EXECUTIVE SUMMARY

Consistent with ORS 414.625(1), Western Oregon Advanced Health, LLC, abn Advanced Health is a local, community-based and community-responsive, Coordinated Care Organization (CCO) meeting the needs of 20,707 Medicaid Members in rural Coos and Curry Counties. In fact, Advanced Health is the only community-governed CCO in this expansive, 3,227 square-mile region that carries federal designations as rural, frontier, sparsely-populated and as being a Dental Health Professional Shortage Area. Advanced Health brings to its table the voices of local Members, advocates, equity partners, and Tribal members, while also including every physician, hospital, and health care system in the Service Area. Amid this backdrop, over its seven-year history Advanced Health has distinguished itself from other CCOs by: being one of only two CCOs to meet financial cost-containment objectives; fully attaining, if not exceeding, quality incentive metrics in five of six years; achieving the highest score on its Quality and Transformation Strategy Plan; and obtaining the only perfect score and initial approval on its Delivery System Network Capacity and Adequacy Analysis. Long before the concept of Social Determinants of Health (SDOH) found its way into common parlance at the Oregon Health Authority (OHA), Advanced Health had invested over $2 million in health-related services and Community benefit activities specifically purposed at addressing SDOH and ameliorating its antecedent and consequent factors (in addition to $1 million invested in workforce development in this federally designated Health Professions Shortage Area).

As Advanced Health seeks re-certification from the OHA through this Application, it sets forth new, Member-directed and evidenced-based strategies. Mid-level practitioners will replicate the House Call model for Fully-Dually Eligible Members residing in long-term care. Advanced Health’s earlier experience in Value-Based Payments will be expanded, resulting in improved quality and cost-containment. A Health Information Technology roadmap will point the way to a community-wide electronic health record. The Consumer Advisory Councils and new Aggregate Council of Advisors will exercise greater influence in identifying matters to come before the board of directors and in determining priority foci, selecting vendors for, and evaluating health-related spending, SDOH investments, and Health Equity initiatives. Primary-care case management and licensed Behavioral Health specialists will be deployed in every primary care setting, and the Assertive Community Treatment (ACT) program will be increased ten-fold and operate in multiple and varied community settings. The System of Care (SOC) will operate through SOC-Teams, bringing coordinated services in geographic proximity to families under the executive direction of consumers and core Community partners (juvenile justice, child welfare, school districts). Advanced Health will add over one hundred Traditional Health Workers and significantly expand its Intensive Care Coordination and Exceptional Needs Care Coordination menu.
Coos Health and Wellness
Mike Rowley, Executive Director
281 LaClair St, Coos Bay, OR 97420
Phone: 541-266-6778, email: Mike.Rowley@chw.coos.or.us

Coos Health and Wellness (CHW) is a current Community partner, stakeholder, and Provider organization to Advanced Health. Advanced Health Members in Coos County receive specialty Behavioral Health services, case management, and medication management through CHW. Advanced Health care managers work with CHW providers and case management staff to coordinate services across physical health, behavioral health, and oral health systems.

Advanced Health also partnered with the local public health department, housed at CHW, to develop the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Other initiatives and work with the local public health department include:

- Public Health Modernization Grant – Advanced Health participates on the Grant Advisory Committee
- AFIX Collaborative – Advanced Health participates, along with many other Provider organizations, in the AFIX Collaborative, facilitated by CHW, with the aim to improve childhood immunization rates in Coos County.
- Reproductive Health Collaborative – Advanced Health is participating in the Collaborative organized by CHW. Participating sectors include healthcare organizations, education, juvenile justice, and local Tribes. The aim is to evaluate access and address barriers to care and health disparities.
- Advanced Health sponsored a free flu vaccination clinic at the Devereux Center, a local shelter for persons who are unstably housed, for uninsured clients.

CHW staff participate in the Adverse Childhood Experiences (ACE) master trainer Program, sponsored by Advanced Health, and provide trainings throughout the community on the impact of ACEs and resiliency.

CHW quality staff participate in the Advanced Health Interagency Quality Committee. This committee reviews CCO quality measure performance, including utilization measures, monitors progress on Performance Improvement Projects, and reviews aggregate data from the member grievance system, among other quality program topics.

CHW also participated in Advanced Health's Quality Innovation Incubator fund with projects to integrate oral health care into a Behavioral Health setting and to stand up a local youth drop-in center.
Bay Area Hospital is a current Community partner, stakeholder, and service Provider to Advanced Health. Advanced Health Members receive inpatient and outpatient Hospital and specialty services at Bay Area Hospital. Advanced Health has a long history of alternative payment model contracting, including a capitated service contract, with Bay Area Hospital and is moving toward a LAN Category 2C or higher value-based payment contract in 2020.

Advanced Health staff participate in a number of regular meetings at Bay Area Hospital in order to collaboratively provide coordination and continuity of care for Advanced Health Members. Advanced Health care management staff attend hospitalist huddles, care management, discharge planning, tumor board, and Transitions of Care meetings.

The Director of Pharmacy Services for Advanced Health’s physical health Subcontractor participates in the Bay Area Hospital Pharmacy and Therapeutics committee and a Bay Area Hospital representative is invited to the CCO Pharmacy and Therapeutics committee. The CCO Chief Medical Officer is a member of the Bay Area Hospital Patient Safety and Quality Improvement steering committee to the board of directors.

Advanced Health is working with a hospitalist physician champion and the Providers and staff in the Bay Area Hospital Emergency Department to develop and implement a program for care navigation for Advanced Health members in the Emergency Department. The care navigation program will use a Traditional Health Worker (THW) to improve pathways to care for Advanced Health members using the Emergency Department for non-emergency services. The THW will work with Bay Area Hospital staff and Providers as well as primary care medical homes to connect Members to follow up with appropriate levels of care in the community.

Bay Area Hospital is the organization that initiated the Community-wide EHR discussions that have coalesced around Epic EHR and are still moving forward as discussed in Attachment 9 of Advanced Health's Application. The significant investments pledged by Bay Area Hospital will make it possible for Provider organizations throughout the Community to participate in the Epic EHR implementation.
Advantage Dental is a current Community partner, stakeholder, and contracted service Provider for Advanced Health members. Advanced Health Members receive oral health care and case management services through Advantage Dental. Advanced Health, through Advantage Dental, maintains a local network of both directly employed dental Providers and contracted, independent Providers to offer a variety of options to members when choosing their primary dental Provider.

In 2017, Advantage Dental took on the long-running oral health screening program in the Coos and Curry county schools and re-branded the program as Everybody Brush. The program offers preventive dental services for children in grades 1, 2, 6 and 7. The Everybody Brush program offers dental screenings, fluoride varnish, sealants, toothbrush kits, and oral hygiene education in the schools and includes a referral to a dentist for urgent oral health care needs.

Advantage Dental case management staff use the software program, Premanage, to monitor for emergency department visits related to dental issues and follow up with Advanced Health Members to engage them in an appropriate level of care to ensure their oral health needs are met.

Advantage Dental’s Community liaison staff participate in Advanced Health Community Advisory Council meetings, are partners in the development of the Community Health Assessment, and also work on the Community Health Improvement Plan (CHIP) initiatives. Advantage Dental was a collaborator on the Coos County CHIP initiative to improve prenatal oral health care for pregnant women through a referral workflow developed and implemented in OB practices at North Bend Medical Center.

Advantage Dental is also a key partner, along with local DHS, Coos Health and Wellness, Dr. Carla McKelvey, and Advanced Health, in the FEARsome clinic. FEARsome is an integrated (physical, behavioral, and oral health) weekly clinic, held in various locations throughout Coos and Curry Counties, that delivers information to foster parents, assesses the health of children in foster care, and coordinates future healthcare for this population.

Advanced Health has also partnered with Advantage Dental for a new Performance Improvement Project (PIP) beginning in 2019 to improve the rate of oral evaluations for Advanced Health Members with a diabetes diagnosis.
Waterfall Community Health Center is a current Community partner, stakeholder, and contracted service Provider for Advanced Health. Waterfall Community Health Center is a Federally Qualified Health Center (FQHC) operating a medical clinic with integrated Behavioral Health, an outpatient mental health center, and a school-based health center in the Coos Bay and North Bend area. Waterfall participates in the Advanced Health Community Advisory Council meetings and the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) processes as well.

Advanced Health has partnered with Waterfall to implement and expand integrated Behavioral Health and expand access to and engagement in preventive primary care for some of Advanced Health's most vulnerable Members. Advanced Health has supported Waterfall's Provider recruitment and retention efforts. Waterfall, along with other Community Providers, has participated with Advanced Health in the technical assistance opportunities through the OHA Transformation Center related to integrated Behavioral Health.

