ATTACHMENT 1 – Application Cover Sheet
Applicant Information - RFA # 3402

Applicant Name: Tri-County Medicaid Collaborative

Form of Legal Entity (business corporation, etc.): Nonprofit 501(c)(3)

State of domicile: Oregon

Primary Contact Person: Janet Meyer Title: Interim CEO

Address: 315 SW 5th Ave, Suite 900

City, State, Zip: Portland, OR 97204

Telephone: 503-449-3698 / 503-416-1798 Fax:

E-mail Address: janet@tricountycollaborative.org

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

Name: Janet Meyer Title: Interim CEO

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: Title: Interim CEO Date: 4/30/12

(Authorized to Bind Applicant)

Applicant Name: Tri-County Medicaid Collaborative

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 • Outcomes and evaluation • Performance measurement • Health management and care coordination activities • System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO • Mental health and addictions coordination and system management • Communications management to providers and Members • Provider relations and network management, including credentialing • Health information technology and medical records • Privacy officer • Compliance officer	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			X	The appropriate collection point

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
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.				for race, ethnicity and language data is at the point the member is accessing services. Primary care providers are in the best position to capture and report this information accurately. Pending implementation of effective Health Information Exchange technology, NewCo will rely on race, ethnicity and language data from OHA Enrollment Files.

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 payments to providers, and limits on physician incentive plans.	X			
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	Yes	No	Yes, Qualified	Explanation if No or Qualified
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 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			
Attestation B-11. Applicant will establish policies, procedures, and standards that:	X			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
• 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.				
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 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	TCMC interprets this attestation to exclude financial audits, corrective action plans, recoupments, or issues related to OHP payment reconciliation due to MMIS error.

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 compliance. [See 42 CFR 438.208 and OAR 410-141-3160]	X			
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			

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 CFR 438.206 to 438.210; and OAR 410-141-3220]	X			
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 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]	X			
Assurance B-11. Applicant will maintain an efficient and accurate billing and	X			

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]				
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 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]	X			
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			The Tri County Medicaid Collaborative intends to execute a Management Services Agreement with Care Oregon and/or other entities to perform, implement, or operate all or a portion of the CCO operations. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.
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			The Tri County Medicaid Collaborative intends to execute a Management Services Agreement with Care Oregon and/or other entities to manage all or a portion of the staffing needs with regards to the operation of the CCO program. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.

Informational Representation	Yes	No	Yes, Qualified	Explanation
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			The Tri County Medicaid Collaborative intends to execute a Management Services Agreement with Care Oregon and/or other entities to perform all or a portion of information technology to operate the CCO program. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.
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			The Tri County Medicaid Collaborative intends to contract with downstream entities to perform all or a portion of the claims administration, processing, and/or adjudication functions. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.

Informational Representation	Yes	No	Yes, Qualified	Explanation
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			The Tri County Medicaid Collaborative intends to execute a Management Services Agreement with CareOregon and downstream entities to perform all or a portion of the Enrollment, Disenrollment, and membership functions. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.
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			The Tri County Medicaid Collaborative intends to contract with downstream entities to perform all or a portion of the credentialing functions. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.
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			The Tri County Medicaid Collaborative intends to contract with downstream entities to perform all or a portion of the utilization operations management. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.

Informational Representation	Yes	No	Yes, Qualified	Explanation
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			The Tri County Medicaid Collaborative intends to contract with downstream entities to perform all or a portion of the Quality Improvement operations. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.
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			The Tri County Medicaid Collaborative intends to contract with downstream entities to perform all or a portion of the call center operations. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.
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			The Tri County Medicaid Collaborative intends to execute a Management Services Agreement with Care Oregon and/or other entities to perform all or a portion of the financial services. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.

Informational Representation	Yes	No	Yes, Qualified	Explanation
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			The Tri County Medicaid Collaborative intends to execute a Management Services Agreement with Care Oregon and/or other entities to perform all or a portion of the services that are not listed. All Management Services Agreements and contracts with downstream entities will be monitored for compliance by the Tri County Medicaid Collaborative.

(Applicant Authorized Officer)
Signature: _____ Title: Interim CEO Date: 4/30/12

1. Technical Application, Mandatory Submission Materials

- ✓ a. Application Cover Sheet (Attachment 1)
- ✓ b. Attestations, Assurances and Representations (Attachment 6)
- ✓ c. This Technical Application Checklist
- ✓ d. Letters of Support from Key Community Stakeholders
- ✓ e. Résumés for Key Leadership Personnel
- ✓ f. Organizational Chart
- ✓ g. Services Area Request (Appendix B)
- ✓ h. Questionnaires
- ✓ (1) CCO Criteria Questionnaire (Appendix A)
- ✓ (2) Provider Participation and Operations Questionnaire (Appendix B)
  - Services Area Table (Readiness Review)
  - Publicly Funded Health Care and Service Programs Table (Readiness Review)
- ✓ (3) Accountability Questionnaire (Appendix C)
- ✓ (4) Medicare/Medicaid Alignment Demonstration Questionnaire (Appendix D)

2. Technical Application, Optional Submission Materials

- ☐ a. Transformation Scope Elements (Appendix H)
- ☐ b. Applicant's Designation of Confidential Materials (Attachment 2)

Letters of Support Summary

1. African American Health Coalition Letter of Support
2. AOCMHP Letter of Support
3. Cascade Aids Project Letter of Support
4. Centro Cultural Letter of Support
5. Children's Health Alliance Letter of Support
6. Clackamas Co Public Health and Mental Health Letter of Support
7. Clackamas Community College Letter of Support
8. Multi Care Dental Letter of Support
9. Multnomah Department of County Human Services DCHS Letter of Support
10. Multnomah County ADSD CCO Letter of Support
11. Multnomah County Public Health Letter of Support
12. NAMI Letter of Support
13. NAYA Letter of Support
14. Northwest Heath Foundation Letter of Support
15. OAFP Letter of Support
16. Oregon Business Council Letter of Support
17. Oregon Health Leadership Council Letter of Support
18. Oregon Pediatric Improvement Partnership Letter of Support
19. Oregon Primary Care Association Letter of Support
20. Outside In Letter of Support
21. Planned Parenthood Letter of Support
22. Project Access Now Letter of Support
23. TCMC Executive Committee Letter of Support
24. Urban League Letter of Support
25. Virginia Garcia Letter of Support
26. Wallace Medical Concern Letter of Support
27. Washington County Local Mental Health Authority Letter of Support
28. Washington County Public Health Authority Letter of Support
29. We Can Do Better Letter of Support
30. Women's Healthcare Associates Letter of Support

EXPERIENCE

Tri-County Medicaid Collaborative, Portland, OR March 2011-Present
Interim Chief Executive Officer

- Serving as Interim Chief Executive Officer of the Tri-County Medicaid Collaborative responsible for leading the management and start-up of this Tri-County CCO.

Tuality Health Alliance, Portland, OR
Chief Operating Officer 2006-March 2011

- Responsible for the development, implementation and on-going management of comprehensive strategies to support current and future market opportunities for the Physician Hospital Organization.
- Develops and manages all contracting relationships with major payers, individuals, and provider networks as they relate to Tuality.
- Responsible for the oversight and coordination of all Health Plan operations for Oregon Health Plan contract including Medical Management, Quality Improvement, Claims, Customer Service, Provider Relations, and Compliance.
- Works collaboratively with leadership and managed care organizations to develop programs to enhance quality and clinical integration in the organization and to develop programs.
- Responsible for the oversight and management of Hospital Case Management and Utilization Review.
- Oversees Third Party Administrator functions for self-insured Tuality Employee Health Plan.

FamilyCare, Inc., Portland, OR 2003-2006
Director of Business Development January 2006-June 2006

- Lead continuing development and expansion of existing product array.
- Identified and developed new business opportunities.
- Provided leadership and contract management with state and federal entities across four products.
- Directed, administered and coordinated company operations for Contracting & Provider Relations and Sales & Marketing.

Director of Operations January 2003-December 2005

- Provided leadership to direct, administer and coordinate company operations at the health plan level including Claims, Customer Service, Medical Management, Contracting & Provider Relations, Sales & Marketing, Information Technology, and Quality Assurance.
- Provided leadership to direct, administer and coordinate Clinic Operations.
- Lead first product diversification initiative in corporate history with successful roll out of a Medicare Advantage product in 2005.
- Ensured all organizational activities and operations were carried out in support of corporate strategic goals and consistent with local, state, and federal regulations and laws governing business operations.
- Provided day-to-day leadership for all managers and staff reflecting the mission and values of the company and ensured successful achievement of all company intended results within the Operations Department.

All Women's Health Services, Portland, OR 1998-2002 (part-time)

- Assisted Executive Director with management of accounts receivable, fee schedules and pricing policies, managed care contracts, credentialing, and business development for non-profit clinic.

United HealthCare/MetLife, Portland, OR
Manager, Provider Relations & Contracting 1993-1996

- Managed pricing arrangements, developed and implemented dynamic and effective provider education programs, and implemented a fully functioning physician credentialing program.
- Represented Provider Network Department as a member of the Marketing and Sales Presentation Team. C
- Completed multiple service area expansions and provider network expansions.

Aetna Health Plans, Denver, Colorado 1989-1993
Senior Contractor 1991-1993

- Negotiated, administered, and renewed contractual relationships with 1,200 physician and 11 hospitals. Supervised development and implementation of full ancillary and physician network to serve expanded service area.
- Served as lead provider network representative for Field Office's sole jumbo national account helping to ensure customer retention.

Financial Analyst 1989-1991

- Reporting to the Executive Director, provided information analysis, reporting and project management support for all aspects of managed care business.

EDUCATION

M.H.A. Health & Hospital Administration
1989 University of Michigan Ann Arbor, MI

B.S. Public Administration
1985 University of Oregon Eugene, OR

EXPERIENCE

Tri-County Medicaid Collaborative, Portland, OR March 2011-Present
Interim Chief Medical Officer

- Serving as Interim Chief Executive Officer of the Tri-County Medicaid Collaborative responsible for the Model of Care initiatives, Clinical Advisory Panel, and Service Delivery Modernization.

CareOregon, Portland, OR
Director of Clinical Support and Innovation 2000-March 2011

- Major focus areas: development of CareOregon's Complex Care Case Management Program, CareSupport; development of delivery system improvement program, Care Support and System Innovation (CSSI)
- Lead for the "Primary Care Renewal" primary care home network collaborative (2007-present).
- Led restructuring of pharmacy, hospital utilization review and DME programs as part of health plan financial turnaround (2003-4).
- Led expansion from safety net provider network to broad community provider network (2000-01.
- Lead for CareOregon as initial participant in the IHI Triple Aim Initiative; IHI Triple Aim Faculty presenting seminars and webinar series.

Oregon Health and Sciences University (OHSU), Portland, OR 1995-2003
Associate Director, OHSU Integrated Primary Care Organization 1999-2003
Medical Director, OHSU Health Center - Sellwood Moreland 1995-2001

- Oversight of internal medicine and pediatric primary care practices; opened / reorganized community clinics
- Created Quality committee, care standards and web based registry tools.
- Practiced Internal Medicine 60 –70% time.

Cook County Bureau of Health Services, Chicago, Illinois 1993-1995
Medical Director, John Sengstacke Ambulatory Care Center March 1994-March 1995

- Oversight of multispecialty clinic serving uninsured and Medicaid population

Senior Physician, Provident Hospital of Cook County September 1993-March 1995

- Helped open the newly rebuilt Chicago South Side Hospital.
- Director of Provident HIV Program.
- Preceptor for Internal Medicine Residents from Cook County Hospital.

EDUCATION

Board Certified in Internal Medicine 1993; Recertified 2003

Residency, Internal Medicine, Oregon Health Sciences University 1990-93

M.D.
1990 Indiana University School of Medicine IN

Ph.D. Cultural Anthropology
1972 University of Chicago Chicago, IL

B.A.
1966 Reed College Portland, OR

POLICY COMMITTEES

Member and Chair Oregon Health Resources Commission Subcommittee on Long-Acting OPIOID Analgesics for Non-Cancer Pain Opioid Taskforce May-June 2002

Co Chair Project Prevention! Task Force (OMAP) 2002-2004

Commissioner, Oregon Patient Safety Commission October 2008-present

National Advisory Board Member, The Practice Change Fellows Program 2008-present

Co Chair Evidence Based Practice Committee, Health Leadership Taskforce June 2009-present

Patient Centered Primary Care Home Standards Advisory Committee, State of Oregon Office for Oregon Health Policy and Research (OHPR) November 2009-January 2010

Co Chair Patient Centered Primary Care Home Pediatrics Standards Advisory Committee, OHPR August 2010-November 2010

Oregon Health Policy Board, Health Incentives and Outcomes Committee March 2010-November 2012

GRANTS

Principle Investigator, Robert Wood Johnson Foundation, "Depression in Primary Care:Linking Clinical and Systems Strategies." Duration: April 1, 2003-March 31, 2005.
Grant Award: $549,457.

Grant Project Lead, Center for Health Care Strategies, Best Clinical and Administrative Practices (BCAP), Achieving Better Care for Asthma April 2001-2002

Grant Project Lead, Center for Health Care Strategies, Best Clinical and Administrative Practices (BCAP), Improving Care for Adults with Chronic Illnesses and Disabilities, April 2003-2004.

Principle Investigator, Center for Health Care Strategies, Business Case for Quality, "Managing Complex Care" Grant, May 2004 – December 2006. Grant Award: $50,000.

Grant Project Lead, Center for Health Care Strategies, Business Case for Quality,

"Medicaid Value Program- Improving Care for Consumers with Multiple Conditions" Grant, October 2005 – 2007

Regional Co Executive Director, Clinical Lead, Commonwealth Fund Safety Net Medical Home Initiative, July 2009 – June 2013

EXPERIENCE

Tri-County Medicaid Collaborative, Portland, OR October 2011-Present
Interim Chief Operating Officer

- Serving as Interim Chief Operating Officer of the Tri-County Medicaid Collaborative responsible for Business Planning, Governance and Compliance, Human Resources, and Provider Networking.

Legacy Health, Portland, OR
Program Director, Health Care Transformation October 2011-Present

- Care Transformation Program Director for Legacy Health with overall responsibility for Portland Coordinated Care Organization development, payor models, and healthcare reform initiatives. Served as overall Project Director of the Tri-County Medicaid Collaborative.

Acting Vice President, Legacy Health Information Services April 2010-Septemer 2011

- Acting Vice President of Legacy Health Information Services with overall responsibility for system-wide implementation of Epic EHR. Project rollout schedule involves 5 hospital implementations and over 40 ambulatory clinic implementations and includes 14 clinical modules and 7 revenue cycle modules.

Director, Inpatient Medicine Service/Medical Multispecialty Clinics April 2008-March 2010

- Administrative director of inpatient and outpatient internal medicine service with oversight of 76 employed physicians and 16 staff including 2 outpatient clinics. Specialties include hospitalists, geriatric hospitalists, intensivists, palliative care, pulmonology, sleep, and EP cardiology. Responsibilities include strategic planning, business development, process improvements, budgeting and forecasting, financial analysis, recruiting and retention, reporting, and compensation plan development and administration.

Director, Inpatient Medicine Service/Primary Care Clinics April 2006-March 2008

- Administrative director of inpatient and outpatient internal medicine service with oversight of employed physicians and staff including 3 outpatient primary care clinics. Specialties included hospitalists, geriatric hospitalists, intensivists, palliative care, and primary care. Responsibilities included strategic planning, business development, process improvements, budgeting and forecasting, financial analysis, recruiting and retention, reporting, and compensation plan development and administration.

Manager, Legacy Inpatient Medicine Service April 2005-March 2006

- Manager of inpatient internal medicine service with oversight of employed physicians and staff. Specialties included hospitalists, geriatric hospitalists, intensivists, and palliative care. Responsibilities included strategic planning, business development, process improvements, budgeting and forecasting, financial analysis, recruiting, reporting, and compensation plan development and administration.

Senior Financial Analyst, Legacy Medical Group May 2004-March 2005

- Senior financial analyst supporting employed physician medical group. Responsibilities included development of financial analysis, reporting, budgeting and forecasting, compensation plan development and administration, and data analysis.

Imark Communications, Portland, OR
Finance Director, Technology Tradeshow Division April 2000-April 2004

- Finance director for a start-up marketing firm that produced technology tradeshows. Responsibilities included development of financial analysis, reporting, budgeting and forecasting, compensation plan development and administration, and data analysis.

Arthur Andersen LLC, San Francisco, CA
Senior Consultant, Healthcare Business Consulting June 1998-March 2000

- Senior consultant for healthcare business consulting practice. Project work included development of financial analysis, financial feasibility studies, mergers and acquisitions, and data analysis.

EDUCATION

Masters in Healthcare Administration
June 1998 University of Pittsburgh Pittsburgh, PA

Masters in Business Administration
June 1998 University of Pittsburgh Pittsburgh, PA

B.S. in Health Policy Administration with Minor in Business
May 1996 Penn State University State College, PA

PROFESSIONAL AFFILIATIONS AND ACTIVITIES

Faculty Member
Pacific University of Oregon Masters of Healthcare Administration Program

Fellow (ACHE)
American College of Healthcare Executives

Volunteer
Start Making A Reader Today Program

EXPERIENCE

Tri-County Medicaid Collaborative, Portland, OR April 2012-Present
Interim Chief Information Officer

- Serving as Interim Chief Information Officer of the Tri-County Medicaid Collaborative responsible for Business and Information Technology.

Press Ganey Associates, Portland, OR 2010-April 2012
VP, Product Management / Development

- Member of the senior management team responsible for product strategy formation and execution regarding Press Ganey's Improvement Portal, electronic data interchange (EDI) platform, and ambulatory care-focused provider performance measurement, analysis, and reporting solution.
- Formalized the role of Product Management and propagated consistent Agile Scrum product development methodology across multiple geographically dispersed locations.
- Led 60 geographically dispersed software development, quality assurance, and product management professionals in the most ambitious software development initiative in the company's history: architecting, designing, developing, and successful delivering Press Ganey's web-based Improvement Portal used by 41,000 unique end-users.
- Established the Portland office and hired 19 software development, quality assurance, and product management professionals within the nine months and led them and a related cross-functional team in architecting, designing, developing an electronic data interchange (EDI) platform supportive of HL7, x12N, and proprietary data formats and an ambulatory care-focused performance measurement, analysis, and reporting solution.
- Negotiated and established two technology partnerships.

iGrafx, a division of Corel, Inc., Portland, OR 2008-2010
VP, Marketing

- Responsible for all facets of marketing iGrafx's comprehensive business process analysis (BPA) solution.
- Repositioned iGrafx's solution; revised existing and produced new, creative marketing collateral including FLASH-based overview movie, complementary product demonstration, and compelling case studies; launched iGrafx 2009 major release.
- Revised iGrafx's product vision and related strategy to broaden its applicability to cross-functional stakeholders.
- Designed and launched new online User Forum fueling active and increasing participation.

WebMD Health Corporation, Portland, OR 2004-2008
Director, Product Management / Product Marketing

- Responsible for defining and continuously refining the product vision regarding WebMD's ASP-deployed, consumer-facing Health and Benefits Manager web portal.
- Accountable for the successful execution of the product strategy and effective packaging, pricing, positioning, and promotion of the portal and related services.
- Revised and evolved product strategy around consumer-directed health care initiatives and imperatives characterizing the employer-funded U.S. Health Care marketplace.
- Executed key product integration strategies leveraging complementary 3rd party technologies and solutions acquired through merger and acquisition or partnerships.
- Fostered key partnerships with large health plans, benefit outsourcers, distributors, and technology vendors and actively participated in strategic corporate acquisition activities.
- Grew and led a team of product managers and product marketing managers while simultaneously improving their stature and effectiveness within the organization.

Epicor Software Corporation, Tualitan, OR 2003
Senior Product Manager

- Responsible for product management and marketing activities regarding award-winning, Internet-based customer relationship management (CRM) software solutions aimed at small-to-medium sized businesses.
- Revised product strategies, defined multiple products' roadmaps, authored two product requirements documents, and successfully influenced executive management to pursue new, creative product, marketing, sales, partner, and development strategies.
- Presented new product strategies and related roadmaps.

Responsys Inc., Portland, OR 2001-2003
Director, Product Management / Product Marketing
Director, Engineering

- Responsible for all activities to create and enhance Internet-based ASP-deployed products and services aimed at marketers within Global 2000 B2B & B2C companies.
- Developed strategies for product integration, localization, deployment, and release to broaden market opportunities and revenue streams, enhance customer loyalty and increase rate of adoption.
- Fostered collaboration and communication among cross-functional stakeholders so that all components of each release were successfully delivered and well understood by internal and external stakeholders.

EDUCATION

B.S. in Computer Science with a minor in Business Administration
1984 *California State University* *Chico, CA*

WORK EXPERIENCE

Tri-County Medicaid Collaborative, Portland, OR March 2012-Present
Interim Chief Strategy Officer

- Serving as Interim Chief Strategy Officer of the Tri-County Medicaid Collaborative responsible for Communications, Change Management and Project Integration.

Multnomah County Health Department, Portland, OR
Policy Advisor, Office of the Director July 2010- March 2012

- Legislative and Policy Liaison from the Health Department to the Board of County Commissioners
- Build partnerships, convene working groups around a local community health response to state and national Health Care Reform with internal and external stakeholders
- Facilitate cross-departmental policy collaborative focused on the Public Health impacts of Land Use and Transportation, Housing and Climate Change

Senior Program Development Specialist, Environmental Health November 2008 –July 2010

- Public Information Officer
- Facilitated citizen advisory committee
- Developed interactive, web-based, environmental housing inspection referral program for medical providers who serve pediatric patients with uncontrolled asthma.
- Analyzed problem of low physician compliance with recommended pediatric lead screening protocols identified innovative solutions to increase lead screening and testing. Developed resource materials and model for pediatric clinicians to use in adopting or improving screening, testing in EPA grant-funded project.
- Supervised and mentored Health and Housing interns, with a focus on expanding the pool of exceptional and diverse entry-level public health employees.

Independent Grant Writing Consultant, Portland, OR November 2008 –January 2009

- Researched tribal methamphetamine epidemic and wrote grant applications on behalf of the Yurok tribe of Northern California to initiate Tribal Drug Court, expand child protection and domestic violence case management offered by existing tribal court.
- Total grant awards $525,00

Governor's Office of Rural Policy, State of Oregon November 2007 –June 2008
Rural Oregon Water and Wastewater Infrastructure Policy Analyst

- Conducted interviews with stakeholders about the needs and challenges of rural Oregonians to improve water infrastructure
- Developed policy paper with specific recommendations for short and long term solutions to close the gap between infrastructure needs and available financial resources

UNICEF, Suriname Country Office June –August 2007
Budget Analyst

- Conducted in-depth analysis of Ministry of Education budget 2004-2007
- Created instrument for citizen use to conduct child friendly analyses of social spending in Ministries of Health, Social Services & Education

United States Peace Corps, Suriname, South America 2002 - 2004
Non-Governmental Organization Management Volunteer

Stichting Maxi Linder HIV prevention and human rights advocacy for high risk groups, people living with HIV/AIDS at a community based organization for sex workers

EDUCATION

Harvard John F. Kennedy School of Government, Cambridge, MA *Master in Public Policy, 2008*
Policy Area of Concentration: Business and Government Policy
Coursework: Budgeting and Financial Management, Finance, Strategic Management of Non-Profit Organizations, Economic Analysis of Public Policy, Financial Management in Public and Not-for-Profit Organizations, Negotiations, Mobilizing Group Resources, Leadership on the Line, Management Finance and Regulation of Public Infrastructure, Industry Structure, Strategy and Public Policy, Food Policy and Agribusiness
Honors: Presidential Scholarship, Full tuition waiver and living stipend for outstanding leadership potential and commitment to public service
Activities: Global Health Professional Interest Council, Corporate Social Responsibility Council, Negotiations club

University of California, Santa Cruz, CA *Bachelor of Arts in Art History, 1998*
Honors: Departmental and Porter College honors. President's Undergraduate Fellowship (1997)

LEADERSHIP

Health Equity Lens/Budget Workgroup, Multnomah County Health Department 2010-2011
Equity Facilitator Group created a tool to aid Program Managers and their teams to reflect on the potential impact their program has on racial and ethnic communities most affected by health inequities, so that negative impacts can be mitigated and positive impacts can be enhanced.

Bridge Builders Conference, Harvard Kennedy School September 2006 – March 2007
Conference Organizer Wrote grant applications to bring 13 community organizers from developing countries to Harvard conference on social and economic development issues, facilitated panels of expert speakers.

Gender and Development Committee *Mi Kondre Makandra* Summer Camp, Surinam 2003 - 2004
Chairperson: Designed camp for 11-14 year-olds from rural Suriname to develop network of young leaders from different tribes, raised funds and facilitated meetings between leaders of civic society and youth groups

PRESENTATIONS

Klein R. **Funding water and wastewater infrastructure in rural Oregon: Leadership strategies to close the needs/resources gap.** American Public Health Association's Annual Meeting and Exposition, Philadelphia, PA (Poster Session, November 2009) & Oregon Public Health Association Annual Meeting and Conference, Corvallis, OR (Oral Session, October 2009)

Klein R. **Instrument for conducting a simple budget analysis in Suriname: a tool to measure results and enhance transparency.** (May 17, 2009). Oral session presented at the 2009 International Health Conference, Oregon State University, Corvallis, Oregon.

EXPERIENCE

Tri-County Medicaid Collaborative, Portland, OR March 2011-Present
Interim Chief Financial Officer

- Serving as Interim Chief Financial Officer of the Tri-County Medicaid Collaborative responsible for leading the financial management and controls of this Tri-County CCO.

