_____
ICT communications/meetings:_____ Plan of Care review date: _____

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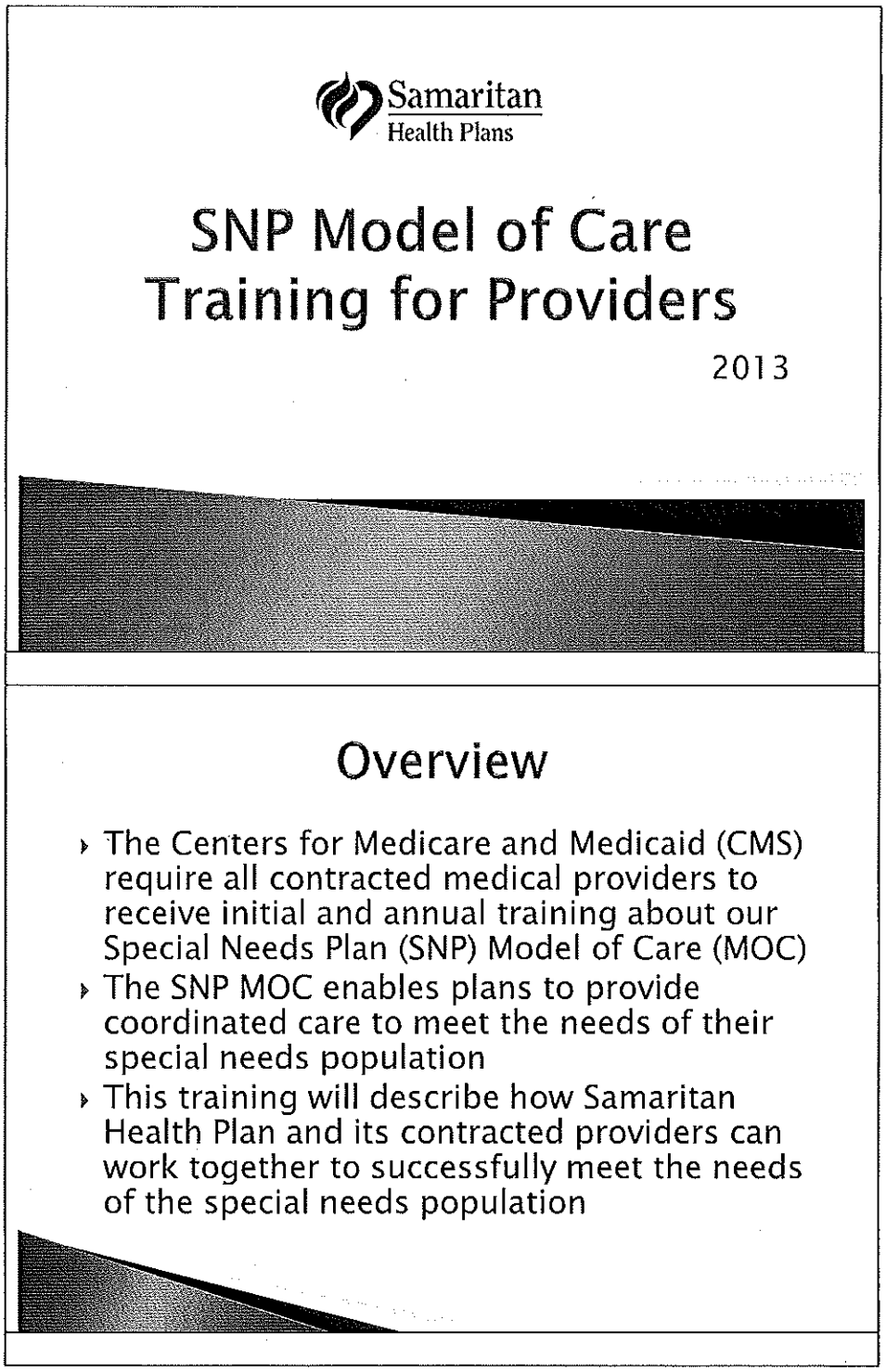
ATTACHMENT B: SNP Model of Care Training Example for Providers



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Learning Objectives

After the training, attendees will be able to:

- Describe the 11 elements of the MOC
- Understand their role in working with our care management staff
- Understand their role in the Interdisciplinary Care Team (ICT)

What is a SNP MOC

- The SNP MOC provides the structure for delivering care management and services to Medicare Advantage members with special needs
- Members included in our SNP plan are dual eligible (meaning they are eligible for both Medicare and Medicaid) and live in Linn or Benton counties

Samaritan Health Plans

Elements of the SNP MOC

1. Description of the SNP specific target population
2. Measurable goals
3. Staff structure and care management roles
4. Interdisciplinary Care Team (ICT)
5. Provider network having specialized expertise and use of clinical practice guidelines and protocols

Elements of the SNP MOC con't

6. Model of Care training for personnel and provider network
7. Health Risk Assessment (HRA)
8. Individualized Care Plan
9. Communication network
10. Care management for the most vulnerable subpopulations
11. Performance and health outcome measurement

Samaritan Health Plans

Measurable goals for the MOC

- Improving access to essential services such as medical, mental health, and social services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across healthcare settings, providers, and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving beneficiary health outcomes

Staff structure and care management roles

- Administrative Staff - coordinate benefits, plan information, data collection and analysis
- Clinical Staff - coordinate care management, provide clinical care, educate, consult on pharmacy issues
- Administrative & Clinical Oversight - verifies licensing, reviews encounter data, reviews claims and utilization data

Samaritan Health Plans

Interdisciplinary Care Team (ICT)

The ICT coordinates the delivery of services and benefits and is composed of:

- Health Plan Care Management Nurse
- Member
- Member's PCP and/or specialist provider
- Member's family or representative
- Others as needed (such as social workers, PT, OT, clinical pharmacist, pastoral specialist, etc)

Interdisciplinary Care Team (ICT) con't

- The ICT develops an Individualized Care Plan
- The Individualized Care Plan is developed based on responses from the initial and annual Health Risk Assessment, member interactions with providers and care managers, etc
- The Individualized Care Plan documents the members needs and directs the ICT in meeting those needs
- The Individualized Care Plan is re-evaluated on a regular basis and when member health status undergoes a substantial change

Samaritan Health Plans

Your Role as a Provider

- Participate in initial and annual training on the MOC
- Communicate & collaborate with health plan care managers, members of the ICT, members and caregivers on developing and updating the Individualized Care Plan for each SNP member
- Participate in the ICT as requested to ensure optimal coordination of care and transition of care
- Utilize evidence-based clinical practice guidelines and nationally recognized protocols

Questions about the MOC Training

Please contact our Medical Director

Samaritan Health Plans

ATTACHMENT C: Model of Care Training Attestation Example

Provider Memo

Re: MODEL OF CARE TRAINING 2013

Centers for Medicare and Medicaid Services (CMS) / Special Needs Plan (SNP) - **mandatory requirement**

Samaritan Health Plans, Special Needs Plan (SNP) is required to provide annual training to our entire care network regarding its Model of Care. The SNP Model of Care is the architecture for our care management policy, procedures and operational systems. We have enclosed written training materials of Samaritan Health Plan's Model of Care for your review and reference, also available on our website.

Please sign this form as evidence of your training on our Model of Care. If you wish to have specific policies and procedures, you may request them by contacting us directly. You may also access our Medical Management program information and Clinical Practice Guidelines through our website.

Thank you for your immediate response and cooperation. This training requirement is mandated by CMS and must be performed annually. Please fax this signed and dated form to **(541) 768-4518: attn: Tim Brown, or drop it off in his office.**

Sincerely,
Timothy Brown
Provider Relations Coordinator

SNP Model of Care Training Confirmation CY 2013

I have received and reviewed the written materials for the SNP Model of Care training.
Signature:_____
Print Name: _____
Date: _____

Samaritan Health Plans

ATTACHMENT D: SNP Model of Care Training Example for Staff

SNP Model of Care Training 2013

SAMARITAN HEALTH PLANS
MEDICAL MANAGEMENT DEPARTMENT

What are Medicare Special Needs Plans (SNPs)?

Medicare Special Needs Plans (SNPs)are specially designed Medicare Advantage plans, which have the following features:

- Enrollment is limited to Medicare beneficiaries within the target SNP population.
- Benefit plan is custom designed to meet the needs of the designated population.
- SNP members normally have additional election periods to change their Medicare coverage.

Samaritan Health Plans

Samaritan Advantage Health Plan - Special Needs Plan

Samaritan Advantage Health Plan (SAHP) offers one Special Needs Plan in 2011 and is considered a full Dual Eligible (D-SNP):

- A Medicare Advantage HMO plan where enrollment is limited to beneficiaries who have Medicaid eligibility.
- Our plan contains members who are in both the Samaritan Advantage Health Plan and the InterCommunity Health Network in 2012.

SNP Eligibility Requirements

In order to join the SAHP Special Needs Plans in 2011, the individual must:

- Have Medicare Part A and Part B coverage.[Beneficiaries are eligible for Medicare through age (> 65) or through disability].
- Live in the county where the plan they wish to join is offered.
- Not have End Stage Renal Disease.
- Be eligible for **some level of Medicaid coverage.**
  Medicaid coverage level is normally determined by income and can range from payment of the Medicare Part B premium for higher income individuals to full medical coverage for lower income individuals.

Samaritan Health Plans

What is the SNP Model of Care?

- The Model of Care is a Medicare requirement
  - 42CFR $422.101; $422.101(f)
- The Model of Care provides the structure for care management processes and systems .
- The Model of Care enables the SNP to provide coordinated care to meet the needs of the special population.
- The SNP MOC must be evidence-based.

What is in the SNP Model of Care?

The SNP Model of Care contains the following elements:

1. Description of SNP specific target population
2. Measurable goals
3. Staff structure and care management roles
4. Interdisciplinary dare team
5. Provider network having special expertise and use of clinical practice guidelines
6. Model of Care training
7. Health Risk Assessment
8. Individualized Care Plan
9. Communication network
10. Care management for the most vulnerable subpopulations
11. Performance and health outcome measurement

Samaritan Health Plans

MOC goals for our members

Our SNP Model of Care Goals:

- Improve access to medical, mental health, and social services,
- Improve access to affordable care and preventive health services
- Help high-risk members transition to appropriate levels of care
- Ensure transitions of care are done in a coordinated way
- Assure appropriate utilization of services
- Improve health outcomes

MOC staff structure and care management roles

- Includes staff who coordinate benefits, plan information, data collection and analysis
- Includes staff who perform clinical functions
  - Coordinate care management
  - Provide clinical care
  - Educate
- Includes staff who perform administrative and clinical oversight functions

Samaritan Health Plans

Interdisciplinary Care Team (ICT)

The ICT coordinates the delivery of services and benefits and is composed of:

- Care management nurse
- Member
- Member's PCP and/or specialist provider
- Member's family
- Others – **each team meets the needs of the individual**

How does our SNP Model of Care operate?

- Our SNPs have an appropriate medical team with clearly defined roles. The team provides the infrastructure necessary to coordinate the plan of care and provide appropriate staff and program oversight.
- The Care Management staff assume an important role in developing and implementing the individualized care plan, coordinating sharing information with the interdisciplinary care team and the member.
- The provider network offers broad practitioner representation from the medical, diagnostic and treatment arenas with the specialized expertise to care for members within the Dual Eligible SNP population.

Samaritan Health Plans

Specialized Provider Network

- **Facilities** (inpatient, outpatient, rehabilitative, long-term care, psychiatric, laboratory, radiology/imaging, etc.)
- Medical **specialists**
- **Behavioral and mental health specialists**
- **Nursing professionals**
- **Allied health professionals** (pharmacists, physical therapists, occupational specialists, speech pathologists, laboratory specialists, radiology specialists, etc.)

SNP provider network requirements

- Providers must be actively licensed and competent
- Insure there is a gatekeeper and that the member is connected to the appropriate service provider
- Coordinate with the ICT and the member
- Assure the services are delivered in a timely and quality way
- Reports are shared with the plan and ICT for member record and incorporation in the care plan
- Services are delivered across care settings and providers
- Providers use evidence-based clinical practice guidelines and nationally recognized protocols

Samaritan Health Plans

MOC Training

SNP must document training plan including:

- Training strategies and content
- How plan assures and documents completion of initial and annual training by staff and providers
- Who is responsible for oversight of MOC training
- Actions plan SNP will take if MOC training has not been completed

Health Risk Assessment

- The Health Risk Assessment (HRA) is a customized survey tool that is sent to SAHP SNP members when they first enroll and annually thereafter. The HRS asks members questions about their current health status.
- If we don't receive a completed survey from one of the members, we follow up with the member since this information is an important evaluation mechanism.
- The survey results are reviewed, analyzed and stratified. These results are used as input in developing the individualized care plan.

Samaritan Health Plans

What is the Individualized Care Plan?