Waterfall staff attend and participate in the Advanced Health Interagency Quality Committee that, among other responsibilities, reviews quality and utilization data for the CCO and works collaboratively to implement improvements across the health system to improve quality of care and outcomes, reduce costs, and eliminate Waste and inefficiencies. The Advanced Health Director of Quality regularly attends Waterfall's Quality Improvement Committee.

Waterfall regularly reports data to Advanced Health as part of the clinical quality measure program. Advanced Health includes Waterfall's data in the annual data proposal and data submission to OHA for all the EHR-based CCO quality incentive measures.

Waterfall is also a key partner in addressing Social Determinants of Health (SDOH) and Health Equity. They have implemented a SDOH screening and resource referral program. Initial reports and aggregate data from the program were presented to the Advanced Health Community Advisory Council in early 2019.
ADVANCED HEALTH
LETTER OF INTENT TO APPLY
Attachment 1

Per Addendum #8, question 6, Advanced Health's Letter of Intent has been previously submitted and is not resubmitted with the completed application.
### Attachment 2 - Application Checklist

The checklist presented in this Attachment 2 is provided to assist Applicants in ensuring that Applicant submits a complete Application. Please complete and return with Application. This Application Checklist is for the Applicant’s convenience and does not alter the Minimum Submission requirements in Section 3.2.

<table>
<thead>
<tr>
<th>Application Submission Materials, Mandatory Except as Noted</th>
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<tbody>
<tr>
<td>Attachment 1 – Letter of Intent</td>
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<td>Attachment 2 – Application Checklist</td>
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<td>Attachment 3 – Applicant Information and Certification Sheet</td>
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<tr>
<td>Executive Summary</td>
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<td>Full County Coverage Exception Requests (Section 3.2)</td>
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<td>(Optional)</td>
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<td>Reference Checks (Section 3.4.e.)</td>
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<td>Attachment 4 – Disclosure Exemption Certificate</td>
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<td>Attachment 4 – Exhibit 3 - List of Exempted Information.</td>
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<td>Attachment 5 – Responsibility Check Form</td>
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<td>Attachment 6 – General Questionnaire</td>
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<td>Attachment 6 – Narratives</td>
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<td>Attachment 6 – Articles of Incorporation</td>
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<td>Attachment 6 – Chart or listing presenting the identities of</td>
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<td>and interrelationships between the parent, Affiliates and</td>
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<td>the Applicant.</td>
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<td>Attachment 6 – Subcontractor and Delegated Entities Report</td>
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<td>Attachment 7 – Provider Participation and Operations Questionnaire</td>
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<td>Attachment 7 – DSN Provider Report</td>
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<td>Attachment 8 – Value-Based Payments Questionnaire</td>
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<td>Attachment 8 – RFA VBP Data Template</td>
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<td>Attachment 9 – Health Information Technology Questionnaire</td>
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<td>Attachment 10 – Social Determinants of Health and Health Equity Questionnaire</td>
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<td>Attachment 11 – Behavioral Health Questionnaire</td>
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<td>Attachment 12 – Cost and Financial Questionnaire</td>
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<td>Attachment 12 – Pro Forma Workbook Templates (NAIC Form 13H)</td>
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<td>Attachment 12 – NAIC Biographical Certificate (NAIC Form 11)</td>
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<td>Attachment 12 – UCAA Supplemental Financial Analysis Workbook Template</td>
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<td>Attachment 12 – Three years of Audited Financial Reports</td>
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<td>Attachment 13 – Attestations</td>
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<td>Attachment 14 – Assurances</td>
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<td>Attachment 15 – Representations</td>
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<td>Attachment 16 – Member Transition Plan</td>
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<tr>
<td>Redacted Copy of Application Documents for which confidentiality is asserted. All redacted items must be separately claimed in Attachment 4. (Optional)</td>
</tr>
</tbody>
</table>
Attachment 3 - Application Information and Certification Sheet

Legal Name of Proposer: Western Oregon Advanced Health, LLC abn Advanced Health

Address: 289 LaClair Street

Coos Bay, Oregon 97420

State of Incorporation: Oregon

Entity Type: Limited Liability

Contact Name: Benjamin J. Messner

Phone: 541.269.0562 (office)

Email: ben.messner@advancedhealth.com

Oregon Business Registry Number: 855424-97

Any individual signing below hereby certifies they are an authorized representative of Applicant and that:

1. Applicant understands and accepts the requirements of this RFA. By submitting an Application, Applicant acknowledges and agrees to be bound by (a) all the provisions of the RFA (as modified by any Addenda), specifically including RFA Section 6.2 (Governing Laws) and 6.4 (Limitation on Claims); and (b) the Contract terms and conditions in Appendix B, subject to negotiation and rate finalization as described in the RFA.

2. Applicant acknowledges receipt of any and all Addenda to this RFA.

3. Application is a firm offer for 180 days following the Closing.

4. If awarded a Contract, Applicant agrees to perform the scope of work and meet the performance standards set forth in the final negotiated scope of work of the Contract.

5. I have knowledge regarding Applicant’s payment of taxes. I hereby certify that, to the best of my knowledge, Applicant is not in violation of any tax laws of the state or a political subdivision of the state, including, without limitation, ORS 305.620 and ORS chapters 316, 317 and 318.

6. I have knowledge regarding Applicant’s payment of debts. I hereby certify that, to the best of my knowledge, Applicant has no debts unpaid to the State of Oregon or its political subdivisions for which the Oregon Department of Revenue collects debts.

7. Applicant does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, gender, disability, sexual orientation, national origin. When awarding subcontracts, Applicant does not discriminate against any business certified under ORS 200.055 as a disadvantaged business enterprise, a minority-owned business, a woman-owned business, a business that a service-disabled veteran owns or an emerging small business. If applicable, Applicant has, or will have prior to Contract execution, a written policy and practice, that meets the requirements described in ORS 279A.112 (formerly HB 3060), of preventing sexual harassment, sexual assault and discrimination against employees who are members of a protected class. OHA may not enter into a Contract with an Applicant that does not certify it has such a policy and practice. See https://www.oregon.gov/DAS/Procurement/Pages/hb3060.aspx for additional information and sample policy template.

8. Applicant and Applicant’s employees, agents, and subcontractors are not included on:

   a. the “Specially Designated Nationals and Blocked Persons” list maintained by the Office of Foreign Assets Control of the United States Department of the Treasury found at: https://www.treasury.gov/ofac/downloads/sdnlist.pdf., or

   b. the government wide exclusions lists in the System for Award Management found at: https://www.sam.gov/portal/
9. Applicant certifies that, to the best of its knowledge, there exists no actual or potential conflict between the business or economic interests of Applicant, its employees, or its agents, on the one hand, and the business or economic interests of the State, on the other hand, arising out of, or relating in any way to, the subject matter of the RFA, except as disclosed in writing in this Application. If any changes occur with respect to Applicant’s status regarding conflict of interest, Applicant shall promptly notify OHA in writing.

10. Applicant certifies that all contents of the Application (including any other forms or documentation, if required under this RFA) and this Application Certification Sheet are truthful and accurate and have been prepared independently from all other Applicants, and without collusion, Fraud, or other dishonesty.

11. Applicant understands that any statement or representation it makes, in response to this RFA, if determined to be false or fraudulent, a misrepresentation, or inaccurate because of the omission of material information could result in a "claim" {as defined by the Oregon False Claims Act, ORS 180.750(1)}, made under Contract being a "false claim" {ORS 180.750(2)} subject to the Oregon False Claims Act, ORS 180.750 to 180.785, and to any liabilities or penalties associated with the making of a False Claim under that Act.

12. Applicant acknowledges these certifications are in addition to any certifications required in the Contract and Statement of Work in Attachment 10 at the time of Contract execution.

Signature: __________________________ Title: Chief Executive Officer Date: 4/11/2019

(Authorized to Bind Applicant)

State of Oregon ss:

County of Oregon

Signed and sworn to before me on 4/11/19 (date) by Benjamin J. Messner, Chief Executive Officer of Western Oregon Advanced Health, LLC abn Advanced Health (Affiant’s name).

Katelyn Cotten

Notary Public for the State of Oregon

My Commission Expires: July 21, 2019
Attachment 4 - Disclosure Exemption Certificate

Benjamin Messner (“Representative”), representing Western Oregon Advanced Health, LLC and Advanced Health (“Applicant”), hereby affirms under penalty of False Claims liability that:

1. I am an officer of the Applicant. I have knowledge of the Request for Application referenced herein. I have full authority from the Applicant to submit this Certificate and accept the responsibilities stated herein.

2. I am aware that the Applicant has submitted an Application, dated on or about 04-19-2019 (the “Application”), to the State of Oregon in response to Request for Application #OHA-4690-18 for CCO 2.0 (the RFA). I am familiar with the contents of the Application.