Providence Health and Services, Portland, OR
Chief Financial Officer *December* 2010-March 2011

- Accountable for the financial health of the organization
- Contributes to the overall strategic planning and operational efficiencies
- Directly responsible for accounting and financial reporting, underwriting and risk management, provider contract administration and business analytics

Hometown Health, Reno, Nevada *May 2000-December 2010*
Chief Financial Officer
Hometown Health (Hometown) is a provider owned regional health plan that provides health insurance and health benefit administrative services to employers and individuals in Nevada. Hometown's parent organization, Renown Health (Renown), is a comprehensive integrated healthcare delivery system located in northern Nevada that includes hospitals, medical practices, and a host of outpatient ancillary services.

- Responsible for all of its financial operations
- Primary day-to-day duties included the oversight and management of the following areas:
  - Accounting,
  - Financial and operational reporting,
  - Underwriting and risk management,
  - Premium billing and enrollment services,
  - Actuarial and analytical review,
  - Provider contracting with affiliated organizations,
  - Regulatory compliance, and
  - Product development.

As a key member of Hometown's management team, Jeff was also responsible for strategic planning, membership growth, quality and service levels and project management.

John C. Lincoln Health Network, Phoenix, AZ 1996-2000
Director of Finance
John C. Lincoln Health Network is a not-for-profit healthcare organization that includes two hospitals, physician practices and a number of community programs for the residents of north Phoenix.

During the early stages of a period of considerable growth for Lincoln, the Director of Finance position was created specifically so that he could join Lincoln's management team and assist them with several critical projects that were expected to last three to four years. Significant projects included the following:

- The acquisition and integration of Phoenix General Hospital,
- The conversion of several of the Lincoln's core information and processing systems,
- The creation of a network of physician practices,

- The construction of several large health center facilities in north Phoenix,
- The development of Lincoln's compliance monitoring program, and
- The redevelopment of Lincoln's budgeting and forecasting system.

Arizona Healthcare Alliance (June 1996 – May 2002)
Financial Consultant
The Arizona Healthcare Alliance (Alliance) was a provider credentialing and contracting organization owned by five of the major hospital systems in the Phoenix area. The Alliance allowed smaller health insurance companies and self-funded employers to contract with a network of physicians, hospitals and other healthcare providers through one organization.

The Alliance was dissolved in May 2002. This was a part-time after-hours position partially related to Jeff's work at Lincoln and overlaps with his experience at Lincoln and Hometown. After several years of considerable losses the Alliance was dramatically reorganized and Jeff was asked to provide financial consulting services to the reorganized company. His responsibilities included all of the accounting and financial reporting as well as consultations on financial and contractual issues.

Arthur Andersen, Phoenix, AZ 1991-1996
Auditor / Consultant

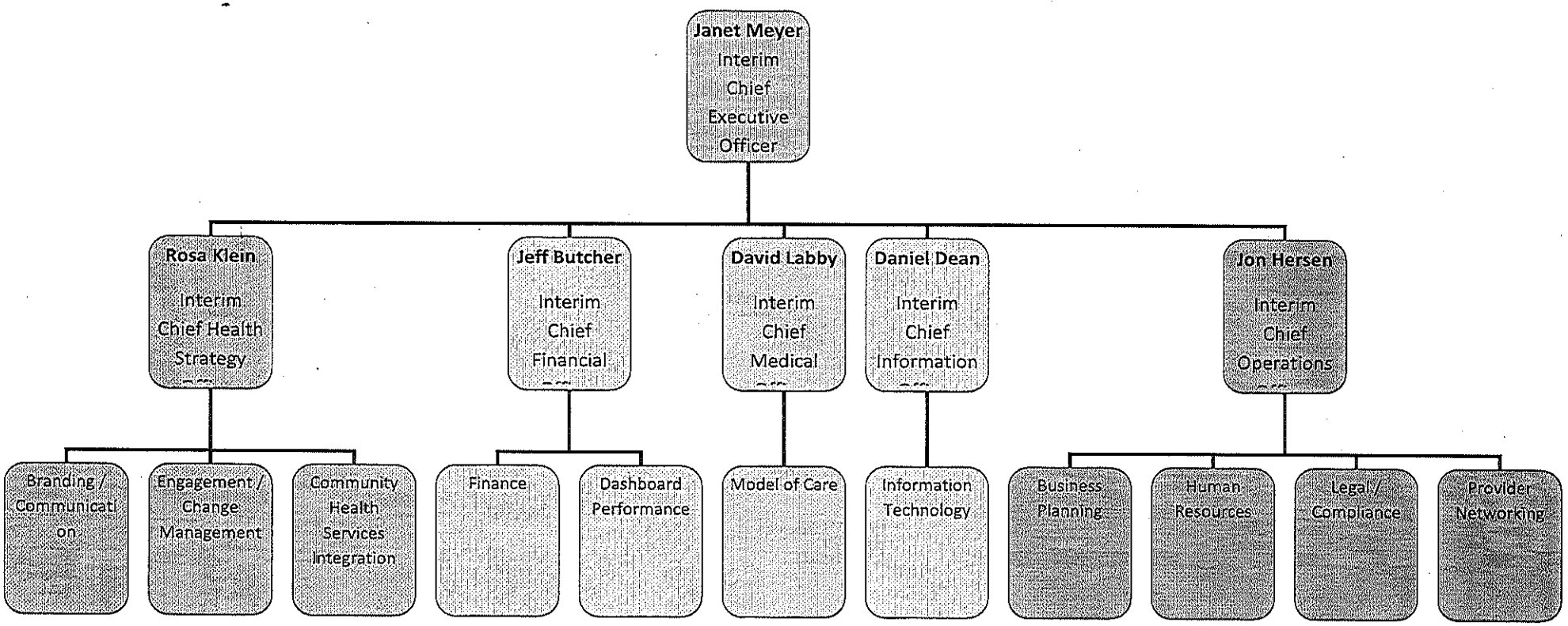
- Staff auditor in Andersen's Enterprise Group
- Join the Healthcare Consulting Group
- Managed audit and consulting engagements for a variety of organizations in Arizona, California, Colorado and New Mexico; the more noteworthy of which included the follow:
  - Four major hospital systems including their affiliated organizations,
  - Two health maintenance organizations,
  - A pharmaceutical distribution company, and
  - Several large physician practice organizations.

EDUCATION

B.S. Accounting
1990 Arizona State University Tempe, AZ

Certified Managed Care Executive (Fellow), Foundation for America's Health Insurance Plans

Tri-County Medicaid Collaborative Transition Leadership Team and Structure



Part I: Background Information about the Applicant

A.I.a Tri-County Medicaid Collaborative (TCMC) is a nonprofit, public benefit corporation domiciled in Oregon.

The TCMC emerged from a group of private and public organizations addressing a single, complicated question: Can we *together* improve the quality of care and the care experience of Oregon Health Plan (OHP) members, and do it for less money? For the last several months Tri-County Medicaid Collaborative's participating organizations have been exploring how to create a unified, regional system of care for the 216,000 Oregonians who receive services through the Oregon Health Plan in Clackamas, Multnomah, and Washington counties. The Tri-County Medicaid Collaborative's approach to partnering with communities to improve and coordinate services has emerged from hundreds of hours of work with local community members, behavioral health providers, primary care providers, social service agencies, community-based organizations, consumer groups, business groups, dental providers, health advocates, health insurers and the Oregon Health Authority. The Tri-County Medicaid Collaborative's CCO application is just the beginning of building a future system that is responsive and accountable to the community we all share. We are committed to engendering a healthy, thriving, engaged population; to eliminating health disparities; and to bending the cost curve so that we have the resources to cultivate healthy communities for generations to come.

A.I.b Applicant Affiliates are: Adventist Health, CareOregon, Clackamas County, Kaiser Foundation Health Plan of the Northwest, Legacy Health, Multnomah County, the Metro Area Community Health Centers, Oregon Health & Science University, Providence Health & Services, Tuality Healthcare, and Washington County.

A.I.c The intended effective date for serving Medicaid populations is August 1, 2012.

A.I.d TCMC is not invoking alternative dispute resolution with respect to any provider at this time.

A.I.e The TCMC intends to submit recommended changes to the Core Contract by June 1, 2012.

A.I.f Clackamas County Zip Codes: 97002, 97004, 97009, 97011, 97013, 97015, 97017, 97019, 97022, 97023, 97027, 97028, 97032, 97034, 97035, 97036, 97038, 97042, 97045, 97049, 97055, 97062, 97067, 97068, 97070, 97071, 97086, 97089, 97140, 97206, 97222, 97267, 97268, 97269, 97362, and 97375.

Multnomah County Zip Codes: 97010, 97014, 97019, 97024, 97030, 97035, 97056, 97060, 97080, 97133, 97201, 97202, 97203, 97204, 97205, 97206, 97207, 97208, 97209, 97210, 97211, 97212, 97213, 97214, 97215, 97216, 97217, 97218, 97219, 97220, 97221, 97227, 97228, 97229, 97230, 97231, 97232, 97233, 97236, 97238, 97239, 97240, 97242, 97256, 97258, 97266, 97280, 97282, 97283, 97286, 97290, 97292, 97293, 97294, and 97296.

Washington County Zip Codes: 97005, 97006, 97007, 97008, 97035, 97062, 97070, 97075, 97076, 97077, 97106, 97109, 97113, 97116, 97117, 97119, 97123, 97124, 97125, 97133, 97140, 97144, 97223, 97224, 97225, 97229, 97231, 97281, 97291, and 97298.

A.I.g TCMC's primary office and administration is located at 315 SW 5th Ave, Suite 300, Portland, OR, 97204.

A.I.h The service area is all of Clackamas, Multnomah and Washington Counties. All three county governments are active participants in the TCMC, and each has a seat on the TCMC Governing Board. TCMC will contract with Affiliate MHOs to ensure continuity of care for the individuals they serve and the behavioral health provider systems they support. TCMC contracts with the Counties will ensure accountability, agreed-upon outcomes, and critical expertise and services including Public Health and Type B Area Agencies on Aging and DHS Local Offices for APD.

A.I.i The legal entity that is TCMC is a new legal entity that has never entered into a contract with the OHA.

A.I.j None of the Affiliate MCOs has been purchased, merged, acquired or otherwise undergone any legal status change since October 1, 2011.

A.I.k The following TCMC Affiliate organizations have current MCO contracts with the OHA:

- Fully Capitated Health Plan – CareOregon, Providence, and Tuality
- Physician Care Organization – Kaiser Foundation Health Plan of the Northwest
- Mental Health Organization – Clackamas County, Multnomah County, and Washington County
- Dental Care Organization – N/A

A.I.l Each Affiliate MCO has a different overall service area in its current contract. All of them participate in all or part of the Clackamas, Multnomah, and Washington County service areas. This application or the resulting agreement with the OHA upon certification would establish a service area for the TCMC, but would not, necessarily, affect the service areas of the MCOs serving the Tri-County region.

A.I.m Current contracts include:

- Oregon Medical Insurance Pool – Kaiser, Providence
- Healthy Kids Connect – Kaiser
- Public Employees Benefit Board – Kaiser, Providence
- Oregon Educators Benefit Board – Kaiser, Providence
- Adult Mental Health Initiative – Clackamas, Multnomah, and Washington Counties
- Other – Clackamas, Multnomah and Washington Counties each have contracts for child mental health, as well as other additional services.

A.I.n The TCMC does not contract with CMS to carry Medicare Advantage. However, the following Affiliate organizations have a contract with CMS for Medicare Advantage: CareOregon, Kaiser Foundation Health Plan of the Northwest, and Providence.

A.I.o The following Affiliate organizations hold a certificate of insurance from DCBS: Health Plan of CareOregon, Inc., Kaiser Foundation Health Plan of the Northwest, and Providence.

A.I.p (1) **Development of alternative payment methodologies:**

Redaction cont'd.

A.I.p (1) Section Redacted

A.I.p (1) Section Redacted (cont)

A.I.p (2) **Coordinating delivery of physical, mental, addiction, oral, and LTC services**

During the early development of the TCMC, a workgroup was launched to develop an improved "Model of Care" including, at its core, expanded care coordination initiatives across delivery systems and provider types. Representatives from all Affiliates as well as a diverse array of nearly 35 different organizations, including providers, clients and advocates from physical health, mental health, addictions, community service agencies, and minority communities participated on the Model of Care Workgroup. The Model of Care attributes, including care coordination, were prioritized for TCMC implementation.

An integral component of care coordination is the implementation of a regional care coordination structure for the highest acuity Members using community outreach workers as part of multidisciplinary (medical, mental health, addictions) teams we call Interdisciplinary Community Care Teams (ICCTs). This ICCT proposal was modeled and included in the "Tri-County Health Commons" CMMI Innovation Challenge Grant proposal submitted by the TCMC to CMS in January, 2012.

As part of existing managed care contracts with the State, all TCMC Affiliate health plans actively engage in the coordination of Member services across physical, mental, and dental health plans. OHA-monitored Performance Improvement Projects continue to drive this transformation at the plan level.

The TCMC will work to establish standardized elements of behavioral health delivery model and minimum set of services available in primary care clinics. Additionally, TCMC will work to establish primary care providers on-site in community mental health centers that provide services to large numbers of people with serious mental illness. Finally, TCMC plans to incorporate peer wellness coaches in helping people with behavioral health needs to engage in wellness programs and activities.

A few examples of these kinds of efforts in which Affiliate organizations are already engaged:

- Verity has worked with CareOregon and Cascadia to place physical health providers in mental health facilities.
- Virginia Garcia, a key strategic partner of TCMC, has co-located behaviorists in their primary care teams for several years.
- Legacy Health's DePaul Treatment Center is working to augment the medical home model with behavioral and addictions support.

Care coordination for the highest need mentally ill children and adults is well developed within the County MHOs. Specialty care coordination programs assign a care coordinator to each identified individual. This coordinator works face to face with the Member, his or her family, and a natural support system in a person/family-driven manner to identify the unique needs of that individual or family in order to set up an individualized plan to address needs. Teams that include behavioral health providers, involved social service agencies, schools or other involved individuals identified by the member, are brought together and facilitated to develop these plans. The coordinator not only acts as an advocate and navigator but also is able to authorize and arrange for resources and support services to address psychosocial barriers to treatment success. Care coordination programs are intensive and focus on providing specialty services to particular populations:

- The Adult Mental Health Initiative (AMHI) focuses on adults with a severe and persistent mental illness who are in the state hospital or at high risk of needing state hospital level of care; and
- Children's Intensive Service Array/Wraparound focuses on children and adolescents who are involved in multiple systems and have serious functional impairments as a result of their mental illness.

All care coordination services emphasize supporting the individual to live successfully in the least restrictive setting and special emphasis is placed on movement out of residential and long term hospitalization.

TCMC will also be working with Multnomah County Aging and Disability Services, Clackamas County Aging & People with Disabilities and Washington County Aging & People with Disabilities to leverage their experience and capacity for care coordination in the delivery of LTC services. The ADS care managers conduct person centered option counseling with Medicaid recipients; assess the functional and financial status of the Member and work to align services and supports based on the desires of the Member. ADS care managers work to provide the most appropriate and the least restrictive long term care supports and services options. Nursing facility transition and diversions are also offered through ADS.

A.I.p (3) **Engaging community members and health care providers**

TCMC Affiliates have a long history of engaging with community leaders and agencies that serve or advocate on behalf of OHP Members to respond to community health needs. Affiliates address health disparities and health inequities by supporting interventions that occur outside of the clinical setting and engage with several advisory groups with membership from health care providers, community partners, allied agencies and family advocates that provide input on improving mental health services and addressing regional, cultural and socioeconomic needs of the population. The TCMC is a common system that enables these efforts to be better coordinated across our community.

The three counties work actively with local residents, consumers, and partners in designing the behavioral health systems of care. Counties host planning meetings or focus groups whenever the system of care is refined. Consumers and partners are closely involved in developing long-term strategic plans. Residents may also participate in one of several ongoing committees that guide county behavioral health policy and focus on continually improving the services available: there are committees for the children's system of care, the adult system of care, and quality management. The biennial plan required of all community mental health programs must be approved by the county's Adult Mental Health and Substance Abuse Advisory Committee (AMHSAAC) before it is accepted by the State.

Examples of community collaboration in population health and addressing health disparities include:

In Clackamas County –

- Launched Community Health Access Initiative (CHAI) in 2008 which brought funders and health organizations together to increase access to healthcare for low-income and vulnerable Clackamas County residents through public and private partnerships. The group regularly met for more than two years resulting in Project Access coming to the County and the opening of the Founder's clinic based on the Volunteers in Medicine model. (The VIM clinic is the third one of this kind in the state.)
- Work collaboratively with four school districts to support opening their school-based health centers (Canby, Milwaukie, Sandy, and Estacada)
- Initiated Dental Access workgroup, similar to CHAI, comprised of public and private entities as well as dental care organizations. The group has been working on increasing prevention and treatment access across the County.
- Increased focus on the Latino community through support services and hiring an outreach worker.
- In 2009-2010, Clackamas County pulled together a representative group of 20 community advisors for a comprehensive assessment using the Mobilizing for Action

through Planning and Partnerships (MAPP) tool. One outcome of that community engagement process was a commitment to fund local health improvement projects focused on healthy eating and active living. The 30 projects funded to date have leveraged additional in-kind and financial contributions throughout the county, while building community gardens, walking trails and new collaborations. The community health assessment was recently updated and about 30 community advisors are again developing a health improvement plan for Clackamas County.

In Multnomah County –

- The Protocol for Assessing Community Excellence in Environmental Health (PACE-EH) assessment, a community-driven process that identified geographic areas where people of color and or people in poverty are disproportionately exposed to environmental hazards;
- The Strategic Intent for Families and Young Children, a broad community assessment to identify disparities, gaps in services, and community need to provide the foundation for redesigning programs and services;
- The ongoing Health Equity Initiative, a program that has included wide-spread community dialogues and the development of policy initiatives to improve equity;
- Implementation of an Equity and Empowerment Lens for policy, budget, and programmatic decision-making;
- Verity administers a cultural competency assessment for all contracted mental health providers annually. Providers choosing not to participate or those without an 80% response rate must complete and submit cultural competency plans; and
- Ongoing coordination between clinical care providers and public health home visiting interventions focused on the most vulnerable families.

In Washington County –

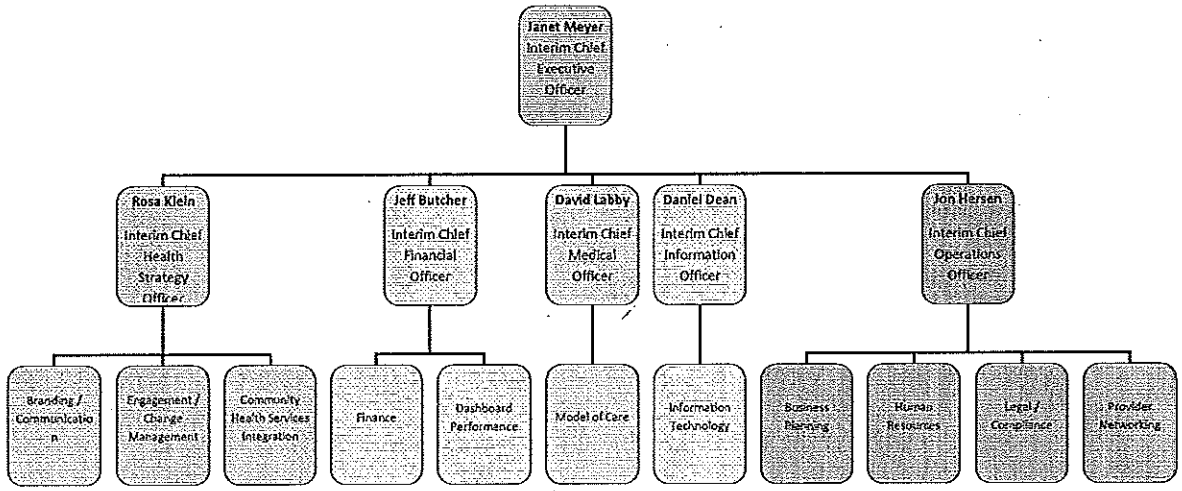
- The Cultural Competency Taskforce identifies and works to address barriers to individuals receiving mental health services. Efforts include improving competency in the use of interpreters, outreach to minority populations, improving the cultural awareness of the mental health providers.

TCMC Affiliate MHOs fund prevention and education programs through contracts with community organizations, and innovative program development by contracted mental health providers. These programs are primarily designed to meet the needs of priority populations including early childhood, parents of children with mental health needs, older adults, and individuals living in rural communities.

In 2010, in a regional effort to align work across organizations and achieve the greatest community health impact possible, TCMC Affiliate delivery systems and county governments came together to plan for an ongoing four-county community health needs assessment. This assessment and TCMCs participation in the CHNA is described in detail in section A.1.6

A.I.q See attached document (A-1) for Key Leadership Resumes.

A.I.r TCMC Organizational Chart



A.I.s TCMC will be deferring Tables B-1 and B-2 until its Readiness Review.

Part II: Community Engagement in Development of Application

A.II The planning process for TCMC has involved wide participation by the community through hundreds of hours of committee work and tactical groups to develop the Model of Care. Participants included individuals from 35 organizations, including: Oregon Center for Children and Youth with Special Health Needs, Virginia Garcia, Women's Health Alliance, Familias en Accion, Coalition of Communities of Color, Central City Concern, Coalition of Community Clinics, Cascadia Behavioral Health, Alliance of Culturally Specific Behavioral Health Providers and Lifeworks Northwest.

Additionally, TCMC has hosted a series of 3 stakeholder meetings to garner input from community leaders (total attendance 300), as well as two focus groups with randomly selected Oregon Health Plan Members in the region.

Finally, there has been extensive collaborative work by county health and human services staff from the three counties who engage in regular conversation to obtain direction from the county governing boards. This application is based on that planning process.

Section 1: Governance and Organizational Relationships

A.1.1 Governance

A.1.1.a In order to achieve the TCMC mission to be an integrated community health system that achieves better care, better health, and lower costs for the Medicaid population and the Tri-County community, the TCMC formed a nonprofit, public benefit corporation under ORS Chapter 65. The Corporation shall be organized and operated exclusively for religious,

charitable, scientific, literary, or educational purposes, within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986. The Corporation will have member organizations who qualify for membership in accordance with the Bylaws of the corporation.

The Board of Directors will consist of representatives of the following Affiliates: Adventist Health, CareOregon, Central City Concern, Clackamas County, Kaiser Foundation Health Plan of the Northwest, Legacy Health, Multnomah County, Oregon Health & Science University, Providence Health & Services, Tuality Healthcare, and Washington County. In addition, the Board of Directors will also include, but is not limited to, the following representatives: 2 physicians in active practice (1 in primary care and 1 in specialty care), 1 nurse or nurse practitioner in active practice in primary care, 1 behavioral health provider, 1 addiction services provider, 2 community-at-large members, the Community Advisory Council (CAC) Chair, and 1 dental care provider in active practice. It is expected that one or more of the health care providers in active practice on the board will also serve on the Clinical Advisory Panel (CAP).

Both the CAP and the CAC will advise and report directly to the Board of Directors.

A.1.1.b In order to achieve TCMC's goal of reducing health disparities in the Tri-County region, consumers and leaders from communities that historically have been disadvantaged by public policies and community investments or who have been inadequately served by the health care system will comprise the bulk of the Community Advisory Council. At least 51% of the CAC will be comprised of people who either are or have been enrolled in OHP, as required by statute. The CAC may include people who identify as: lesbian, gay, bisexual, or transgender; immigrants and refugees; people of color; disabled; elderly; people who have been incarcerated or otherwise institutionalized; children or representatives of children who have been wards of the state; people experiencing mental illness; and people in recovery from addiction.

Additionally, TCMC will seek representatives for the CAC from two types of local agencies: 1) those tasked with planning for population health needs such as local mental health and public health authorities, the local Commission on Children Families and Community (or the Early Learning Council Hub that replaces it); and 2) community agencies that serve or advocate on behalf of community members enrolled in OHP.

Nominations to the CAC will be solicited from the community at large, and submitted to the TCMC selection committee. The Chief Health Strategy Officer of TCMC will facilitate a CAC member selection committee composed of equal numbers of Board Directors and county representatives. The selection committee will also select the initial CAC Chair and Vice Chair, who will serve in those roles for one year, after which time the Chair and Vice Chair positions will be elected by majority vote of the full CAC. Members of the CAC will serve for a term of 3 years. The CAC Chair will also serve on the TCMC Board of Directors. To enhance communication between the CAC and the CAP, two members of the CAC will also be members of the CAP, one who is an OHP Member, and one who is a community agency representative. The CAC members will select members to participate on the CAP.

The CAC will meet no less than once every three months (but may meet more frequently), with subcommittees meeting as necessary to perform to the following duties:

a) Identifying and advocating for preventive care practices to be utilized by TCMC;

b) Maximizing engagement of those enrolled in OHP;

c) 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 TCMC. The activities, services and responsibilities defined in the plan may include, but are not limited to:

i. Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
ii. Health policy;
iii. System design;
iv. Outcome and quality improvement;
v. Integration of service delivery;
vi. Workforce development; and
vii. Annually publishing a report on the progress of the community health improvement plan.

The TCMC will establish a policy for reimbursing advisory group members, as appropriate, to mitigate barriers to participation (i.e., transportation to meetings, childcare).

A.1.1.c To facilitate transparency and accountability of CAC consideration of recommendations by the TCMC Board of Directors several steps will be established. First, as mandated by the legislation, the Chair of the CAC will have a seat on the TCMC Board of Directors. To ensure that the CAC is aligned with and able to advise the CAP, one member of the CAC will participate on the CAP. CAC members will elect the CAC Chair as well as those CAC members that also participate on the CAP.

As mentioned above, both the CAC and the CAP will report directly to the Board of Directors.

A.1.1.d The TCMC Governance Structure will reflect the needs of Members with severe and persistent mental illness and Members receiving DHS Medicaid-funded LTC (long term care) services and support in several ways.