- The Individualized Care Plan (ICP) is the initial and ongoing mechanism of evaluating the member's current health care condition and medical history, and for formulating an action plan to address areas of concern.
- Since members can have varying levels of health (ranging from very good to very bad), the ICP provides a structure to organize outreaches to the interdisciplinary care team and to document results.
- The ICP is re-evaluated on a regular basis or if the member's health status undergoes a substantial change

ICP Generation

- Individualized Care Plans are generated in the ICT, based on the responses from the newly enrolled and annual HRA survey, member interactions with providers and Care Managers, etc.
- These care plans are reviewed by Case Management to identify clinical issues.
- Members are assigned to the appropriate resources (Case Management, Mental Health or Disease Management) for medical management.

Samaritan Health Plans

Integrated Communication Network

SNP's communication network must:

- coordinate delivery of services and benefits through integrated systems of communication (Web-based, Audio conferences, Face-to-face meetings)
- Connect plan, providers, beneficiaries, public and regulatory agencies
- Be preserved (recordings, minutes, newsletters, websites)
- Have staff with oversight responsibility

How do we communicate with the SNP team?

- The ICT will have meet as needed to discuss the needs, challenges and successes of SNP members.
- Goal of these meetings is to work together to move these members towards their **optimal health status**

Samaritan Health Plans

Care management for the most vulnerable subpopulations

- Most vulnerable members are:
  - Frail
  - Disabled
  - Developing end-stage renal disease
  - Near the end-of-life
  - Those with multiple and complex chronic conditions
- SNP must provide care coordination for most vulnerable subpopulation members

Performance and health outcome measurement

SNPs must conduct performance and health outcome measures:

- Evaluate MOC
- Have staff assigned to act on data
- Have plans for use of the results
- Document and preserve evaluation
- Communicate improvements to stakeholders
- Have staff with oversight responsibility

Samaritan Health Plans

How will we know if we have achieved our SNP goals?

SNP MOC Definitions

- Transitions of care
- Coordinated care
- Utilization of services
- Affordable care
- HEDIS – HealthCare Effectiveness Data & Information Set

Samaritan Health Plans

ATTACHMENT E: Example of employee sign in sheet for training

SHPO Employee MOC Training

Date	Print Name	Department	Signature

ATTACHMENT F: Example of Tracking log for Provider Attestation for MOC Training

Tracking log for Provider MOC Training Attestations

Date training sent to provider	Date Attestation returned from provider	Provider Name	Name of Staff who received Returned Attestation

Samaritan Health Plans

ATTACHMENT G: 2013 Health Risk Assessment Tool

Samaritan Health Plans

Building healthier communities together

2013 Samaritan Advantage Health Plan HMO Information Form

Welcome to Samaritan Advantage Health Plan HMO! Please help your Primary Care Provider by answering the following questions about your health. Then, mail this form back in the envelope we have provided (no postage required). ***All information given in this form will be kept confidential and will not affect your benefits in any way.*** After receiving this information your doctor or a nurse may contact you. If you have any questions or **immediate needs,** please contact us at 1-800-832-4580 or TTY 1-800-735-2900. **Please return this form in one week.** Thank you!

Name _____ H&CA ID# _____

Subscriber ID # _____ ☐ Male ☐Female

Address _____ City _____ State _____ Zip _____

Telephone number (_____) _____ Birth date _____ Age _____

Height _____ (feet) _____ (inches) Weight _____ (lbs)

Blood Pressure (if you know it) _____

Write the name of your Primary Care Provider: _____

GENERAL HEALTH QUESTIONS

1. Whom do you live with? (Circle only one)
   a. Alone
   b. With someone else (spouse, family, roommate, etc.)
   c. In assisted living or adult foster care home
   d. Nursing home
2. Compared to one year ago, how is your health? (Circle only one)
   a. Better
   b. Same
   c. Worse

3.	Yes	No	Do you have any concerns about your current living situation?
4.	Yes	No	Do you smoke tobacco products? (cigarettes, cigars, pipes, snuff)
5.	Yes	No	Do you live or work in a smoky environment?

Samaritan Health Plans

MEDICAL HEALTH QUESTIONS

6.	Yes	No	During the past 6 months, has your work or social activities been limited due to a problem with your physical health?
7.	Yes	No	During the past 6 months, have you fallen?
8.	Yes	No	If you have fallen in the past 6 months, did you have to go to the emergency room or be admitted to the hospital after the fall?
9.	Yes	No	During the past year, have you been to the emergency room?
10.	Yes	No	During the past year, have you been to urgent care?
11.	Yes	No	During the past year, have you been admitted to the hospital?
12.	Yes	No	During the past year, have you seen your primary care doctor?
13.	Yes	No	During the past year, do you have any disabilities?
14.	Yes	No	During the past year, do you use any medical equipment or supplies? (such as oxygen tank, wheel chair, hospital bed, cane, walker, diabetic or wound care supplies, etc) Please list:
15.	Yes	No	During the past year, is there equipment that you feel you need that you have not received? Please list:

MEDICAL SERVICES QUESTIONS Please ☑ the appropriate one(s).

16. Are you currently receiving services such as:
    - ☐ Care of a specialist provider
      Please list name and location: _____
    - ☐ Visiting Nurse
    - ☐ Skilled Nursing Facility
    - ☐ Therapist (Physical, Speech, Occupational)
    - ☐ Outpatient Surgery
    - ☐ Homemaker/Home Health Aide
    - ☐ Social Worker
    - ☐ Adult day care or social day care
    - ☐ Home delivered meals
    - ☐ Other _____

17. Are you currently waiting for or using services such as:
    - ☐ Specialist appointment - *Please list name and location:* _____
    - ☐ Home Health nurse or rehabilitation therapy
    - ☐ Dialysis
    - ☐ Chemotherapy/Radiation
    - ☐ Scheduled surgery. If yes, facility name and date planned _____
    - ☐ Injectable medications administered in the doctor's office
    - ☐ Mental Health/Chemical Dependency services

Samaritan Health Plans

18. PHARMACY QUESTION

What medications are you currently taking including any prescription medications or over the counter, herbal therapy or natural remedies?

List name of medication and reason you take it:

_____

_____

_____

_____

_____

_____

19. ACTIVITIES OF DAILY LIVING **Please circle a, b or c for each of these activities.**

	No assistance required	Need some help	Can not do at all without help
Bathing	a	b	c
Dressing	a	b	c
Eating	a	b	c
Toileting	a	b	c
Walking	a	b	c
Taking medication	a	b	c
Meal preparation	a	b	c
Housekeeping chores	a	b	c
Shopping and errands	a	b	c
Getting to medical appointments	a	b	c
Money Management	a	b	c

20. MEDICAL CONDITIONS Please ☑ the appropriate one(s).

Asthma	□ Currently	□ Past History	□ Never
Cancer	□ Currently	□ Past History	□ Never
Congestive heart failure (CHF)	□ Currently	□ Past History	□ Never
Chronic obstructive pulmonary disease (COPD)	□ Currently	□ Past History	□ Never
Coronary Artery Disease (CAD) such as angina (chest pain) or MI (heart attack)	□ Currently	□ Past History	□ Never
Depression	□ Currently	□ Past History	□ Never
Diabetes Type 1 (high blood sugar)	□ Currently	□ Past History	□ Never
Diabetes Type 2 (high blood sugar)	□ Currently	□ Past History	□ Never
Hyperlipidemia (high cholesterol)	□ Currently	□ Past History	□ Never
Hypertension (high blood pressure)	□ Currently	□ Past History	□ Never
Kidney Disease	□ Currently	□ Past History	□ Never

Samaritan Health Plans

Seizure Disorder	□ Currently	□ Past History	□ Never
Stroke	□ Currently	□ Past History	□ Never

I give authorization to release this information to Samaritan Advantage Health Plan HMO and my primary care provider. I understand that this information is private and will not be shared with any other people. I understand that it will not affect my health insurance benefits in any way.

_____ _____

Print Name *Signature Date*

Thank you for filling out this questionnaire and mailing the form back to us in the envelope enclosed.

H3811_CM110_2012A - CMS Approved: 3/18/05; revised 7/13/05; 3/28/07; 6/25/07, 3/04/09, 11/12/09, 10/01/10, 8/24/11

Samaritan Health Plans

ATTACHMENT H: Example of Template utilized for documenting annual MOC evaluation

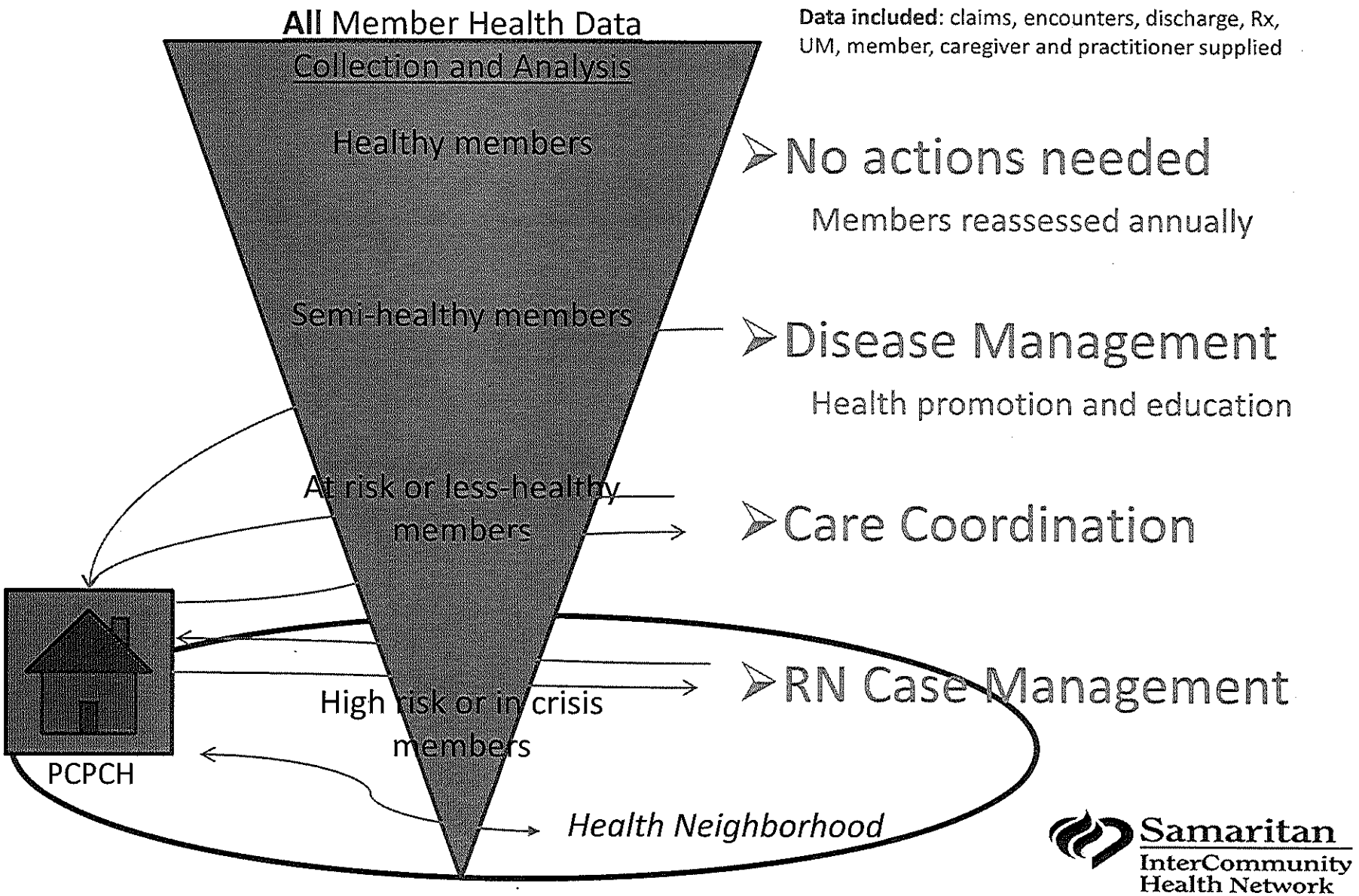
Template Example
Samaritan Advantage Health Plan HMO
SNP Model of Care Annual Evaluation

Plan	Do	Study	Act	
Activity/Measure/ Component (measurable goal from MOC)	Actions Interventions	Results: Strengths	Results: Area of Improvement	Plans or Recommendations for Future
1) Improving access to essential services such as medical, mental health, and social services				
Maintain and monitor adequate and appropriate contracted provider network.				
<20% of all care should be received out of network				
2) Improving access to affordable care				
Maintain PCP panel adequate for our members				
all members are assigned a PCP within 7 days of enrollment				
3) Improving coordination of care through an identified point of contact (e.g., gatekeeper)				
Monitor and assist members to ensure they receive follow-up care after a hospital discharge.				
all members receive follow care within 5 days of hospital discharge				
4) Improving seamless transitions of care across healthcare settings, providers and health services				
Facilitate improved transitions of care through evaluation of claims data such as readmission rates.				
Hospital readmission rate is at or better than benchmark.				
5) Improving access to preventive health services				
Maintain reports measuring use of CMS recommended preventive health services.				

Samaritan Health Plans

Activity/Measure/ Component (measurable goal from MOC)	Actions Interventions	Results: Strengths	Results: Area of Improvement	Plans or Recommendations for Future
All SNP members receive preventive health services per CMS recommended guidelines.				
6) Assuring appropriate utilization of services				
Monitor data on members with diabetes.				
At least 90% of members with diabetes receive care in an outpatient setting.				
7) Improving member health outcomes				
HEDIS data supports health outcome improvement				
HEDIS measures for DDE and DAE meet or exceed benchmarks in 2013.				