3. I have read and am familiar with the provisions of Oregon’s Public Records Law, Oregon Revised Statutes (“ORS”) 192.311 through 192.478, and the Uniform Trade Secrets Act as adopted by the State of Oregon, which is set forth in ORS 646.461 through ORS 646.475. I understand that the Application is a public record held by a public body and is subject to disclosure under the Oregon Public Records Law unless specifically exempt from disclosure under that law.

4. I have checked Box A or B as applicable:
   A. [ ] The Applicant believes the information listed in Exhibit A to this Exhibit 4 is exempt from public disclosure (collectively, the “Exempt Information”), which is incorporated herein by this reference. In my opinion, after consulting with a person having expertise regarding Oregon’s Public Records Law, the Exempt Information is exempt from disclosure under Oregon’s Public Records Law under the specifically designated sections as set forth in Exhibit A or constitutes “Trade Secrets” under either the Oregon Public Records Law or the Uniform Trade Secrets Act as adopted in Oregon. Wherever Exhibit A makes a claim of Trade Secrets, then Exhibit A indicates whether the claim of trade secrecy is based on information being:
      1. A formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information that:
         i. is not patented,
         ii. is known only to certain individuals within the Applicant’s organization and that is used in a business the Applicant conducts,
         iii. has actual or potential commercial value, and
         iv. gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.
      Or
      2. Information, including a drawing, cost data, customer list, formula, pattern, compilation, program, device, method, technique or process that:
         i. Derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclosure or use; and
         ii. Is the subject of efforts by the Applicant that are reasonable under the circumstances to maintain its secrecy.
   B. [ ] Exhibit A has not been completed as Applicant attests that are no documents exempt from public disclosure.
5. The Applicant has submitted a copy of the Application that redacts any information the Applicant believes is Exempt Information and that does not redact any other information. The Applicant represents that all redactions on its copy of the Application are supported by Valid Claims of exemption on Exhibit A.

6. I understand that disclosure of the information referenced in Exhibit A may depend on official or judicial determinations made in accordance with the Public Records Law.

Representative’s Signature

Benjamin J. Messner
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<th>Section Redacted</th>
<th>ORS or other Authority</th>
<th>Reason for Redaction</th>
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<tr>
<td><strong>Attachment 6</strong></td>
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<tr>
<td>Questionnaire</td>
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<td>Portions of Questions B.1.b, C.1.b, C.1.c, &amp; F.1.a,</td>
<td>ORS 192.501(2)</td>
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<tr>
<td>Organizational Chart (all)</td>
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<td>Chart or Listing Presenting the Identities of and Interrelationships Between the Parents, Affiliates, and the Applicant (all)</td>
<td>ORS 192.501(2)</td>
<td>Trade Secret</td>
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<tr>
<td>Subcontractor &amp; Delegated Entities Description (all)</td>
<td>ORS 192.501(2)</td>
<td>Trade Secret</td>
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<td><strong>Attachment 7</strong></td>
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<tr>
<td>Questionnaire</td>
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<td>Portions of Question 12.f.(6) (Standard #6)</td>
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<td><strong>Attachment 8</strong></td>
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<tr>
<td>Questionnaire</td>
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<td>Portions of Questions C.1, C.2, C.3, C.4, &amp; C.5</td>
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<td>Trade Secret</td>
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<td>CCO RFA Data Collection – Value Based Payments (Min, Max, Best) (all) and accompanying notes</td>
<td>ORS 192.501(2)</td>
<td>Trade Secret</td>
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<td>Section Redacted</td>
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<td><strong>Attachment 10</strong>&lt;br&gt;Community Engagement Plan&lt;br&gt;pp. 2 &amp; 3 : Names of Consumer Members on BOD and CACs</td>
<td>ORS 192.502(2)</td>
<td>Personal Information (names of consumer members would identify them as receiving health services)</td>
</tr>
<tr>
<td><strong>Attachment 12</strong>&lt;br&gt;Questionnaire</td>
<td>ORS 192.501(2)</td>
<td>Trade Secret</td>
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<tr>
<td>Portions of Questions: B.1, H.1, I.1, I.2, I.3, &amp; I.4</td>
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<td><strong>Attachment 12</strong>&lt;br&gt;NAIC Forms 13H (Min, Max, Best) (all)</td>
<td>ORS 192.501(2)</td>
<td>ORS 192.501(2)</td>
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<tr>
<td><strong>Attachment 12</strong>&lt;br&gt;UCAA Balance Sheets (3)&lt;br&gt;UCAA P and L (3)&lt;br&gt;CCO Pro Forma Analyses (3)&lt;br&gt;Accompanying Notes (2 pages)</td>
<td>ORS 192.501(2)</td>
<td>Trade Secret</td>
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<tr>
<td><strong>Attachment 12</strong>&lt;br&gt;Consolidated Financial Statements for the Years ended December 31, 2015 and 2014 (12 pages)</td>
<td>ORS 192.501(2)</td>
<td>Trade Secret</td>
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<tr>
<td><strong>Attachment 12</strong>&lt;br&gt;Consolidated Financial Statements for the Years ended December 31, 2017 and 2016 (13 pages)</td>
<td>ORS 192.501(2)</td>
<td>Trade Secret</td>
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<tr>
<td>Attachment 12</td>
<td>NAIC Forms 11 For CRANE, ROWLEY, BRIGHAM, WARNER, BELL, SCOTT, LOWTHER, MESSNER, BURLES, MOORE (M), WEBSTER, TESDAHL-HUBBARD, HAACK, SHARMAN, MOORE (B), LANG, &amp; RAVURI</td>
<td><strong>ORS 192.502(2)</strong> Personal Information</td>
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**Attachment 5 - Responsibility Check Form**

OHA will determine responsibility of an Applicant prior to award and execution of a Contract. In addition to this form, OHA may notify Applicant of other documentation required, which may include but is not limited to recent profit-and-loss history, current balance statements and cash flow information, assets-to-liabilities ratio, including number and amount of secured versus unsecured creditor claims, availability of short and long-term financing, bonding capacity, insurability, credit information, materials and equipment, facility capabilities, personnel information, record of performance under previous contracts, etc. Failure to promptly provide requested information or clearly demonstrate responsibility may result in an OHA finding of non-responsibility and rejection.

1. Does Applicant have available the appropriate financial, material, equipment, facility and personnel resources and expertise, or ability to obtain the resources and expertise, necessary to demonstrate the capability of Applicant to meet all contractual responsibilities?
   - **YES [ ]  NO [X]**.

2. Within the last five years, how many contracts of a similar nature has Applicant completed that, to the extent that the costs associated with and time available to perform the contract remained within Applicant’s Control, Applicant stayed within the time and budget allotted, and there were no contract claims by any party? Number: __
   - How many contracts did not meet those standards? Number: __ If any, please explain.

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<th>Response:</th>
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3. Within the last three years has Applicant (incl. a partner or shareholder owning 10% or more of Applicant’s firm) or a major Subcontractor (receiving 10% or more of a total contract amount) been criminally or civilly charged, indicted or convicted in connection with:
   - obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract,
   - violation of federal or state antitrust statutes relating to the submission of bids or proposals, or
   - embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property?
   - **YES [X]  NO [ ]**

   If "YES," indicate the jurisdiction, date of indictment, charge or judgment, and names and summary of charges in the response field below.

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4. Within the last three years, has Applicant had:
   - any contracts terminated for default by any government agency, or
   - any lawsuits filed against it by creditors or involving contract disputes?
   - **YES [ ]  NO [X]**

   If "YES," please explain. (With regard to judgments, include jurisdiction and date of final judgment or dismissal.)

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<th>Response:</th>
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5. Does Applicant have any outstanding or pending judgments against it?

YES ☐ NO ☑

Is Applicant experiencing financial distress or having difficulty securing financing? YES ☐ NO ☑.

Does Applicant have sufficient cash flow to fund day-to-day operations throughout the proposed Contract period?

YES ☑ NO ☐

If "YES" on the first question or second question, or "NO" on the third question, please provide additional details.

Response:

6. Within the last three years, has Applicant filed a bankruptcy action, filed for reorganization, made a general assignment of assets for the benefit of creditors, or had an action for insolvency instituted against it?

YES ☐ NO ☑

If "YES," indicate the filing dates, jurisdictions, type of action, ultimate resolution, and dates of judgment or dismissal, if applicable.

Response:

7. Does Applicant have all required licenses, insurance and/or registrations, if any, and is Applicant legally authorized to do business in the State of Oregon?

YES ☑ NO ☐

If "NO," please explain.