First, representatives of Clackamas, Multnomah, and Washington Counties have participated on the TCMC Executive Steering Committee from its inception and will remain on the TCMC Board of Directors. In addition, numerous community-based organizations providing mental health and addiction services have participated in the Model of Care and Large Stakeholder Workgroups.

Crucial to TCMC's success is the support of and benefit from strong, efficient and effective public health, mental health and addictions systems. Skills, knowledge and expertise of county mental health programs, county public health departments, and local community-based organizations in addressing health disparities, providing preventive services, care coordination, and conducting community assessments is especially needed.

At startup, TCMC will contract with Affiliate MHOs to ensure continuity of care for the individuals they serve and the behavioral health provider systems they support. Counties and other community-based organizations will enter into agreements with TCMC to ensure accountability, agreed-upon outcomes, and critical expertise and services needed in this

area. TCMC is committed to supporting the Local Mental Health Authority financially in terms of delivery system and programmatic and supporting structures.

Second, in addition to mental health and addiction practitioners, the three county Affiliates will have membership on the Board of Directors, as well as representation on the CAC. Representation on both the Board of Directors and the CAC will ensure that the needs of Members with severe and persistent mental illness and Members receiving Medicaid-funded LTC services are met.

A.1.2 Clinical Advisory Panel

A.1.2.a A Clinical Advisory Panel (CAP) that will report directly to the Board of Directors will be established. One or more of the health care providers in active practice who sit on the Board of Directors will also participate on the CAP. The CAP will include clinicians from physical and mental health, epidemiology, addictions treatment, long term care as well as representatives of minority communities. The CAP will be staffed by TCMC's Chief Medical Officer.

The CAP Charter is to advise the TCMC Board of Directors regarding clinical and provider issues with an emphasis on recommendations to drive transformation and achieve the Triple Aim. The goal of the CAP is to advise TCMC and its Board of Directors on methods for improving patient care and affordability through the adoption of community standards of care, application of performance results to improve value and outcomes and recommendations for development of technical assistance programs to build provider capacity for increasing accountability for Triple Aim outcomes.

Monitoring of clinical functions delegated to Affiliate health plans, mental health & addiction services, and long-term care will be included in the CAP's scope of responsibility with the goal of sharing and spreading best practices across Affiliate health plans and delivery systems.

A.1.3 Agreements with Type B Area Agencies on Aging and DHS Local Offices for APD

A.1.3.a The agencies operating the Medicaid Long-Term Care programs in the tri-county area are Multnomah County Aging & Disabilities Services Division, a Type B Area Agency on Aging; Clackamas County Aging & People with Disabilities, a state APD office; and Washington County Aging & People with Disabilities, a state APD office. TCMC will establish a Memorandum of Understanding with these three office/agencies detailing system coordination. TCMC will utilize the State's guidance for developing its MOU detailing system coordination agreements for TCMC Members receiving LTC services.

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

A.1.4.a As stated above in A.1.1.d, representatives of Clackamas, Multnomah, and Washington Counties have participated on the TCMC Executive Steering Committee since its inception and will remain on the TCMC Board of Directors. At startup, TCMC will contract with Affiliate MHOs to ensure continuity of care for the individuals they serve and the behavioral health provider systems they support. TCMC contracts with the Counties will ensure accountability, agreed-upon outcomes, and critical expertise and services needed in the following areas:

Public Health Departments:

- Sharing population-based health metrics data
- Payment for point of contact services as defined in ORS 414.153(1) to (3). including immunizations, sexually transmitted diseases, and other communicable disease services, family planning services, HIV/AIDS services and maternity case management, well-child care, prenatal care, school-based health clinics
- Payment for model practice case management home visit interventions that support the triple aim, and CCO criteria of navigating the health care system, improving health equity and coordinating with clinical and community care; Family Nurse Partnership, Babies First, Healthy Homes, Healthy Birth Initiative.
- Collaboration and support for evidence-based health prevention programming
- Screening services for early detection of health care problems among low- income women and children, migrant workers and other special population groups.
- Leadership in an Integrated Community Health Assessment process

Behavioral Health CMHP/LMHA Departments:

- Support to maintain and improve the mental health safety net including 24 hour crisis services;
- Integrated Service Array/Wraparound services and care coordination for high-risk children and families
- Adult Mental Health Initiative Services and Supports and care coordination for adults at risk of entering/transitioning from State Hospital or long term care
- Support to maintain or improve a variety of community-based specialized services including supported housing, supported education, and early psychosis programming.
- Support for specialized services to reduce involvement in the criminal justice system.
- Assist in integrating behavioral health services into health homes and establishing health homes within community mental health programs
- Assure timely access to needed mental health services for TCMC Members.

A.1.4.b Individuals who are transitioning out of long-term psychiatric programs are eligible for the array of services and supports that are available through the Adult Mental Health Initiative (AMHI). Through AMHI, a care coordinator is assigned to ensure that community-based services are available in a timely manner, services are matched to the clinical need of the individual and that barriers to treatment are minimized. AMHI staff members have a variety of resources available including access to all community treatment programs paid through the MHOs and flexible supports that have not traditionally been funded through mental health but are critical for successful transition are available. AMHI services are prioritized to individuals transitioning out of extended or long-term care.

In Multnomah County, the Forensic Diversion Program focuses on diversion from the criminal justice system for persons charged with misdemeanors and ordered to undergo evaluation/restoration at the Oregon State Hospital. Staff provide mental status evaluations, as well as linkage to basic needs in the community; time-limited coordination/linkage to treatment services, housing, financial and medical entitlements, and social services. The Call Center participates in the State Hospital Waitlist Reduction program and is available to evaluate individuals for diversion from the state or local hospital.

A.1.4.c The TCMC Model of Care Workgroup recommended the expansion of diversion options, including walk-in, integrated crisis centers, additional medical detoxification beds and sober stations as well as respite and recuperative care as a priority to address high utilizers and those experiencing a mental health crisis. As plans to actualize these options are developed, the TCMC will share alternatives with emergency service agencies and work with them to promote the appropriate response and direction for Members experiencing mental health crisis. An example of existing efforts is the positioning of crisis workers in the Clackamas County sheriff's office to identify people at high risk. These crisis workers coordinate with officials to develop the proper response.

All of the county MHOs have established relationships with Community Emergency Service agencies. Each of the three counties has coordinated police/mental health response programs to respond to calls involving mentally ill individuals in crisis. In addition, each of the MHOs contributes funding to local mental health crisis lines, mental health crisis teams and urgent access services. These crisis programs help the counties/MHOs maintain a close working relationship with law enforcement and EMS. For individuals who have been convicted of crimes and have a mental illness, there are three different, well established mental health courts that provide additional support to help the participants successfully complete their probation. There is also close coordination with probation and parole and juvenile justice for shared clients.

A.1.5 Social and Support Services in the Service Area

A.1.5.a County Affiliates work closely with allied agencies, community partners and social and support service organizations in the provision of mental health services to OHP Members. In particular, through the implementation of the Children's System Change Initiative and the AMHI, the counties through their MHOs have developed strong working relationships with the following systems, agencies, and programs: DHS Children's Adults and Families (CAF) field offices; the Oregon Youth Authority (OYA) and Juvenile Departments; the Department of Corrections and local community corrections and law enforcement; school districts and educational services districts; early childhood care and education systems; developmental disabilities programs; tribal organizations and organizations serving tribal members; local housing authorities and providers of housing to special needs individuals; advocacy groups, family support groups and peer support organizations; and a variety of community organizations such as the faith community, domestic violence organizations, homeless councils, cultural organizations, mentor programs, and afterschool activity programs. Through these relationships with allied agencies and community partners, the counties have developed a comprehensive system of care that addresses the needs of Members beyond their mental health treatment needs, integrating social services and supports that assist Members in maintaining stability in the community.

Specific illustrations of the partnerships in local communities include on-site behavioral health consultation to school districts; collaboration with Head Start and Healthy Start; alternatives to incarceration such as drug court and mental health court; and participation in regional housing collaboratives to address barriers to housing for people with disabilities and children with asthma, migrant farm workers, families in poverty and other disenfranchised groups.

In all three counties, contracted behavioral health providers are available on-site in the child

welfare branches to provide assessments for all children taken into custody, and referral to appropriate treatment and resources.

Moving forward, TCMC will identify, convene and facilitate meetings of representatives from core public and private organizations that serve community members on the Oregon Health Plan including, but not limited to, DHS, the OYA, Adult and Juvenile Corrections, school and educational service districts, programs for seniors and people with disabilities (physical and developmental), tribes, urban Indian organizations and other organizations working on behalf of Native Americans and their family members, faith communities, and advocacy organizations, with the objectives to:

- Build a formal network of community partners, organizations and coalitions in order to have routine communication, gather input and enhance relationships with them.
- Facilitate a learning collaborative that meets at least twice a year to decrease the fragmentation and confusion, and enhance awareness and understanding of available services in the various communities.

TCMC leadership will also periodically attend meetings of community coalitions to provide updates and gather input. Examples include, but are not limited to, Healthy Kids Learn Better, Elders in Action/Senior Advisory Councils, Disability Services Advisory Councils, Allies for Healthier Oregon, the HOPE Coalition, Health Services Coalition of Oregon (HSCO), Oregon Health Action Committee (OHAC), and the DD Coalition. The TCMC will seek opportunities to reach out, gather input and build relationships with community organizations and coalitions.

TCMC Affiliates are members of the regional Metro Aging & Disability Resource Connection (ADRC) Consortium. This Consortium provides: single-entry point access to Medicaid and other public benefits for older adults and people with disabilities; a robust state-wide public database (ADRCofOregon.org) with 2,000 community support resources for the metro area; intensive information, assistance and options counseling to support individuals and families seeking community and long-term care supports; care coordination and care transitions for Medicaid and private pay older adults and people with disabilities, and evidence-based health promotion and chronic disease self-management services.

TCMC will dedicate staff for building and maintaining existing relationships and fostering the highest level of collaboration on behalf of TCMC Members.

TCMC has begun conversations with the organization 211info regarding a proposal to draw on 211info's experience and organizational assets as Oregon's central gateway to social services for persons in need. 211info has built a database with more than 5000 health, social and community services in Oregon that could serve as a resource to CCO members and patient navigators to access community and social support services.

TCMC is already participating in a promising Upstream Youth Violence Prevention demonstration project sponsored by Pathfinders of Oregon. The project is an effort to organize social service providers in the Rockwood neighborhood of Portland (an area that community leaders have identified as one of the geographic centers of greatest need in the metro area) into a seamless network of social services to support our most vulnerable families and individuals. This demonstration project, combined with the work of Project

Access NOW to create a universal eligibility screening and referral system for social services will inform the TCMC's efforts to craft an efficient and effective referral process that will connect Members to health supporting social services. See attachment (A-4) map of links between the Rockwood Health Clinic and Community Organizations.

A.1.6 Community Health Assessment and Community Health Improvement Plan

A.1.6.a The Community Advisory Council (CAC) will be responsible for the oversight of the community health needs assessment (CHNA) and the resulting community health improvement plan (CHIP).

In order to avoid duplication, save community cost and improve the likelihood of meaningful community health improvement, the CAC will collaborate with the Multi-County Health Needs Assessment Group (MCHNA) for both the assessment and the improvement plan.

The MCHNA is a large, self-organized, public-private collaborative comprised of the following organizations: Adventist Health, Kaiser NW, Legacy Health System, OHSU, Providence Health & Services, PeaceHealth, and Tuality Healthcare and the Public Health Administrators from the Oregon Counties of Clackamas, Multnomah, and Washington along with Clark County, Washington. The MCHNA received start-up assistance from the Oregon Association of Hospitals and Health Systems. Together they represent fourteen hospitals and four Local Public Health Authorities in the metro area.

This public-private partnership reflects what has been recently cited in the March 2012 edition of *Health Progress* as "best practice" for community health needs assessment.[1] According to the Hilltop Institute in the article, these types of collaborations:

- Increase assessment quality;
- Reduce overall costs borne by all partners and the community at large;
- Lead to shared accountability for outcomes; and
- Promote trust and relationship building among hospitals, local health departments and the community at large.

The vision for this group is to align efforts to develop an accessible, real-time assessment of community health across the four county regions. This unified approach will eliminate duplicate efforts; lead to prioritization of needs, and enable joint efforts for implementing and tracking improvement activities. The particular strengths of the TCMC for the assessment and improvement plan requirements include a history of shared governance and decision-making; commitment to a minimum of three years participation; the participation of diverse Affiliates across the three county region; and the breadth of skills the organizations bring to the collective table.

The MCHNA and improvement plan will strive to meet the participating 14 hospitals' Accountable Care Act 990H IRS reporting requirements as well the assessment and planning requirements for the Local Public Health Authorities. In addition, the public web format for presentation of relevant quality community health statistics will create a unique public asset designed to inform and engage the broader community in the health status of the entire community.

[1] *Health Progress*. March-April 2012.

The MCHNA recognizes the importance to the community of an inclusive community health needs assessment that builds in a process for the inclusion of the representative input of all populations within the four counties served. The stakeholder group is committed to a process that assesses the whole community and identifies health equity issues. In addition, there are significant regulatory requirements to design a process that documents that all populations have been heard and included – with a special emphasis on those experiencing barriers to participation. PPACA states that the newly required community health needs assessments must be inclusive of the entire community served. In addition, The Treasury Department and the IRS have reiterated that hospital community health needs assessments must take into account, at a minimum, input from:

- Public health experts
- Representatives of underserved and low income populations, minorities, and populations with chronic diseases in the community served by the hospital facility
- "Federal, tribal, regional, State or local health or other departments or agencies with current data or other information relevant to the health needs of the community served by the hospital facility." [2]

The MCHNA considers fulfilling these requirements as a minimum specification for a thorough assessment and community health improvement plan.

Healthy Communities Institute (HCI)[3] - The MCHNA is contracting with HCI for the Community Health Needs Assessment (CHNA) web system as a common assessment framework for stakeholders. This web system brings together in one system, data from multiple geographies and disparate sources. The system provides a dashboard of indicators that is constantly updated. The indicators include a combination of county, zip code, and census tract data and can be viewed by ethnicity, age, and gender. Therefore, indicators can be compared across locations and disparities by ethnicity, age, gender and location can be identified.

The system aligns with Healthy People 2020 and the Oregon Health Improvement Plan indicators; provides a customizable landing page for each participating entity, including the TCMC; links to data sources and best practices; and includes the ability to upload local data and reports. This system will free staff time to focus on the processes related to partnerships, vetting the quantitative data and collecting primary qualitative data from the community; and the programmatic activity necessary for advancing health in the region. This standard survey instrument and dataset has been vetted by representative public health epidemiologists and hospital community benefit leaders to meet the requirements of the four-county region.

The MCNA is also contracting with Multnomah County Public Health Department to both manage the HCI contract and manage the community assessment project with the skills, support and work time of members of the MCHNA workgroup. This contractor will be supported by the LPHA epidemiologists as well as key hospital staff who have been instrumental in previous community health assessments.

The MCHNA will develop a process to assess, monitor, and improve the health of the people

[2] IRS, 2011, pp. 15-16
[3] http://www.healthycommunitiesinstitute.com

living in the four-county area through a community-driven process that aims to 1) eliminate duplication of effort; 2) promote joint implementation of health needs assessment and health improvement strategies, and 3) rely on shared responsibility for monitoring progress on the population's health. The approach will be based on the Mobilizing for Action through Planning and Partnerships (MAPP) Model from the National Association of County and City Health Officials. This model is designed to promote strategic thinking among an inclusive set of community partners in order to prioritize community health issues and identify resources to address them.

The MCHNA is currently in the early stage of formation. High level discussions regarding format and process for the assessment have been held. The process outlined below represents the early draft consensus, based on prior participant practices and national standards for this assessment. There is consensus agreement that the MCHNA will implement a multi-step process with an explicit inclusive and multicultural stakeholder engagement strategy to convene partners, engage the entire community and organize the work. In order to avoid duplication and to capitalize on existing work, an inventory of previous and current community engagement projects and assessments across hospitals, public health and other community partners will be developed. The MCNA steering committee will work with Multnomah County as the contracted convener and HCI to finalize the quantitative indicators.

The health indicators data will be presented to stakeholders, community partners and members of communities through an extensive series of meetings. While the HCI indicators and quantitative data are useful tools, identifying and convening community members to meaningfully engage diverse populations will be a key and substantial step in the process to assure that those data are vetted with the community. Only then, will a true community health assessment be meaningful. Collaboration with the CAC will be crucial to identifying existing ecosystems of care that may be less prominent and historically overlooked. This will include representatives or members of medically underserved and low-income populations as well as communities of color, those whose primary language is not English, individuals experiencing mental illness, immigrants and refugees, individuals with disabilities, the elderly, and people who have been institutionalized.

Multnomah County, in its role as convener, and the MCHNA steering committee will convene stakeholders to prioritize strategic issues based in the findings from the data, community input and brainstorm current and future issues that may affect the health of the community including relevant policies, funding, and services. Finalizing the health indicators that will be used to measure and monitor progress toward addressing the identified strategic issues and priorities for the region and smaller communities/service areas will also be completed. This step will include identifying resources available across the partners and stakeholders to address the identified priority health issues. This level of cooperation and coordination is new for the Tri-County community and the TCMC. While commitments have been made to this process conceptually, the details of the development of the community health improvement plan are still to be determined.

The steps described above will lead to the creation of a sustainable process and more formal relationships between the hospitals, public health, the CAC and other partners and stakeholders that can be repeated on a triennial basis and maintained in the interim.

Section 2: Member Engagement and Activation

A.2.1 Member and Family Partnerships

A.2.1.a The TCMC will build, maintain and support a robust CAC that results in meaningful communication and influence on board and governance decisions.

The TCMC scheduled a series of facilitated listening sessions to hear from community members on OHP, their caregivers and family members. The sessions were held in late spring 2012 and were coordinated and facilitated by an outside consultant with expertise in community engagement and input.

These listening sessions involved outreach to community members from each of the three counties, including, but not limited to, single adults, adults with children, people with disabilities – physical and developmental, pregnant women, people living with chronic disease, people of color, immigrant communities, Native Americans, members of the LGBTQ community, people whose primary language is other than English, seniors, from the core metropolitan area and outlying, rural areas.

Reaching those on OHP (and those who are uninsured and potential OHP members) will require building relationships with traditional and non-traditional sources of support. The TCMC will foster relationships with health providers, community advocacy organizations, service providers (i.e., housing, transportation and food/nutrition supports), schools and school districts, faith and worship communities, job placement, police/corrections and many more.

Upon enrollment in the TCMC, members will be informed that the TCMC's success and their health and wellness depend on their involvement and input. This will set the stage for openness between the CCO and OHP enrollees. New Members to the TCMC will be provided with materials (with choice of language and format as noted below.)

In any organizational chart or other printed material, the CAC will be clearly delineated and the role of member input will be highlighted. Multiple ways to provide input will be available, including web-based, email, 800-phone access, and scheduled community input sessions. A dedicated point person will be in place to assure those members and their support networks can be meaningfully engaged in their care, as well as guiding the TCMC.

All materials will be available in multiple languages, including Braille, and written in such a way to encourage questions, and identify who members should address their questions to. All materials will be available in multiple formats – printed copy, audio, and via the web.

The language that is used will aim for clarity of message and intent, in accordance with OHA guidelines. The CAC will be used to test the accessibility of language and policy/process content so that materials are most effective in communicating with members.

A.2.1.b In order to truly achieve the Triple Aim, it is critical that the TCMC and Affiliate delivery systems engage OHP Members as partners in the new model of practice and care. This also requires that the TCMC approach and engage individuals as Members upon enrollment, therefore reaching them and beginning the process of communication whether Members

are currently accessing services or not.

There are some natural connections for reaching and supporting the population beyond their Member status in the TCMC. It is not necessary for a new Member to know the minutiae involved in coverage, billing and reimbursement systems, for example. However, it is critical that Members understand the philosophy, approach and model of care that the TCMC has as its framework. It is that framework that sets the precedent and expectations for Members and providers as they work together toward health – which may or may not involve the medical system, and optimal ways to access services and the care team. To maximize the impact, the TCMC will:

- engage a communications experts to work on language and framing in order to gain the highest level of patient activation;
- rely on the CAC to provide input on key communication questions and outreach strategies;
- provide training and support that allows the CAC to lead this work, not just respond to work presented before them;
- solicit and use feedback around linguistically and culturally appropriate language, context and strategies;
- include multiple ways for enrollees to learn and own their Member rights, responsibilities and opportunities to play key roles in their own health; and
- ask questions of Members, seeking their input, and all input is shared and used in upcoming decisions;
- utilization of already established referral services.

Specific aspects of TCMC's comprehensive communications approach are outlined below:

- Mail or email Member handbooks and newsletters at regular intervals to all Members.
- Make Member handbooks and newsletters available at provider locations or other locations frequented by Members.
- Utilize local radio stations for public service announcements for individuals with limited English language skills and/or limited literacy both in English or other language spoken at home.
- Provide written materials to all consumer councils, advisory groups, and network provider offices.
- Prepare consistent content areas as well as local information for posting on various media and internet locations.
- Regional Tri-County, TCMC, and Affiliate websites will continue to be used to post Member handbooks and newsletters as well as a calendar of wellness events in the community and community resources related to mental health and wellness.

TCMC will encourage Members to be active partners in their health care by:

- Disseminating evidence-based practices for use by peer wellness specialists in most settings such as In SHAPE Lifestyles.
- Utilizing behavioral health staff within primary care medical homes and medical neighborhoods and designing workflows and referral patterns within the primary care home teams with a specific focus on increasing the use of behavioral activation therapy.
- TCMC Affiliate delivery systems offer Living Well with Chronic Conditions/Tomando Control and consideration is underway for implementation across the region.
- Engaging in the Affiliate health plans' and delivery systems' member/patient portals

(e.g. Epic MyChart) to:

- Find a provider
- Schedule appointments
- View/manage their personal health record (PHR) inclusive of test results and personalized action plan
- Chart/track key measurements of their health
- Participate in online health living and wellness programs
- Research health conditions, treatment options and costs
- Request prescription refills
- Converse securely with their provider
- View health benefits
- Review their insurance claims history and details
- Pay medical bills
- Order a replacement Member ID card

In order to achieve optimal health and outcomes for all Tri-County OHP enrollees, it is essential that Members have access to health care services designed with sensitivity to cultural and linguistic needs and that address issues of health literacy. TCMC is dedicated to ensuring all communication, written materials and information regarding available choice of providers is representative of the Membership and provided in a culturally and linguistically appropriate manner. TCMC phone-based Member services will be staffed with culturally competent staff able provide information, consultation and referral to a Member's choice of culturally appropriate provider or culturally specific outreach and service.

With the wealth of established culturally specific resources and programs across the Tri-County region, Members have the choice to access care from providers representing more than sixteen different ethnic groups. Some programs offer culturally-specific services that are non-traditional and lead to Triple Aim goals for specific cultural groups. Non-traditional, culturally-specific services have been shown to increase satisfaction and engagement in care which lead to improved health outcomes. Additionally, TCMC will partner with culturally-specific community centers to engage members in culturally appropriate prevention and wellness activities. These centers provide prevention services, community engagement and have excellent rates of participation in whole-person and integrated care. Non-traditional health care workers, family navigators and youth mentors have also shown to be very effective in engaging specific Members and families. For those Members who desire language interpreters, language interpretation services are also available to engage Members and families.

Health literacy is also an area of focus for TCMC. Low health literacy is more prevalent among older adults, minority populations, those with low socioeconomic status and medically underserved populations – in short, those individuals typical of the Medicaid population. TCMC will develop materials that address issues of health literacy and work with providers to ensure that information, both written and verbal, is given in such a way as to maximize the individual's ability to understand and make health decisions appropriate for that individual.

TCMC will educate Members on how to navigate the coordinated care approach and ensure access to advocates including peer wellness and other non-traditional healthcare worker resources through:

- Collaborative focus groups and or existing focus group materials to develop a communication strategy and explore reactions to message concepts and implement throughout new organization.
- Wellness and health fair events.
- Incorporation of peer support specialists will be encouraged within primary care medical homes and specialty mental health and addiction clinics.
- Close partnerships with and support of TCMCs provider network since providers will be the face of the coordinated care approach and will most frequently refer Members to work with the inter-disciplinary coordinated care teams (ICCTs) or peer wellness specialists.

TCMC will encourage Members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate by:

- Providing culturally and linguistically appropriate alternatives and events for lifestyle choice and co-locate health and social services whenever possible using, for example, Asian Health and Services Center and NARA services as sites for wellness and prevention resources.
- Offering additional programs that show positive outcomes in assisting Members in making healthy lifestyle choices in one area of the region, such as the Living Well/Tomondo Control program, may be offered in the entire region.

TCMC will provide plain language narrative that informs patients with regard to their rights and responsibilities; and will

- Develop a single rights and responsibility statement in English and alternative languages written at 6th grade level and provide copies for all network primary care clinics mental health and alcohol and drug providers.
- To best meet the needs of the TCMC's Members, written materials and communications will be provided in a way that maximizes the Member's ability to understand their rights and responsibilities so they can make informed decisions.

TCMC will meaningfully engage the CAC to monitor and measure patient engagement and activation through the following:

- The CAC will be used as the hub from which Member input is solicited prior to the development of patient engagement and activation materials and activities.
- This includes holding structured, facilitated System of Care Feedback sessions where Members provide guidance to TCMC on their System of Care priorities.
- These priorities will be made part of the guiding principles developed by the CAC.
- The CAC will periodically hold additional system feedback sessions/ focus groups resulting in a prioritized list of actions to be taken by the CAC, CAC subcommittees, and TCMC. The CAC will have both permanent and ad hoc subcommittees which address system issues in real-time.