IHN – CCO Care Coordination Model



IHN-CCO

APPENDIX B – Provider Participation and Operations Questionnaire

Section 1 -Service Area and Capacity

See Attachments B.1_ServiceAreaCapacityTable.pdf and B.1_ServiceAreaTable.xlsx

Section 2 -Standards Related To Provider Participation
Standard #1 -Provision of Coordinated Care Services

The IHN-CCO will use current processes developed as a FCHP and MHO as it works toward a unified approach. IHN-CCO will maintain and monitor a network of providers who use Evidence Based Practice guidelines and Clinical Protocols to serve our members. These providers consist of primary care providers, specialty physicians and mental health providers along with nontraditional providers as appropriate. IHN-CCO places a priority on ensuring that the majority of providers in our network are Board Certified when appropriate to their certification. All providers participate in both Medicare and Medicaid ensuring that our member's care is coordinated to the highest level possible. The existing provider network includes contracted providers with specialists in all areas to meet the needs of our members and provides 24 hour access to clinical consultation. In the rare case where the plan does not have a contract with a particular specialist requested due to a unique situation, the primary care provider and the IHN- CCO Medical Director collaborate to identify the nearest qualified provider. An online Network Provider listing will be updated regularly and will contain a complete directory of the contracted providers in the IHN-CCO provider network. See attachment B.2.1_ProviderNetwork.pdf for a complete list of the IHN-CCO provider network. The IHN-CCO will use current processes developed as a FCHP and MHO as it works toward a unified approach regarding the provision of coordinated care services. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

Standard #2 – Providers for Members with Special Health Care Needs

IHN-CCO's existing MCO's have contracts in place with multiple specialties and sub-specialties that address the complex health care needs of our population, including the dually-eligible special needs members. This provider network was developed upon our experience with members in our three counties, and the community's specific healthcare needs. IHN-CCO's experience in working with members with special health care needs include our Exceptional Needs Care Coordinator, who has been working with the aged, blind and disabled population for over 14 years. In addition to working with specialists in prevalent conditions in our service area (including diabetes, cardiovascular disease and mental health) IHN-CCO works with care management teams, both in Patient-Centered Primary Care Homes and other clinic settings to collaborate on high need, complex cases. IHN-CCO also includes a utilization management/case management manager that focuses on chemical dependency and care coordination. IHN-CCO's case managers also collaborate with community resources to ensure members conditions and needs are met. IHN-CCO arranges MOU's for those providers that we do not have contractual arrangements in place for specialized member needs. Ultimately the IHN-CCO will work to fully incorporate Community Health Workers and Peer Wellness Specialists into Primary Care Homes. Community Health Workers (CHWs) will provide a spectrum of

person-centered services, including clinical navigation and chronic disease self-management support as a member of the primary care team, outreach and enrollment assistance for insurance, dental, and social services, and community health education and advocacy. Peer Wellness Specialists will provide peer mental health support and advocacy, and will function as navigators and liaisons between the mental health and primary care systems.

Examples of our partner facilities and providers specialized qualifications include:

Mental Illness and Chemical Dependency: Inpatient psychiatric services for adults are provided by participating providers in our service area, and facilities in Portland, Salem, Eugene and Bend. IHN-CCO also contracts with alternatives to psychiatric hospitalization for adults (step-down and diversion).

Elderly and Disabled: IHN-CCO contracts with several Internal Medicine providers with a focus on Geriatrics, as well as specialists in endocrinology, cardiology, neurology and nephrology.

Children: 60% of the population in Linn, Benton and Lincoln Counties are under the age of 19, and our provider network consists of multiple Pediatric primary care providers, as well as specialists in pediatric cardiology, allergists with a focus on pediatrics, and child and adolescent psychiatry. IHN-CCO contracts with OHSU's CDRC program, which includes all pediatric specialists. IHN-CCO contracts with following providers who offer intensive services to children are skilled in serving children/youth in substitute care or adoptive placements and who experience mental health and/or chemical dependency disorders. Each child receives the medically necessary service array, from one or more providers, coordinated by their child and family team. Services for intensive services to children include: Residential treatment, Day treatment, Sub-acute, Community-based crisis respite, Intensive home & community-based supports and Children's inpatient psychiatric services. Inpatient psychiatric services and some intensive services are provided by non- participating providers as appropriate. Additional information is available upon request at readiness review.

Standard #3 – Publicly funded public health and community mental health services
Publicly Funded Health Care and Service Programs Table

See Attachment B.3_PublicallyFundedService.xlsx

(a) The IHN-CCO began involving public entities over a year ago with discussions between IHN, the Mental Health Organizations and the county leadership in Linn, Benton and Lincoln counties. Workgroups have been meeting since early 2011 to discuss the aspects of integration, coordination and supporting functions such as information technology, care coordination and quality improvement.

(b) These agreements are under negotiation.

(c) All parties have agreed to collaborate under the IHN-CCO, and will be finalized at the time of the CCO go-live in August 2012. Additional information is available upon request at readiness review.

Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN)

(a) IHN has a small AI/AN population in our three counties (under 300 members currently),

and we have provided services successfully for this population in our past 17 years. We work with our provider community to annually train on cultural awareness for AI/AN and other cultures. The IHN-CCO will use current processes developed as a FCHP and MHO as it works toward a unified approach regarding the provision of coordinated care services. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation Additional information is available upon request at readiness review.

Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities

(a) IHN-CCO would follow its normal non-contracted provider process. The IHN-CCO will use current processes developed as a FCHP and MHO as it works toward a unified approach regarding the provision of coordinated care services. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

Standard #6 – Integrated Service Array (ISA) for children and adolescents

(a) IHN-CCO contracts with a number of agencies and individuals in order to provide a full range of services to clients determined eligible for the Integrated Service array. This includes services in the community, (i.e. individual and family therapy, skills training, respite and day treatment), as well as services provided in out of home levels of care, (i.e. Psychiatric Residential Treatment Services, Sub acute and Acute care). Care Coordination for the ISA population will be conducted primarily by staff at the local County Mental Health agencies. Additional information is available upon request at readiness review.

(b) IHN-CCO, historically provided by MVBCN, New Solutions program provides an Integrated Services Array for children and youth with severe mental or emotional disorders. We have invested in training, coaching and monitoring to achieve full-fidelity wrap around services based on system of care principles, with a team creating a family-driven plan for each child in partnership with other child-serving systems. This program has reduced the percentage of children needing residential care, shortened the length of stay, and created a menu of community-based supports that enable children to be maintained in permanent homes in the community. This program provides the largest of the 3 pilot sites for the Children's Wraparound Demonstration Project; we are exploring whether than can be expanded to include Benton and Lincoln Counties. Members served in Benton and Lincoln counties also receive services as part of the ISA with Wrap around as the primary model used for team facilitation and care coordination. The county mental health programs for these two counties traditionally determined ISA eligibility and partnered with all local child serving agencies through the Wrap process and Community Care Coordination Committees. The IHN-CCO plans to continue to support these arrangements. Trainings in Wraparound and team facilitation have occurred and the services listed in 6(a), above, are provided when documented as a need in the members Wrap around Plan of care. Psychiatric Residential Treatment Services, Sub acute and Acute levels of care are utilized in a manner that best meets the needs of the client and as medically necessary. The number of members served in all 3 of these levels of care has been reduced since the ISA was originally obligated through the MHO contract with a related increase in the number of members and services provided to

members in the community. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

(c) One of IHN-CCOs affiliates, ABHA, has adopted Practice guidelines to prescribe the elements needed to insure that the service delivery approach delivered to clients who are determined eligible for the ISA meet the requirements for Wraparound model. This ensures that services are family-driven, strength-based and culturally competent. In addition and in coordination with our Care Coordinators and other ISA MHO providers across the state, IHN-CCO has created Principles and Practices for Wraparound services. MVBCN has achieved high fidelity wrap around practice that ensures practice based on these principles, and has twice scored above the national mean using a recognized evaluation tool.

Standard #7A– Mental Illness Services

(a) The delivery system that the applicant will adopt from the current MHOs includes public and private provider agencies offering outpatient mental health and/or chemical dependency treatment, contractors providing residential, day treatment and community-based services for children, and inpatient psychiatric care. This will be combined with the historical chemical dependency services and panel currently provided by IHN. Intensive services for children and for adults qualifying for AMHI provided in the community include: medication assisted therapies, individual and group therapy, case management, skills training, respite, peer delivered services and a wide range of other supports for successful independent living. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

(b) IHN-CCO staff will assist with PCPCH incorporation of routine mental health and chemical dependency screening in office visits through a number of strategies, beginning with training on use of screening tools to be used in the primary care office, progressing to fully integrated behaviorists who can receive a warm hand-off from the medical provider to evaluate for and organize the medically appropriate response to positive screenings. This may include interventions in the PCP office, engagement of care management or NTHW staff, or arrangement of referrals to mental health specialty care. Chemical dependency treatment staff will screen for and respond to mental health concerns. Mental health crisis teams in each county respond to hospital emergency departments to assist in assessing mental health and substance abuse needs and arranging for appropriate care. The IHN- CCO will assist its hospital partners to incorporate screening and brief motivational interventions (SBIRT) for substance abuse problems in emergency and in-patient settings. The IHN-CCO will use current processes developed as a FCHP and MHO as it works toward a unified approach regarding the provision of coordinated care services. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation Additional information is available upon request at readiness review.

Standard #7B – Chemical Dependency Services

(a) Chemical dependency services are available throughout the region in nearly every city in Linn, Benton and Lincoln counties, providing services at a close location for our members. Medical Transportation services will also be available and work is being done to facilitate MOUs with local transportation services, to help those without transportation to attend treatment sessions. Because of the need for members' support of others working through their own recovery, having the member attend treatment in their community improves outcomes. For those who are not medically stable enough for transportation to the treatment center, we will review and evaluate building capacity for chemical dependency services to be delivered in the home, by phone, or through encrypted web-based communications, and would include family and/or care giving staff as appropriate. The IHN-CCO will use current processes developed as a FCHP and MHO as it works toward a unified approach regarding the provision of coordinated care services. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

(b) Chemical dependency members are routinely screened for mental health symptoms and are referred to mental health treatment when these services cannot be met by the chemical dependency program. When members are referred to mental health, screening for substance abuse problems is required, with coordination of services between the agencies so that both chemical dependency as well as mental health issues is addressed directly and in conjunction with the other treatment. This intervention approach will use the Ken Minkoff, MD, four quadrant model of co-occurring disorders and its treatment. The IHN-CCO will use current processes developed as a FCHP and MHO as it works toward a unified approach regarding the provision of coordinated care services. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation. Linn County's addiction and mental health programs have a clearly articulated program for integrated treatment approaches. The Community Support Services program for adults with serious mental illness includes an integrated dual diagnosis program with EBP fidelity. The addictions treatment program includes services for co-occurring anxiety disorders (including PTSD) and depression, including medication management. Screenings are currently being developed for chemical dependency and abuse for those over utilizing emergency departments through an SBIRT screening, intervention, and referral to treatment process. Once this process is established in emergency departments throughout the region, then SBIRT will be progressively developed in FQHCs, primary care, and specialty care (prenatal, chronic pain, etc). An aspect of SBIRT implementation in primary care is to screen all members annually with a few general screening questions at first then progressing to more specific screening and assessment, such as the AUDIT and DAST. As members are screened into having substance misuse, abuse and dependency levels, a brief intervention is delivered and then as appropriate a referral to treatment. Annual screens would also screen for tobacco use as well as depression. Future screening would add early psychosis. IHN-CCO is working toward incorporating SBIRT into all mental health services for adolescents and adults. The IHN-CCO is also developing identification and referral to Early Assessment and Support Alliance (EASA) project agencies in our region. The IHN-CCO will use current processes developed as a FCHP and MHO as it works toward a unified approach regarding the provision of coordinated care services. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop

strategies to achieve health care transformation. Additional information is available upon request at readiness review.

Standard #8 – Pharmacy Services and Medication Management

(a) IHN-CCO has an existing OHP plan that has had a contract with the State of Oregon since 1994. During the years of delivering medical coverage for OHP members IHN-CCO has faced multiple occasions where review was necessary to determine the ability for the plan to cover or deny coverage for the treatment in regards to coverage guidelines. IHN-CCO's plan has criteria and process in place for review of such instances. The IHN-CCO will use current processes developed as a FCHP and MHO as it works toward a unified approach regarding the provision of coordinated care services. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

(b) IHN-CCO has extensive experience with a restrictive formulary. One such formulary has been in practice since February 2000. Plan has policy, process, and criteria in place for review and appropriate coverage of medications. IHN-CCO's plan currently has a formulary in place that allows evidence based and cost effective options for all covered diagnoses. These options include over the counter medications when appropriate. IHN-CCO's Plan has proven controls in place that have been developed by a clinical team and has been reviewed by clinical experts. Formulary and prescription drug market is reviewed on an ongoing basis. Plan has the support of a Pharmacy and Therapeutics Committee comprised of community doctors and pharmacist as well a support staff. This committee is responsible for reviewing the formulary to ensure the most accurate, evidence based, cost effective formulary is in place for the members. This committee meets 6 times per year and adhoc as needed. Additional information is available upon request at readiness review.