Response:

8. Pay Equity Certificate. This certificate is required if Applicant employs 50 or more full-time workers and the prospective Contract price is estimated to exceed $500,000. [This requirement does not apply to architectural, engineering, photogrammetric mapping, transportation planning or land surveying and related services contracts.] Does a current authorized representative of Applicant possess an unexpired Pay Equity Certificate issued by the Department of Administrative Services?

YES ☐ NO ☑ N/A ☑

Submit a copy of the certificate with this form.

Response:

AUTHORIZED SIGNATURE

By signature below, the undersigned Authorized Representative on behalf of Applicant certifies to the best of his or her knowledge and belief that the responses provided on this form are complete, accurate, and not misleading.

Applicant Name: RF A 0690 - Advanced Health
Western Oregon Advanced Health, LLC
abn Advanced Health

RFA: OHA-4690
Project Name: Coordinated Care Organizations 2.0

Signature: Benjamin J. Messner

Title: Chief Executive Officer

Date: 04/11/19

Attachment 5 - Responsibility Check Form 2 of 2
State of Oregon

OFFICE OF THE SECRETARY OF STATE
Corporation Division

Certified Copy  435X228P7

I, LESLIE CUMMINGS, Deputy Secretary of State of Oregon, and Custodian of the Seal of said State, do hereby certify:

That the attached

Document File

for

WESTERN OREGON ADVANCED HEALTH, LLC

is a true copy of the original document(s).

In Testimony Whereof, I have hereunto set my hand and affixed hereto the Seal of the State of Oregon.

LESLIE CUMMINGS, DEPUTY SECRETARY OF STATE
4/1/2019

Come visit us on the internet at sos.oregon.gov/business
REGISTRY NUMBER
85542497

TYPE
DOMESTIC LIMITED LIABILITY COMPANY

1. ENTITY NAME
WOAH LLC

2. MAILING ADDRESS
243 W COMMERCIAL AVE
COOS BAY OR 97420 USA

3. NAME & ADDRESS OF REGISTERED AGENT
STEVE WILGERS
243 W COMMERCIAL AVE
COOS BAY OR 97420 USA

4. ORGANIZERS
STEVE WILGERS
243 W COMMERCIAL AVE
COOS BAY OR 97420 USA

5. DURATION
PERPETUAL

6. MANAGEMENT
This Limited Liability Company will be manager-managed by one or more managers

7. OPTIONAL PROVISIONS
The company elects to indemnify its members, managers, employees, agents for liability and related expenses under ORS 63.160.
By my signature, I declare as an authorized authority, that this filing has been examined by me and is, to the best of my knowledge and belief, true, correct, and complete. Making false statements in this document is against the law and may be penalized by fines, imprisonment, or both.

By typing my name in the electronic signature field, I am agreeing to conduct business electronically with the State of Oregon. I understand that transactions and/or signatures in records may not be denied legal effect solely because they are conducted, executed, or prepared in electronic form and that if a law requires a record or signature to be in writing, an electronic record or signature satisfies that requirement.

ELECTRONIC SIGNATURE

STEVE WILGERS
Articles of Amendment/Dissolution - Limited Liability Company

Check the appropriate box below:

☐ ARTICLES OF AMENDMENT
(Complete only 1, 2, 3, 6)

☐ ARTICLES OF DISSOLUTION
(Complete only 4, 5, 6)

REGISTRY NUMBER: 855424-97

In accordance with Oregon Revised Statute 192.410-192.460, the information on this application is public record. We must release this information to all parties upon request and it will be posted on our website. For office use only.

Please Type or Print Legibly in Black Ink. Attach Additional Sheet if Necessary.

1) ENTITY NAME: WOAH LLC

2) THE FOLLOWING AMENDMENT(S) TO THE ARTICLES OF ORGANIZATION IS MADE HEREBY: (State the article number(s) and set forth the article(s) as it is amended to read.)

Article 1. The name of the limited liability company is WESTERN OREGON ADVANCED HEALTH, LLC

3) PLEASE CHECK THE APPROPRIATE STATEMENT:

☐ This amendment was adopted by the manager(s) without member action. Member action was not required.
   Date of adoption of each amendment: 06/20/12

☐ This amendment(s) was approved by the members. ______ percent of the members approved the amendment(s).
   Date of adoption of each amendment: ______

ARTICLES OF DISSOLUTION ONLY

4) NAME OF LIMITED LIABILITY COMPANY:

5) DATE OF DISSOLUTION:

6) EXECUTION: (Must be signed by at least one member or manager.)
   By my signature, I declare as an authorized authority, that this filing has been examined by me and is, to the best of my knowledge and belief, true, correct, and complete. Making false statements in this document is against the law and may be penalized by fines, imprisonment or both.

Signature: ____________________________
Printed Name: Phil Greenhill
Title: Manager

FEES
Required Processing Fee: $100
No Fee for Member/Manager Change Only.
Processing Fees are nonrefundable. Please make check payable to "Corporation Division."
Free copies are available at FilingInOregon.com, using the Business Name Search program.

FILED
JUN 21 2012
OREGON SECRETARY OF STATE
ARTICLES OF AMENDMENT ONLY

1) ENTITY NAME:
Western Oregon Advanced Health, LLC

2) THE FOLLOWING AMENDMENT(S) TO THE ARTICLES OF ORGANIZATION IS MADE HEREBY: (State the article number(s) and set forth the article(s) as it is amended to read.)
A new Article 12 in the form attached as Appendix 1 is hereby added.

3) PLEASE CHECK THE APPROPRIATE STATEMENT:

☐ This amendment was adopted by the manager(s) without member action. Member action was not required.
   Date of adoption of each amendment:

☐ This amendment(s) was approved by the members. 100 percent of the members approved the amendment(s).
   Date of adoption of each amendment: July 13, 2012

ARTICLES OF DISSOLUTION ONLY

4) NAME OF LIMITED LIABILITY COMPANY:

5) DATE OF DISSOLUTION:

6) EXECUTION: (Must be signed by at least one member or manager.)
By my signature, I declare as an authorized authority, that this filing has been examined by me and is, to the best of my knowledge and belief, true, correct, and complete. Making false statements in this document is against the law and may be penalized by fines, imprisonment or both.

Signature: Phil Greenhill
Printed Name: Phil Greenhill
Title: Manager

Fees
Required Processing Fee: $100
No Fee for Member/Manager Change Only.
Processing Fees are nonrefundable. Please make check payable to "Corporation Division."
Free copies are available at FilingInOregon.com, using the Business Name Search program.

CONTACT NAME: (The person in whose name the business is registered)
WESTERN OREGON ADVANCED HEALTH

REGISTRY NUMBER: 855424-97

FILED
JUL 13 2012
OREGON SECRETARY OF STATE
Western Oregon Advanced Health, LLC

Articles of Amendment

Appendix 1

Article 12

A. **Business Purpose.** The purpose of the Company is to enter into and perform that certain Health Plan Services Contract, Coordinated Care Organization Contract #139073 with the State of Oregon, acting by and through the Oregon Health Authority, dated as of June 22, 2012 (as amended from time to time, the "CCO Contract"), and to exercise all powers not prohibited by law or by this Article 12 necessary or convenient to the conduct, promotion, or attainment of the transactions, business, or purposes contemplated by the CCO Contract (the "Authorized Activities").

B. **Amendment to Article 12.** This Article 12 may not be amended, altered, changed, or repealed without the consent of all of the Managers and Member(s) of the Company.

C. **Limitations on Company's Activities.**

1. This Section 12(B) is being adopted in order to comply with certain provisions required in order to qualify the Company as a "special purpose" entity.

2. So long as the CCO Contract remains in effect, the Company shall, and the Managers and Member(s) must do all things necessary and appropriate to cause the Company to, comply with all of the following covenants:

   (a) The Company will not engage in any business other than the Authorized Activities.

   (b) The Company will not merge into or consolidate with any other individual, corporation, limited liability company, trust, joint venture, association, company, limited or general partnership, unincorporated organization, governmental authority, or other entity (each a "Person").

   (c) The Company will not dissolve, terminate, liquidate in whole or in part, transfer, or otherwise dispose of all of its assets or change its legal structure.

   (d) The Company will observe all organizational formalities, preserve its existence as an entity duly organized, validly existing, and in good standing under applicable law, and comply with the provisions of its organizational documents.
(e) The Company will not change its state of organization or name.

(f) The Company will not own any subsidiary, or make any investment in any other Person.

(g) The Company will not commingle its assets with the assets of any other Person.

(h) The Company will maintain its records, books of account, bank accounts, financial statements, accounting records, and other entity documents separate and apart from those of any other Person; except that the Company's financial position, assets, liabilities, net worth, and operating results may be included in the consolidated financial statements of an affiliate, provided that such consolidated financial statements contain a footnote indicating that the Company is a separate entity and that it maintains separate books and records.