Section 3: Transforming Models of Care

A.3.1 Patient-Centered Primary Care Homes

A.3.1.a TCMC is fortunate in that many of the TCMC'Affiliate delivery systems' providers operate in certified PCPCHs, or in Public Employee Benefit Board (PEBB) certified Primary Care Homes, which collectively serve 80% of TCMC anticipated membership. Also, TCMC will leverage

resources in the Affiliate health plans, all of whom have a demonstrated commitment to supporting and spreading the PCPCH model, including a willingness to promote alternative payment methodologies.

CareOregon has a highly developed program to provide technical assistance to PCPCHs and TCMC will be able to expand access to that program across provider networks.

Furthermore, TCMC's Model of Care Workgroup has already launched an initiative to standardize the hospital discharge process as it relates to PCP communication. This is an important tool in coordinating care transitions and ensuring that information is communicated accurately and appropriately with the Member and family.

As noted in A.3.1.c, TCMC is committed to enabling PCPCHs through the implementation of new technologies to enhance coordination – e.g. EDIE, IRIS, and Epic Care Everywhere. TCMC is also fortunate to have Quality Corporation (QCorp) as a strategic partner in the information technology component of the coordinated system of care. The strength of QCorp in standardized data collection and sharing will be key to driving system change. Ninety percent of the Affiliate health plans' Member level data is already submitted to and processed by QCorp.

Finally, we acknowledge that many Members identify their behavioral health provider as their "health home," particularly those with severe and persistent mental illness. TCMC's Model of Care workgroup is developing a "Behavioral Health Home" model, generally based on the Missouri Model, in collaboration with the MHOs and delivery systems. Additionally, culturally-specific providers and advocates have been working with the Model of Care Workgroup to ensure that the Model supports cultural and linguistic proficiency specifically for culturally competent, trauma-informed care and monitoring for health literacy.

A.3.1.b TCMC will work with its CAC to provide guidance in Member engagement with PCPCH development. In addition, TCMC has created the position of Chief Health Strategy Officer to partner with the Chief Medical Officer to transform the system of care through collaboration with Members, the network of community health and social service providers and to invest resources in community prevention activities and social support networks where they will have the most impact. This innovative role has Member engagement at the heart of its work.

The Collaborative is also fortunate to have the active participation of the FQHCs in light of their long history of consumer majority boards and active engagement in the establishment of health homes in these clinics. Many FQHC clinics also have their own member advisory boards that engage in this work as well and TCMC will be using a best practices approach to expand this model.

A.3.1.c At this time, 80 percent of Members in TCMC Affiliate health plans are already enrolled in certified PCPCHs or the Public Employee' Benefit Board (PEBB) certified Primary Care Homes. With active engagement of the CAP, the TCMC will implement a standardized alternate payment methodology that will add incentives for clinics to continue moving up in PCPCH Tiers. In addition, TCMC will recommend that Affiliate health plans pass 100% of enhanced pmpm payments for ACA-qualified Members assigned to the PCPCH in a transparent and meaningful way.

The combination of previously mentioned plans to implement alternate payment methodologies, provide technical assistance, use data to inform the transformation process and deliver culturally competent provider and Member education, will support TCMC Affiliate health plans in increasing the number and tier level of PCPCHs in the Tri-County area. TCMC will also be working with practices who have achieved meaningful use certification to encourage practices to apply for PCPCH.

TCMC supports the OHA goal of transforming care and enrolling 75% of Oregonians by 2015. TCMC's PCPCH enrollment targets are as follows:

	2013	2013	2014	2014	2015	2015	2016	2016
	Target	Benchmark	Target	Benchmark	Target	Benchmark	Target	Benchmark
Tier 1	5%	75%	5%	75%	0%	75%	0%	75%
Tier 2	5%	75%	5%	75%	0%	75%	0%	75%
Tier 3	80%	75%	85%	75%	95%	75%	100%	75%

TCMC is committed to implementing new technologies to enhance coordination and is exploring several web-based systems to enhance two-way communication between the PCPCH and other health service providers. The widespread use of the EPIC system and its Care Everywhere functionality already enables enhanced communication. Additional work will be done to facilitate information exchange from all providers, regardless of their EMR status. Other technologies under consideration are the Emergency Department Information Exchange (EDIE) which was developed so ED clinicians could track and receive alerts on individuals and their care plans across different systems but could be used more broadly; and the Internet Referral Information System (IRIS), current being implemented by the Portland IPA to connect primary care and specialty clinicians. The TCMC Chief Information Officer (CIO) will be charged with moving this strategy forward in the first year of operation.

A key criterion in selecting the communication systems noted above is their ability to connect medical and non medical providers. The EDIE system is under consideration precisely because it has that capacity to receive information from and send alerts to any provider designated as being involved in the care of a specific individual.

A.3.1.d The TCMC Model of Care Workgroup had a tactical group focused on the accountabilities of the PCPCH. One of the primary functions of the PCPCH is to provide care coordination and linkages to LTC services. One of the proposals of TCMC is to develop a patient registry so that a Member's care plan is accessible by all providers including LTC providers.

Legacy Health has an integrated program with several LTC providers in the area. In this program, geriatricians and internists along with geriatric nurse practitioners are employed who see patients within the designated facilities, act as medical director at the facilities and liaison between the facilities, referring institutions and the patient's PCP as needed. In their role as medical director, the physicians are responsible for monitoring quality of care at the site, creating and monitoring care protocols as well as caring for patients who do not have a physician available to follow them.

The Affiliate delivery systems are also currently working collaboratively with Clackamas, Columbia, Multnomah, and Washington counties on a CMS proposal for three year funding

to support a Community-Based Care Transitions program. The purpose of the collaborative is to build and sustain a community coalition for improving transitions of care for patients with a specific focus on Medicare fee for service beneficiaries, including dual eligible Members. Additionally, the collaborative is designing a vehicle to facilitate a patient and family voice in care transitions, patient engagement through person-centered and person-directed models of care and to collaborate and encourage partnerships between organizations with shared visions. The collaborative plans to submit the application by April, 2012 with program funding provided by July, 2012.

A.3.1.e TCMC will require Affiliate health plans to include Federally Qualified Health Centers, Rural Health Clinics, School Based Health Centers, Migrant Health Centers and other "safety net" clinics in their network and will encourage consistent payment methodologies across all provider types. At this time, 34% of the enrollees in TCMC's Affiliate health plans are assigned to these safety net clinics.

A.3.2 Other Models of Patient-Centered Primary Health Care

A.3.2.a In addition to strategies already initiated, TCMC is planning to implement integrated community mental health homes that are modeled after the Missouri Primary/Behavioral Health Care Integration Initiative. Community mental health centers already fulfill many functions of the health home, including identification and active management of high-risk, high-cost individuals; individualized care planning and a patient-centered approach to care; coordination with consumers, caregivers and providers; promotion of self-management by the consumer; and linkage of the consumer to community and social supports. This "whole person" approach emphasizes health and wellness, assures consumers receive the preventive and primary care they need, and assists them in managing their chronic illnesses.

Strategies within the Missouri model to be implemented include: onsite nurse care managers to facilitate access to primary care and monitor chronic health conditions; coordination of care through electronic health records and case management; medical disease management for persons with serious mental illness; health behavior interventions for medical risks such as smoking, obesity, metabolic syndrome, and screening for prevention and treatment; and health education and promotion.

A key component of this model is the use of onsite nurse case management to provide comprehensive care management and assist in the identification of high-risk individuals, assessment of initial treatment needs, development of individualized treatment plans and appropriate referrals, coordination and follow-up with physical health care. The nurse case manager provides a single point of accountability to ensure communication and coordination with primary care is effective.

The Community Mental Health Home is an alternative approach to the delivery of health care to individuals with serious mental illness that is anticipated to improve the patient experience, achieve better outcomes and reduce costs, consistent with the Triple Aim. These results will be achieved through comprehensive care management, health promotion, and coordination of care across providers and systems, referrals to community and support services and use of health information technology to link resources.

A.3.2.b The TCMC Model of Care process involving providers from all parts of the health delivery system defined the health home as the center of health system transformation. Whether

that health home is in the behavioral health system or the primary care system, its function is to provide the right first contact care by the right person at the right time. There is agreement that this implies a significant expansion of what is expected from "health homes" vs. current practice, with increased accountabilities for access, comprehensiveness – particularly with behavioral / medical integration – and outreach, including the use of outreach workers to connect with high acuity enrollees. Health system transformation is to be built around the patient's relationship with their heath home. The central and guiding questions are: what is best provided in the health home setting, what is best provided by more specialized or acute care providers in the health delivery system, and what is best provided in partnership with the community.

A.3.2.c The TCMC understands that it will need to invest in new forms of technology to support two way communication and coordination between its health homes and other service providers. The EDIE system, referenced above, has been identified as having the kind of functionality that will be required, although other systems are also being evaluated. One of the values of the TCMC will be to enable this kind of "community utility" critical to producing better outcomes.

A.3.2.d Communication with DHS Medicaid funded LTC providers will be facilitated both on a technological level – using EDIE like systems described above for day to day care coordination – and on an ongoing collaborative care design system level. The TCMC has already launched a "model of care" process that this involved providers across the health service spectrum, including LTC providers. This process was highly valued by all participants in that it brought to light both the needs and innovative ideas from multiple care providers. The TCMC is committed to continuing this inclusive process through its Clinical Advisory Panel and related subcommittees.

A.3.3 Access

A.3.3.a TCMC is looking beyond the existing networks of Affiliates to develop a diverse network of providers including providers working in non-traditional settings. Additionally, TCMC plans to develop a culturally competent workforce of community health workers and peer volunteers who can embed themselves in the community. While these workers will be embedded in a specific clinical or other care setting, they will be spending their time in the community and will develop relationships and engage with community members in order to appropriately guide them through the health care system.

The participation of TCMC's Affiliate health plans in the Tri-County region provides a broad geographic infrastructure of services. In addition to the existing system, the TCMC has designed and will support a community-based "Integrated Community Care Team" (ICCT) using community outreach workers to engage and support high acuity Members struggling with high ED and hospital use. This new workforce will be connected to physical and behavioral health homes but will also be coordinated through a regional collaborative system that will provide ongoing training, development and necessary information systems. Included in this system is ED Guides and Care Transition staff for high-risk hospital discharges. This is the central initiative of TCMC's "Health Commons" CMMI proposal.

The provider networks leveraged by the Affiliates of the TCMC provide for a diverse, geographically accessible array of primary care, behavioral health and specialty providers.

Affiliates utilize GIS technologies to map the locations of available services and where Members reside to assure convenient access. Stratification by ethnicity or language variables is also possible.

Within the behavioral health system, culturally specific providers such as Asian Health and Human Services and OHSU Intercultural program are participating providers and locations of services are available in all areas with high concentrations of under-served populations and communities of color. Health disparities will be addressed through additional outreach and engagement to these communities with programs such as Promotoras (cultural community members who home-visit to promote health), bilingual bi-cultural community health nurses and community health workers, and providing health access information in community centers, churches, and local agencies that underserved populations are likely to visit.

A.3.3.b The Health Commons CMMI proposal referenced above has a well developed timeline for taking the ICCT model to scale. While it is unrealistic to believe that it will be fully functional at the TCMC Contract start date, hiring and scale up has already begun. It is anticipated that the system can be launched within a year's time.

A.3.3.c At the broadest level, TCMC is developing a communications strategy to articulate to the community the core elements of the new regional model of care and has already begun a series of Stakeholder meetings. More specifically, creating such a Member and community engagement strategy will be one of the initial charges for the CAC. At the individual provider and practice level, Motivational Interviewing (MI) training will be available using local established experts to enhance the effectiveness of Member engagement. All community outreach workers will be trained in MI. TCMC has also taken community engagement to the highest level of the organization with the role of Chief Health Strategy Officer to work on engagement across the care spectrum and communities we serve.

A.3.4 Provider Network Development and Contracts

A.3.4.a TCMC will utilize the existing provider networks of Affiliate health plans for the delivery of physical and mental health services. As noted previously, a large percentage of TCMC's Affiliate plans' enrollees are currently assigned to PCPCHs, which further supports the delivery of coordinated and team-based care. In addition, the TCMC Affiliate health plans have access to national specialty networks, such as LifeTrac or InterLink, through reinsurance policies to ensure access to services not currently provided in the service area.

Affiliated MHOs support continuity of care for Members who become enrolled during an episode of treatment through arrangements with non-participating providers. Similarly, single-case contracts are arranged with out-of-area providers to address unique Member needs. Examples include specialized inpatient and residential eating disorder programs, electroconvulsive therapy and specialized psychiatric residential treatment programs for children and adults. Additionally, due to the shortage of inpatient acute psychiatric capacity in the Tri-County region, MHOs routinely authorize admissions to hospitals throughout Oregon.

A.3.4.b As mentioned previously, the TCMC plans to facilitate work with community partners to develop additional diversion options to keep people out of the inpatient setting and manage them more locally. One of the efforts that the TCMC aims to initiate is a comprehensive clearinghouse of available resources, which can be shared with both providers and

Members.

Additionally, many of TCMC's Affiliates are exploring options related to adding behavioral health to the service offerings within the primary care setting. For example, OHSU currently offers extended clinic hours at their Richmond clinic for behavioral health services so that people have access after traditional clinic hours. Legacy is partnering with DePaul Treatment Centers to add behavioral health and addictions counseling to the primary care setting.

Lastly, TCMC plans to provide additional Screening, Brief Intervention, and Referral to Treatment (SBIRT) training for providers in primary care and the ED. Under the SBIRT model, Members automatically undergo a quick screening to assess their alcohol and drug use. If they are at risk of developing a serious problem, they receive a brief intervention that focuses on raising awareness of substance abuse and motivating them to change behavior. Members who need more extensive treatment receive referrals to specialty care. The purpose of this work would be to reduce inpatient utilization and focus on upstream initiatives to reduce the problem.

The Counties have well-established care management strategies that divert unnecessary inpatient psychiatric admissions or decrease lengths of stay. These strategies include: community-based crisis stabilization services for children and families; mobile mental health ED diversion teams; use of partial hospitalization programs as a diversion or step-down from inpatient; daily on-site or telephonic concurrent review of individuals on inpatient units to ensure medical necessity standards are still met; and intensive discharge planning and care management to prevent readmissions and ensure a smooth transition to outpatient services.

Alternative programs include facility-based crisis respite programs for adults and home-based crisis and planned respite services for children and families; 24-hour alcohol and drug sobering program, walk-in urgent mental health care centers in Clackamas and Multnomah Counties; and the Crisis Assessment and Treatment Center hospital diversion program in Multnomah County. All Members are educated about these alternative programs and encouraged to access them first in a mental health crisis.

The Health Commons CMMI proposal, if awarded, would increase the region's capacity to divert unnecessary inpatient admits, decrease length of stay and readmission and reduce emergency department visits. New resources provided via these grant dollars include the expansion of Intensive Transition Teams that have demonstrated success in Washington County by reducing inpatient readmission for Members with mental health and substance abuse needs and ED navigation services based on a diversion model in New Mexico employing nontraditional workforce members to link patients to primary care homes and support services would be established across the region.

A.3.4.c The TCMC will utilize the MHO's well-established network of behavioral health providers for the provision of mental health services to OHP Members, and for mental health and addiction treatment services to uninsured county residents. These providers include inpatient, sub-acute, outpatient, community-based, and culturally specific service providers. Many of the providers in this network offer both mental health and addiction treatment services, both individually and in co-occurring treatment models. Individuals are to be served in the most normative, least restrictive, least intrusive, and most cost effective level

of care appropriate to their diagnosis and current symptoms, degree of impairment, level of functioning, treatment history and the extent of family and community supports available to them. While the network offers a full array of mental health and addiction treatment services, to the greatest extent possible services are provided in the home or community, supporting individuals in the most independent living setting possible.

As part of the Adult Mental Health Initiative, MHOs maintain a system of services and supports to assure that Members in licensed residential treatment settings gain independent living skills and move as quickly as possible to the least restrictive living setting. This includes Sustainable Housing Brokerage services to keep Members in their current housing; Supported Housing with 7-day-a-week Skills Trainers to develop Member skills and enable movement to less structured housing; creative use of peer supports to meet the unique needs of Members; single-case agreements with specialty providers (e.g., Medical Intensive Case Management Services) to address the unique challenges of Members with complex medical and psychiatric needs; Exceptional Needs Care Coordinators to manage complex system issues; and Residential Services staff to assure Members receive services within their residential placements

A.3.5 Coordination, Transition, and Care Management

Care Coordination:

A.3.5.a Information and care coordination is essential to achieving the Triple Aim. TCMC will work towards the implementation of a community-wide care coordination registry. To support flow of information between all providers, the registry will be linked to all provider IT systems. Interdisciplinary Community Care Teams (ICCTs) will be used to coordinate care plans and interventions to best meet the health, human service and recovery needs of individuals with severe mental illness. These teams will include peer wellness and behavioral health staff trained to motivate, engage and coordinate recovery-based care for individuals with chronic mental health conditions.

The regional mental health crisis service system also plays a pivotal role in coordinating care and supporting the flow of information across the region for consumers with severe mental illness. TCMC Affiliates have decades of expertise serving individuals with severe mental illness and operating 24-hour programs that include crisis lines, mobile outreach teams and urgent walk-in clinic services. These programs serve a high volume of Members with chronic mental health conditions in our community and are successful at engagement and reducing unnecessary acute care costs and ED visits, avoiding duplication of services and increasing the flow of information between providers. These crisis programs interact multiple times a day with hospital EDs, LTC service providers, family members, consumers, police, schools, PCPCHs, PCPs and other human service agencies. This coordination is critical for cost effective delivery and coordination of services for individuals with severe mental illness, addictive disorders and other high-risk Members of the TCMC community.

Staff from these programs regularly provide education and outreach to community partners such as Type B AAA staff, DHS LTC providers, home and community-based service providers, residential providers, hospitals and schools and are experts at coordinating care and information with these 24-hour services. To ensure immediate follow up for any Member with severe mental illness who may benefit from outreach, engagement or urgent follow up,

TCMC's community-wide registry will also be connected to the regional crisis provider system.

The Adult Mental Health Initiative has also been instrumental in coordinating the care of individuals with severe and persistent mental illness. The coordination provided is designed to effectively communicate the needs of the individual by ensuring that a single person is charged with knowing a client's history, treatment needs and support system and building on the strengths of the individual. Once engaged, the care coordinator can coordinate with LTC to facilitate transition planning, identify physical and dental care needs, coordinate with crisis and acute care systems as indicated while continually supporting the individual to live in the least-restrictive setting possible. This coordinator is able to take a system-wide view to ensure services are not duplicated and consistent with identified needs. Systems that the care coordinator will interact with include: primary care, habilitative supports (funded with the 1915i SPA), mental health treatment supports, residential services, state hospital services, community corrections, developmental disabilities programs, Aging and Disability Services, and many more.

Additionally with the LTC system in Multnomah County, Verity has partnered in processes and targeted problem solving groups to facilitate permissible sharing of client information with care managers and system partners to ensure seamless assistance for the consumer and to problem solve best use of shared resources. Examples of Multnomah County LTC resources for coordination include: 24-Hour Access Resource Helpline, a single entry point model for access to services, community resources and crisis services; and participates in a four (4) county Aging and Disability Resource Consortium ensuring consistent and seamless services for individuals residing in the Portland metropolitan area.

Protection and Safety:

Adult Protective Services (APS) – This program provides investigation and crisis support for vulnerable adults who may be experiencing abuse or neglect. APS works across systems to address incidents of abuse and neglect, coordinating with health providers, mental health providers, law enforcement, and community provider networks.

Public Guardian/Conservator Office – obtains and implements court-appointed guardianship and/or conservatorship for individuals who are profoundly mentally incapacitated, unable to care for themselves, and are at high risk due to abuse, exploitation or extreme self-neglect.

Multi-Disciplinary Team – an inter-disciplinary team targeted to assisting individuals with complex needs and/or abuse/neglect issues. The team includes social workers, community health RNs, adult protective service investigators, law enforcement, mental health consultants, etc.

Multi-System Staffing Team – coordinating across disciplines and funding sources to ensure coordination of care for individuals with complex needs who are high utilizers of multiple systems of care, such as: long term care, mental health, developmental disabilities, community health clinic and emergency response (911) services.

A.3.5.b TCMC Affiliates recognize that even a transformed model of care will not be able to address the social and individual drivers of health that mainly determine outcomes. All of the Affiliate health plans have "Exceptional Needs Care Coordinators" who assist providers in

linking patients to appropriate resources. The community outreach worker ICCT program described above is a step in moving towards addressing those issues at a deeper level. As part of their role, outreach workers provide the link between the clinical provider system and social and support services as well as community and self-management programs. The Peer Wellness Specialist Program in behavioral health that has been developed by Cascadia Behavioral Health is a further resource that will be expanded. The Health Commons CMMI proposal further contains a community liaison position to link the ICCT program to community programs and resources, developing partnerships at the local community specific level.

In addition, TCMC has established a position of Chief Health Strategy Officer (CHSO) as part of its executive leadership team. The CHSO will work with community partners not only to help foster a more coordinated care approach to social and support services, but also to create a broader coordinated care approach with TCMC. The previously described Model of Care Workgroup has already identified areas within the behavioral health crisis management system and in prevention, particularly in the area of addiction, which need to be priorities for TCMC in its care transformation efforts.

A.3.5.c TCMC's Cultural Competence Strategic Plan (outlined in A.4.1) will include the creation of tools for providers to use to communicate with Members in a culturally appropriate way about care coordination and provider and Member responsibilities in assuring effective communication. TCMC will build upon Affiliates' materials such as attachment (A-5) CareOregon's "Better Together" communication tool (attached), attachment (A-6) Multnomah County's Culturally Competent Health Care Practices Toolkit (attached) and attachment (A-7) Kaiser's extensive Cultural Competency resources (description attached).

A.3.5.d As previously described, TCMC intends to implement the Health Commons CMMI proposed initiative to create a regional ICCT program focused on high acuity TCMC Members. These Members will be identified by several methods. First, a common definition will be applied to claims data across all Affiliate health plans to create a list of "candidates" for referral to ICCTs. Merged data between the existing physical and behavioral health plans will maximize identification rates. These lists are then reviewed with the primary providers to identify those who could benefit from ICCT program referral. Engagement of providers in reviewing their panels for such high needs individuals creates a second path for identifying Members: proactive provider referral. As providers understand the programs available for their most complex patients, they can identify and refer others who have not yet been identified by claims. A third pathway develops as service agencies have experience with the program – or participate in it through shared technology such as EDIE – and also become referral sources.

All high-risk/high-utilizing Members will have an assigned care coordinator. Using person-centered models of care coordination developed within county behavioral health programs, involved agencies and family members will form teams facilitated by the care coordinator to develop individualized coordination plans tailored to address needs. In the case of persons with developmental disabilities, teams would include the CDDP and/or Brokerage Case Manager. The team participates in identifying the needs of the client/patient and what services and supports will address the barriers in advancing their health/behavioral health goals. This process is highly person-centered and family-driven, and results in a plan with assigned accountabilities for all parties including the Member and/or the Member's family.

A.3.5.e Regional counties are safety net providers of human services who have decades of experience coordinating care for individuals with severe and persistent mental illness connected to multiple systems. Care for this population has changed significantly over the past 30 years. Currently the counties support a recovery-based philosophy that supports the belief all consumers can recover from symptoms of mental illness. What that looks like varies from individual to individual and community-based wraparound services are a part of assisting consumers with chronic mental health conditions in their recovery or disability that has qualified them for Medicaid-funded LTC services.

A.3.5.f See description above regarding the ICCT program.

Assignment of Responsibility and Accountability:

A.3.5.g TCMC will initially assign Members to their existing Affiliate health plans in order to ensure continuity of care for currently enrolled Members. New enrollees not already assigned to Affiliate plans will be assigned initially using the State's current Auto Assignment algorithm. Future Member assignments are expected to be based on performance measures that emphasize the outcome goals under the Triple Aim as well as PIP measures such as "Time to First Appointment."

All Members are assigned to a Primary Care Provider within 30 days of enrollment and relevant PCP contact information is provided to the Member upon assignment. Members are assigned based on prior history with a primary care provider, Member preference, or provider availability in terms of capacity or geography. The PCP also has access to an assigned roster on a regular basis so that the provider can accommodate patient requests upon initial contact. Member education materials encourage the establishment of care immediately upon attaining benefit eligibility.

A.3.5.h TCMC will provide written communication or signing tools to assist hearing impaired and speech disabled patients free of charge. Members who are hearing impaired will have access to the TTY services through Sprint TRS. Interpretation assistance will also be provided free of charge to non-English speaking Members.

TCMC believes quality medical care is most appropriately rendered in the Member's prevalent language with awareness for and sensitivity to cultural differences and similarities, and the effect of those on the experience of the Members medical care. Access to qualified interpretation services shall be provided in person or by telephone in providers' offices, TCMC administrative offices and other contracted ancillary or facility providers or administrative offices of Affiliate health plans. TCMC will require that communication preferences are documented in the medical records including documentation on accommodations made. TCMC will require that interpreters have required training and certification, are proficient in communicating in English and the primary language of the Members and able to interpret medical information effectively. A minor child should not be used as a communicator. Family members or friends should only be used as adjunctive communicators if the Member prefers.

Comprehensive Transitional Care:

A.3.5.i TCMC Affiliate delivery systems are engaged in a wide variety of comprehensive care transition strategies related to reducing readmissions. These programs are designed at the

system level to benefit all and improve care transitions with essential plan elements designed to successfully transition Members from inpatient status to other care settings.

A TCMC Affiliate, Central City Concern, currently offers a recuperative care program (RCP) that is supported by TCMC's Affiliate delivery systems. This program provides patients who are homeless with immediate housing, intensive case management and primary care for post-hospital treatment. Patients are picked up from the hospital, given their own room and are immediately established with a PCP and case management team. This program is an excellent example of the type of transitional care support that TCMC would like to advance.