(c) IHN-CCO contracts with a Pharmacy Benefit Manager and the members enjoy a national pharmacy network comprised of all the major chain pharmacies and the majority of the local pharmacies in particular areas. 95 % of the pharmacies in the plan's services area is contracted and part of the network. Additional information is available upon request at readiness review.

(d) IHN-CCO contracts with a Pharmacy Benefit Manager which allows for real-time claims adjudication for all participating pharmacies. The system is set up to capture a complete picture of all claims that pass through the claims system. Eligibility including primary and secondary coverage is sent to the Pharmacy Benefit Manager for accurate claims payment and appropriation of state and federal money. Additional information is available upon request at readiness review.

(e) IHN-CCO has policy, process, and criteria in place to manage all prior authorizations that are submitted to the Plan. PAs are processed seven days per week 365 day per year. All requests have decisions within at least 72 hours and most are done within 24. Prescribers and Pharmacies are able to submit requested 24 hours per day. Additional information is available upon request at readiness review.

(f) See attachment B.3.8.f_ContractualDiscountAWP.pdf

(g) IHN-CCO's parent organization contains four Hospitals that are 340B eligible and the plan currently process claims for members who are eligible to participate in this program. This has been a very successful program for Samaritan as a whole Samaritan actively pursues 340B eligibility whenever applicable. Additional information is available upon request at readiness review.

(h) IHN-CCO contracts with physician clinics that operate as Primary Care Homes. The intent is to include Medication Therapy Management as a part of the Primary Care Home's services for their patients and to have a reporting structure to include the plan in the findings and actions. Additional information is available upon request at readiness review.

(i) IHN-CCO contracts with physician offices that have the ability to e-prescribe through the capabilities of their EMR system for all medications legal in the State of Oregon. Additional information is available upon request at readiness review.

Standard #9 – Hospital Services

(a) **Indicate what areas cannot be provided locally...**The IHN-CCO will use current processes developed as a FCHP and MHO as it works toward a unified approach regarding the provision of coordinated care services. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation. IHN-CCO can provide the majority of services within our three-county service area. Specialized services such as transplants or neo-natal care are provided at our contracted facilities in Portland or Eugene, which is within the community standard of care for those services. Additional information is available upon request at readiness review.

Describe Applicant's system for monitoring...IHN monitors member grievances of access to care, and reviews authorization requests and data to determine access issues. Internal quality and data committees review for trends and potential provider and community access issues. Additional information is available upon request at readiness review.

(b) **Procedures that will be used for tracking...**
IHN-CCO will review utilization through notification from contracted ER and Urgent Care facilities, as well as retrospective review of Ambulance and ER claims to determine member's utilization of services. Emergency, hospital, home health, inpatient mental health & outpatient authorization data is reviewed and analyzed regularly to evaluate improved access to medical, mental health and social services. Utilization data will be reviewed at internal quality review meetings, and results analyzed down to the provider level. Additional information is available upon request at readiness review.

Procedures for improving appropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics...IHN-CCO will evaluate using the analysis noted above to develop member-specific scripting for outbound education calls, and to invite member feedback to determine potential barriers in appropriate access to care, such as PCP availability, or access to transportation. The members PCP and care team will be communicated with regarding member's utilization of services. IHN-CCO has existing

materials for education of members of Urgent care use. Additional information is available upon request at readiness review.

(c) IHN identifies adverse events and hospital acquired conditions by identifying specific ICD-9 diagnoses and ICD-9 procedure codes indicative of such events that are billed on a UB-04 claim from an acute hospital Type of Bill with a Present on Admission (POA) Indicator of 'N' or 'U.' IHN-CCO will monitor and ensure non-payment of potential adverse events and hospital acquired conditions through the grievance reporting process and by reviewing claims. A full investigation of the potential event is conducted. All documentation to support the service billed is collected and reviewed by clinical staff and, when appropriate, by the medical director. In the event a hospital acquired condition or adverse event is determined through a thorough medical documentation review process, the claim is denied for adverse events, and a refund is requested. The DRG is regrouped for hospital acquired conditions, and a refund is requested, if applicable. The Quality Department will report all adverse events or hospital acquired conditions to the Clinical Advisory Committee who is responsible for monitoring facility trends and for determining corrective action plans, if necessary, with facilities in question. Additional information is available upon request at readiness review.

(d) As part of our care coordination efforts, IHN-CCO will collaborate with hospital discharge planners, community resources and programs to ensure low readmission rates. These resources and programs include the Senior and Disability Services Hospital to Home Demonstration Project, contracted home health providers, meals on wheels, etc. In addition IHN-CCO case managers are available to monitor all discharges for follow up. These activities ensure members have appropriate medications, follow-up medical care visits scheduled, appropriate home environment and equipment, resources necessary and that they are engaged in self-management activities needed to bring them back to optimal health. IHN-CCO will continue to monitor and enforce this through data analysis and reporting of the readmission rates which are managed by the Physicians Advisory and Quality Committee. Additional information is available upon request at readiness review.

(e) IHN-CCO will evaluate making out-going calls for new members to explain primary and preventative care services and to gain feedback on member barriers to care. Innovative approaches may include providing non-emergent transportation, case management or health navigator assistance with PCP appointments, and individualized care plans for members utilizing hospital services inappropriately. Additional information is available upon request at readiness review.

Section 3 -Assurances of Compliance with Medicaid Regulations and Requirements

As current OHP contractors and Managed Care providers of physical, mental and dental health, IHN-CCO follows our current contracts to deliver all 14 of the required Medicaid requirements. Our existing policies and processes document our commitment to member rights, education, access to emergency services, and other requirements identified in 42 CFR Part 438. IHN-CCO's long history of integrating Medicaid regulatory requirements into our core business functions has been proven through multiple DMAP and EQRO audits and site visits, and external reporting of data and quality measures. Additional information is available upon request at readiness review.

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RFA Attachment

Response to Appendix B

Section 1- Service Area Capacity

Service Area Capacity Table

Service Area Description	Zip Codes	Maximum Number of Members – Capacity Level
Linn	97389, 97374, 97329, 97358, 97386, 97377, 97322, 97327, 97336, 97360, 97446, 97335, 97355, 97345, 97321, 97348	Unlimited
Benton	97370, 97339, 97324, 97326, 97456, 97330, 97331, 97333	Unlimited
Lincoln	97368, 97380, 97367, 97388. 97394, 97391, 97390, 97364, 97343, 97357, 97498, 97366, 97365, 97376, 97341, 97369	Unlimited

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Response to Appendix B

Section 2- Standards Related to Provider Participation

Standard #1- Provision of Coordinated Services

IHN-CCO Provider Network

- Hospitals (acute inpatient care, outpatient care, laboratory, speech therapy, occupational and physical therapy, radiology and imaging care)
- Skilled nursing facilities/ long-term care facilities
- Kidney dialysis centers
- Rehabilitation facilities
- Specialty providers (cardiology, nephrology, psychiatry, gerontology, neurologists, endocrinologists, obstetricians, gynecologists, pulmonologists, surgeons, etc.)
- Primary care providers (family practice, internal medicine, gerontologists, general practitioners, etc.)
- Ancillary providers (including stand alone laboratories, radiography/imaging facilities and other provider specialties/clinics)
- Durable Medical Equipment providers (prosthetics, orthotic devices and equipment or supplies)
- Home health services (in-home nursing and therapy)
- Chemical dependency and mental health services (outpatient chemical dependency services provided by Certified Alcohol and Drug Counselors, mental health services provided in the outpatient setting, inpatient services and facilities)

Appendix B – Publically funded health and community mental health services

Name of publicly funded program	Type of public program (i.e. county mental health dept.)	County in which program provides services	Specialty/Subspecialty codes
Public Health Department	Chemical Dependency	Linn	16
Public Health Department	Immunization	Linn	286
Public Health Department	HIV	Linn	286
Public Health Department	Sexually Transmitted Diseases	Linn	286
Public Health Department	Communicable Diseases	Linn	286
Outpatient treatment services – children	Linn County Mental Health Services	LINN	92
MVWRAP – Child welfare wrap around	Linn County Mental Health Services	LINN	92
New Solution – child psychiatric and wrap around	Linn County Mental Health Services	LINN	92
Outpatient treatment Services – adults	Linn County Mental Health Services	LINN	92
Community Support Services	Linn County Mental Health Services	LINN	92
Crisis Services	Linn County Mental Health Services	LINN	92
Adult residential Services – foster care	Linn County Mental Health Services	LINN	92

AMHI – state hospital diversion	Linn County Mental Health Services	LINN	92
Senior outreach	Linn County Mental Health Services	LINN	92
PASRR	Linn County Mental Health Services	LINN	92
PSRB	Linn County Mental Health Services	LINN	92
SAFE schools – school based MH	Linn County Mental Health Services	LINN	92
EASA early psychosis project	Linn County Mental Health	LINN	92
Outpatient & Intensive Outpatient Substance Abuse Treatment for Adults	County Alcohol & Drug Program	Linn	16
Outpatient & Intensive Outpatient Substance Abuse Treatment for Adolescents	County Alcohol & Drug Program	Linn	16
Outpatient & Intensive Outpatient Substance Abuse Treatment for High-risk Adult Offenders	County Alcohol & Drug Program	Linn	16

Outpatient & Intensive Outpatient Substance Abuse Treatment for DUII Offenders	County Alcohol & Drug Program	Linn	16
Occupational Drivers License Evaluation & Monitoring	County Alcohol & Drug Program	Linn	16
Outpatient & Intensive Outpatient Substance Abuse Treatment for At-Risk Parents	County Alcohol & Drug Program	Linn	16
Substance Abuse Prevention	County Alcohol & Drug Program	Linn	16
Problem Gambling Prevention	County Alcohol & Drug Program	Linn	16
Transportation to Substance Abuse Treatment	County Alcohol & Drug Program	Linn	16
Drug-Free Housing Rent Assistance & Case Management	County Alcohol & Drug Program	Linn	16
Client Outreach &	County Alcohol & Drug Program	Linn	16
Recovery Coaching	County Alcohol & Drug Program	Linn	16
Intensive Case Management with Special Populations	County Alcohol & Drug Program	Linn	16

Medical & Dental Assistance to Uninsured	County Alcohol & Drug Program	Linn	16
HIV Testing	County Alcohol & Drug Program	Linn	16
Child Care Assistance	County Alcohol & Drug Program	Linn	16
Employment Assistance	County Alcohol & Drug Program	Linn	16
Safe Schools – School Based A&D	County Alcohol & Drug Program	Linn	16
Family Planning	Public Health	Linn	145/286
Immunizations	Public Health	Linn	286
STI	Public Health	Linn	286
Maternity Case Management	Public Health	Linn	286/513/326
TB/CD	Public Health	Linn	286
HIV Case Management	Public Health	Linn	286/508

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Response to Appendix B
Standard #8

f. Contractual discount percentages from AWP

INFORMATION REDACTED

Pharmacy Contract Information Redacted

IHN-CCO
APPENDIX C – Accountability Questionnaire

Section 1- Accountability Standards

Definitions

ABHA:	Accountable Behavioral Health Alliance
CAHPS:	Consumer Assessment of Healthcare Providers & Systems Survey
CMS:	Centers for Medicare and Medicaid Services
DCBS:	Department of Consumer and Business Services
DMAP:	Division of Medical Assistance Program
EQRO:	External Quality Review Organization (Acumentra)
HEDIS:	Healthcare Effectiveness Data & Information Set
HOS:	Health Outcome Survey
IHN:	InterCommunity Health Network – Oregon Health Plan Managed Care Plan
MVBCN:	Mid Valley Behavioral Care Network
NCQA:	National Committee for Quality Assurance
OHA:	Oregon Health Authority
OPHP:	Office of Private Health Partnerships (Healthy KidsConnect)

IHN-CCO's intent in answering questions in this section is to take the best of all programs across the region and expand them region wide. Due to the page limitation, examples provided in specific answers may only describe the service in one county by specific provider types as an illustration of the good work going on where it is most developed.

a. IHN's reporting infrastructure has been extensively tested to guarantee high quality output over a broad range of healthcare data needs and has remained in place as new lines of business have been added. We employee several programming, report writing and systems analyst staff to assist with data extraction, reporting and validating. Data is collected and analyzed to evaluate the various aspects of our Samaritan Health Plans' Quality Management Program, which encompasses all of our lines of business. By evaluating the various aspects we develop an overall evaluation of the effectiveness of our Quality Management Program on an annual basis and make improvements as identified.

In addition to our internal reporting, we currently contract with a NCQA certified HEDIS vendor to collect and report all appropriate Medicare HEDIS measures to NCQA and CMS yearly for our Medicare Advantage and Special Needs Plans. Prior to submission of HEDIS measures the data is validated by our contracted NCQA certified HEDIS auditor. This HEDIS process has been in place since 2006 with both of the vendors.