(i) The Company will maintain its assets in such a manner that it will not be costly or difficult to segregate, ascertain, or identify its individual assets from those of any other Person.

(j) The Company will not assume or guaranty the debts of any other Person, hold itself out to be responsible for the debts of any other Person, pledge its assets for the benefit of any other Person, or otherwise hold out its credit as being available to satisfy the obligations of any other Person.

(k) The Company will file its own tax returns or file a consolidated federal income tax return with another Person (unless prohibited or required, as the case may be, by applicable law).

(l) The Company will hold itself out to the public as a legal entity separate and distinct from any other Person, conduct business solely in its own name, and take reasonable measures to correct any known misunderstanding regarding its separate identity.

(m) The Company will maintain adequate capital for the normal obligations reasonably foreseeable in a business of its size and character and in light of its contemplated business operations.

(n) The Company will not, without the unanimous written consent of its Member(s) and Managers, (i) file or consent to the filing of any petition, either voluntary or involuntary, to take advantage of any debtor’s rights laws, (ii) seek or consent to the appointment of a receiver, liquidator, or any similar official, (iii) take any action that might cause such entity to become insolvent, or (iv) make an assignment for the benefit of creditors.
(o) The Company will reasonably allocate shared expenses (including, without limitation, shared office space and services performed by an employee of an affiliate) among the Persons sharing such expenses and use separate stationery, invoices, and checks.

(p) The Company will remain solvent and pay its own liabilities (including, without limitation, salaries of its own employees) only from its own funds.

(q) The Company will not acquire obligations or securities of its partners, Member(s), or other affiliates.

(r) The Company will not violate, or cause or allow to be violated, the assumptions made with respect to the Company and its principals in any opinion letter pertaining to the Company's substantive consolidation delivered in connection with the OCC Contract.

(s) The Company will maintain a sufficient number of employees in light of its contemplated business operations.
Articles of Amendment/Dissolution - Limited Liability Company

Check the appropriate box below:

☑ ARTICLES OF AMENDMENT
(Complete only 1, 2, 3, 4)
☐ ARTICLES OF DISSOLUTION
(Complete only 4, 5, 6)

REGISTRY NUMBER: 855424-97

In accordance with Oregon Revised Statute 102.410-102.490, the information on this application is public record. We must release this information to all parties upon request and it will be posted on our website. For office use only

Please Type or Print Legibly in Black Ink. Attach Additional Sheet if Necessary.

ARTICLES OF AMENDMENT ONLY

1) ENTITY NAME:
Western Oregon Advanced Health, LLC

2) THE FOLLOWING AMENDMENT(S) TO THE ARTICLES OF ORGANIZATION IS MADE HEREBY: (List the article number(s) and set forth the article(s) as it is amended and read.)

The Articles are Restated in their entirety as described in Exhibit 1.

3) PLEASE CHECK THE APPROPRIATE STATEMENT:

☐ This amendment was adopted by the manager(s) without member action. Member action was not required.

☐ This amendment(s) was approved by the members. 100 percent of the members approved the amendment(s).

4) NAME OF LIMITED LIABILITY COMPANY:

5) DATE OF DISSOLUTION:

6) EXECUTION: (Must be signed by at least one member or manager.)

By my signature, I declare as an authorized authority, that this filing has been examined by me and is, to the best of my knowledge and belief, true, correct, and complete. Making false statements in this document is against the law and may be penalized by fines, imprisonment or both.

Signature: 
Printed Name: Aleksander Curcin
Title: Secretary, Board of Directors, Manager

CONTACT NAME: (To resolve questions with this filing.)
Gwend
PHONE #: 503-80

Fees:
$100 
Member/Manager Change Only.

am available at FilingOregon.com. using the Business Name Search program.
Restated Articles of Organization

Western Oregon Advanced Health, LLC

Article 1

The Company's name is Western Oregon Advanced Health, LLC.

Article 2

The Company's duration will be perpetual.

Article 3

The street address of the Company is 750 Central Ave., Suite 100, Coos Bay, Oregon, 97420. The mailing address of the company is PO Box 1096, Coos Bay, Oregon, 97420. The Company's registered agent is TT Administrative Services, LLC, the address of which is 888 SW Fifth Avenue, Suite 1600, Portland, Oregon 97204.

Article 4

The Company will be managed by a manager, which shall be the Board of Directors of the Company. Any officer of the Board may execute or certify documents on behalf of the Board of Directors acting as Manager.

Article 5

A. Business Purpose. The purpose of the Company is to enter into and perform that certain Health Plan Services Contract, Coordinated Care Organization Contract #139073 with the State of Oregon, acting by and through the Oregon Health Authority, dated as of June 22, 2012 (as amended from time to time, the "CCO Contract"), and to exercise all powers not prohibited by law or by this Article 5 necessary or convenient to the conduct, promotion, or attainment of the transactions, business, or purposes contemplated by the CCO Contract (the "Authorized Activities").

B. Limitations on Company's Activities.

1. This Section 5(B) is being adopted in order to comply with certain provisions required in order to qualify the Company as a "special purpose" entity.
2. So long as the CCO Contract remains in effect, the Company shall, and the Manager and Members must, do all things necessary and appropriate to cause the Company to, comply with all of the following requirements:

(a) The Company will not engage in any business other than the Authorized Activities.

(b) The Company will not merge into or consolidate with any other individual, corporation, limited liability company, trust, joint venture, association, company, limited or general partnership, unincorporated organization, governmental authority, or other entity (each a "Person") unless the Company is the surviving entity or the approval of Members owning at least seventy-five percent (75%) have approved the transaction.

(c) The Company will not dissolve, terminate, liquidate in whole or in part, transfer, or otherwise dispose of all of its assets or change its legal structure without the approval of Members owning at least sixty percent (60%) of the outstanding Units.

(d) The Company will observe all organizational formalities, preserve its existence as an entity duly organized, validly existing, and in good standing under applicable law, and comply with the provisions of its organizational documents.

(e) The Company will not change its state of organization or name.

(f) The Company will not own any subsidiary, or make any investment in any other Person, that has a value greater than twenty-five percent (25%) of the value of the Company as a whole without the approval of Members owning at least seventy-five percent (75%) of its outstanding Units.

(g) The Company will not own any subsidiary, or make any investment in any other Person, that has a value equal to twenty-five percent (25%) of less of the value of the Company as a whole without the approval of Members owning at least sixty percent (60%) of its outstanding Units.

(h) The Company will not commingle its assets with the assets of any other Person.

(i) The Company will maintain its records, books of account, bank accounts, financial statements, accounting records, and other entity documents separate and apart from those of any other Person; except that the Company's financial position, assets, liabilities, net worth, and operating results may be included in the consolidated financial statements of an affiliate, provided that such consolidated financial statements contain a footnote indicating that the Company is a separate entity and that it maintains separate books and records.
(j) The Company will maintain its assets in such a manner that it will not be costly or difficult to segregate, ascertain, or identify its individual assets from those of any other Person.

(k) The Company will not assume or guaranty the debts of any other Person, hold itself out to be responsible for the debts of any other Person, pledge its assets for the benefit of any other Person, or otherwise hold out its credit as being available to satisfy the obligations of any other Person, unless such Person is a wholly owned subsidiary of the Company.

(l) The Company will file its own tax returns or file a consolidated federal income tax return with another Person (unless prohibited or required, as the case may be, by applicable law).

(m) The Company will hold itself out to the public as a legal entity separate and distinct from any other Person, conduct business solely in its own name, and take reasonable measures to correct any known misunderstanding regarding its separate identity.

(n) The Company will maintain adequate capital for the normal obligations reasonably foreseeable in a business of its size and character and in light of its contemplated business operations.

(o) The Company will not, without the unanimous written consent of its Members and Manager, (i) file or consent to the filing of any petition, either voluntary or involuntary, to take advantage of any debtor's rights laws, (ii) seek or consent to the appointment of a receiver, liquidator, or any similar official, (iii) take any action that might cause such entity to become insolvent, or (iv) make an assignment for the benefit of creditors.

(p) The Company will reasonably allocate shared expenses (including, without limitation, shared office space and services performed by an employee of an affiliate) among the Persons sharing such expenses and use separate stationery, invoices, and checks.

(q) The Company will remain solvent and pay its own liabilities (including, without limitation, salaries of its own employees) only from its own funds.

(r) The Company will not acquire obligations or securities of its Members or their affiliates.

(s) The Company will not violate, or cause or allow to be violated, the assumptions made with respect to the Company and its principals in any opinion letter pertaining to the Company's substantive consolidation delivered in connection with the CCO Contract.
(f) The Company will maintain a sufficient number of employees in light of its contemplated business operations.