Also, as previously mentioned, TCMC is looking to standardize the admission and discharge transition process so that PCPs are notified at admission and coordination occurs not just at discharge, but throughout the patient's stay. At discharge, a standard discharge document would be sent to the Member's PCP or other primary provider and if they do not have one, the hospital would identify one and set up a follow-up appointment. Another component of this process is developing standard risk assessment tools that will be used across TCMC's provider network to identify those who are especially at risk and will require additional support. Lastly, the primary reason for readmission is related to medications. TCMC is committed to establishing a single formulary and working with Affiliate delivery systems to ensure accurate medication reconciliation occurs at each transition.

Improving hospital care transitions is a priority for TCMC and was one of the primary intervention areas proposed in the Health Commons CMMI proposal. TCMC will leverage some of the longstanding work already completed in the region including engagement from hospital, primary care, and community-based providers. TCMC has begun the process of operationalizing a standard community transition process with defined workflows and accountabilities, starting by focusing on the transition from hospital to primary care.

Much of this work is modeled on the work of a number of TCMC Affiliate delivery systems. For example, Kaiser already has this type of system in place within its integrated system. The Legacy hospital system has already begun to standardize inpatient risk assessment, post-acute planning and communication of discharge needs. Initially, Legacy will work with its own clinics and the Multnomah County clinics. The standard will then spread to the other systems. A HIPAA-compliant EDIE or similar platform will facilitate transmission of discharge summaries from any hospital Electronic Health Record (EHR) and transmit them to the primary health home within 24 hours of discharge, with concurrent alerts to the PCP and other involved caregivers.

EDIE or similar systems can be multi-directional, used not only to communicate hospital discharge needs to community providers but also to communicate primary care based care plans to hospital, ED, or other acute care providers. Any of the care managers discussed in previous sections will be able to attach their care plans to identified Members so that they are immediately available to providers at different points of care. As more care management is built into primary health homes, this information technology will allow a much higher level of information sharing and care coordination.

The EDIE or similar system can also function to coordinate transitions between other care settings. Just as it can transmit discharge summaries from hospital to primary care and alert key providers, the system can transmit care summaries and send alerts from any level of

care setting to the patient's next providers. This can facilitate the standardization of workflows, including follow up contacts and scheduling appointments or intakes, across the multiple settings that may be involved in a patient's care. Once standard workflows to and from primary care have been established, workflows to other settings such as skilled nursing facilities and assisted living, will be added.

A.3.5.j Expectations will be established through Memoranda of Understanding and agreements with providers to engage Aging & People with Disabilities or Aging and Disability Services (Type B AAAs) at the onset of the discharge process while the Member is still in the acute setting. Care transition coaching and planning will begin at that time to enable a Member-coach relationship and trust. The APD or ADS Care Transition coach will keep the team informed on the member/patient's status post discharge and request support and assistance if the patient experiences difficulty with the discharge instructions/plans. Along with care transition coaching, wrap around supports and services will be provided such as home delivered meals; transportation to physician office visits and medication management.

A.3.5.k See above for the description of the EDIE or similar transition tracking system. For Members who need a care management support as part of their hospital transition because of a high likelihood of readmission, TCMC will expand two current successful existing interventions: (1) The Care Transitions Innovation (C Train) developed at OHSU for medical patients; and (2) The Intensive Transition Team (ITT) developed by Washington County Health and Human Services for high acuity hospitalized mental health and substance use patients. Both provide a care manager who works with hospital staff to ensure successful discharge and with the Member to create a Personal Health Record to optimize their understanding of what will follow. Within 2-3 days after discharge, a home assessment is conducted, and follow up phone calls are made for up to 30 days to provide support and links to community resources. If appropriate, the care manager can refer the patient to an ICCT.

Individual Care Plans:

A.3.5.l All high-risk/high utilizing Members will have an assigned care coordinator. Care coordination as a system integration tool is highly developed within the Tri-County in behavioral health. For adults with severe mental illness at risk for state hospitalization, and for children and youth at risk for hospitalization and residential care, Affiliate MHOs have implemented care coordination within the Adult System Change Initiative and the Children's Integrated Services Array. In both of these initiatives, a care coordinator convenes and facilitates a team of involved health care, social service and education providers in addition to the Member and family being served. Depending on the level of multi-system involvement, team membership can be as small or large as appropriate for the targeted Member's needs. This team participates in identifying the needs of the Member and what services and supports will address the barriers in advancing his or her health/behavioral health goals. This process is highly person-centered and family driven, and results in a plan with assigned accountabilities for all parties including the Member and/or his or her family. TCMC will adapt this vision for the activities of care coordination throughout the health care system.

A.3.5.m Upon enrollment, all TCMC Members will be mailed a health assessment survey as part of their Welcome Packet. Returned surveys will be screened by the Care Coordination team

and followed up as appropriate.

Certain eligibility categories of TCMC Members will be automatically referred for intensive care coordination. In addition, TCMC Members may also be identified for intensive care coordination services upon enrollment via Self-Reported Health Risk Assessments, self-referral, from a PCP, agency caseworker, a representative, other health care or social services agencies and through claims-based or diagnosis-driven trigger lists throughout eligibility with TCMC. Intensive care coordination services will also be available to coordinate covered services for Members who exhibit inappropriate, disruptive or threatening behavior in a practitioner's office.

Information about services available through intensive care coordination is communicated to the eligible Member according to the most appropriate communication method including accommodations for impaired, disabled, alternative language or other cultural differences.

A.3.5.n TCMC is currently in discussions with AAA/APD to finalize standard memoranda of understanding with local Medicaid LTC agencies. MOUs will outline requisite roles, responsibilities and scopes of work. This document will be available at the time of the Readiness Review.

A.3.5.o Within the facilitated team process described above, team members will meet again within an agreed-upon timeline upon which the plan is reviewed and modified as needed. In behavioral health, the team meetings generally occur monthly, or more often as needed. Frequency should be individualized but no less frequent than every 6 months

A.3.5.p In the case of Members who are involved with type B, AAA, APD or LTC, these involved agencies and care providers would be members of the person-centered teams described above. The care coordination plans developed in the facilitated team process would reflect the resources, services and supports to be brought to bear by these participants and the assignments, accountabilities and timeframes to be accomplished will be documented. All team members agree to the plan and can access the plan to assure its consistent implementation.

A.3.6 Care Integration

<u>Mental Health and Addiction Services and Supports:</u>

A.3.6.a All of TCMC's Affiliates are already responsible for the planning, funding, development and oversight of services and provider networks to meet the capacity and behavioral health needs of all age groups, Medicaid Members and uninsured residents in the region. In partnership with the community, the counties make ongoing improvements to the availability, accessibility, and quality of culturally appropriate prevention, treatment and recovery oriented services.

Changes in Medicaid enrollment, employment or unemployment and overall population growth all impact the need to increase or decrease capacity in the provider network. The provider panel is routinely adjusted to expand or contract service capacity to ensure adequate access to services. The contracted programs offer culturally appropriate and specific services for all age groups ranging from crisis intervention available to the entire community to evidence based general behavioral outpatient, intensive outpatient including

24-hour intensive service wraparound service programs, early psychosis intervention, peer run and peer delivered services, supported employment and education programs, respite care, residential treatment programs, sub-acute facilities and inpatient treatment services. Many of the same mental health and addiction agencies offer services across the entire region with some providers specific to service provision in one county.

The provider networks and service programs have become increasingly more diverse as the populations served have become more culturally and socially diverse. The workforce is also changing from what has traditionally been a professionally-driven workforce focused on reduction of symptoms, to greater inclusion and employment of peer mentors and peer support specialists working on mental health promotion and overall wellness in recovery. Some specialized treatment services and prevention programs like early childhood mental health, school based mental health, crisis services, child and family Wraparound care coordination, culturally specific addiction prevention programs for youth and adults, early psychosis intervention, pre- and post-commitment services are not contracted out and the services are performed directly by county staff.

A.3.6.b Care for consumers in the Tri-County region is focused on community-based treatment services that include: assessment, individual and group counseling, medication and medication monitoring, peer wellness recovery services, assistance in accessing state and federal benefit programs, skills training to promote independent living, supported employment, supported education, and drop-in socialization programs. Care is provided in the least restrictive environment that can meet the needs of each client, and is provided in a trauma-informed, strengths-based, and recovery-oriented way. For those consumers with serious mental illness, care coordination is provided to ensure that service providers and systems are working together in the most efficient way to meet the client's individualized needs. This is provided through the Integrated Service Array (ISA) and Wraparound for children and adolescents and the Adult Mental Health Initiative (AMHI) for adults. When mental illness and addiction are co-morbid conditions, consumers have access to an array of providers that offer integrated treatment in the region.

As the focus has changed nationally from institutional LTC to transitional institutional services targeted at promoting skills attainment and preparation for community-based supported or independent living, the regional county Local Mental Health Authorities have worked with providers to develop new programs and retool current housing programs that had been long term placements for many individuals with severe mental illness. Community addictions programs have been grounded in recovery for years and provide access to sobering services, residential medically monitored detoxification services, housing first programs combined with treatment, assessment, intensive and general outpatient services along with recovery management services. Regionally, many of the same providers operate in each county and the majority of providers offer mental health, dual diagnosis and addictions services.

A.3.6.c As the regional Local Mental Health Authorities, Clackamas, Multnomah and Washington counties are the organizations that have been accountable to develop high quality systems of integrated care to meet the range of age, developmental stages, cultural and social needs for individuals with mental health and addiction disorders. Regional crisis services are one door to the systems of care and are available to all Medicaid Members and residents. 24 hours a day, consumers can access culturally appropriate phone based and community

outreach programs that provide preventive support and information, engagement, screening for mental health and addiction issues, coordination of care and immediate or follow up referrals based on acuity and need.

Medical staff is also embedded in many crisis programs and provides primary care screening as well as identification of co-morbid medical issues and need for medication. These services also collaborate with consumers and families on crisis planning that ensures a coordinated response to accessing care through a provider.

These programs are closely linked to the entire system of community-based providers including PCPCHs, DHS programs, behavioral health providers, culturally-specific service providers, hospitals, housing providers and schools. The crisis programs regularly participate in community-wide events to proactively screen and promote health and wellness related to behavioral health issues. Referrals from the crisis programs or community events may be to primary care homes, peer and family wellness support, specialty mental health and addiction services. Upon contact with a provider, a consumer or family will participate in a collaborative assessment process to identify mental health and addiction concerns and need for further evidence based services. While one role of the provider network is to offer effective evidence based services in the right setting to the right person for the right amount of time, they play a large role in integrating care through coordination, communication and linkage with primary health care homes and other providers.

In all of the region's Federally Qualified Health Centers, consumers can access screening and brief intervention for mental health and addiction issues along with their primary care. Likewise, specialty mental health team based programs including early psychosis programs, 24-hour intensive case management programs, culturally specific socialization programs as well as respite and sub-acute services all offer primary care screening and services through nurses or other team medical staff. There are also several projects across the region where behavioral health agencies co-locate nurses who offer limited primary care screening and services as well as lab monitoring.

We look forward to implementing PCPCH models across the region building on the work that has taken place to date.

A.3.6.d The regional Tri-County Local Mental Health Authorities who are also TCMC Affiliates have developed integrated regional systems of care that include significant funding for prevention services. Several different prevention programs operate across the region with a community focus with other programs providing selective preventive interventions or indicated preventive interventions Universal community-based prevention and mental health or addiction promotion activities change over time based on community health needs. They include community-wide events and educational sessions promoting mental health wellness, information on recognizing early symptoms of psychosis, culturally specific suicide risk awareness, classes through organizations like NAMI for family and peer based wellness, community campaigns focused on mental health wellbeing, social inclusion and reduction of stigma associated with mental illness and addiction. Other strategies include strategic placement of multi-lingual billboards in specific communities to increase awareness of 24-hour support and crises lines.

Member mailings and newsletters will also be used to provide prevention information

including tobacco cessation and other resources that can promote longer term mental and physical health and overcome addiction problems. County websites provide 24 hour access to prevention messages, resources and health promotion.

Since fostering emotional and social health of children leads to healthy development, many nationally and internationally recognized mental health and addiction prevention efforts are provided in Head Start programs, schools and school based health centers, domestic violence centers, sponsored after-school clubs, through public housing programs and culturally specific community centers. Other preventive interventions are provided for high-risk families and individuals connected to Family Dependency Court; early intervention for youth aged 14-25 experiencing initial signs and symptoms of psychosis; screening and specific prevention services for seniors; and culturally-specific prevention for at risk immigrant populations.

In collaboration with the TCMC Affiliate health plans and delivery systems, TCMC Affiliate MHOs have been partners in funding integrated primary care projects across the region. Projects have supported practice-based team models in primary care and included embedding behavioral health consultants into primary care, supporting implementation of nationally-recognized models like IMPACT and working across systems to co-locate primary care staff in behavioral health centers. MHOs' PIP-funded RNs in behavioral health clinics provide limited primary care services and improve communication. Culturally-specific behavioral health programs have also co-located primary care with their programs, or created partner relationships with medical clinics. TCMC is a fully engaged partner to implement a regional infrastructure for PCPCHs in both primary care and specialty behavioral health.

Each of the Affiliate MHOs has a system of provider selection and quality oversight to ensure that contracted providers are qualified, competent and utilize appropriate evidence-based practices in service delivery. Utilizing a competitive process to select providers ensures that only agencies with a demonstrated history of effective treatment provision, established evidence-based practice programs and adequate capacity are contracted as service providers. Once contracted, each provider receives comprehensive quality oversight including tracking of access standards, critical incident review, monitoring for potential fraud and abuse, review of fidelity measures, and ensuring that service delivery is consistent with contractual language. Special emphasis is placed on strengths-based service delivery, cultural competence and family/support-inclusive service delivery. Providers are incentivized to deliver services in the community when clinically appropriate.

The TCMC's Affiliates MHOs function as Local Mental Health Authorities. These organizations have decades of expertise operating 24-hour programs that provide crisis intervention, coordinate flow of information and linkage to community care. This is critical for cost-effective delivery and coordination of services for individuals with severe mental illness, addictive disorders and other high-risk Members who access care through multiple state or local agencies. The 24-hour programs include crisis lines, mobile outreach teams, urgent walk-in clinics, sub-acute hospital diversion program and respite care services that are culturally appropriate and age specific. Staff from the programs provide education and outreach to community partners so they know how to coordinate care and information with these 24-hour services. TCMC will use these services regionally as community hubs for 24-hour coordination of information and care. The programs reduce unnecessary acute care

costs and ED visits, avoid duplication of services, can identify medication concerns, and provide linkage to PCPCHs.

In line with legislative mandates, TCMC's Affiliate MHO's have been accountable for planning, funding and oversight of a delivery system that offers evidence-based, best practice treatment and recovery services. This has included promoting a delivery system of services that are culturally-specific, recovery-oriented, family and peer driven and trauma-informed. Through the procurement and contracting process, regional counties and TCMC Affiliate MHOs have purchased nationally-recognized and best practice models of care, specific to age and population. As new treatment technology and models document outcomes, counties pilot or integrate new services into the system. In line with national health care reform, counties implemented integrated care models within FQHCs and in the community, with targeted populations serving individuals with severe mental illness. The integrated care models have been successful in providing better coordinated care with improved outcomes. As TCMC funds and develops PCPCHs, the infrastructure for behavioral health primary care homes will be expanded to ensure the Triple Aim is achieved for populations with severe mental illness and addictions.

Oral Health:

A.3.6.e TCMC intends to begin discussions with Dental Care Organizations (DCO) operating in Multnomah, Washington or Clackamas counties in early 2013 to evaluate the feasibility of developing contractual arrangements to serve the oral health needs of TCMC Members prior to July, 2014, pursuant to HB 3650. The Board of Directors of TCMC has elected to include a dental care provider on the Board of Directors at the inception of the organization.

A.3.6.f The timeline described above will not, however, delay TCMC's pursuit of enhanced care collaboration as we progress to care integration with oral health. Great disparities exist in oral disease prevalence and the Medicaid population is often disproportionately burdened with oral disease. Access to preventive and routine dental care is a determinant of overall disease status. Therefore, TCMC will also undertake a dental needs assessment in the TCMC service area and, if indicated, explore enhanced access opportunities through alternative care delivery models, including community-based prevention strategies, and school-based prophylactic dental clinics.

In addition, TCMC will work to enhance communication and referral strategies through Model of Care Transformation so that oral, physical, and behavioral health needs are shared across provider disciplines. These enhanced communication strategies may include a formal referral system and protocol that can be used by EDs, PCPs, dentists, behavioral health specialists and others for referring TCMC Members with oral health needs.

Hospital and Specialty Services:

A.3.6.g As detailed in earlier responses, TCMC's Affiliates include the six major delivery systems, the three county governments, four local physical health and three mental health plans, as well as most of the FQHCs currently serving the Tri-County community. The TCMC Affiliates have invested heavily in improving coordination between providers, between care settings, and across service entities.

In addition to the hospital transition processes already described, TCMC is committed to

community wide roll-out of a specialty referral communication system, such as the IRIS system mentioned above now being launched by the Portland IPA. Discussions have already begun with that group on the feasibility and cost of using IRIS on a community wide basis. IRIS, or a similar system, not only allows communication of the referral and the request for an appointment to the specialist and the return of the results of the consultation, but also has functionality to improve the referral process.

Decision rules can be developed to ensure that the referring provider has performed all necessary evaluations, that the referral is appropriate and that the provider is sending critical needed information with the patient. Such systems can also be further developed to allow short consultations ("curbsides") with specialists regarding patient management issues without the patient having to be seen for every issue. This provides more efficient and cost-effective care and also provides the opportunity for PCPs to broaden their skills and manage a more complicated panel of patients.

A.3.7 DHS Medicaid-funded Long Term Care Services

A.3.7.a TCMC expects that its MOU with the AAA/APD will include the following functions to ensure coordinated care services for the Members:

Care Coordination and Option Counseling. Care Managers will conduct person centered options counseling with TCMC Members. Option counseling helps the consumer identify their long term care supports and services needs and then arranges for these services to be provided to the consumer. Ongoing case management is provided to the consumer to ensure services were received and appropriate as well as the identification of additional service needs.

Care Transitions. ADS will conduct care transition services for individuals transitioning across LTC settings and from hospital or Skilled Nursing Facility to home or residence of choice.

Nursing Facility Transition/Diversion. Assisting individuals with transitions across LTC services to ensure the most appropriate and least restrictive care setting.

Co-location of Medicaid Intake Staff at Hospitals. ADS currently partners with several TCMC Affiliate delivery systems to locate a Medicaid Intake worker at the hospital to facilitate Medicaid eligibility.

Community Contract RN Services. Contract RNs provide consultation and delegation of nursing tasks for individuals living in home and community-based care settings, and coordinate closely with medical professionals involved in their care.

TCMC will encourage the use of the evidence-based Coleman model for care transitions of Members and will set up process and outcome measures that ensure coordination of care across health and LTC systems. Consideration may also be given to developing financial incentives structures that include shared savings and incentive payments tied to desired outcomes, and encouraging process/structure of coordination across the systems.

Data sharing agreements will also be established with LTC agencies to facilitate cross-system communication and protocols for using information to coordinate care across care settings and systems. Use of more flexible funds may be used to support individuals (e.g. DME,

technology for self-management, respite for family members, etc.) in their homes in a way that reduces overall system cost. TCMC will also partner with ADS to provide integrated navigation of health and LTC service and supports systems and maximize opportunities for diverting and transitioning individuals from nursing facilities.

Through agreements with LTC agencies, TCMC will pursue co-location of ADS care coordination staff in health home settings to facilitate integrated approach to care for individuals needing long-term services and supports as well as integrating ADS staff into hospitals care transitions teams to identify and follow individuals who would benefit from community-based care transitions support. Ensuring the ADS-contracted RNs have access to the regional TCMC registry and other critical health information will also be important for better coordination between medical and LTC systems. In order to maximize opportunities for diverting and transitioning individuals from nursing facilities, TCMC will also educate the provider network and contractors on the availability of the ADS 24-Hour Access Resource line for after-hours access to advice, services and appropriate medical care and long-term services and supports.

- Co-Location: co-location of staff such as type B AAA and APD case managers in healthcare settings or co-locating behavioral health specialists in health or other care settings where Members live or spend time,
- Team approaches: care coordination positions jointly funded by the DHS Medicaid-funded LTC and health systems, or team approaches such as a multi-disciplinary care team including DHS Medicaid-funded LTC representation,
- Services in Congregate Settings: DHS Medicaid-funded LTC and health services provided in congregate settings, which can be limited to one type of service, such as "in home" personal care services provided in an apartment complex, or can be a comprehensive model, such as the Program of All-Inclusive Care for the Elderly (PACE).
- Clinician/Home-Based Programs: increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform assessments, plan treatments, and provide interventions to the person in their home, community-based or nursing facility setting.

A.3.8 Utilization Management

A.3.8.a Utilization management (UM) functions will remain with the Affiliate health plans, which have established processes as well as knowledge of the special needs of the populations they currently serve. As with other functions, the TCMC will standardize UM across the plans to the extent this improves performance and decreases administrative cost and redundancy.

TCMC Affiliate MHOs have already begun this regional process. Below is a high level summary of the draft plan of Affiliate MHOs to standardize UM procedures for the region. The guidelines of the regional Mental Health UM plan are:

- To ensure that mental health services are individualized consumer and family driven, strengths-based, flexible, coordinated, culturally competent and medically necessary.
- To ensure that clients are served in the most normative, least restrictive, least intrusive level of care appropriate to their history, degree of impairment, level of intellectual and development disability, current symptoms, and extent of family and community supports.
- To ensure that service intensity is individually tailored to client need.

- To respect client choice in the selection of a mental health provider.
- To ensure that mental health services are based on a recovery oriented, strengths-based model and that the client is the primary determiner of treatment goals.
- To ensure a prompt response to requests for service authorization.
- To ensure that services provided to TCMC Members are medically appropriate and medically necessary, covered mental health services, and funded condition-treatment pairs on the OHP Prioritized List of Health Services.

For outpatient and community-based rehabilitative services for children and adults, authorization will occur by way of assignment to one of three levels of care. Services are provided at the level of care based on an initial mental health assessment from the provider. Criteria and service expectations are described in detail in Policies and Procedures and include a Child and Adolescent Service Intensity Instrument (CASII) or Early Childhood Service Intensity Instrument (ECSII) score for children and a Level of Care Utilization System (LOCUS) score for adults as decision support tools for determining the appropriate level of service.

No clinical review for pre-authorization for outpatient services is required for Basic or Intermediate levels of care. Clinical review for pre-authorization is required for the Intensive level. Continued Stay reviews are done for Intensive levels of care. UM will also take place when transfers between levels of care are requested. UM chart audits and post-payment review are conducted periodically. Such reviews include determination of both over- and underutilization by individual Member profiles and by provider profiles, as well as evaluation of whether the clinical documentation supports the services billed. High-utilizing Members are identified for focused care management.

Providers are expected to manage utilization throughout the authorization period consistent with the service intensity expectations for each level of care and ensure that the client is assigned to the correct level of care as indicated by medical necessity.

The levels and authorization periods are:

Authorization Type	Authorization Period	Clinical review for Pre-auth required?	Clinical review Re-auth required?
Basic	One Year	No	No
Intermediate	One Year	No	No
Intensive (Adults)	One Year	Yes	Yes
Intensive (Children)	Three Months	Yes	Yes

Acute Inpatient and Sub-Acute Psychiatric Services

All non-emergency admissions to inpatient/acute care and all admissions to sub-acute care must be pre-authorized. If the admission is not an emergency, MHO Staff or after hours staff will review medical necessity criteria as defined herein, and authorize if the admission is deemed medically necessary. Staff will provide consultation and resources to the caller regarding alternatives to hospitalization such as respite care, crisis team follow-up or intensive outpatient services in order to ensure that less restrictive options have been ruled-out prior to considering inpatient care. If alternatives to hospitalization have been ruled out, and the admission meets medically necessary criteria, staff will authorize the admission.

It is not necessary to obtain pre-authorization for emergency admissions. An emergency is defined as:

> A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.[4]

A Notice of Mental Illness (i.e. mental health "hold") is always defined as an emergency.

Continued Stay Authorization is required on the first business day following admission to obtain authorization for continued stay. The Care Coordinator will continue to evaluate the client's mental health status at pre-determined intervals throughout the hospitalization. Utilization Review (UR) will occur every two days except as otherwise agreed upon by both the Care Coordinator and facility utilization review staff. Time between additional UR contacts may be lengthened or shortened depending on clinical presentation and other external factors.

A similar standardization of UM for TCMC Affiliate health plans will also occur. The TCMC will have delegation oversight responsibility as part of its contracting with all delegated entities to ensure that the standardized UM plan is implemented consistent with best practices and remains compliant with state and federal regulations.

TCMC is exploring available systems for aggregating data from the Affiliate organizations and providing the analytic capacity to identify risk adjusted over- and under-utilization compared to best community practice and national benchmarks. TCMC Affiliates have or are building capacity to perform this function. An example of a state of the art system that is locally available would be Milliman's MedInsight® Analytic Platform which can analyze cost, efficiency, health, benefit design, and provider contracting arrangements to identify opportunities for improvement.

An important functionality of any utilization evaluation process is the capacity for customization based on specific characteristics of the region's Medicaid population. A truly accurate method of identifying over- and underutilization will have to adjust for many social and contextual factors. TCMC acknowledges that, while it can start with existing technology and criteria, there is still much to be learned. Fortunately, TCMC can bring to bear access to Affiliate expert resources, at CORE, CHR, OHSU and elsewhere, to help it become increasingly sophisticated with its methodology.

[4] OAR 410-12-0000, "Emergency medical condition."