For the Medicaid population IHN has submitted asthma performance data directly from our claims system to DMAP (OHA) for several years. This data has been validated by Acumentra (the state's

External Quality Review Organization – EQRO). The asthma performance measures have now been retired and replaced by the HEDIS Ambulatory Care measure which is reported to DMAP (OHA) yearly. In addition to the Ambulatory Care measure our HEDIS vendor calculates all appropriate Medicaid measures and that data is reviewed internally to look for opportunities for improvement. The IHN-CCO will use these current processes developed as a FCHP and those developed by the historical MHOs as it works toward a unified approach.

Various HEDIS measures are also collected by our HEDIS vendor and reported yearly to OPHP for our Healthy KidsConnect plan.

Our HEDIS vendor calculates all appropriate "commercial" measures for our self-funded employee health plan and that data is reviewed internally to look for opportunities for improvement.

The various organizations within the CCO will work collaboratively to collect and report any of the Metrics from attachment 8 tables that will need to be reported whether the data comes from claims data, encounter data or HEDIS data. Additional information is available upon request at readiness review.

b. As noted above, in addition to our internal reporting, we currently contract with a NCQA certified HEDIS vendor to collect and report all appropriate Medicare HEDIS measures to NCQA and CMS yearly for our Medicare Advantage and Special Needs Plans. Prior to submission of HEDIS data the data is validated by an NCQA certified HEDIS auditor.

HEDIS measures are also reported yearly to OPHP and DMAP (OHA) as required per contract.

Samaritan Health Plans currently contracts with an NCQA certified CAHPS & HOS vendor for our Medicare Advantage and Special Needs Plans.

Samaritan Health Plans currently reports Structure and Process measures for our Special Needs Plan to NCQA annually as required by CMS. There are 5 structure and process measures (with many sub-measures) that we report on and they are related to Complex Case Management, Improving Member Satisfaction, Clinical Quality Improvements, Care Transitions and Coordination of Medicare & Medicaid Coverage. Additional information available upon request at readiness review.

c. IHN-CCO expectations for our providers and contractors is to enhance the health of our communities through quality effective, efficient, and caring integrated health care. We expect all provider to work toward meeting the quality standards set by the CCO. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation. Additional information is available upon request at readiness review.

d. The IHN-CCO will use current processes developed as a FCHP and those developed by the historical MHOs as it works toward a unified approach for sharing performance information. We currently share overall HEDIS performance information and performance improvement information via the Provider Newsletter, The Navigator and individually when requested. The IHN-CCO delivery systems workgroup will further evaluate how best to ensure the CCO is performing this requirement and develop strategies to achieve health care transformation

ABHA currently shares performance information with providers and contractors in its Quality Assurance Committee. A quality dashboard is utilized as well as more detailed performance reports on a regular basis.

MVBCN's Quality Management Committee (40% of members are advocates) currently develops and monitors an extensive annual quality plan, with public data reporting and other mechanisms to hold providers accountable for performance. An annual consumer satisfaction survey obtains member feedback related to specific quality initiatives and allows for comparison of performance across provider agencies. MVBCN providers receive performance information in the Quality Management Committee, multiple subcommittees, and Regional Advisory Council. Additional information is available upon request at readiness review.

e. ABHA currently shares performance improvement information with members who participate in the Adult Advisory Committee, the Youth and Family Advisory Committee, and the Quality Assurance Committee. The ABHA Member Affairs Specialist meets with members prior to each meeting to prepare them to be active participants in these meetings and to assure the material is presented in a culturally and linguistically appropriate manner.

MVBCN has more than 40 advocates who participate in various committees in which performance information is shared and discussed. MVBCN has been recognized by AMH for its "outstanding family/youth/consumer involvement in systems work.....reflected not only in the number of advocates involved but in the depth and breadth of that participation."

The IHN-CCO will build upon these practices as it moves toward a unified approach for sharing performance information in a culturally and linguistically appropriate manner to its members. Additional information is available upon request at readiness review.

f. The IHN-CCO will implement payment methodologies that support the Triple Aim. This includes a thorough evaluation of system capabilities within the CCO, an evaluation of possible solutions and a foundational understanding by all the stakeholders of the requirements, process and goals. The ultimate resultant strategy will be a powerful mechanism to control costs by lowering medical spending while improving the quality of patient care. Currently the Business Operations Workgroup within the IHN-CCO is leading the charge regarding how to best proceed and will have a strategy and timeline in place within the first year of operations. Additional information is available upon request at readiness review.

g. The IHN-CCO's health information system, FACETs, is a combination of commercially available

core business applications and a custom developed reporting infrastructure. For example, one of our core applications enables us to collect and store all initial and annual health risk assessment information, another application collects care management information and another application collects claims and encounter data. Reporting from any of these applications is available.

To ensure that data is accurate and complete, the FACETs database transaction logs are backed up every 15 minutes and a full backup is performed nightly of the database. The FACETs servers, including the destination of the FACETs transaction log backups and full database backup have nightly incremental backups on tape. The tape backups are kept onsite at Samaritan Health Services and copies are sent offsite to a secure storage vendor, Iron Mountain, on a daily basis. Hardware is continuously maintained and monitored to ensure the integrity and accuracy of the data. All data is retrievable as requested by regulatory agencies.

The IHN-CCO has extensive disaster recovery plans and business continuity plans. Personal computing devices that may contain personal health information (PHI) are protected with enterprise class hard disk encryption. We also have structures and training in place to ensure that HIPAA and privacy issues are given the highest levels of organizational vigilance.

The IHN-CCO employs several programming, report writing and systems analyst staff to assist with data extraction, reporting and validating. Data is collected and analyzed to evaluate the various aspects of our Quality Management Program. Our reporting infrastructure was developed and extensively tested to guarantee very high quality output over a broad range of healthcare data needs.

We utilize a NCQA-certified software vendor (Verisk) to calculate all of the HEDIS measures. Our HEDIS Coordinator works closely with the vendor. Data is pulled from our claims system utilizing the vendor data specifications. Verisk calculates HEDIS rates for all our current lines of business. For Medicare reporting supplemental files (from sources outside our core system, such as electronic medical record and laboratory data) are also provided to our vendor based on specifications from our NCQA-certified HEDIS auditor. Our HEDIS auditor (Attest) ensures that our data for HEDIS is reliable, valid, complete, comparable and timely. Our NCQA-certified HEDIS auditor (Attest) validates and approves our HEDIS measures prior to submission to NCQA and CMS for our Medicare line of business. Our Medicare HEDIS rates are reported to NCQA via their Interactive Data Submission system. We also contract with an NCQA-certified vendor (Synovate) for our Medicare HOS and Medicare CAHPS surveys.

HEDIS rates are reported to other regulatory agencies such as DMAP (OHA) and OPHP as required. All HEDIS rates are reviewed and analyzed internally to determine areas for improvement.

There are numerous monthly, quarterly and annual reports due to CMS for Medicare Part C and D. These reports are pulled internally and then our Medicare Part C & D Data Validation vendor (Attest) validates our data prior to submission to CMS.

Both ABHA and MVBCN currently have capability of collecting and reporting many quality and performance measures.

The IHN-CCO will use current processes developed as a FCHP and those developed by the historical MHOs as it works toward a unified approach for sharing performance information.

Additional information is available upon request at readiness review.

Section 2- Quality Improvement Program

a. Our Quality Management Program is designed to meet all regulatory requirements for a quality program for each of our lines of business which include OHP – Medicaid, Medicare (Advantage and Special Needs/dual eligible), Healthy KidsConnect and our self-funded Samaritan Health Services employees.

The purpose of our Quality Management Program is to monitor the care provided to our members to ensure that they receive quality health care services. The program has many components such as a Quality Management Plan, a work plan, numerous quality projects and an annual evaluation.

Our Quality Management Plan includes the goals, objectives, scope, principles, authority, organizational model, oversight, reporting and evaluation requirements of the Quality Management Program. It is reviewed and updated annually to encompass any regulatory changes.

Our Quality Management Program, via an annual Quality Work Plan, monitors four key areas:

- Utilization of services – both under and over utilization
- Member satisfaction – both with the plan and with our providers is monitored through various methods including the CAHPS survey for Medicaid & Medicare, member complaints & grievances and member appeals.
- Clinical services – includes disease management, preventive care, maternity care, newborn care, the chemical dependence program, the mental health program, and regional programs.
- Various administrative services – includes policies & procedures, processes and various operational issues.

Our Program includes numerous Quality Improvement Projects, Performance Improvement Projects, and a Chronic Care Improvement/Disease Management Program with components of care management, evidence-based clinical practice guidelines, member education, member self management and outcome measurements (from HEDIS and/or claims and various other internal measurements). Over the years we have developed many collaborative projects with other OHP and Medicare Advantage plans as well as with Acumentra, the state Quality Improvement Organization for Medicare Region X.

We perform a yearly evaluation of our Quality Management Program to look for opportunities for improvements in the program. Reporting is done as indicated per various regulatory agencies (such as CMS, DMAP (OHA), EQRO, DCBS, and OPHP)

The mission of the ABHA Quality Improvement Program is to support ABHA, Partner Counties and contracted service Providers to comply with the quality assurance and performance improvement standards. This applies to all mental health services and related activities (e.g., grievance process) provided to ABHA members and families, community agencies and other stakeholders.

ABHA's Quality Improvement Program includes Performance Improvement Projects as well as other quality initiatives .The program implements training initiatives to assure evidence based practices are in place in provider agencies. Assertive Community Treatment and Collaborative Problem Solving are the two most recent examples of training initiatives the Quality Improvement Program has overseen.

MVBCN has been recognized as Oregon's most innovative Mental Health Organization and is experienced in strategies to select, implement and sustain evidence-based practices. Successful clinical improvement has included integration of mental health and chemical dependency services, wellness supports, trauma-informed care, full-fidelity wrap around, early psychosis intervention, Collaborative Problem Solving with adults, Parent-Child Interaction Therapy, and peer delivered services. MVBCN uses a quality improvement process motivated by a spirit of collaborative innovation, driven by face-to-face discussion and decision making with all impacted parties. MVBCN has been recognized by the Oregon Addictions and Mental Health Services for its "outstanding family/youth/consumer involvement in systems work.....reflected not only in the number of advocates involved [40 in multiple committees], but in the depth and breadth of that participation." It brings together clinical leaders, member and family advocates and Mental Health Organization staff to analyze needs and identify, implement and monitor practice improvements. The Quality Management Committee (40% of members are advocates) develops and monitors an extensive annual quality plan, with public data reporting and other mechanisms to hold providers accountable for performance. An annual consumer satisfaction survey obtains member feedback related to specific quality initiatives and allows for comparison of performance across provider agencies.

The Quality Management/Improvement Program for the IHN CCO will include all the above elements so that there will be an ongoing collaborative quality program for services provided to their members in accordance with 42 CFR 438.240. Additional information is available upon request at readiness review.

b. The IHN-CCO Quality Management Program is overseen by the Board of Directors who retains authority and accountability for all quality activities. The Director of Quality & Compliance is responsible for the daily operations of the Quality Management Program and works closely with the Medical Director, the Director of Medical Management and other

Operations managers. The Director of Quality & Compliance reports directly to the Chief Executive Officer.

IHN's Physician Advisory & Quality Committee monitors the ongoing effectiveness of the Quality Management Program. The committee includes the Director of Quality & Compliance, the Medical Director and numerous practicing physician representatives from our various communities. They provide the Board of Directors with regular reports, at least on a quarterly basis, which include findings, actions and recommendations regarding the various aspects of the Quality Management Program. The Physician Advisory & Quality Committee meets at least every other month. Members of the committee are approved by the Board of Directors and include practicing providers from the diverse communities we serve. This committee receives regular updates and information from several other committees.

Our Healthcare Assessment Committee is a subcommittee of the Physician Advisory & Quality Committee. The committee includes the Director of Quality & Compliance, the Medical Director, the Director of Medical Management, our Clinical Pharmacist, several Operations Managers, Analytics Department Manager and Business Analysts. The purpose of the Healthcare Assessment Committee is evaluation of data as it relates to the Quality, Utilization Management, Care Management and Pharmacy functions as required by Medicaid and Medicare and other regulatory agencies. They are also responsible for evaluating the effectiveness of the Model of Care for our Special Needs Plan. This committee analyzes healthcare data and develops recommendations for improvements based on the data analysis and forwards their recommendations to the Physician Advisory & Quality Committee.

Our Policy and Procedure Committee reviews and approves all policies that are required by regulatory agencies to operate our various health plans. After the Policy and Procedure Committee approves policies that relate to quality, clinical or utilization issues these policies are then forwarded to the Physician Advisory & Quality Committee for review/revisions/approval. Any recommended revisions are then returned to the Policy and Procedure Committee for a final approval.

Our Pharmacy and Therapeutics Committee monitors the ongoing effectiveness of the Pharmacy Program. They oversee the formularies, all pharmacy related prior authorization criteria and all pharmacy related reporting requirements. They report directly to the Board of Directors and as needed they report to the Physician Advisory & Quality Committee.