ARTICLE 6

The Company's Articles of Organization may be amended only with the written consent of Members owning seventy-five percent (75%) of the outstanding Units.

ARTICLE 7

A. The Company will indemnify to the fullest extent permitted by law any person who is made or threatened to be made a party to, witness in, or otherwise involved in, any action, suit or proceeding (any "Claim"), whether civil, criminal, administrative, investigative or otherwise (including an action, suit or proceeding by or in the right of the Company), by reason of the fact that the person (an "Indemnified Person") is or was a member or manager of the Company, or a fiduciary within the meaning of the Employee Retirement Income Security Act of 1974 with respect to any employee benefit plan of the Company, or serves or served at the request of the Company as a director, manager, officer, employee or agent or as a fiduciary of an employee benefit plan, of another limited liability company, corporation, partnership, joint venture, trust or other enterprise. The Company will advance to or pay on behalf of an Indemnified Person expenses (including attorney fees and disbursements) incurred or to be incurred by the Indemnified Person in defending a Claim to the fullest extent permitted by law; provided, however, the Company may recover from an Indemnified Person any advance or payment if it is subsequently determined by a court decision from which no appeal may be taken that the Indemnified Person was not entitled to be indemnified with respect to the Claim. Any indemnification provided pursuant to this Article 7 shall not be exclusive of any rights to which the Indemnified Person may otherwise be entitled under any provision of these Articles of Organization, or under any operating agreement, other agreement, statute, policy of insurance, vote of members or managers, or otherwise.

B. To the fullest extent permitted by law, no Indemnified Person will be personally liable to the Company or its members for damages by reason of any act or omission performed or omitted which the Indemnified Person believed to be in the interests of the Company.

C. If Oregon statutes are amended after these Articles of Organization are filed with the Secretary of State (i) expanding the conditions under which the Company may indemnify an Indemnified Person or (ii) authorizing action further eliminating or limiting the personal liability of any Indemnified Persons, the statutes, as amended, will apply to the obligations of the Company and the rights of the Indemnified Persons under this Article 7. No (iii) amendment or repeal of this Article 7 by the Company; or (iv) amendment of these Articles of Organization inconsistent with this Article 7; or (v) change in Oregon statutes, will diminish the obligations of the Company or the rights of the Indemnified Persons under this Article 7 with respect to a Claim which arose in whole or in part before the effective date of the amendment or repeal of this Article 7 or these Articles of Organization or the change in Oregon statutes.
WESTERN OREGON ADVANCED HEALTH, LLC

By: Aleksander Curcin, MD

It's: Secretary of the Board of Directors, the Manager
### ADVANCED HEALTH
**CHART OR LISTING PRESENTING THE IDENTITIES OF AND INTERRELATIONSHIPS BETWEEN THE PARENTS, AFFILIATES, AND THE APPLICANT**

**Attachment 6**

<table>
<thead>
<tr>
<th>Name of Organization &amp; Type of Legal Entity</th>
<th>STATE</th>
<th>EIN</th>
<th>Relationship of Affiliate* to Advanced Health and Business Functions Provided</th>
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</thead>
<tbody>
<tr>
<td><strong>Limited Liability Company</strong></td>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Corporation</strong></td>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Limited Liability Company</strong></td>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Limited Liability Company</strong></td>
<td>OR</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Affiliate is defined as a person that directly, or indirectly through one or more intermediaries Controls, or is controlled by, or is under common Control with, Advanced Health. RFA, Appendix A.*

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**Attachment 6 - Chart or Listing Presenting the Identities of and Interrelationships Between the Parents, Affiliates, and the Applicant**

1 of 1
## ADVANCED HEALTH

### CONTACT LIST

**(RESPONSIBILITY CHART)**

Attachment 6

<table>
<thead>
<tr>
<th>Area of Application</th>
<th>Contact Name</th>
<th>Telephone Number</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application (as a whole)</td>
<td>Ben Messner</td>
<td>541-269-4566</td>
<td><a href="mailto:Ben.messner@advancedhealth.com">Ben.messner@advancedhealth.com</a></td>
</tr>
<tr>
<td>Attachment 6</td>
<td>Ben Messner</td>
<td>541-269-4566</td>
<td><a href="mailto:Ben.messner@advancedhealth.com">Ben.messner@advancedhealth.com</a></td>
</tr>
<tr>
<td>Attachment 7</td>
<td>Ben Messner</td>
<td>541-269-4566</td>
<td><a href="mailto:Ben.messner@advancedhealth.com">Ben.messner@advancedhealth.com</a></td>
</tr>
<tr>
<td>Attachment 8</td>
<td>Chris Hogan</td>
<td>541-269-4569</td>
<td><a href="mailto:Chris.hogan@advancedhealth.com">Chris.hogan@advancedhealth.com</a></td>
</tr>
<tr>
<td>Attachment 9</td>
<td>Erica Tesdahl-Hubbard</td>
<td>541-266-6503</td>
<td><a href="mailto:Erica.hubbard@advancedhealth.com">Erica.hubbard@advancedhealth.com</a></td>
</tr>
<tr>
<td>Attachment 10</td>
<td>Anna Warner</td>
<td>541-269-4560</td>
<td><a href="mailto:Anna.warner@advancedhealth.com">Anna.warner@advancedhealth.com</a></td>
</tr>
<tr>
<td>Attachment 11</td>
<td>Kent Sharman, MD</td>
<td>547-269-4555</td>
<td><a href="mailto:Kent.sharman@advancedhealth.com">Kent.sharman@advancedhealth.com</a></td>
</tr>
<tr>
<td>Attachment 12</td>
<td>Keith Lowther</td>
<td>541-269-0495</td>
<td><a href="mailto:Keith.lowther@advancedhealth.com">Keith.lowther@advancedhealth.com</a></td>
</tr>
<tr>
<td>Attachment 13</td>
<td>Ben Messner</td>
<td>541-269-4566</td>
<td><a href="mailto:Ben.messner@advancedhealth.com">Ben.messner@advancedhealth.com</a></td>
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<td>Attachment 14</td>
<td>Ben Messner</td>
<td>541-269-4566</td>
<td><a href="mailto:Ben.messner@advancedhealth.com">Ben.messner@advancedhealth.com</a></td>
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<tr>
<td>Attachment 15</td>
<td>Ben Messner</td>
<td>541-269-4566</td>
<td><a href="mailto:Ben.messner@advancedhealth.com">Ben.messner@advancedhealth.com</a></td>
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<tr>
<td>Attachment 16</td>
<td>Caryn Mickelson</td>
<td>541-269-4558</td>
<td><a href="mailto:Carym.mickelson@advancedhealth.com">Carym.mickelson@advancedhealth.com</a></td>
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<td>Contact Name</td>
<td>Telephone Number</td>
<td>Email Address</td>
</tr>
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<td>Sample Contract (as a whole)</td>
<td>Ben Messner</td>
<td>541-269-4566</td>
<td><a href="mailto:Ben.messner@advancedhealth.com">Ben.messner@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit A</td>
<td>Ben Messner</td>
<td>541-269-4566</td>
<td><a href="mailto:Ben.messner@advancedhealth.com">Ben.messner@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit B</td>
<td>Ben Messner</td>
<td>541-269-4566</td>
<td><a href="mailto:Ben.messner@advancedhealth.com">Ben.messner@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit C</td>
<td>Chris Hogan</td>
<td>541-269-4569</td>
<td><a href="mailto:Chris.hogan@advancedhealth.com">Chris.hogan@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit D</td>
<td>Keith Lowther</td>
<td>541-269-0495</td>
<td><a href="mailto:Keith.lowther@advancedhealth.com">Keith.lowther@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit E</td>
<td>Keith Lowther</td>
<td>541-269-0495</td>
<td><a href="mailto:Keith.lowther@advancedhealth.com">Keith.lowther@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit F</td>
<td>Keith Lowther</td>
<td>541-269-0495</td>
<td><a href="mailto:Keith.lowther@advancedhealth.com">Keith.lowther@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit G</td>
<td>Kent Sharman, MD</td>
<td>547-269-4555</td>
<td><a href="mailto:Kent.sharman@advancedhealth.com">Kent.sharman@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit H</td>
<td>Chris Hogan</td>
<td>541-269-4569</td>
<td><a href="mailto:Chris.hogan@advancedhealth.com">Chris.hogan@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit I</td>
<td>Anna Warner</td>
<td>541-269-4560</td>
<td><a href="mailto:Anna.warner@advancedhealth.com">Anna.warner@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit J</td>
<td>Erica Tesdahl-Hubbard</td>
<td>541-269-0495</td>
<td><a href="mailto:Erica.hubbard@advancedhealth.com">Erica.hubbard@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit K</td>
<td>Keith Lowther</td>
<td>541-269-0495</td>
<td><a href="mailto:Keith.lowther@advancedhealth.com">Keith.lowther@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit L</td>
<td>Kent Sharman, MD</td>
<td>547-269-4555</td>
<td><a href="mailto:Kent.sharman@advancedhealth.com">Kent.sharman@advancedhealth.com</a></td>
</tr>
<tr>
<td>Sample Contract—Exhibit M</td>
<td>Anna Warner</td>
<td>541-269-4560</td>
<td><a href="mailto:Anna.warner@advancedhealth.com">Anna.warner@advancedhealth.com</a></td>
</tr>
<tr>
<td>Area of Application</td>
<td>Contact Name</td>
<td>Telephone Number</td>
<td>Email Address</td>
</tr>
<tr>
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</tr>
<tr>
<td>Sample Contract—Exhibit C, Attachment 1</td>
<td>Chris Hogan</td>
<td>541-269-4569</td>
<td><a href="mailto:Chris.hogan@advancedhealth.com">Chris.hogan@advancedhealth.com</a></td>
</tr>
<tr>
<td>Rates and Solvency</td>
<td>Keith Lowther</td>
<td>541-269-0495</td>
<td><a href="mailto:Keith.lowther@advancedhealth.com">Keith.lowther@advancedhealth.com</a></td>
</tr>
<tr>
<td>Readiness Review</td>
<td>Ben Messner</td>
<td>541-269-4566</td>
<td><a href="mailto:Ben.messner@advancedhealth.com">Ben.messner@advancedhealth.com</a></td>
</tr>
<tr>
<td>Membership and Enrollment</td>
<td>Chris Wilson</td>
<td>541-269-4568</td>
<td><a href="mailto:Chris.wilson@advancedhealth.com">Chris.wilson@advancedhealth.com</a></td>
</tr>
</tbody>
</table>
ADVANCED HEALTH
GENERAL QUESTIONS
Attachment 6