Section 4: Health Equity and Eliminating Health Disparities

A.4.1 Each of TCMC's Affiliates has its own approach to embedding cultural competence into the delivery of care. TCMC's task is to design a system of shared standards and hold Affiliate and sub-contracted organizations accountable to common policies and expectations that will result in the most culturally competent workforce possible across all networks of providers. Cultural competency thought leaders from Affiliates, members of the CAC, members of the CAP and the TCMC executive leadership team and staff will work together to implement a Systemic Strategy for Cultural Competence which includes:

a) Comprehensively capturing racial, ethnic, educational attainment, sexual orientation, disability and socio-economic information in a culturally competent manner;
b) Conducting a multi-level needs assessment;
c) Developing a Cultural Competence Policy statement;
d) Reaching consensus on definitions, principles, and benchmarks associated with providing culturally competent Member-centered care;
e) Developing a Cultural Competence Mission Statement;
f) Identifying and adopting Cultural Competence standards;
g) Engaging in the development of a Cultural Competence Strategic Plan (with measurable goals, outcomes, timeframe);
h) Infusing Cultural Competence measures and standards in CCO Performance Reviews;
i) Designing or identifying Member-centered Cultural Competence curriculum to pilot with both clinical and non-clinical staff, including creating tools for providers to use to communicate with members in a culturally appropriate way about care coordination and provider and member responsibilities in assuring effective communication;
j) Creating talking points that will promote alignment among Tri-County leaders when interacting with underserved communities and the community at large.

A.4.2 The foundation for collecting accurate data on member race, ethnicity and primary language will be built in the health home, and will be a fundamental driver of TCMC's work to build Health Information Technology capacity in the areas of data analytics, quality improvement and patient engagement.

Demographic information such as race, ethnicity, primary language, mental health and substance abuse are entered into the Practice Management system of the primary care provider's Electronic Health Record.

This demographic data can then be cross referenced to quality measures. Mental health and substance abuse information can be tracked by querying the corresponding diagnosis codes; race, ethnicity and language information are entered into reportable fields in the Practice Management section of the EHR.

Rates of data collection and quality of these categories of demographic data are currently inadequate. TCMC will build on quality improvement initiatives from affiliated FQHCs that have decreased the instances of front desk staff marking Member race and ethnicity based on observation alone, increased the comfort level of staff to ask for Member race and ethnicity and decreased the percentage of unanswered/refused race/ethnicity from 8% to 4% over the first two months of the quality improvement project. Accurate collection of this sensitive demographic data requires culturally competent intake-workers trained in appropriate data collection.

Section 5: Payment Methodologies that Support the Triple Aim

A.5.1 All of TCMC's Affiliate health plans currently provide some form of pay-for-performance for their providers. PCPCH payments are distributed based on tier, performance, or administrative costs. Some also offer gain sharing on budget targets with PCPCHs or quality bonuses based on meeting HEDIS or other best-practice targets; this gain sharing also happens with community-based providers in some instances. Others offer bundled payments for particular services.

All Affiliate health plans also have care and disease management program whose goals are to educate, motivate and empower Members to improve their health and to educate Members on prevention and how to manage chronic conditions. This is achieved by identifying the most vulnerable beneficiaries, encouraging preventive screenings, and nurse outreach.

In addition, most Affiliates participate in the Oregon Health Leadership Council's High Value patient-centered care project which offers providers a PMPM case management fee to care for Members with a high risk score. In another pilot in the community, a health plan has been modeling and testing an age-based adjustment to reward practices who manage high-need patients, including both adult and pediatric populations.

Going forward, TCMC plans to require all Affiliates to use alternative payment methodologies for Members assigned to PCPCHs. These payments are in addition to the pm/pm payments for ACA-qualified members, which will be expected to pass 100% to the PCPCHs. In addition, the payment methodology will require that payments are structured to incentivize progression to higher PCPCH Tiers. Currently 80% of TCMC Affiliate health plan members are already assigned to a certified PCPCH or PEBB certified primary care home. The estimated annual financial impact of the proposed alternative payment methodology will be $635,870 for the primary care community serving TCMC Members.

In addition, three of the four Affiliate health plans are participants in the recently awarded CMS Comprehensive Primary Care Initiative (CPCI) for the State of Oregon. This four-year, multi-payer program was awarded to only seven markets in the nation. TCMC is excited to participate in this synergistic group of payers, as this program has the potential of facilitating a dramatic makeover of primary care in Oregon.

In close collaboration with the Model of Care Workgroup and eventually with the Clinical Advisory Panel, and other community stakeholders, TCMC is developing a Tri-County payment incentive model focused on improving the quality and affordability of health care. The model will offer performance-based incentives to the providers regardless of which Affiliate health plan the Member is assigned. TCMC believes this will drive greater accountability and transparency for the providers and payers in the system.

The proposed model uses the CCO Accountability Metrics and Transparency Measures based on encounter and other clinical data. Depending on the measure, providers may be evaluated based on performance according to statewide averages or Achievable Benchmarks of Care. Whenever possible, results will be reported according to race and ethnicity to drive reductions of disparities.

TCMC has agreed in principle with stakeholders to work towards performance-based auto

assignment to Affiliate health plans with consideration for deployment by January 2014.

Section 6: Health Information Technology

A.6.1.a TCMC and its Affiliates will be actively engaged in improving HIT in the areas of data analytics, quality improvement and patient engagement. TCMC has created an IT Steering Committee comprising the Chief Information Officers or equivalent from each of the Affiliate organizations as well as IT and clinical leaders from other community partners like OCHIN and Quality Corporation. Led by the TCMC CIO, the IT Steering Committee will drive the HIT strategy for TCMC. The HIT strategy will include fueling adoption of federal ONC certified EHRs and implementation of patient portals motivating patient engagement across the provider network and implementing:

- a directory of available services and related service providers;
- a standardized discharge summary;
- secure provider-provider and provider-patient online communication;
- patient referral system;
- provider performance measurement, analysis, and reporting system; and
- a community-wide, web-based patient registry enabling population health management and outreach.

Additionally, many of the TCMC Affiliates have been individually developing their own data analytics capabilities for both claims management as well as optimization of inpatient and outpatient care. Affiliated plans use their data populated with provider and pharmacy claims, Member enrollment, lab and diagnostic results and other information for a variety of analytical purposes including program evaluation and system analysis. Affiliated delivery systems have also been utilizing clinical informatics departments that will integrate clinical operations with IT and ultimately finance. TCMC understands the importance of data analysis and business intelligence required to perform population management, and improve quality outcomes, patient safety and clinical effectiveness and recognizes the requirement for appropriate data sharing agreements to exist among TCMC partners.

Due to the widespread use of Epic by the TCMC Affiliates, MyChart is a tool employed to engage patient's online through secure communication and provide patients electronic access to lab and diagnostic test results, appointment scheduling functions and their personal health record. For those without Epic, many have or are exploring the addition of similar patient portals. Additionally, there are pilot projects that engage clients through the use of text messages and cellular technology. TCMC will work to support these pilots and other efforts that will encourage better patient engagement while maintaining patient's HIPAA rights to privacy.

A.6.2.b TCMC Affiliates have been and will remain actively engaged in tracking and increasing adoption rates of federal ONC-certified EHRs across the provider network. Legacy Health and Adventist Health are both working with community providers to subsidize the purchase of their EHRs for use in clinic practices. Many of the Affiliate plans also track the types of EHRs used by contracted providers, as well as the number and percentage that are certified. In order to increase adoption rates, these organizations are working to varying degrees with providers to educate them and help them achieve meaningful use and receive the state and federal incentive payments. TCMC Affiliates also encourage physician offices to contact and

leverage the services of OCHIN, Oregon's Regional Extension Center.

One of the initiatives included in the Health Commons CMMI proposal is the creation of a community-wide patient registry to interface with EHRs throughout the community. As such, the IT Steering Committee will encourage the adoption of federal ONC-certified EHRs, which will interface with the registry and allow for more timely and efficient secure access to information.

A.6.2.c As cited previously, TCMC is looking to develop a web-based patient registry to allow providers and other care givers to have access to relevant patient information regardless of whether they have an EHR, or what system they use. The efforts of TCMC Affiliates are in support of these objectives. For example, Providence is intending to develop a privately-funded Health Information Exchange for connecting private physician office EMRs to Providence's Epic implementation and to other outside organizations. Additionally, many of the delivery systems employ technology that allows clinical information (lab orders, results, and clinical summaries) to be exchanged with Affiliate and referring providers with direct connect to their office. Providers utilizing Epic will be able to electronically exchange information with other systems and providers through Epic's Care Everywhere functionality. Lastly, some Affiliate delivery systems also provide a read-only version of their EHR for providers who have different EHRs.

As stated previously, TCMC Affiliates are also actively engaged in supporting the achievement of meaningful use of EHRs for their own hospitals and employed providers as well as community physicians.

TCMC affiliate representatives and TCMC leadership are and will remain actively involved in regional and statewide information exchange discussions and fully commits to participating in community-wide solutions when implemented. Additionally, TCMC would like to be engaged in marketing the Direct-enabled Health Information Services Provider (secure routing of messages) to the provider network. TCMC will educate providers on the availability of the service after the State has finished the pilot.

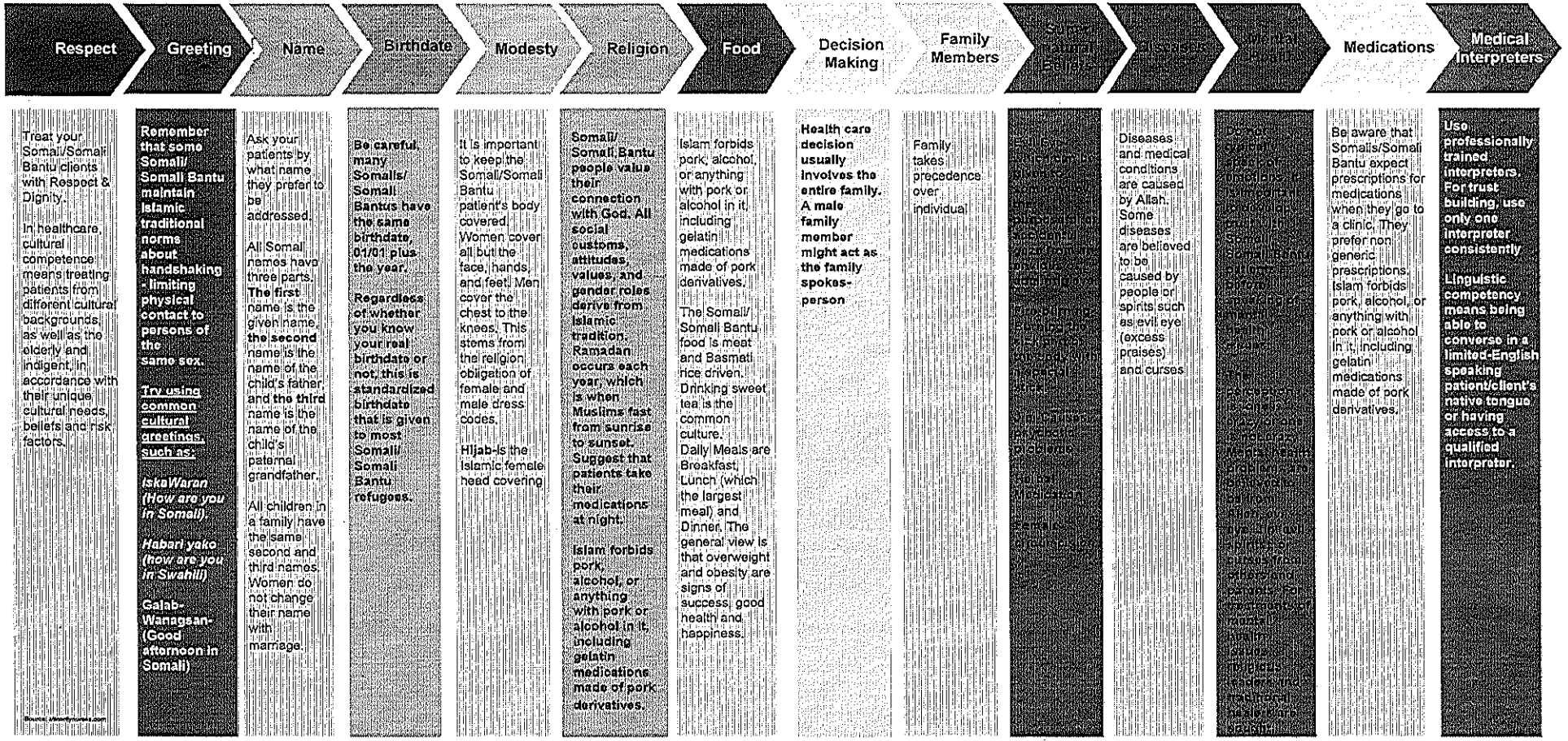
TCMC Additional Material Summary

A-1	Resumes of Key Leadership Personnel
A-2	Tri-County Medicaid Collaborative Transition Leadership Team and Structure
A-3	Letters of Support from Key Community Stakeholders
A-4	Rockwood Map
A-5	CareOregon's Better Together Communication Tool
A-6	Multnomah County's Culturally Competent Health Care Practices Toolkit
A-7	Kaiser Foundation Health Plan of the Northwest's Cultural Competency Resources
C-1	TCMC Model of Care Design

MULTNOMAH COUNTY
Health Department
Human Resources/Training

Moving Towards Culturally Competent Health Care Practices
Somali/Somali Bantu Population
Toolkit

Public Health
Prevent. Promote. Protect.

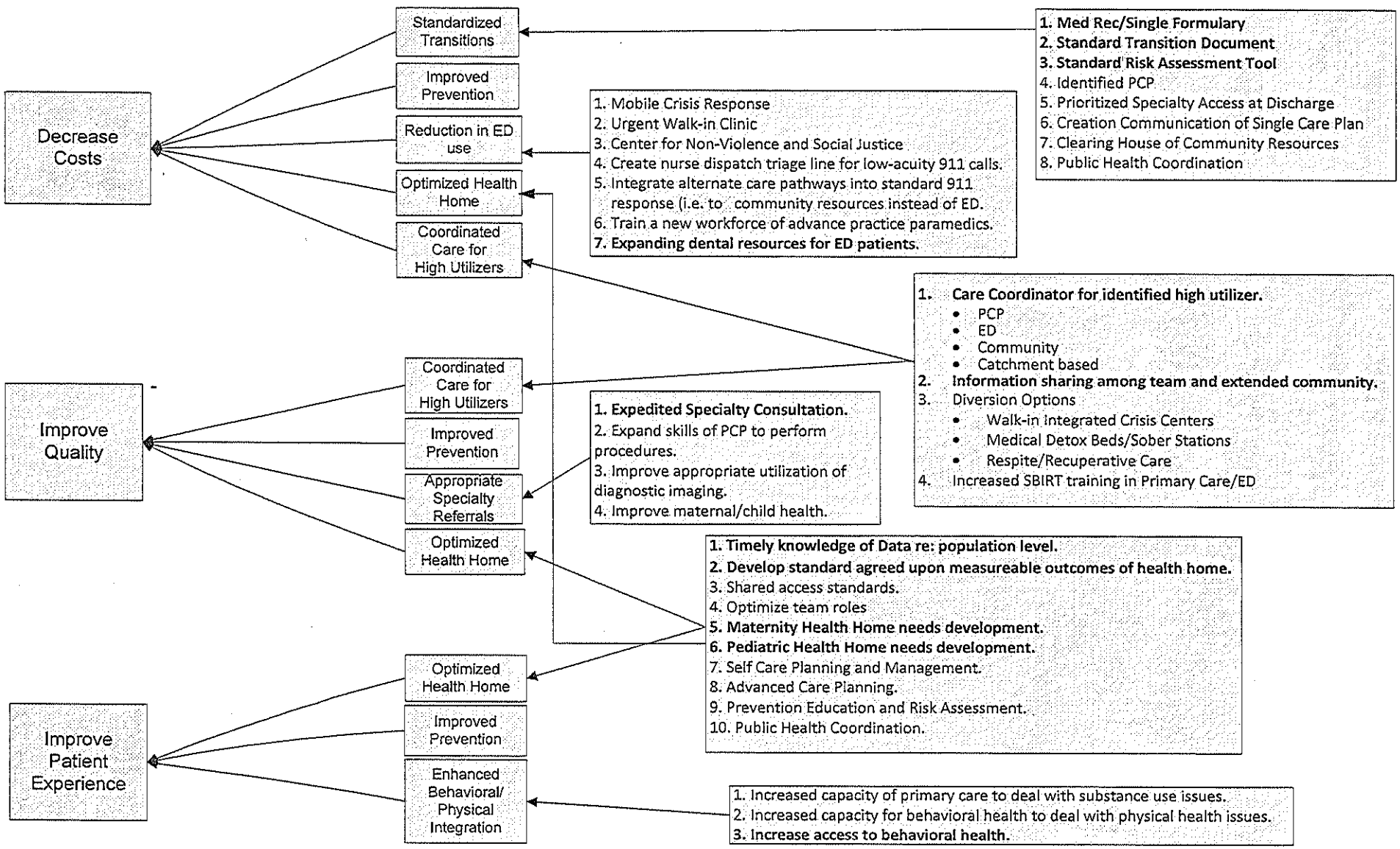


Tri-County Medicaid Collaborative

Diagram C-1 – Model of Care Driver Design

Implementation Essentials:

- Cultural Awareness
- Cultural competence training: for all
- Care Coordination Training: SBIRT, Trauma Informed Care, Cultural Competence
- Data on population: profile of diagnosis/ utilization patterns
- Information sharing platform: HUB, EDIE
- Alternate payment models
- Health Literacy



KP Cultural Competency Resources
April 2012

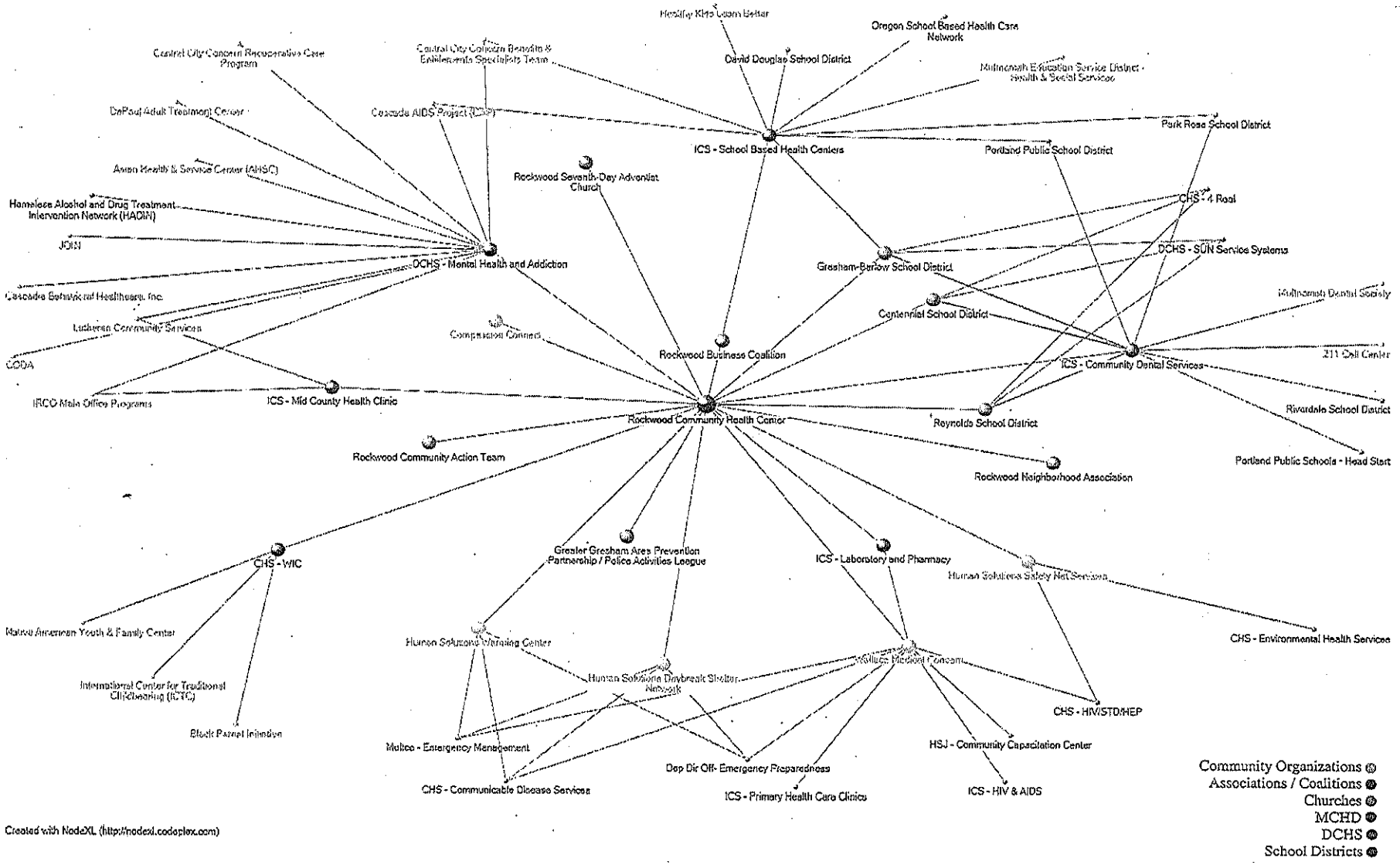
KPNW utilizes regional interpreter service data, census data, as well as information voluntarily provided by members to assist in determining cultural, ethnic, and linguistic needs. When possible, practitioners who can communicate in a foreign language are strategically placed in high demand areas. Other accommodations include employing a full time interpreter at sites that are frequented by members in high volume who speak a specific foreign language. For instance, the Beaverton Medical office which has one of the highest rates of Spanish speaking members in the region, employs six practitioners who speak Spanish and one full-time Spanish interpreter.

In addition to accommodating the ethnic and linguistic needs of members, KPNW also provides clinicians with comprehensive cultural competency resources and trainings. Kaiser Permanente's initiative, Achieving Our Mission and Growing the Business through the National Diversity Agenda, makes diversity and inclusion central to the organization's competitive advantage and its ability to deliver culturally competent health care to members. The National Diversity Agenda is an organizational framework to develop an engaged, professional, and diverse workforce sensitive to the needs of patients and members. The cultural competency initiative included developing a comprehensive set of tools for providers at KP:

1) Provider's handbooks on culturally competent care for individuals with disabilities, Latinos, African-Americans, Asians, Pacific Islanders, Lesbian, Gay, Bisexual and Transgender communities.
2) The KP National Culturally Competent Care Directory – A comprehensive directory of culturally competent resources available across the KP program.
3) Video and DVD series on culturally competent care and how to navigate the KP healthcare system.
4) Pocket Cards that include tips and strategies designed to aid in communicating with cultural, ethnic, linguistic, and special needs.
5) Diversity Library – Includes a collection of articles, studies, and other resources to advance diversity.
6) Annual National Diversity Conference – This annual conference hosts an array of internal and external experts on diversity issues, concepts, practices and trends in diversity management, culturally competent care delivery, linguistic services and care access, and marketing to diverse populations. The conference is open to KP employees and providers. Most of sessions and materials have been made available for viewing online via recorded webex.

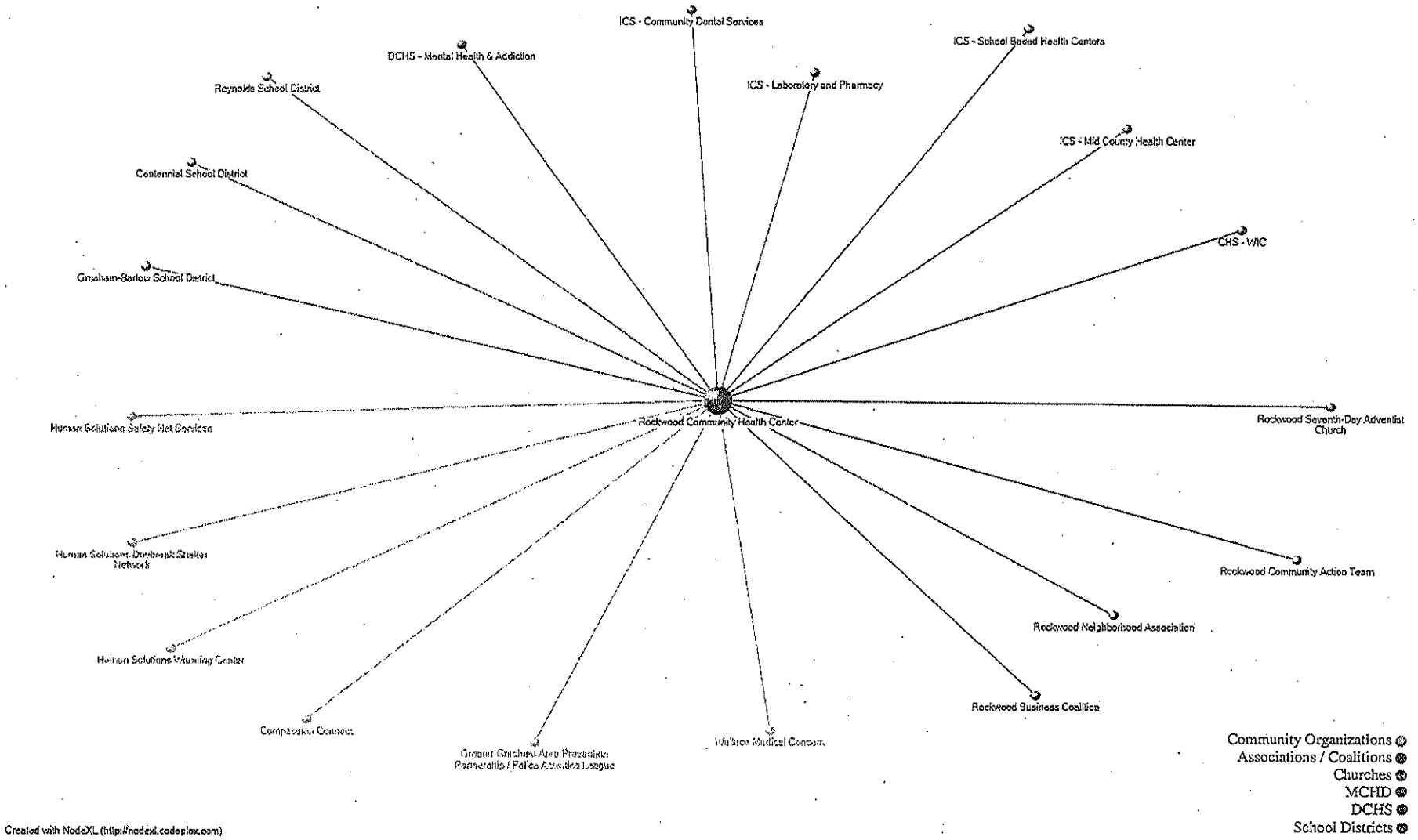
Cultural competency trainings, tools, and resources are available online on the National Diversity website http://diversity.kp.org/index.html

Identified Relationships Between Rockwood Community Health Center and the Community (3/26/12)



Created with NodeXL (http://nodexl.codeplex.com)

Identified Relationships Between Rockwood Community Health Center and the Community (3/26/12)



Created with NodeXL (http://nodexl.codeplex.com)

Availability of CCO Applicant Utilization Dataset

Overview

The Oregon Health Authority (OHA) will provide utilization data to prospective CCOs that have submitted an accepted letter of intent. This data will span the prospective CCO's proposed geographic area as provision of the data is specifically for purposes of the administration of the medical assistance programs. Specifically, these data are being provided to allow applicants to build their own understanding of the proposed covered populations for the development of their application. Applicant CCOs must acknowledge understanding of the data use agreement included with the CCO web portal terms and conditions that governs the use of all OHA data in order to receive these datasets.