ABHA's Quality Assurance Committee consists of representation from all county partners, the ABHA Medical Director, ABHA Quality Manager, ABHA Member Affairs Specialist, and at least 25% member representation. The Quality Assurance Committee reports to the Administrative Council and is accountable to the ABHA Governing Board.

MVBCN's Quality Management Committee includes 12 representatives of the outpatient delivery system and 8 advocates and links with multiple subcommittees focused on specific areas of

service and reports to the Regional Advisory Council.. The Committee develops and monitors an extensive annual quality plan, with public data reporting and other mechanisms to hold providers accountable for performance. An annual consumer satisfaction survey obtains member feedback related to specific quality initiatives and allows for comparison of performance across provider agencies.

The over arching Quality Committee for the IHN CCO will retain authority and accountability to the executive(s) for the quality assessment and performance improvement of care for its members. Individuals who are being sought to fill these various clinical leadership roles will be a mix of affiliate providers (See A.I.b for affiliates). Additional information is available upon request at readiness review.

c. The IHN-CCO Quality Management Plan will be developed yearly based on the various state and federal regulatory requirements for all lines of business within Samaritan Health Plan Operations. These requirements are found in contracts, OARs, CFRs, Medicare manuals and other regulatory documents. As part of the Quality Management Plan a quality work plan is also developed yearly and maintained/revised throughout the year as requirements change. The Plan-Do-Study-Act model is utilized.

ABHA's Quality Management Plan is developed yearly based on member feedback, consumer satisfaction survey results, and state requirements. The Quality Assurance Committee decides on what areas to focus on and develops the goals and measurable objectives collaboratively. The plan is reviewed and approved by the Administrative Council and Governing Board prior to submission to the Oregon Addictions and Mental Health Services for approval. Progress made towards goals is reviewed at least quarterly and a Plan-Do-Study-Act model is implemented to assure progress is made toward goals. MVBCN's Quality Management Plan is developed yearly based on member and provider feedback, consumer satisfaction survey results and state requirements. The Plan includes several domains such as access; education, outreach & prevention; integration & coordination; quality improvement; outcomes; utilization management and quality assurance monitoring. The Quality Management Committee develops and monitors the Quality Management Plan which is also submitted to the Oregon Addictions and Mental Health Services for approval.

The Quality Management/Improvement Program for the IHN CCO will include all the above elements so that there will be an ongoing collaborative quality program for services provided to their members. Additional information is available upon request at readiness review.

d. IHN-CCO will utilize historical practices initiated in the MCOs. For example, the ABHA Quality Improvement Program obtains guidance and feedback from the ABHA Adult Advisory Council and the Youth and Family Advisory Council. The ABHA Quality Assurance Committee consists of at least 25% representation from members, two of which chair the Advisory Councils. Many of the Quality work plan goals are developed directly from member participation. The ABHA Quality Manager reports to the Advisory Councils on a regular basis to report on quality assurance

measures and obtain feedback on member experience of care. A representative from each county participates in the Quality Assurance Committee and is responsible for obtaining feedback from other practitioners in their respective counties.

MVBCN's quality management and many other committees have specified representation to ensure participation by a range of providers across the region. Active recruitment of advocates ensures a diversity of experience relevant to the work of each body is represented. Oversight of the children's system includes system partners and 51% family and youth advocates representing the diverse ethnic communities and family configurations we serve. Additional information is available upon request at readiness review.

e. By monitoring our internal data, HEDIS data, CAHPS data and HOS data the IHN-CCO will be able to identify any inequities in care and make corrections as appropriate.

As a historical managed care organization we have improved seamless transitions of care across healthcare settings, providers and health services by developing policies & procedures and processes for transitions which include training providers and monitoring all types of transitions by the care manager for each member. Safe transitions of care and support of members through transitions is done by collaborating with providers on specific tasks and monitoring transitions through audits of clinical records to ensure that transitions are facilitated safely and coordinated between care settings. We plan to continue this practice within the IHN-CCO.

The ABHA Quality Improvement program assures that care coordination is occurring and results in high quality outcomes. Monitoring of transitions between care settings is also conducted by the Quality Improvement program to assure that state requirements are met and that members are not harmed.

MVBCN has specific quality initiatives to ensure care coordination using fidelity adherence to Evidence Based Practice such as wrap around for children and Collaborative Problem Solving with adults. Intensive teams provide support for children and adults moving between levels of care. Additional information is available upon request at readiness review.

f. IHN-CCO will conduct regular monitoring of provider's compliance through our clinical medical record review process. Any provider that obtains a failing score will receive further monitoring and/or be required to submit a corrective action plan as deemed necessary by the Medical Director. Monitoring activities of the clinical record review are reported to the Physician Advisory &Quality Committee and may be used for re-credentialing purposes as deemed appropriate by the Medical Director.

The ABHA Quality Management program conducts annual audits of high volume providers. Any areas of non-compliance that are identified must be addressed in the provider's corrective action plan. ABHA assures that corrective actions are sufficient and complete. Follow up audits are

conducted to assure that areas of noncompliance have been resolved. The ABHA Quality Manager provides technical assistance to providers as requested.

MVBCN contracts only with licensed agencies to form the provider panel, and performs an annual review to assure compliance with delegated activities. In addition, each agency is measured on their performance on specified quality improvement targets. We use a stepped process called Holding Ourselves Accountable for corrective actions, and have found it to be very powerful.

The IHN-CCO will use the above current processes developed as a FCHP and MHO as it works toward a unified approach. Additional information is available upon request at readiness review.

g. **Customer satisfaction: clinical, facility, cultural appropriateness**

To ensure a high level of member satisfaction the IHN-CCO will monitor all member complaints/grievances/appeals internally on an ongoing basis to identify areas for improvement. We monitor member satisfaction via external agencies such as through the CAHPS survey and per Federal, State and contractual requirements to identify areas for improvement. We implement and monitor appropriate interventions when areas for improvement in member satisfaction are identified. Results of monitoring member satisfaction are reported to the Physician Advisory & Quality Committee and to the appropriate Board of Directors as indicated but at least on a yearly basis. In addition we maintain a strong collaborative relationship with the provider network and community entities.

For MVBCN, an annual consumer satisfaction survey obtains member feedback related to overall care as well as specific quality initiatives, and allows for comparison of performance across provider agencies.

The IHN-CCO will build upon the above current processes developed as a FCHP and MHO as it works toward a unified approach. Additional information is available upon request at readiness review.

Fraud and Abuse/Member protections

IHN has many policies and procedures in place that address fraud and abuse that will form the foundation of the IHN-CCO. We have a Compliance Manager, a Compliance Plan, a Compliance Committee, an Internal Compliance/Claims Audit Program to monitor for fraud and abuse. We perform periodic Compliance Threat and Internal Risk Assessments. In addition the Reimbursement Department conducts monthly chart review audits of medical charts associated with potentially fraudulent claims. The Provider Services Department ensures that we don't contract with providers who are sanctioned by CMS or the State of Oregon. Member grievances including quality of clinical care are monitored and reviewed. The Quality Department reviews, tracks and reports quality of clinical care grievances to the Credentialing department, contracting

committee and quality committees as appropriate per our policies & procedures and processes. Additional information is available upon request at readiness review.

Treatment planning protocol review/revision/dissemination and use with evidence based guidelines

IHN's Physician Advisory & Quality Committee approves evidence-based clinical practice guidelines. These guidelines are used to assist providers and members in making decisions about appropriate health care for specific clinical circumstances including "self-management" of chronic diseases. The guidelines are intended to improve the quality and consistency of care provided to our members.

The guidelines are reviewed and updated periodically and presented to the Physician Advisory & Quality Committee for re-approval as appropriate but at least every two years. Numerous evidence-based clinical practice guidelines have been approved and are currently in place. The list includes: Asthma; Coronary Artery Disease; Congestive Heart Failure; Diabetes; Obesity Assessment and Treatment; Osteopenia/Osteoporosis Screening and Treatment; Recommended Adult & Child Preventive Screenings and Immunizations, Early Childhood Cavities Prevention, Oral Health Care in Pregnancy, Evaluation & Management of Low Back Pain and Tobacco Cessation.

The evidence-based clinical practice guidelines are shared with providers as part of our provider education and communication processes. Methods for this communication may include distributing the guidelines as part of our provider newsletter, placing them on our website and Medical Director presentation to providers.

We ensure that network providers use evidence-based clinical practice guidelines and nationally recognized protocols through methods such as:

- Internal review of outcome data such as HEDIS per provider per clinic on such things as Diabetes Care, Colorectal Cancer Screening and Breast Cancer Screening
- Analysis of provider reports that show the HEDIS results. This information is distributed to providers and/or discussed with individual providers by our Medical Director
- Through our Clinical Record Review Process in which random chart audits are conducted
- Contract language stipulating delivery of services in accordance with evidence-based clinical practice guidelines and nationally recognized protocols

The IHN-CCO will use the above current processes developed as a FCHP and MHO as it works toward a unified approach between community partners. Additional information is available upon request at readiness review.

C.2.2. Clinical Advisory Panel

a. IHN-CCO will modify its current Physician Advisory Panel within its historical FCHP to meet this requirement. The current FCHP Physician Advisory Panel provides assistance in developing the most comprehensive resource for clinical plan management and assuring best practices. The panel is comprised of physicians and health specialists from around the service area and may include our affiliates listed in A.I.b. In general, their role is to support our mission of delivering better health, at the appropriate time and the lowest cost. The panel provides oversight for health information and clinical guidelines and serves as spokespersons to educate and advocate the health care community and public about our services. This team monitors peer-reviewed medical journals to ensure research supported systems and practices are integrated into the care management model. This team will be evaluated and modified going forward to ensure appropriate representation of the additional mental health, dental and long term care needs of the members the IHN-CCO will be covering. Additional information is available upon request at readiness review.

b. IHN-CCO intends to establish a CAP and to develop processes to ensure information flow from the CAP to the Governing Board. Additional information is available upon request at readiness review.

c. See C.2.2.a and C.2.2.b, above.

C.2.3. Continuity of Care/Outcomes/Quality Measures/Costs

a. The IHN-CCO will utilize the Policy and Procedure Committee that reviews and approves all policies that are required by regulatory agencies to operate the various Samaritan health plans. Policies are currently in place for claims, enrollment, medical management/clinical, compliance (including HIPAA), contracting, customer care, pharmacy, provider relations, quality and reimbursement. Additional information is available upon request at readiness review.

b. Examples of key quality measures currently in include:

- All Medicaid, Medicare and Commercial HEDIS measures such as breast and cervical cancer screening, controlling high blood pressure, comprehensive diabetes care, antidepressant and antipsychotic medication management, follow up after hospitalization for mental illness to name a few of the more than 70 HEDIS measures.
- HOS survey – this survey assesses a Medicare Advantage Organization's ability to maintain or improve the physical and mental health of its Medicare members over time. Questions include those related to physical activity in older adults, fall risk management, osteoporosis testing in older women to name a few.
- CAHPS survey measures. This survey is performed on both the Medicare and Medicaid populations. For the Medicaid population there is a survey for both children and adults. Questions on the CAHPS survey include those related to tobacco usage/cessation, flu and pneumonia shots to name a few.

- Assuring appropriate utilization of services by monitoring data on primary care physician (PCP) visits, Emergency Department (ED) visits, inpatient visits, and educating each member and/or the provider on the appropriate utilization of services.

Data is routinely reviewed by our Healthcare Assessment Committee and our Physician Advisory & Quality Committee. Based on the data quality improvement projects are and will continue to be implemented when necessary for improving overall member health outcomes. Additional information is available upon request at readiness review.

c. Wellness and health improvement activities for all Health Plan members are very important. We encourage our members to have regular PCP visits and to actively participate in their health care, both for preventive care and self management of any chronic conditions. Preventive care services that we promote are those recommended and supported for adults, adolescents, children and infants by the US Preventive Services Task Force, the Advisory Committee on Immunizations Practices of the Center of Disease Control Services, and the Health Resources and Services Administration. We improve access to these important preventive health services by reducing or eliminating barriers such as not requiring referrals or authorizations for certain routine and preventive service and/or by facilitating transportation and coordination of services.

For Samaritan's self-funded employee plan the Samaritan Stewardship's Everyday Choices program was developed. It was developed by employees, for employees. It is a way to support each other and receive incentives to keep up the commitment to pursue better health. In addition to the Everyday Choices program there is also an Employee Wellness program that provides high quality education and support programs that empower employees to not only develop, but also maintain, healthy life habits. Employees who work at least 32 hours per month, including casual, are eligible for the wellness benefit. There is a variety of memberships, classes and activities available, all with little or no out-of-pocket cost.

All members on any Samaritan Plan receive health education in a variety of methods such as through their PCP, through our care managers, through targeted health education mailings, through our website and through our quarterly member health education newsletter called Your Health Matters. Health education topics vary according to member needs and may include information on various preventive screenings, immunizations, healthy lifestyle choices and/or information about self management of certain diseases. Members are encouraged to attend classes and support groups. Periodic surveys of our members provide information on the types of health education they would like to see.