A. Background Information about the Applicant

A.1. Describe Applicant's Legal Entity status, and where domiciled. Advanced Health is a limited liability company that is organized, operated and domiciled in Oregon.

A.1.a. Describe Applicant's Affiliates as relevant to the Contract. Advanced Health owns 100% of the outstanding membership interests in South Coast Oregon Technical Innovations, LLC, an Oregon limited liability company. Southwest Oregon IPA, Inc., an Oregon corporation, owns 60% of the outstanding membership interests in Advanced Health. Unrelated individuals, none of whom own more than 2% of the voting stock, own all of the stock in Southwest Oregon IPA, Inc. Southwest Oregon IPA, Inc., owns 100% of the outstanding membership interests in DOCS Management Services, LLC, an Oregon limited liability company, and in LaClair Properties, LLC, an Oregon limited liability company.

A.1.b. Is the Applicant invoking alternative dispute resolution with respect to any Provider (see OAR 410-141-3268)? No.

A.1.c. What is the address for the Applicant's primary office and administration located within the proposed Service Area? 289 LaClair St., Coos Bay, OR 97420.

A.1.d. What counties are included in this Service Area? Coos and Curry. Describe the arrangements the Applicant has made to coordinate with county governments and establish written agreements as required by ORS 414.153. Advanced Health is a party to written Subcontracts with Coos County (services provided by Coos Health and Wellness) and with Curry County (services provided by Curry Community Health) for Behavioral Health services. These contracts specify agreed-upon outcomes and specify authorizations and payments required for the services required by the statute. Discussions are underway to amend and restate these agreements to take into account the requirements of the 2020 Contract and applicable OHA rules and policies, along the restructuring of the Behavioral Health benefit as contemplated by the RFA and described in Attachment 11.

A.1.e.(1) Is Applicant is the Legal Entity that has a contract with OHA as a CCO as of January 1, 2019 (hereinafter called "Current CCO")? Yes.
A.1.e.(2) If no to 1, is Applicant the Legal Entity that had a contract with OHA as a CCO prior to January 1, 2019? Not applicable.

A.1.e.(3) If no to 1 and 2, is Applicant the Legal Entity that had a contract with OHA as a CCO prior to January 1, 2019? Not applicable.

A.1.e.(4) If no to 1, 2, and 3, what is Applicant history of bearing health care risk in Oregon? Not applicable.

A.1.f. Current experience as an OHA contractor, other than as a Current CCO. Does this Applicant (or an Affiliate of Applicant) currently have a contract with the OHA as a licensed insurer or health plan third party administrator for any of the following (hereinafter called "Current OHA Contractor")? If so, please provide that information in addition to the other information required in this section.

- Public Employees Benefit Board: No.
- Oregon Educators Benefit Board: No.
- Adult Mental Health Initiative: No.
- Cover All Kids: No.
- Other (please describe): Southwest Oregon IPA, Inc., an Affiliate of Advanced Health, held the contract to provide physical health services to OHA from 1997 until the creation of the CCO system in 2012 for the Coos County service area, and from 1997-2000 for the Curry County service area. Prior to that time, Southwest Oregon IPA, Inc. was a Subcontractor to the entity contracting with OHA for these services.

A.1.g. Does the Applicant (or an Affiliate of Applicant) have experience as a Medicare Advantage contractor? Does the Applicant (or Affiliate of the Applicant) have a current contract with Medicare as a Medicare Advantage Contractor? What is the Service Area for the Medicare Advantage Plan? At this time, Advanced Health is neither the sponsor of a Medicare Advantage plan nor affiliated with a sponsor of such a plan. Over the past seven years, Advanced Health has coordinated benefits and care for the 1,200 Fully Dual Eligible Members in its Service Area, working with the variety of Medicare Advantage (and other Medicare) plans that operate in this Service Area. Because precisely the same panel of physical health, oral health, and Behavioral Health Providers and Provider Organizations serve these Members for their Medicaid and Medicare care, Advanced Health is in a favorable position to ensure a seamless coordination of care and benefits for this population of Members who are aged/indigent or Members who are disabled. Recognizing the new requirements of the 2020 CCO Contract, Advanced Health is in the process of selecting an appropriate plan with which to have a formal contractual arrangement, which requires an analysis of which plan(s) are most widely used by Members assigned to Advanced Health. This contract will be in place by the time of the Readiness
Review. In the likely event that not all Fully Dual Eligible Members in the Service Area will be served by the selected plan, Advanced Health will enter into arrangements with the other Medicare Advantage plans to ensure that it continues to coordinate care and benefits for the Members served by other Medicare Advantage plans.

A.1.h. Does Applicant have a current Dual Special Needs Coordination of Benefits Arrangement with OHA to serve Fully Dual Eligible Members? No.

A.1.i. Does the Applicant (or an Affiliate of Applicant) hold a current certificate of authority for transacting health insurance or the business of a health care service contractor, from the Department of Consumer and Business Services, Division of Financial Regulation? No.

A.1.j. Does the Applicant (or an Affiliate of Applicant) hold a current contract effective January 1, 2019, with the Oregon Health Insurance Marketplace? No.

A.1.k. Describe Applicant's demonstrated experience and capacity for engaging Community members and health care Providers in improving the health of the Community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among Applicant's enrollees and in Applicant's Community. Advanced Health has a seven-year history of engaging its Community through its two Community Advisory Councils (CACs), and healthcare Providers through its Clinical Advisory Panel, with the singular goal of improving the Community's health. In 2011, Advanced Health's CACs adopted their first Community Health Assessment (CHA) and resulting Community Health Improvement Plan (CHIP), and made steadfast progress on that CHIP until 2016, when the CHA and CHIP were thoroughly updated to increasingly reflect cultural, socio-economic, and other disparities. Beginning in 2018, both CACs undertook the arduous work, in concert with clinical and non-clinical Community stakeholders, to develop an entirely new CHA for both counties. That Assessment is now informing a new and exciting CHIP, which is scheduled for completion in the next several weeks. The new CHIPs call for increasing Member engagement through a wide array of Member-designed and Member-directed initiatives, including: Adverse Childhood Experiences (ACEs); prescription drug overdose prevention; improving access to Behavioral Health services; suicide prevention; healthy eating and active living; kindergarten readiness; and health equity. With respect to the latter category, health equity, Advanced Health and its CACs sought technical assistance from the OHA's Transformation Center, Office of Equity and Inclusion, to analyze Consumer Assessment of Healthcare Providers and Systems (CAHPS) data for significant differences on a wide array of individual and composite variables according to
respondents' reported ethnicity or disability status. In consultation with the Office of Equity and Inclusion, it was concluded that there were no statistically significant differences in any access, satisfaction, or outcome variables on the basis of race, ethnicity, or national origin. However, it was learned that for a handful of variables, and particularly those variables related to access, disparities did exist for persons with certain disabilities, primarily persons with mobility disabilities. Advanced Health engaged in Corrective Action by conducting on-site ADA and barrier assessments at every clinical practice, requiring improvement when those improvements could be made, and working with Members who evidence mobility impairments to assign them to Providers who are located in inviting facilities that are fully ADA compliant. The CACs have asked Advanced Health to provide support for the development of a formal Health Equity Coalition, as Coos and Curry Counties are currently unserved by such a Coalition. This undertaking has been added to the Community Engagement Plan. This activity will launch concurrently with a two-county Diversity Conference to be hosted by Advanced Health this autumn. As Advanced Health begins the formal process of screening Members for Social Determinants of Health (SDOH) in their primary care settings, the Clinical Advisory Panel is learning more about the wide array of determinant factors that contribute to health disparities or poor health status, and is making recommendations about addressing antecedent and consequent conditions. This work will include fostering resiliency for parents and children, and is becoming a new focus under Advanced Health's health-related spending priorities.