The datasets are being provided to the applicant CCOs at the claims level with personal identifying information removed. Claims data expertise will be required to understand and manipulate these data sets. OHA will work directly with designated contacts from the legal entity to ensure secure transmittal of the data.

Data Description

Datasets will include claims for the proposed geographic service area from July 2009-June 2008. Utilization data provided in this set closely corresponds to that submitted on UB04/UB92 and CMS 1500 forms. Data will be provided for physical and mental health items and services provided. In the case that the applicant intends to integrate dental care in its initial proposed CCO submission, dental claims will be included in the dataset as well.

Data fields included in the datasets

- Claim Type
- Claim Indicator (Managed care or fee-for-service)
- Recipient Deidentified ID
- Recipient age on date of service
- Recipient Medicare Status
- Recipient Zip Code (first three digits only)
- Recipient County
- Recipient Eligibility Group
- Recipient DMAP Rate Group (proxy provided for FFS populaiton)
- Recipient Gender
- Recipient Race
- Recipient Ethnicity
- Recipient Tribal Status
- Encrypted Claim Number
- Claim detail Number
- Claim Status
- Place of Service
- Length of Hospital Stay in days
- Date Service Begin (year/mth)
- Principal Diagnosis through 7th
- Hospital Diagnostic Related Group
- ICD9 Surgical Procedures
- Revenue Code
- CPT or HCPCS Code
- CPT Modifiers
- Unit of Service (Quantity)
- UB Discharge Status
- NDC Code
- Drug Days Supply
- Drug Dispensed as Written Indicator
- Drug Metric Quantity Dispensed
- Encrypted id of billing provider
- Billing Provider Type
- Billing Provider Specialty
- Encrypted id of Performing Provider
- Performing Provider Type
- Performing Provider Specialty
- Total Billed Amount (Only on FFS claims)
- Paid Amount (Only on FFS claims)

Availability of CCO Applicant Utilization Dataset

Data Use Agreement

Applicant CCOs must acknowledge understanding of the data use agreement found with the CCO web portal terms and conditions in order to receive these datasets. This agreement requires that the applicant is responsible for maintaining the security and privacy of all OHA obtained. "Data" includes all copies of the Data and any document that uses or is derived from any part of the Data. Applicant understands that OHA will provide access to Data and that these Data are provided to Applicant solely for purposes of the administration of the medical assistance program and implementation of state laws establishing the Oregon Integrated and Coordinated Health Care Delivery System by the use of Coordinated Care Organizations.

Applicant warrants that:

- The confidentiality of all Data will be protected as mandated by state and federal laws and regulations, including HIPAA Privacy and Security Rules;
- The Data will not be used for any other purposes than those related to this RFA and Application unless prior written authorization is obtained from an authorized OHA representative;
- No findings, listing or information derived from the Data will be released or disclosed to other parties with or without identifiers, if such findings, listings, reports or information contain any combination of Data elements that might allow the deduction of a patient's identification;
- Access to the Data will be limited to those individuals directly involved in the Applicant's Application to the extent necessary to achieve the purposes of the RFA response, and that access will be limited to the minimum amount of Data necessary to achieve the purposes stated above;
- Applicant will report to OHA any breach of security or violations of this Agreement as soon as the Applicant becomes aware of the violation;
- Applicant will apply appropriate administrative, technical and physical safeguards so that the Data will be protected to prevent unauthorized use;
- Applicant will grant OHA authorized representatives access upon request to review Applicant's security arrangements;
- If the Applicant ceases to participate in the RFA for any reason (including but not limited to the withdrawal of its Application, OHA's denial of certification, or OHA's not awarding a Contract to Applicant), Applicant will return to OHA or destroy all of the Data and not later than 60 days after the participation ceases will provide to OHA an attestation that all the Data have been returned to OHA or destroyed, unless written agreement between OHA and the Applicant establishes another method for the Data to be handled;
- Applicant will enter into written agreements with any other persons who assist Applicant with the Data or otherwise obtain or use the Data obtained by Applicant, binding such person to all of the terms in this Agreement. Applicant will disclose such written agreements to OHA upon request; and
- Applicant will be responsible for any use by any person of the Data.

4/6/12

4/16/12

Section 1: Service Area and Capacity

B.1

Service Area Table

Section 1: Service Area and Capacity
B.1 Service Area Table
Redacted

Section 2: Standards Related to Provider Participation

B.2.1 **Provision of Coordinated Care Services**

TCMC is fortunate to participate in the Community Health Needs Assessment (CHNA) collaborative led by the Oregon Association of Hospitals and Health Systems (OAHHS), a membership organization representing Oregon's 58 acute care hospitals and health systems.

On Nov. 4, 2011, OAHHS convened community partners, hospital members and public health departments, who agreed to develop a single CHNA for the four-county region of Washington, Multnomah, Clackamas, and Clark (WA) counties. This approach will, for the first time, enable joint prioritization of needs and collaborative efforts for implementing and tracking improvement activities. Ultimately, the CHNA report will include a description of communities served, how communities were defined and determined, description of the process and methods used to conduct assessment, sources and dates of data and other information used by each hospital and by other organizations, identification of analytical methods applied to identify community needs and identification of information gaps that impact the ability to assess needs. For more information see the vendor RFP here: http://www.oahhs.org/public-docs/community.pdf)

TCMC will have access to a consistent assessment of community health in the region through the OAHHS's CHNA process. The assessment framework will include timely, accurate data, ease of data entry, and flexible reporting with a repository of comprehensive community health information for the region. This comprehensive CHNA will inform the Health

Improvement Plan for delivery of integrated and coordinated health, mental health, and chemical dependency treatment services and supports in the TCMC service area.

Table B-1 (Participating Provider Table) will be available at Readiness Review.

B.2.2 **Providers for Members with Special Health Care Needs**

The Tri-County community has the state's greatest concentration of providers and specialists with the skills necessary to provide comprehensive, coordinated care to individuals with special health care needs. These providers range from community-based organizations serving cultural minorities (Asian Health and Service Center, NARA), to health system-based specialty treatment centers (Legacy Children's Orthopedic Clinic, Kaiser Permanente Pain Clinic), to specialized services for individuals with mental health and chemical dependency needs (Central City Concern, LifeWorks, Cascadia), to services for children with developmental disabilities (OHSU's Child Development and Rehabilitation Center, Trillium Family Services), and specialized services for the elderly (Providence ElderPlace, Multnomah County STAR Caregivers). See Table B-1 for a more complete list of these providers and specialists. These providers' locations and services span the Tri-County region, and they currently work closely as contracted partners in providing care for these vulnerable populations. As common Affiliates of TCMC, the ability to work together to coordinate care for members with special health care needs will only grow.

B.2.3 **Publicly Funded Public Health and Community Mental Health Services**

B.2.3.a Dozens of publicly-funded community stakeholders have contributed to TCMC workgroups including Model of Care, Governance and Revenue. In addition, county governments, Multnomah, Clackamas and Washington, as well as representatives from the Federally Qualified Health Centers are Affiliates of TCMC.

Affiliate health plans contract with publicly funded, public health and community mental health services. See Table B-2 at Readiness Review.

B.2.3.b TCMC's agreements with Affiliate counties for authorization of and payment for point-of-contact services and for cooperation with local mental health authorities will be available by the Readiness Review.

B.2.3.c TCMC is negotiating MOUs with the counties in the service area for point-of-contact services such as immunizations, communicable diseases, family planning, HIV/AIDS prevention, and maternity case management, among others. In addition, TCMC will support the delivery of health services for children provided through schools and Head Start programs as well as screening services to provide early detection of health care problems among low income women and children, migrant workers and other special population groups.

B.2.4 **Services for the American Indian/Alaska Native Populations (AI/AN)**

B.2.4.a TCMC's Affiliates currently provide care to AI/AN individuals. TCMC is committed to strengthening relationships with this historically underserved community. Maximizing cultural competence throughout our community is a primary TCMC goal. Key areas of work include increased access to care; connecting clinical care to Native cultures, traditions, and languages; addressing issues of trust; and increasing understanding of the impact of social determinants of health on health status and appropriate treatment plans for this community. Many Affiliates have developed partnerships with key AI/AN organizations such as the Native American Rehabilitation Association (NARA), the Native American Youth and Family Center (NAYA), and the Portland-Area Indian Health Board.

Some specific examples of partnerships with TCMC Affiliates include:

Communication between native health advocates, CareOregon and the local MHOs that ensures plans are responsive to native clinic needs; a formal agreement with Kaiser related to IHS diabetes services that have been recognized as producing outstanding clinical outcomes-grant to study and replicate; Providence has donated medical equipment to open a new NARA clinic at 124th and Burnside; and the NARA clinic is across from Legacy Emanuel and the two organizations have a good working relationship.

The recent release of the Native American Community Profile by the Coalition of Communities of Color has brought new attention and commitment to addressing the serious health disparities faced by the AI/AN population, and TCMC intends to be at the forefront of this work. TCMC is in planning stages of partnering with the local AI/AN community on a demonstration project that will build off the health home and demonstrate more options specialty referrals for native people via patient navigators, community health workers and peer wellness specialists stationed at tribal health centers.

B.2.5 Indian Health Services (IHS) and Tribal 638 Facilities

B.2.5.a All Tribal 638 facilities and IHS providers in the State of Oregon will be TCMC participating panel providers.

B.2.6 Integrated Service Array (ISA) for Children and Adolescents

B.2.6.a TCMC Affiliate mental health plans are experts on the provision of ISA to families, youth and children, and will continue to serve in this role while increasing health services integration. Affiliate MHOs in the region incorporate wraparound principles in their delivery of ISA services. A particular asset to TCMC is Washington and Multnomah Counties' programs where services are provided with fidelity to the evidence-based Wraparound model.

All MHOs have established referral and screening processes for the ISA with important community partners such as Child Welfare, Juvenile Justice and School Districts, which allows for rapid screening within three business days. Youth found eligible are assigned to a Care Coordinator, who remains constant across levels of care and service delivery systems until the youth and family no longer needs the ISA level of service intensity. The coordinator works face to face with the Member, his or her family, and a natural support system in a person/family-driven manner to identify the unique needs of that Member or family, in order to set up an individualized plan to address needs. The coordinator not only acts as an advocate and navigator but also is able to authorize and set up resources and supports to address psychosocial barriers to treatment success.

Contracts with an array of providers are in place to ensure a comprehensive delivery system that includes psychiatric residential and psychiatric day treatment services and alternatives to these high cost services that include intensive community-based services, non-traditional services and supports, peer-delivered services, and specialized services such as Dialectical Behavior Therapy, Parent Child Interaction Therapy, respite care, and others.

B.2.6.b In each county, there are local committees and advisory councils that meet regularly to identify and resolve operational or system level barriers to a successful system of care. These groups include representatives from child welfare, juvenile justice, Oregon Youth Authority (OYA), education, addictions, early childhood, physical health, developmental disabilities, and family and youth consumers and advocates. They provide oversight and evaluation of policies, outcome and satisfaction data, budget and financial strategies, and new program development to enhance the system for these highest needs youth and families. MOUs,

contracts and BAAs are also used to establish clear expectations for coordination of care and appropriate sharing of information between partners in the ISA system implementation.

B.2.6.c The main component of the ISA is the child and family team, and all service planning decisions are made with the youth and family voice at the table. In addition to the family and youth, teams also include behavioral health providers, involved social service agencies, schools, pediatricians, or other individuals identified by the family. Service plans are developed only after a comprehensive assessment of the strengths, needs and culture of the youth and family is complete. The result is a culturally sensitive service plan that builds on the strengths and identifies strategies to meet the identified needs. Youth and families drive the development of the plan, along with input from, friends or natural supports and other professionals on the team. The ISA is based on the system of care values and principles, and teams strive to ensure youth are able to remain in the least restrictive setting possible to meet their needs. To that end, creative, flexible plans are often implemented that are more effective and less expensive than traditional programs and services.

B.2.7A Mental Illness Services

B.2.7A.a As discussed in detail in Appendix A, the TCMC will utilize Affiliate mental health plans' well-established network of behavioral health providers for the provision of mental health services to Members. Currently, ~ 20% of MHO expenditures have community Place of Service codes including homes, schools, EDs, shelters and other community settings. TCMC's goal is to increase the proportion of services in community settings even further for the highest risk adults and children with mental illness. Habilitative services and supports, funded under the 1915i SPA, are always provided in home and community settings, and can include assistance with activities of daily living, housekeeping, shopping, and other activities that allow individuals to reside in the most independent setting possible.

B.2.7A.b As described in Appendix A, all new Members will be routinely contacted by phone and interviewed regarding special healthcare needs such as behavioral health needs. Additionally, health homes will routinely screen for depression, substance dependency, and other behavioral health issues utilizing effective models such as SBIRT and IMPACT. School-based health centers and care coordination programs will also screen and identify youth and children and connect them with needed services. Finally, a "no wrong door" approach will allow members to self-identify and access services directly through network behavioral health providers. Affiliate MHOs have systems in place to track over- and under-utilization by specific member groups and by individual. Care managers are used to engage members over-utilizing services to improve outcomes by coordinating care and communication between all providers a member is seeing and developing community plans and interventions to meet the care needs for the member.

B.2.7B Chemical Dependency Services

B.2.7B.a TCMC will utilize Affiliate health plans' well-established networks of addiction providers for the provision of chemical dependency services to OHP Members that include outpatient, detoxification, and residential, drug-free housing and recovery support services. Many adults with severe mental illness also have substantial substance use disorders, and require integrated treatment approaches that may include the home and community-based habilitative services afforded through funding authorized by the 1915i SPA. These services are already being provided within the County's behavioral health provider networks.

B.2.7B.b All new members will be contacted by phone and interviewed regarding any special healthcare needs such as behavioral health needs. Health homes will routinely screen for

substance dependency, and other behavioral health issues utilizing effective and AMH-approved screening practices and standardized protocols and tools [BASIC (Brief Alcohol Screening Instrument for Medical Care), the AUDIT (Alcohol Use Disorders Identification Test) for adults and the ADIS (Adolescent Drug Involvement Scale) for adolescents].

The American Society of Addiction Medicine (ASAM PPC II) assessment tool will be used for more in-depth evaluation of individuals who screen positive for at risk alcohol and drug usage. This instrument identifies the level of service need, intensity of care, problem severity and recovery support, addressing salient characteristics such as age, culture and language.

B.2.8 Pharmacy Services and Medication Management

B.2.8.a As long-standing participants in OHP, all TCMC Affiliate health plans have extensive experience providing prescription drug benefits following the funded Condition/Treatment pair guidelines. All have the experience and the ability to continue to provide this benefit.

B.2.8.b All Affiliate health plans currently develop and maintain a restrictive Medicaid formulary that has FDA approved drug products in each therapeutic class in addition to including over-the-counter medications. Access to products not on the formulary is managed through a formulary exception process.

Each plan's formulary is developed and maintained through a Pharmacy Committee that is either staffed internally or with input from the plan's contracted PBM. The Committees evaluate, appraise and select from available drugs those considered to be the most appropriate for patient care and general use. The formularies include at least one FDA approved drug for each therapeutic class. All plans have minimal barriers to OTC products.

Utilization tools such as prior-authorization (PA), step-therapy, quantity limits, age edits, drug interaction edits and other quality interventions are used, reviewed and updated regularly.

Formulary decisions are evidence-based, commonly using the Delfini review method. Committee members and staff review primary literature sources in addition to tertiary reviews and meta-analyses through various entities (i.e. Washington State University Formulary Monograph Service, Oregon Drug Effectiveness Review Project, University of Utah, Cochrane Collaborative, National Institute for Health and Clinical Excellence, etc.) In addition to published literature, FDA review materials, manufacturer dossiers, and other sources of unpublished information are reviewed. Each review is evaluated for strength of evidence, graded, and developed into a summary monograph. Subject matter experts including physician and non-physicians specialists are also included in review to provide perspective and recommendations.

While this work is currently done separately by each Affiliated health plan, it is the intention of the TCMC to move towards a more coordinated approach that leverages the knowledge, skills and capabilities of each plan and reduces duplication of effort and cost. A TCMC Pharmacy workgroup is charged with defining this process.

B.2.8.c Affiliate health plans either have extensive pharmacy networks (Providence, CareOregon, and Tuality), or provide on-site plan owned and operated pharmacies (Kaiser).

Formulary changes, including new drug additions and formulary deletions, are posted to the online formulary documents, reprinted when necessary, updated on plan-based websites, and, commonly, Epocrates. Mid plan-year changes are rare and are usually restricted to new safety warnings released by the FDA. Most plans notify, in writing, all specific Members directly impacted by drugs removed from the formulary. Providers are notified of the

changes via staff meetings, newsletters, and clinic faxes.

Providers can access information on how to submit a PA request, including the PA form, online or by calling a Pharmacy technician.

B.2.8.d All Affiliate health plans have established capacity to process pharmacy claims either using a national pharmacy benefits manager (PBM) or an in-house system that meets national standards. All pharmacy claims processing systems allow real time inquiry and update access to all components of pharmacy claims processing.

All systems capture the relevant clinical and historical data required for claims payment and include appropriate coordination of benefits application. Pharmacy provider reimbursement is tracked and coordinated from the claims processor on a regular basis.

B.2.8.e Providence Health Plan's Pharmacy department currently processes all pharmacy PAs in-house. Providence Health Plan's Pharmacy Technical and Clinical Help Desk hours of operation are M-F, 8am-6pm. For emergency needs after hours, weekends and Holidays PHP has a pharmacist on call 24 hours a day, every day.

CareOregon PAs are all done in-house by CareOregon pharmacists, accepted via fax 24/7. CareOregon is open M-F, 8am-5pm. CareOregon pharmacists process PA requests through-out the weekend. Express Scripts covers after hours urgent requests and inquiries from pharmacies or providers. A CareOregon pharmacist provides 24/7 coverage for urgent needs Express Scripts cannot resolve. Express Scripts and CareOregon staff can provide emergency supplies of medication when necessary for immediate coverage of urgent medications.

Kaiser provides centralized PA assistance M-F, 8am-6pm. All Kaiser staff are educated on after hours procedures that ensure patient access to necessary medications.

PAs may be faxed to Tuality (THA) at any time, although THA hours of operation are M-F, 8am-5pm. A Referral Specialist checks incoming PAs for appropriateness and forwards all medical necessity submissions to case managers for further review and determination. When PAs or non-formulary medications are sought outside of normal business hours, THA's process allows the pharmacy to provide these medications one time. THA reviews the PA the next business day and makes medical necessity determinations at that time. If the medication is approved, THA will enter the authorization for the approved time period. If denied, THA will provide appropriate denial notifications to the member and the provider.

B.2.8.f Affiliate health plans each have contractual arrangements with PBMs or the entities provide that service in-house to their members. The negotiated rates vary by contract, as do the rebate and incentive agreements. Rates are confidential, but do not exceed -15% of the AWP for either retail brand or generic drugs. Mail order rates do not exceed -20% AWP. As TCMC moves towards a more coordinated pharmacy system for all members, we will continue to look for ways to increase efficiency around prescription drug pricing.

Rebate and incentive arrangements also vary by Affiliate plan. All rebates are handled according to State and Federal regulations and as stipulated by PBM contract.

Dispensing fees vary across the Affiliate plans but do not exceed $2.00 for either brand name or generic drugs. Generally, mail order prescriptions do not have a dispensing fee.

Administrative fees paid by Affiliate plans also vary. TCMC will work with ensure that these fees are kept to a minimum.

B.2.8.g Further development of 340B providers and pharmacies is a significant opportunity for the TCMC. CareOregon has contracts with substantially all 340B-qualified pharmacies associated serving the CareOregon OHP population. Providence Health Plan currently supports 340B providers and pharmacies. However, Kaiser and Tuality do not have experience with 340B providers. An active pharmacist collaborative with pharmacists representing key 340B pharmacies is in place to optimize 340B utilization, increase use of pharmacies eligible to process 340B, and expand best practice in clinical pharmacy services with 340B revenue.

B.2.8.h All Affiliate health plans consider Medication Therapy Management (MTM) to be an integral part of their PCPCH services, with most having an established MTM program.

B.2.8.i All Affiliate health plans currently provide E-prescribing for providers to utilize with their EMR systems. Providers can access eligibility, formulary information and patient history. Affiliate plans follow E-prescribing industry standards for provider access to information.

B.2.9 Hospital Services

TCMC will utilize Affiliate health plans' existing provider networks for the delivery of inpatient and outpatient hospital services. These networks represent 100% of the Primary, Secondary and Tertiary Acute Care Hospitals in the Tri-County region, including General Hospitals and Pediatric Hospitals.

Affiliate MHOs have arrangements in place to support continuity of care for Members who become enrolled during an episode of treatment through arrangements with non-participating providers. Similarly, single-case contracts are arranged with out-of-area providers to address unique Member needs. Examples include specialized inpatient and residential eating disorder programs, electroconvulsive therapy and specialized psychiatric residential treatment programs for children and adults. Additionally, due to the shortage of inpatient acute psychiatric capacity in the Tri-County region, MHOs routinely authorize admissions to hospitals throughout Oregon.

B.2.9.a Affiliate health plans have access to national specialty networks, such as LifeTrac and InterLink through reinsurance policies to ensure access to services not currently provided in the service area. For behavioral /chemical dependency access, see above information.

B.2.9.b Agreements with Affiliate health plans will require that inpatient and outpatient hospital services are available to Members at the same level as non-Members. TCMC compliance monitoring will evaluate Affiliate health plans' performance on access to inpatient and outpatient hospital services. Monitoring and evaluation will include inappropriate ED utilization rates, admission rates for ambulatory sensitive conditions and length of stay.

B.2.9.c Culturally relevant Member education material will be available through Affiliate health plans, Affiliate delivery systems, as well as at Members' PCPCH or health home. Agreements with Affiliate health plans will include performance metrics and financial penalties around inappropriate ED use, as well as monitoring for access challenges.

B.2.9.d TCMC will establish and monitor performance metrics for Affiliate health plans to measure inappropriate use of ambulance services, ED and the use of urgent/walk-in clinics. Corrective action plans will be implemented for those Affiliate health plans not unable to improve their performance in these areas. Eventually, TCMC plans to use performance-based auto assignment to Affiliate health plans based, in part, on these types of performance metrics.

B.2.9.e TCMC Affiliates have committed to transparency in sharing performance metrics across all delivery systems and health plans. TCMC Model of Care workgroups are developing and

implementing best practice guidelines for improving appropriate use of ambulance services, ED and the use of urgent/walk-in clinics.

HAC/Provider Preventable Conditions: TCMC will require each Affiliate health plan to implement an automated claims payment system that will identify claims for HAC/Provider Preventable Conditions and deny payments for such claims. TCMC will monitor the rate of these events by Affiliate delivery system.

Readmission Policy: TCMC Affiliate health plans will follow guidance found in OAR 410-125-0410 for patients discharged and readmitted to a hospital within 15 days for the same or related diagnosis. In those cases, Affiliate health plans will make one payment for the for the combined service. Readmissions for a diagnosis that may require episodic acute care hospitalizations to stabilize the medical condition will not be subject to the combined reimbursement policy.

TCMC will also include metrics for monitoring readmissions at the Affiliate delivery system level as part of overall quality/performance improvement initiatives. The OAHHS offers a robust data reporting tool through Apprise that evaluates hospitals based on risk-adjusted readmissions rates. TCMC will evaluate the use of that tool with Affiliate delivery systems.

Outlier Payments: TCMC will comply with requirements in SB 204 directing the use of a uniform Medicare payment methodology established by CMS for hospital and ambulatory surgical center services. Specifically, TCMC will be using the Medicare Outlier Methodology for Inpatient DRG Hospitals as dictated by CMS.

Section 3: Assurances of Compliance with Medicaid Regulations and Requirements

B.3 All TCMC Affiliate delivery systems, providers, physical health plans and mental health plans have extensive experience working within the state and federal Medicaid regulatory system, ensuring compliance with Medicaid standards, and abiding by federal and state law, regulation and contract. As all TCMC Affiliates have committed to transparency in terms of quality metrics and financial reporting, the TCMC is confident that Affiliates and their sub-contractors will honor that transparency when it comes to delegation oversight, compliance audits, and contract management. The TCMC will work with all Affiliates and their sub-contractors to standardize written policies and procedures for Medicaid Assurances to maximize compliance, to minimize confusion, to help foster common community standards.