MVBCN has several years experience with wellness initiatives across the network addressing tobacco use, weight management and metabolic syndrome. The IHN-CCO will build upon the above foundational structure as it moves toward a unified approach. Additional information is available upon request at readiness review.

d. Our reporting infrastructure was developed many years ago and extensively tested to guarantee

high quality output over a broad range of healthcare data needs. We have an Analytics Department that employs several programming, report writing and systems analyst staff to assist with data extraction, reporting and validating. There are many policies & procedures and processes in place for all aspects of data collection and reporting.

In addition to our internal reporting, We currently contract with an NCQA certified HEDIS vendor to collect and report all appropriate Medicare HEDIS measures to NCQA and CMS yearly for our Medicare Advantage and Special Needs Plans. Prior to submission of HEDIS data the data is validated by our contracted NCQA certified HEDIS auditor. This HEDIS process has been in place since 2006 with both of the vendors.

For the Medicaid population we have submitted asthma performance data directly from our claims system to DMAP (OHA) for several years. This data has been validated by Acumentra (the state's EQRO). The asthma performance measures have now been retired and replaced by the HEDIS Ambulatory Care measure which is reported to DMAP (OHA) yearly.

Various HEDIS measures are also collected and reported to OPHP for Samaritan Health Plans Healthy KidsConnect plan.

The various organizations within the CCO will work collaboratively to collect and report any of the Metrics from Attachment 8 tables that will need to be reported whether the data comes from claims data, encounter data or HEDIS data. Additional information is available upon request at readiness review.

e. Plans haven't yet been developed but this will be discussed by the partners in the CCO specifically The IHN-CCO delivery systems workgroup will further evaluate how best develop strategies to improve patient care outcomes, decrease duplicative services and ensure members receive appropriate care at the right time. Additional information is available upon request at readiness review.

f. Organizationally and with our affiliate partners have improved seamless transitions of care across healthcare settings, providers and health services by individually developing policies & procedures and processes for transitions which include training providers and monitoring all types of transitions by the care manager for each member. Safe transitions of care and support of members through transitions is done by collaborating with providers on specific tasks and monitoring transitions through audits of clinical records to ensure that transitions are facilitated safely and coordinated between care settings. As the IHN-CCO we will use the above current processes developed as a FCHP and MHO as it works toward a unified approach.

IHN has had an extensive Utilization Management Program in place since IHN started and has expanded as new lines of business have been added. The utilization management staff accepts and processes authorization requests as required by CMS, DMAP (OHA), all applicable federal and state regulations, and plan contracts. Services requiring a prior authorization are listed in the plan

documents. The utilization management staff review Special Needs Plan authorization requests under both the Advantage and IHN guidelines in order of coverage. The utilization management staff applies IHN benefits if there is no benefit under Advantage. All authorization requests are time/date noted upon receipt. The utilization management staff documents all clinical information used to make the decision in FACETS. The Compliance Department conducts quarterly audits to ensure regulatory compliance. The Healthcare Assessment Committee reviews and analyzes reports on utilization management patterns and trends, including, but not limited to, over- and under-utilization of services. Additional information is available upon request at readiness review.

IHN-CCO
APPENDIX D – Medicare/Medicaid Alignment Questionnaire

Section 1 -Background Information – Inclusion of Dually Eligible Individuals in CCOs

Section 2 - Ability to Serve Dually Eligible Individuals

D.2.1. Describe the Applicant's approach to be able to provide Medicare benefits to dually eligible Members by January 1, 2014. Include:

D.2.2.

a. IHN-CCO's affiliate Samaritan Advantage Health Plan is a Medicare Advantage plan, and includes a Special Needs Plan in Linn and Benton Counties, and will include Lincoln County January 1, 2013. SAHP has been covering special needs members since 2005.

b. IHN-CCO's affiliate plan is already covering Special Needs members, and will cover all three counties (Benton, Lincoln and Linn) beginning January 1, 2013.

c. IHN-CCO will meet this requirement through its existing Medicare Advantage plan.

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Appendix H: Transformation Scope Elements

A. CCO Criteria

Part 1 – Governance and Organizational Relationships

1. Governing Board and Governance Structure

Contractor establishes, maintains and operates with a governance structure that complies with the requirements of ORS 414.625(1)(o).

2. Community Advisory Council (CAC)

Contractor establishes a Community Advisory Council (CAC) that includes appropriate community representation in each service area. The duties of the CAC will be developed in Year 1 and may include:

(1) Identifying and advocating for preventive care practices to be utilized by the Contractor;

(2) Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the Contractor; and

(3) Annually publishing a report on the progress of the community health improvement plan.

3. Clinical Advisory Panel

Contractor establishes an approach within its governance structure to assure best clinical practices. This will be developed in Year 1 and may include a clinical advisory panel. If Contractor convenes a clinical advisory panel, this group may have representation on the governing board. The clinical advisory panel has representation from behavioral health and physical health systems and may have Member representation.

4. Community Health Assessment and Community Health Improvement Plan

Contractor's CAC partners with the local public health authority, local mental health authority, community based organizations and hospital system to develop a coverage area community health assessment and adopt a community health improvement plan to serve as a strategic population health and health care system service plan for the community(s) served by Contractor. Community health assessment includes a focus on health disparities experienced by various dimensions of the community, including but not limited to racial and ethnic disparities in the community. The health assessment is transparent and public in both process and result.

a. The community health assessment adopted by the CAC describes the scope of the activities, services and responsibilities that the Contractor considers upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

(1) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(2) Health policy;

(3) System design;

(4) Outcome and Quality Improvements;

(5) Integration of service delivery; and

(6) Workforce development

Through its community health assessment, Contractor identifies health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, occupation or other factors in its service areas. Contractor and Contractor's CAC work with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities.

b. Community Health Improvement Plan

The Contractor, through its CAC, will develop and implement a community health improvement plan based on Year 1 work by the CAC with oversight by the Governing Board. The community health improvement plan describes the scope of the activities, services and responsibilities that the Contractor considers upon implementation of the plan. The Contractor provides a copy of the plan and any updates to the OHA, as determined by the Contractor. The activities, services and responsibilities defined in the plan may include, but are not limited to:

(1) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(2) Health policy;

(3) System design;

(4) Outcome and Quality Improvement;

(5) Integration of service delivery; and

(6) Workforce development.

Part 2 – Health Equity and Eliminating Health Disparities

Contractor carries out the health improvement strategies tailored to reduce health disparities and improve the health and well-being of all Members, utilizing data and criteria developed by the CCO in accordance with its goals and identified measures.

Contractor collects and maintains race, and primary language data, including mental health and substance abuse disorder data, for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS. Contractor tracks and reports on agreed upon quality performance improvements and outcome

measures by these demographic factors and develops, implements, and evaluates strategies to improve health equity among Members.

Contractor partners with local public health and culturally, linguistically and professionally diverse community partners to address the causes of health disparities.

Part 3 – Payment Methodologies that Support the Triple Aim

Contractor demonstrates how it will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for their Members.

The schedule by which Contractor implements alternative payment methodologies will be developed over year 1, in coordination with CCO goals and objectives. Payments to Patient-Centered Primary Care Homes for individuals with chronic conditions, however, are implemented immediately.

Contractor's payment methodologies comply with additional requirements established in law in conjunction with those requirements under Health System Transformation that encourage efficiency and the elimination of care defects and waste. Specific payment methodologies will be assessed and addressed as a CCO during year 1 implementation. These may include:

1. Contractor pays hospitals other than Type A and B Rural hospitals using Medicare-like payment methodologies that pay for bundles of care rather than paying a percentage of charges.

2. Contractor does not pay any provider for services rendered in a facility if the condition is a health care acquired condition for which Medicare would not pay the facility.

3. Contractor or its Subcontractors are responsible for appropriate management of all federal and state tax obligations applicable to compensation or payments paid to Subcontractors under this Contract.

Part 4 – Health Information Systems

1. Electronic Health Information

Contractor demonstrates how it will achieve minimum standards in foundational areas of HIT use (electronic health records, health information exchange) and develop its own goals for transformational areas of HIT use (analytics, quality reporting, patient engagement, and other health IT).

a. Electronic Health Records Systems (EHRs)

Contractor facilitates Providers' adoption and meaningful use of EHRs. Electronic Health Records are a foundational component of care coordination because they enable Providers to capture clinical information in a format that can be used to improve care, control costs, and more easily share information with patients and other providers. In order to facilitate advanced EHR adoption and meaningful use, Contractor:

(1) Identifies EHR adoption rates; rates may be divided by provider type and/or geographic region.

(2) Develops and implements strategies to increase adoption rates of certified EHRs.

(3) Considers establishing minimum requirements for EHR adoption over time. Requirements may vary by region or provider type;

b. **Health Information Exchange (HIE)**

(1) Contractor facilitates electronic health information exchange in a way that allows all Providers to exchange a patient's health information with any other of its Participating Providers, including ensuring that every Provider is working toward the following goals in Year 1-3:

(a) Registered with a statewide or local Direct-enabled Health Information Service Provider (HISP); or

(b) A member of an existing Health Information Organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within Contractor's network.

(2) Contractor may establish minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time. A work plan will be developed in Year 1 of the CCO implementation.

(3) Contractor leverages HIT tools to transform from a volume-based to a value-based delivery system. In order to do so, Contractor initially identifies its current capacity and develop and implement a plan for improvement (including goals/milestones, etc.) in areas developed and agreed upon by the CCO to meet is strategic goals that may include:

(a) Analytics that are regularly and timely used in reporting to its provider network (e.g., to assess provider performance, effectiveness and cost-efficiency of treatment, etc.).

(b) Quality Reporting (to facilitate Quality Improvement within Contractor as well as to report the data on quality of care that allows the OHA to monitor Contractor's performance).

(c) Patient engagement through HIT (using existing tools such as e-mail).

(d) Other HIT (e.g., telehealth, mobile devices).

B. Delivery of Benefits

Part 1 – Benefits

1. Flexible Services and Supports

In addition to traditional service and supports for physical, mental health and chemical dependency, Covered Services include the provision of Flexible Services and supports that are consistent with achieving wellness and the objectives of an individualized care plan. A Flexible Service or support is ordered by and under the supervision of a Network Provider in accordance with Contractor policy for authorizing Flexible Services or supports.

2. Children's Wraparound Demonstration Project Responsibilities

As mandated by ORS 418.975 to 418.985, Contractor creates a system of care by continuing to maximize utilization of the Children's Wraparound Demonstration Project, providing oversight and, in collaboration with OHA, evaluation.

Contractor develops local and state level partnerships to collaborate with OHA on the implementation of ORS 418.975 to 418.985 in the development of the Statewide Children's Wraparound Initiative.

Part 2 – Patient Rights and Responsibilities, Engagement and Choice

1. Member and Member Representative Engagement

Contractor actively engages Members as partners in the design and, where applicable, implementation of their individual treatment and care plans through ongoing consultation regarding individual and cultural preferences and goals for health maintenance and improvement. Member choices are reflected in the development of treatment plans and Member dignity is respected. Members are positioned to fulfill their responsibilities as partners in the primary care team at the same time that they are protected against underutilization of services and inappropriate denials of services.

Contractor demonstrates the means by which Contractor:

a. Uses Community input and the Community health assessment process to help determine the best, most culturally appropriate methods for patient activation, with the goal of ensuring that Member act as equal partners in their own care.

b. Encourages Members to be active partners in their health care and, to the greatest extent feasible, develop approaches to patient engagement and responsibility that account for the social determinants of health and health disparities relevant to Members.

c. Engages Members in culturally and linguistically appropriate ways.

d. Educates Members on how to navigate the coordinated care approach.

e. Encourages Members to use wellness and prevention resources, including mental health culturally-specific resources provided by community based organizations and service providers, and to make healthy lifestyle choices.

f. Meaningfully engages the CAC to monitor patient engagement and activation.

g. Provides plain language narrative and alternative (video or audio) formats for individuals with limited literacy that inform patients about what they should expect from Contractor with regard to their rights and responsibilities.

h. Works with the Member's care team, including providers and community resources appropriate to the Member's individual and cultural health as a whole person.

2. Member Engagement and Activation

Contractor implements policies and procedures assuring that each Member:

a. Is encouraged to be an active partner in directing the Member's health care and services and not a passive recipient of care.

b. Is educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

c. Has access to advocates, including qualified Peer Wellness Specialists where appropriate, Personal Health Navigators, and qualified Community Health Workers who are part of the Member's care team to provide assistance that is culturally and linguistically appropriate to the Member's need to access appropriate services and participate in processes affecting the Member's care and services.

d. Is encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

e. Is encouraged to work with the Member's care team, including providers and community resources appropriate to the Member's health as a whole person

Part 3 – Providers and Delivery System

1. Integration and Coordination

Contractor develops, implements and participates in activities supporting a continuum of care that integrates mental health, addiction, dental health and physical health interventions in ways that are seamless and whole to the Member and serves Members in the most integrated setting appropriate to their health. Integration activities span a continuum ranging from communication to coordination to co-management to co-location to the fully integrated Patient Centered Primary Care Home.

2. Delivery System Features

Contractor ensures that Members have access to high quality appropriate integrated and coordinated care. Contractor accomplishes this through a Provider Network capable of meeting Health System Transformation objectives. Contractor focuses on the following elements of a transformed delivery system critical to improving the Member's experience of care as a partner in care rather than as a passive recipient of care:

a. Patient-Centered Primary Care Homes

Contractor demonstrates the method and means by which Contractor uses PCPCH and primary care home capacity to achieve the goals of health system transformation including:

- How Contractor partners with and implement a network of PCPCHs and primary care homes as defined by Oregon's and national standards to the maximum extent feasible, including but not limited to the following
  - A concrete plan for increasing the number of enrollees served by certified PCPCHs and primary care homes over the first five years of operation, including targets and benchmarks; and
  - A concrete plan for Tier 1 PCPCHs to move toward Tier 2 and 3 of the Oregon standard over the first five years of operation, including targets and benchmarks.

- How Contractor requires Contractor's other contracting health and services providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology, where available, in order to assure a comprehensive delivery system network with the PCPCH at the center, and with other health care providers and local services and supports under accountable arrangements for comprehensive care management.

- How Contractor's PCPCH and primary care home delivery system elements ensures that Members of all communities in its service area receive integrated, culturally and linguistically appropriate person-centered care and services, and that Members are fully informed partners in transitioning to this model of care.

- How Contractor encourages the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as PCPCHs to ensure the continued critical role of those providers in meeting the health of underserved populations.

  IHN-CCO requests that any mental health or substance abuse services delivered within a PCPCH fall under the medical documentation rules in 410-141-0180 rather than under mental health's Integrated Services and Supports Rule. This is already true for psychiatric medication management provided by any appropriate professional. To support integration and expedite access to other behavioral health services consistent with the primary care model, there should not be separate intake and assessment documentation requirements in addition to what is contained in the PCPCH clinic's medical records Currently behaviorist health work on medical issues is allowed by a QMHP employed by an agency holding a Letter of Approval for outpatient services. We also want to allow a medical practice to employ a licensed provider (psychologist, social worker, counselor or marriage and family therapist) for this role, billing health and behavior assessment and intervention codes.

b. Care Coordination

Contractor demonstrates the methods and means by which Contractor addresses the following elements of care coordination throughout year 1:

- How Contractor supports the flow of information, identify a lead Provider or care team to confer with all providers responsible for a Member's care, and, in the absence of full health information technology capabilities, how Contractor implements a standardized approach to patient follow-up.

- How Contractor works with Providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific community based organizations, community based mental health services, DHS Medicaid-funded LTC services and mental health crisis management services.

  IHN-CCO is requesting to to deploy SBIRT in mental health clinics to assure evidence-based screening and motivational intervention. We request permission to report SBIRT services by mental health providers and chemical dependency providers using the same codes (99420, 99408/9) as those allowed in medical settings. This will allow universal screening and consistent metrics for accountability.

- How Contractor develops culturally and linguistically appropriate tools for provider use to assist in the education of Members about care coordination and the responsibilities of each in the process of communication.

- How Contractor meets OHA goals and expectations for coordination of care for individuals receiving DHS Medicaid-funded LTC services given the exclusion of Medicaid funded long term services from Contractor's global budget.

- How Contractor meets OHA goals and expectations for coordination of care for individuals receiving both Medicaid-funded and non-Medicaid-funded residential addictions and mental health services given the initial exclusion of these services from Contractor's global budget.

- How the contractor coordinates with the state institutions and other mental health hospital settings to facilitate incoming Member's transition into the most appropriate, independent, and integrated community-based settings.

Contractor demonstrates the methods and means by which Contractor utilizes evidence-based or innovative strategies within Contractor's delivery system networks to ensure coordinated care, especially for Members with intensive care coordination health, including members with severe and persistent mental illness receiving home and community based services under the State's 1915(i) State Plan Amendment, as follows:

- *Assignment of responsibility and accountability:* Contractor demonstrates that each Member has a primary care Provider or primary care team that is responsible for coordination of care and transitions.

- *Individual care plans:* Contractor uses individualized care plans to the extent feasible to address the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with intensive care coordination health. Plans reflect Member, Family or caregiver preferences and goals to ensure engagement and satisfaction.

- *Communication*: Contractor demonstrates that Providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with Members and their Families, extended family, kinship networks or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record (EHR) capabilities, etc.).

Contractor develops a coordinated and integrated delivery system Provider Network that demonstrates communication, collaboration and shared decision making across the various providers and care settings. Contractor demonstrates, over time:

- How Contractor ensures a network of Providers to serve Members' health care and service health, meet access-to-care standards, and allow for appropriate choice for Members. Services and supports are geographically as close to where Members reside as possible and, to the extent necessary, offered in nontraditional integrated settings that are accessible to families, socially, culturally, and linguistically diverse communities, and underserved populations.

- How Contractor builds on existing Provider Networks and transforms them into a cohesive network of providers, including how it arranges for services with providers external to

Contractor's service area, to ensure access to a full range of services to accommodate Member health.

- How it works to develop formal relationships with providers, community health partners, including culturally and socially diverse community based organizations and service providers, and state and local government support services in its service area(s), and how Contractor participates in the development of coordination agreements between those groups. IHN-CCO plans to utilize a number of tools to develop formal relationships with stakeholders, such as subcontracting or executing memourandum of understanding (MOU).

c. Care Integration

- *Mental Health and Chemical Dependency Treatment:* Outpatient mental health and chemical dependency treatment are integrated in the person-centered care model and delivered through and coordinated with physical health care services by Contractor.

- *Oral Health:* By July 1, 2014, Contractor will have a formal contractual relationship with any DCO that serves Members of Contractor in the area where they reside.

- *Hospital and Specialty Services:* Contractor provides adequate, timely and appropriate access to hospital and specialty services. Hospital and specialty service agreements are established that include the role of patient-centered primary care homes and that specify: processes for requesting hospital admission or specialty services and performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. Contractor demonstrates how hospitals and specialty services are accountable to achieve successful transitions of care. Contractor transitions Members out of hospital settings into the most appropriate, independent, and integrated community-based settings.

3. Delivery System Dependencies

a. Shared Accountability for DHS Medicaid-funded Long-term Care Services

DHS Medicaid-funded LTC services are legislatively excluded in HB 3650 from CCO global budgets and will be paid for directly by the Department of Human Services, creating the possibility of misaligned incentives and cost-shifting between Contractor and the DHS Medicaid-funded LTC system. Cost-shifting is a sign that the best care for a beneficiary's health is not being provided. In order to prevent cost-shifting and ensure shared responsibility for delivering high quality, culturally and linguistically appropriate person-centered care, Contractor and the DHS Medicaid-funded LTC system share accountability, including financial accountability.

A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the Contractor and/or to the DHS Medicaid-funded LTC system in its Service Area. Other elements of shared accountability between Contractor and the DHS Medicaid-funded LTC system in its Service Area will include contractual elements such as specific requirements for coordination between the two systems; requirements to clearly define roles and responsibilities between the two systems, through a memorandum of

understanding, a contract, or other mechanism; and reporting of metrics related to better coordination between the two systems.

Further, since individuals receiving DHS Medicaid-funded LTC services and supports represent a significant population served by Contractor, Contractor includes these individuals and the DHS Medicaid-funded LTC delivery system in its Service Area in the community health assessment processes and policy development structure

b. Intensive Care Coordination for Special Health Members

(1) Contractor prioritizes working with Members who have chronic health care diagnoses, multiple chronic conditions, mental illness or chemical dependency and communities experiencing health disparities (as identified in the community health assessment) and involves those Members in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.

(2) Contractor provides intensive care coordination or Case Management Services to Members who are aged, blind, disabled or who have complex medical health consistent with ORS 414.712, including Members with mental illness and Members with severe and persistent mental illness receiving home and community based services under the State's 1915(i) SPA.

(3) Contractor implements procedures to share the results of its identification and Assessment of any Member identified as aged, blind, disabled (including mental illness or substance abuse disorders) or having complex medical health with Participating Providers serving the Member so that those activities need not be duplicated. Contractor creates the procedures and shares information under ORS 414.679 in compliance with the confidentiality requirements of the Contract.

(4) Contractor establishes policies and procedures, including a standing referral process for direct access of specialists, in place for identifying, assessing and producing a treatment plan for each Member identified as having a special healthcare need. Each treatment plan is:

(a) Developed by the Member's designated practitioner with the Member's participation;

(b) Includes consultation with any specialist caring for the Member;

(c) Approved by the Contractor in a timely manner, if this approval is required; and

(d) In accordance with any applicable State quality assurance and utilization review standards.

c. State and Local Government Agencies and Community Social and Support Services Organizations

Contractor promotes communication and coordination with state and local government agencies and culturally diverse community social and support services organizations, including early child education, special education, behavioral health and public health, as critical for the development

and operation of an effective Delivery System Network (DSN). Contractor consults and collaborates with Contractor DSN Providers to maximize Provider awareness of available resources for different Members' health, and to assist DSN Providers to be able to make referrals to the appropriate providers or organizations. The assistance that Contractor provides to DSN Providers in making referrals to State and local governments and to community social and support services organizations takes into account the following referral and service delivery factors:

d. Cooperation with Dental Care Organizations

Contractor coordinates preauthorization and related services with DCOs to ensure the provision of dental care that is required to be performed in an outpatient hospital or ambulatory surgical setting due to the age, disability, or medical condition of the Member.

e. Cooperation with Residential, Nursing Facilities, Foster Care & Group Homes

Contractor arranges to provide medication that is part of Capitated Services to nursing or residential facility and group or foster home residents in a format that is reasonable for the facility's delivery, dosage and packaging requirements and Oregon law.

C. Accountability

Part 1 - Quality and Performance Outcomes and Accountability

1. Quality and Performance Outcomes

As required by Health System Transformation, Contractor is held accountable for its performance on outcomes, quality, and efficiency measures it created and as incorporated into the Contract, with the exception of ethnicity data for years 1-3. Accountability metrics function both as an assurance that Contractor is providing quality care for all of its Members and as an incentive to encourage Contractor to transform care delivery in alignment with the goals of Health System Transformation. Further, Members and the public know about the quality and efficiency of their health care so metrics of outcomes, quality and efficiency are publicly reported. Health care transparency provides consumers with the information necessary to make informed choices and allows the community to monitor the performance of Contractor.

Contractor works toward implementing data reporting systems necessary to timely submit claims data to the All Payer All Claims data system in accordance with ORS 414.625, and the requirements of ORS 442.464 to 442.466. Contractor will assess data reporting systems in Year1 and report annually to OHA progress and milestones.

2. Quality Assurance and Improvement

Contractor implements quality assurance and improvement measures demonstrating the methods and means by which Contractor carries out planned or established mechanisms for:

a. Establishing a complaint, Grievance and Appeals resolution process, including how that process is communicated to Members and providers;

b. Establishing and supporting an internal Quality Improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops; and

c. Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.

3. Measurement and reporting requirements

Contractor plans and implements the necessary organizational infrastructure to address performance standards established for the Contract.

a. In the first year, accountability is for reporting only.

b. In future years, Contractor may be accountable for meeting specified performance benchmarks (see accountability standards below), specifically: to meet or exceed minimum performance expectations set for core measures and to improve on past year performance for transformational measures (see below for description of care and transformational categories).

c. Initially, "reporting year" is based on the effective date of each the contract, with year 1 running August 2012 through December 2013.

d. Performance relative to targets affects Contractor's eligibility for financial and non-financial rewards. Contractor's performance with respect to minimum expectations is assessed as part of OHA monitoring and oversight. Initially, monitoring and oversight is aimed at root cause analysis and assisting Contactor in developing improvement strategies; continued subpar performance leads to progressive remediation established in the Contract, including increased frequency of monitoring, Corrective Action Plans, Enrollment restrictions, financial and non-financial sanctions, and ultimately, non-renewal of contracts.

e. OHA will work closely with contractor and its Metrics and Scoring Committee to assist in building measure specifications and establishing performance targets for year 2 forward. The Committee will also advise OHA annually on adopting, retiring, or re-categorizing Contractors performance measures, based on evaluation of the metrics' appropriateness and effectiveness.

f. Annual reporting serves as the basis for holding Contractor accountable to contractual expectations; however, OHA assesses performance more frequently (e.g. quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement recommendations to Contractor. The parties document any changes agreed to during these informal procedures.

g. The performance measures reporting requirements measure the quality of health care and services during a time period in which Contractor was providing Coordinated Care Services. The performance measures reporting requirements expressly survive the expiration, termination or amendment of the Contract, even if Contract expiration, termination or amendment results in a termination, modification or reduction of the Contract or the Contractor's Enrollment or service area.

h. Contractor includes any additional measures requested by CMS from its Adult Medicaid and CHIPRA core measure sets as CCO accountability measures.

4. Specific areas of CCO accountability metrics

Contractor is accountable for both core and transformational measures of quality and outcomes:

a. Core measures are triple-aim oriented measures that gauge Contractor performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. The measures are uniform across CCOs and encompass the range of services included in CCO global budgets (e.g. behavioral health, hospital care, women's health, etc.).

b. Transformational metrics assess Contractor progress toward the broad goals of Health System Transformation and therefore require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which Contractor may have less measurement experience) or indicators that entail collaboration with other care partners.

c. Accountability metrics that are applicable in Year 1 of this Contract are found at in RFA Table C-1.