TCMC Affiliate health plans and/or delivery systems have an established history of ensuring access to emergency and urgent care services; requiring HIPAA-compliant record keeping; maintaining efficient and accurate billing and payment processes in accordance with accepted professional standards; participating as a trading partner with OHA in conducting timely, accurate, and HIPAA-compliant electronic transactions; maintaining efficient and accurate systems for capturing, reporting and validating encounter data; and maintaining an efficient and accurate process to validate Member Enrollment and Disenrollment.

Assurances such as Continuity of Care, Quality Improvement, Coordinated Care Services, and Intensive Care Coordination are at the heart of the Triple-Aim-focused Model of Care TCMC aims to achieve

Finally, equity-based Assurances (distribution of language-appropriate materials, ongoing and culturally-appropriate Member education and information, and treating Members with dignity and respect) speak to primary values that TCMC holds, and are integral in engaging Members in improving and maintaining their own health.

Section 1: Accountability Standards

C.1.1.a Initially TCMC will rely on current quality measurement and reporting systems available through Affiliate health plans. Contracts with these Affiliates will include language requiring the sharing of all quality measurement and performance reporting with TCMC and all Affiliate health plans. Whenever possible, provider performance will be compiled across Affiliate health plans to provide a more robust monitoring and feedback opportunity.

The TCMC is committed to establishing an organization-wide measurement system that will allow transparent monitoring and feedback of provider performance. While the measures are still in development, it is agreed that these must encompass clinical quality and patient experience, as well as utilization. Once the OHA releases its next set of measures in May, TCMC will use these as a minimum set to be built upon to ensure that all participating providers have clear outcomes expectations and that clinical quality based incentives can be built into new payment models. Given the limited resources available, all Affiliates recognize that it will be critical to hold each other accountable to produce the best possible outcomes by establishing a robust and accurate regional reporting/monitoring process.

An aggregate data reporting system will be established within the first year, using informatics resources already available within the TCMC Affiliates, to provide regular accountability metrics. Since many parts of the provider network do not currently have systems in place to track quality measures for the services they provide, it is recognized that building this data capacity at all levels will take time and will have to be supported with technical assistance.

While committed to creating a regional measurement system to monitor and report overall outcomes, the TCMC is also committed to ensuring that quality measurement is only one part of an overall continuous learning system. Equal emphasis will be placed on promoting innovation in care delivery with the potential for developing new, more meaningful metrics.

The transformation of care will require workforce development efforts so that providers can skillfully use measurement for micro system improvement as well as macro system monitoring. The TCMC will encourage and support training around Process improvement skills, including the use of Plan-Do-Study-Act Cycles, the Model for Improvement and the full portfolio of LEAN tools, including visual management systems that promote measurement as a tool for improvement throughout all areas of care.

The full quality vision of the TCMC is a transformed system of care provided by a workforce fully trained to use measurement in their daily work as a way to continuously improve outcomes, constantly fine tuning workflows, eliminating waste, and developing entirely new processes to get better outcomes.

C.1.1.b The TCMC has no current plans to participate in external quality reporting programs. TCMC Affiliate health plans (CareOregon and Kaiser) are already NCQA certified and plan to maintain their certification. All of the Affiliate healthcare providers administer CAHPS surveys (e.g. HCAHPS) to assess patient satisfaction. The use of HEDIS and CAHPS survey results will be evaluated as part of the total quality measurement and reporting system. The design and implementation of the system will rely on input from TCMC Affiliates.

C.1.1.c All Affiliate health plans are contracted OHP providers and as such have met DMAP performance benchmarks. As above, the TCMC will establish system wide internal standards following final publication of the OHA metrics.

C.1.1.d The TCMC will initially use Affiliate health plans to share performance information with providers and contractors. Contracts between the TCMC and Affiliate plans will specify the performance information to be shared and the frequency of reporting and will build upon existing infrastructure. Whenever possible, TCMC will facilitate performance reporting across all Affiliate health plans in order to provide a more complete picture of the provider's performance for TCMC OHP Members.

In addition, the TCMC is creating a Clinical Advisory Panel (CAP) drawn from participating providers which will provide oversight over all Quality Improvement (QI) work, including the setting of metrics, monitoring performance, and performance feedback. Data from Affiliate health plans, as well as from their network providers, will be reviewed at the CAP level for the identification of best practices and for areas needing improvement. As TCMC builds its own monitoring and feedback system for providers, clinical information will be incorporated as well as claims-based data. The CEO and Chief Medical Officer and staff will be responsible for providing feedback on an individual basis to providers or contractors when that is required.

C.1.1.e The CAC will be used as the hub from which performance information is shared with Members. The CAC will advise TCMC Board and TCMC Executive team on Member communication and engagement strategies.

Multiple modes of communication will be utilized, including web-based, email, and scheduled community input sessions. TCMC has also established a dedicated point person to facilitate meaningful engagement with Members and their support networks across Affiliate health plans. Each of TCMC's Affiliates has its own approach to embedding cultural competence into member communication strategies. TCMC's task is to design a system of shared standards and hold Affiliate and sub-contracted organizations accountable to policies and behaviors that will result in the most culturally competent Member communication strategy across all networks of providers. Cultural competency thought leaders from Affiliates, members of the CAC, members of the CAP and the TCMC executive leadership team and staff will work together to implement a Systemic Strategy for Cultural Competence including sharing performance information with Members.

All materials will be available in multiple languages, including Braille, and written in such a way to promote member engagement, and identify who members should address their questions to. All materials will be available in multiple formats – printed copy, audio, and via the web.

At a minimum, the language that is used will be accessible and tested for clarity of message and intent. The CAC will be used to test the accessibility of language and policy/process content so that materials are most effective in communicating with members.

C.1.1.f As noted above, the TCMC is committed to establishing new community-wide payment models that use quality incentives as an increasingly large portion of total compensation for all components of care. Through meaningful and transparent collaboration across all Affiliates, TCMC is well positioned to accelerate the use of alternative payment mechanisms based on quality measures and reporting

C.1.1.g Measures from Table C-1 that are encounter based (e.g. utilization rates) or provided by the State on enrollment (e.g. rate based on race and ethnicity) can be reported on an aggregate basis by the TCMC across all Affiliate health plans. Measures that require clinical data

usually found in electronic health records, such as blood pressure rates, can be aggregated from some, but not all, provider systems and will require significant infrastructure investment to be universally reportable. Member experience data and measures based on data reportable from member surveys will be incorporated in the strategic plan for TCMC.

A significant component of TCMCs business plan in year one includes the investment in a robust information system that is connected to the TCMC model of care in a meaningful way. TCMC Affiliates are committing significant resources to the design and implementation of a region-wide system for collecting performance and quality measures both clinically and financially.

Section 2: Quality Improvement Program

C.2.1 Quality Assurance and Performance Improvement (QAPI)

C.2.1.a All Affiliate health plans have established Quality Improvement Programs that have overall responsibility for:

1. Monitoring overall clinical performance using standard metrics (e.g. HEDIS) and overseeing initiatives to promote improvement;
2. Monitoring and improving accessibility and availability of clinical care services;
3. Ensuring that those with exceptional needs and individuals at risk for poor outcomes are provided appropriate supportive resources;
4. Establishing evidence based standards of care and clinical practice guidelines;
5. Monitoring, evaluating and responding to episodes of poor quality care or plan service;
6. Ensuring that members are provided relevant information in a culturally and linguistically appropriate manner;
7. Maintaining an up to date credentialing and recredentialing process of providers and organizations;
8. Assuring high member satisfaction with health care delivery, including plan functions, to ensure it is Member and community centered;
9. Aligning efforts with community and State quality improvement initiatives;
10. Providing oversight of all delegated relationships;
11. Assuring the appropriate use of plan resources and adherence to OHP benefit design; and
12. Promoting integration with other clinical and social service providers

These are documented in each Affiliate health plan's contractually mandated annual Quality Improvement Plan. While it is important for TCMC Affiliates to monitor their own performance and develop improvement initiatives, the TCMC provides an opportunity for community-wide initiatives based on population needs.

Since health outcomes are significantly driven by non-medical, social issues, the TCMC is committed to developing a quality improvement framework in alignment with the CAC community needs assessment. At the broadest level, as part of the Regional Community Health Improvement Plan developed out of the community needs assessment, the TCMC will define region-wide initiatives for all TCMC Affiliates in partnership with community agencies. As an example, a regional initiative to address the current epidemic of prescription opioid use is already under discussion. Such an initiative will involve establishing new standards of care for prescribers, but it will also require addressing the need for supportive housing for those struggling to overcome addiction issues.

At the community level, the TCMC will promote the development of "community quality improvement plans" involving both the integrated delivery system and local agencies. Neighborhood-specific issues, such as the lack of access to fresh fruits and vegetables or need for recreation areas, impact medical outcome issues, such as obesity and diabetes. The Community Advisory Council will be charged in the first year with the design of 2-3 "health system/community partnership initiatives" to test this broader approach to quality improvement.

C.2.1.b As noted, each of the Affiliate health plans has established Quality Committees accountable for the areas listed above. All Quality Committees have Provider members and tend to reflect different subsystems within the TCMC service area. Representatives from each of these plan committees will be convened as a subcommittee of the Clinical Advisory Panel. Working with the CAP, the subcommittee will develop a standard set of Affiliate health plan annual accountabilities and will provide regular reports on the progress towards meeting them. The CAP, in turn, will be responsible for reporting their review of progress to the Board of Directors for direction and approval through the CAP Board representative.

On at least a semiannual basis, there will be a joint meeting of representatives from the CAP and the CAC. The function of these meetings will be to align the findings regarding social needs from the community assessment and the areas found to need clinical improvement to develop more effective solutions leveraging the knowledge and assets of both groups. Depending on the initiatives identified, further joint working groups will be created to develop interventions and monitor progress.

While both the CAC and the CAP have unique and separate contributions to make, the TCMC is committed to exploring how the two groups can increasingly work together toward a more comprehensive approach to producing better health outcomes.

C.2.1.c Alignment of the Quality Plan with the transparent metrics by which the partners monitor each other's use of scarce resources means that Quality is a central part of the business strategy of the TCMC. The CAC will develop an annual Quality Improvement Plan that identifies performance targets (and performance improvement targets) in key domains. This will include definition of measures, activities to accomplish stated objectives and the rational for each goal. Examples of domains of interest include: Access to Services, Integration and Coordination, Outcomes, Prevention/Education/Outreach, and Member-Centeredness/Experience of Care. The Quality Improvement Plan will be approved by the Board of Directors and will be used in the contracting process with Affiliate health plans. A follow-up work plan will be submitted on a yearly basis to track progress and reset goals as needed.

Further, because of the projected decreases in funding, the TCMC business plan is significantly dependent on transformational initiatives to produce better outcomes at lower cost, as well as identifying providers who produce the highest quality outcomes at the lowest cost – reflecting the central premise of the Triple Aim. The Quality plan is therefore an integral part of the business plan and will be reviewed on an ongoing basis as part of regular business reviews.

The CAP will have direct oversight of provider performance and of the clinical initiatives driving care transformation and their associated metrics and will report them at least quarterly to the Board of Directors.

C.2.1.d The goal of establishing performance metrics as an increasing portion of payment is to drive and support practice change at the provider level. The Providers who are actively engaged in leading improvement work will necessarily have to be involved in the co design of these metrics if this goal is to be achieved. Ideally, Providers will view the new payment system as aligning payment with best practices, and not as an administrative burden. The CAP will be responsible for ensuring that this level of input from the delivery system is incorporated in the planning, design and implementation of the performance incentive system. Subcommittees of the CAP may be tasked with engaging sub groups of providers and community-based organizations to facilitate this co-design.

The meetings of the joint CAC and CAP, as noted above, will be used to involve members and community based organizations in the QI program. Beyond the development of regional and community specific initiatives, these joint meetings will ensure further consumer and community input into the programs being developed for clinical practice.

Consumer advisory panels, focus groups, and input at the practice level, which already exists in some of the practices serving the Medicaid population (e.g. FQHCs), will also be encouraged so that local improvement efforts receive maximal community input as they are implemented.

TCMC will also be relying upon the Community Health Needs Assessment (CHNA) as a resource to help inform the Quality Improvement program. The CHNA will also draw input from practitioners and culturally diverse community based organizations in the final recommendation process for the CHNA.

C.2.1.e Performance metrics will be regularly evaluated to see if there are specific sub-population disparities. Results will be reported to the CAC as part of the yearly Quality Improvement Work Plan review.

As noted in other sections, improvement in care transitions and enhancement of care coordination are major areas of interest for the TCMC and were the foundational initiatives proposed in the Health Commons CMMI Challenge Grant proposal.

C.2.1.f Monitoring of provider compliance and development of corrective actions will continue to be performed at the existing Affiliate health plan level. TCMC will explore the possibility of combining Affiliate health plan efforts where this would provide cost savings and/or more effective approaches. The TCMC is committed to accountable self-governance at the community level and to reducing unnecessary duplicative effort.

C.2.1.g Similarly, functions such as addressing customer satisfaction and fraud and abuse will continue to be performed at the Affiliate health plan level with the potential for simplification where justifiable.

The development of protocols will be coordinated through the CAC and its Quality subcommittee with the goal of establishing new evidence-based community standards of care on high impact issues. The region's recent experience establishing a community-wide standard of medical necessity criteria for elective inductions before 39 weeks gestation – and the implementation of a "hard stop" scheduling process to assure application of the standard – has provided an excellent model for further efforts of this nature.

C.2.2 Clinical Advisory Panel

C.2.2.a A representative of the CAP is included on the Board of Directors.

C.2.2.b A CAP will be established.

C.2.3 Continuity of Care/Outcomes/Quality Measures/Costs

C.2.3.a As noted above, the TCMC will initially depend on the policies, processes, practices and procedures in place in the Affiliate health plans to improve outcomes. These generally include:

1. Benefit management, including prior authorizations, to assure that services provided Members meet effectiveness criteria as defined by the prioritized list and current clinical standards of care;
2. Evidence based formularies and medication therapy management;
3. Concurrent review processes to assure acute care services meet established standards for appropriateness;
4. Quality reporting for program improvement and provider profiling;
5. Care Coordination and case management for members with exceptional needs or increased risk or at transitions of care;
6. Establishment of evidence based guidelines and performance targets for clinical practice;
7. Complaint monitoring and creation of corrective action plans;
8. Member education programs to promote wellness and optimal chronic disease management;
9. Fraud and abuse monitoring;
10. Feedback of actionable data to providers; and
11. Quality performance incentives.

In responding to the CMMI Innovation Challenge Grant, TCMC participants developed a core set of initiatives that will be implemented on a community-wide basis as the foundation for transforming the model of care for the Medicaid population. This proposal has three goals:

Goal 1: To implement key integrative care processes linking all partner services.

Key Services: 1) Implementation of a community-wide Care Coordination Registry with real-time alerts to enable high levels of care coordination across all service sites; 2) Standardized discharge transition processes from hospitals to primary care to reduce re-admission rates; and 3) ED navigation services to divert non-urgent cases and link patients to primary care homes.

Rationale: These activities and services will create small per-member savings across a large number of patients and will function as screening and capture points for high-acuity patients. These activities will also ensure successful transitions of care and improve Member experience.

Goal 2: To implement targeted high-intensity community-based programs that efficiently and effectively address the complex needs of high-acuity patients.

Key Services: 1) Intensive patient support services through geographically-based Integrated Community Care Teams (ICCTs) that include primary and specialty care, mental health, and addictions services; and 2) Hospital care transition teams for at risk discharges, including mental health discharges, to reduce re-admission rates.

Rationale: The activities and services under this goal will create large per-member savings and improved health among the small number of Medicaid patients that utilize the most services and resources.

Goal 3: To create a learning environment to promote continuous workforce development.

Key Services: 1) Design and implementation of scalable training modules for the new and existing workforce; 2) Ongoing technical assistance and mentorship to improve both care and process effectiveness; and 3) Development of Learning Collaboratives to share ideas, key learning, and best practices throughout the region.

Rationale: The activities and services under this goal will enable TCMC to train, deploy, and integrate a new health care workforce focused on supporting a new model of health care delivery and support the dissemination and implementation of best practices and health care reform throughout the region and beyond.

C.2.3.b As noted previously, once the OHA has defined the CCO required quality measures, the TCMC will assess what further metrics are desirable and feasible in order to assure progress towards improved outcomes.

C.2.3.c TCMC Affiliate health plans currently have member education and engagement programs to promote wellness and health improvement. TCMC will build on those existing programs and leverage the synergy between the Community Advisory Committee and Clinical Advisory Panel to work with community service organizations and develop strategic plans to improve Member engagement in wellness and health improvement. This could include the development of incentive programs to improve compliance with preventive measures or improve participation in health improvement activities such as smoking cessation, medication adherence, etc. TCMC will also be working closely with its network of Patient Centered Primary Care Homes to support provider initiatives addressing wellness and health improvement. This includes alternative payment methodologies and indirect support such as technical assistance.

C.2.3.d TCMC Affiliate health plans have established capacity to collect and report encounter-based quality data as well as experience using this data to monitor and improve performance benchmarks.

In addition, TCMC Affiliates have varied experience using electronic medical record data across delivery systems for quality improvement. One of the most fundamental strategic initiatives for TCMC is working on systems to better leverage data from electronic health records across the service area to improve patient care. A TCMC IT steering committee comprised of Health IT leaders from the Affiliate health plans and delivery systems has been formed and a Chief Information Officer has been hired. This group is tasked with improving the use of data systems to enhance the TCMC Model of Care.

The TCMC also has access to the data expertise of the Center for Outcomes Research and Education (CORE) within the Providence system. CORE was selected to do the evaluation for the CMMI Challenge grant work based on its ability to work with large complex data bases, its experience using the All Payer All Claims Database in the Oregon Health Study, and its capacity to do qualitative evaluation. Together with resources at Kaiser's Center for Health Outcomes and OHSU, all of which are affiliated with the TCMC and expressed interest in working on TCMC-related programs, the TCMC has access to a rich pool of experts in both qualitative and quantitative evaluation.

C.2.3.e Following submission of the Health Commons CMMI proposal, a Model of Care Workgroup was created to identify other areas providers and the community felt would provide significant improvements in Member outcomes. This model (Diagram C-1 – Model of Care Design) is illustrated on page 10 of this appendix. After multi-facilitated, multi-stakeholder meetings involving close to 90 different providers and community partners other improvement opportunities were defined:

The TCMC is now in the process of evaluating and prioritizing the interventions listed, specifically looking for those that are more readily implemented and can produce the greatest improvement in health outcomes in the context of scare resources.

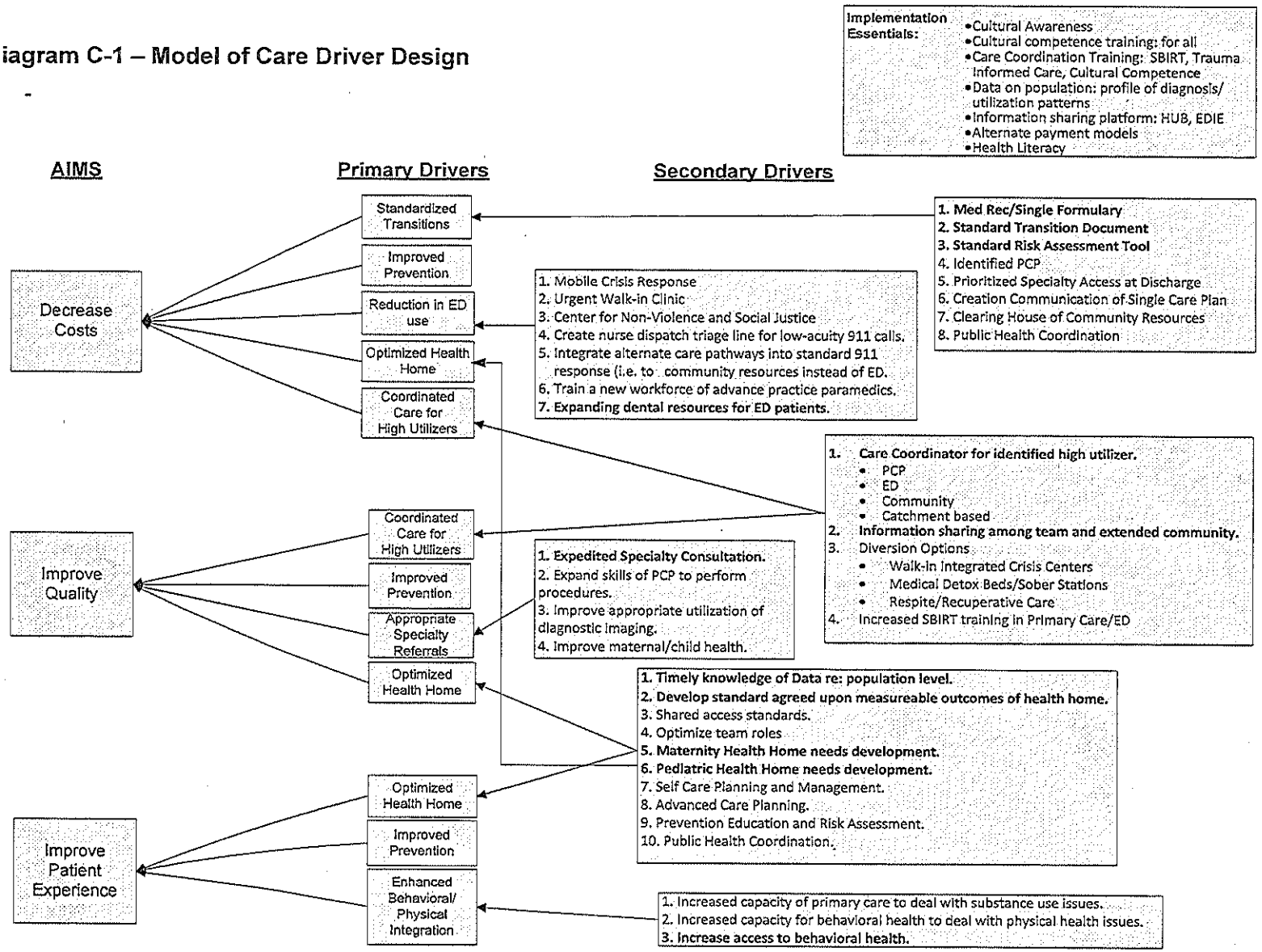
C.2.3.f The TCMC is committed to promoting and supporting community-wide strategies linking the multiple, currently separate, parts of the health service delivery system. As part of the Health Commons CMMI grant proposal, TCMC proposed the implementation of a care tracking system that would allow care management information to follow a Member as they move through different points of care and that alert providers when the Member interfaces with the care system.

One existing technology for doing this was identified, the Emergency Department Information Exchange (EDIE) that has been extensively implemented in Emergency Departments in Washington State, but could be used across any array of health providers. Care plans, or other information such as discharge summaries, can be attached to any Member entered into the EDIE system. When the member presents to a health provider, EDIE shows the provider what other parts of the health care system the Member is connected to and, as available, makes the care plan available; the system is also able to send automatic immediate alerts to other providers engaged in the Member's care that the encounter is occurring.

This kind of technology, whether it is EDIE or other emerging systems under evaluation, will be critical in coordinating care for the highest acuity members involved in the Integrated Community Care Team (ICCT) program. It could also be used to transmit discharge summaries from hospital to primary care and specialty, or potentially link all those critically engaged with a member around health issues. The TCMC is actively exploring the technologies available and intends to make implementation part of the CCO start up.

Improving the linkage between specialty and primary care is another priority. The Portland IPA has begun implementing a web based referral/consultation system developed to facilitate this, the Internet Referral and Information System (IRIS). This technology allows referring providers to schedule into a specialty practice directly; it can implement decision rules that define appropriate work up prior to and indications for referral; it can allow transfer of information to and from the specialist; and it can potentially allow more collaborative care models where specialists provide input on difficult cases without actually seeing the patient. Given that IRIS is already being rolled out in the TCMC region and solves a difficult communication problem, there are ongoing discussions with the Portland IPA about further spread of this technology.

Diagram C-1 – Model of Care Driver Design



What makes a visit to a health clinic the best it can be?

It takes a team: patients, providers and clinic staff working together.

We will be honest and respectful of each other.

We will agree together on my treatment.

But we understand that treatment is my choice and my responsibility.

My next appointment

Use this area to write down the details of your next health care visit.

My health care provider's name is:

_____

My next appointment is on this date:

_____

The appointment time is _____
but I'll get there 15 minutes early.

The office address is:

_____

_____

_____

I can get there by (check one)
☐ car or ☐ Bus # _____

If I can't make it, I'll call. The telephone number is: _____

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Better Together

Together, we can make the best possible use of our visit

We're Better Together

We will be ready for our visit together.

"I will make a list of one to three most important things to talk about."

"I will make sure your biggest health concerns are addressed."

We will be open.

"I will find out what any tests or lab results mean."

"I will help you understand your test results and my diagnosis."

We will honor each other's time.

"I will arrive 15 minutes early in case I need to fill out papers or have any tests."

"My staff will tell you if I'm taking longer than expected with other patients."

We will treat each other with respect.

"I will ask for a translator in advance, and bring a caregiver if I need them."

"I will treat you with dignity and honor your cultural needs."

We will talk honestly.

"I will try to understand the risks and benefits of each medical option."

"I will recommend options, including preventive measures and lifestyle changes."

We will recognize each other's needs.

"I will bring my health plan ID and anything else needed to provide my care."

"I will recognize that you may have other needs, such as transportation."

We will focus on one to three priorities.

"If I have more issues, I'll make another appointment."

"I'll help you set priorities for our visit, and assure you we can meet again."

We will agree on a treatment plan.

"If I have any questions about my health or my plan, I will ask you to explain."

"I will give you a written plan, and be sure you are comfortable with it."