A.1.l. Identify and furnish resumes for the following key leadership personnel (by whatever titled designated): Chief Executive Officer; Chief Financial Officer, Chief Medical Officer, Chief Information Officer, Chief Administrative or Operations Officer. Chief Executive Officer: Benjamin J. Messner; Chief Financial Officer: Keith Lowther; Chief Medical Officer: Kenton D. Sharman, M.D.; Chief Information Officer: Erica Tesdahl-Hubbard; Executive Program Director: Anna Warner. Resumes attached.

A.1.m. Provide a chart (as a separate document, which will not be counted against page limits) identifying Applicant's contact name, telephone number and email address for each of the following: (1) The Application generally; (2) Each Attachment to the RFA; (3) The Sample Contract generally; (4) Each Exhibit to the Sample Contract (separate contacts may be furnished for parts); (5) rates and solvency; (6) Readiness Review (separate contacts may be furnished for parts); (7) Membership and Enrollment. Attached.
B. Corporate Organization and Structure

B.1.a. Provide a certified copy of the Applicant’s Articles of Incorporation, or other similar legal entity charter document, as filed with the Oregon Secretary of State or other corporate chartering office. Attached.

B.1.b. Provide an organization chart listing of ownership, Control or sponsorship, including the percentage Control each person has over the organization.

As discussed more fully in F.1.a., some Board of Director decisions, typically those involving critical financial matters, must be referred to the Members of Advanced Health (equity owners) for consent. Such consent requires varying voting percentages for approval.

B.1.c. Describe any licenses the corporation possesses. Advanced Health is qualified to do business in the State of Oregon and is licensed to do business in the City of Coos Bay.

B.1.d. Describe the administrative service or management contracts with other parties where the Applicant is the provider or Recipient of the services under the contract. Affiliate contracts are excluded in this item and should be included under Section C. No such contracts exist with unaffiliated entities.

C. Corporate Affiliates, Transactions, Arrangements

C.1.a. Provide an organization chart or listing presenting the identities of and interrelationships between the parent, the Applicant, Affiliated
insurers and reporting entities, and other Affiliates. The organization chart must show all lines of ownership or Control up to Applicant's ultimate controlling person, all subsidiaries of Applicant, and all Affiliates of Applicant that are relevant to this Application. When interrelationships are a 50/50% ownership, footnote any voting rights preferences that one of the entities may have. For each entity, identify the corporate structure, two–character state abbreviation of the state of domicile, Federal Employer's Identification Number, and NAIC code for insurers. Schedule Y of the NAIC Annual Statement Blank—Health is acceptable to supply any of the information required by this question. If a subsidiary or other Affiliate performs business functions for Applicant, describe the functions in general terms. Attached.

C.1.b. Describe of any expense arrangements with a parent or Affiliate organization. Provide detail of the amounts paid under such arrangements for the last two years. Provide footnotes to the operational budget when budgeted amounts include payments to Affiliates for services under such agreements.

C.1.c. Describe Applicant's demonstrated experience and capacity for (1) Managing financial risk and establishing financial reserves; (2) Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350. Although Advanced Health has not been subject to DCBS reserve standards, the Advanced Health Board and equity owners have attended to its financial operations in a manner that has produced steady increases in reserves, with the goal of establishing and maintaining healthy reserves to fund unusual health events and meeting or exceeding DCBS standards.

D.1.a. Please identify and describe any business functions the Contractor subcontracts or delegates to Affiliates. Advanced Health has entered into a Subcontract with Southwest Oregon IPA, Inc., for the latter to provide all physical health services to Members assigned to Advanced Health. Starting in 2020, this
Subcontract will be amended and restated to include integrated Behavioral Health services. Advanced Health has entered into a Subcontract with DOCS Management Services, LLC to provide administrative services, equipment and supplies to Advanced Health. LaClair Properties, LLC, leases office space to DOCS Management Services, LLC, and the latter provides shared office space to Advanced Health as part of the administrative services agreement.

D.1.b. What are the major Subcontracts the Applicant expects to have? Advanced Health will enter into Subcontracts with Southwest Oregon IPA, Inc. (for physical health and integrated Behavioral Health services), Bay Cities Ambulance (for Non-Emergent Medical Transportation Services), Advantage Dental (for Dental Services), and Coos Health and Wellness (certain specialty and residential behavioral health services). These Subcontracts will be Privileged Provider Subcontracts, which will allow the Subcontractor to engage, with appropriate Advanced Health oversight, in certain specified activities in addition to the provision of Provider services, such as credentialing, contract monitoring for contracted downstream Providers, and utilization management. In addition, Advanced Health will enter into a restated administrative services contract with DOCS Management Services, LLC, to provide certain administrative services to Advanced Health. (Please provide an example of subcontracted work and describe how Applicant currently monitors Subcontractor performance or expects to do so under the Contract. (example of subcontracted work does not count toward page limit). Attached.

E. Third Party Liability.

E.1.a. How will Applicant ensure prompt identification of Members with TPL across its Provider and Subcontractor network? As part of Advanced Health's administrative services agreement with DOCS Management Services LLC, the latter is obligated to: assess potential Third Party Liability (TPL) for Covered Services with respect to new Members; periodically review such determinations and update Member information; assess existence of TPL when an event occurs that could create new TPL; take all reasonable steps to actively pursue and monitor TPL claims; make all TPL required reporting to OHA and Advanced Health; and seek continual improvements to Advanced Health's TPL system. Both Providers and Subcontractors are contractually obligated to cooperate in the collection and development of such information and to do so in accordance with Advanced Health's and OHA's policies and procedures. Advanced Health's policies and procedures provide more in-depth guidance on this obligation and the mechanisms for fulfilling it in accordance with applicable privacy laws, probate laws, and third-party insurance requirements.

E.1.b. How will Applicant ensure the prompt identification of Members covered by Medicare across its Provider and Subcontractor network? As
part of Advanced Health's administrative services agreement with DOCS Management Services LLC, the latter is obligated to: assess the status of each new Member to determine such Member's eligibility for Medicare; work with Advanced Health's contracted Medicare Advantage Plan to make such determinations; periodically review such determinations; and seek continual improvement of the coordination of Medicare and Medicaid benefits. Both Providers Subcontractors are contractually obligated to provide this information and to do so in accordance with Advanced Health's policies and procedures, which provide more in-depth guidance on this obligation, including mechanisms for fulfilling it in accordance with applicable privacy laws.

F. **Oversight and Governance. Please describe:**

F.1.a. **Applicant's governing board, how board members are elected or appointed, how the board operates, and decisions that are subject to approval by a person other than Applicant.** Advanced Health is a manager-managed limited liability company, and its central governance document is called an *operating agreement*. Its operating agreement establishes a Board of Directors (the *Board*) that serves as Advanced Health's manager. The Board is responsible for ensuring that Advanced Health establishes appropriate objectives and achieves them.

F.1.b. **Please describe Applicant's key committees including each committee's composition, reporting relationships and responsibilities, oversight responsibility, monitoring activities and other activities**
The Executive Committee, which is made up of the officers of the Board, is responsible for oversight of the Chief Executive Officer (CEO), appointment of committee members, development of Board meeting agendas, the exercise of financial oversight between Board meetings, and assisting the CEO with thorny personnel or other questions as needed. The Nominating Committee works to identify potential Directors to ensure compliance with ORS 414.625 and all applicable OHA rules and also helps to ensure that elected directors represent a cross section of the Community. The Compliance Committee is responsible for ensuring that Advanced Health’s operations (including policies, procedures and operations) comply with federal and State law, regulations and best practices in healthcare governance. The Board has the authority to appoint ad hoc committees as it desires. All Board committees report to the Board as a whole, and committees do not have independent authority to act unless action is specifically delegated by the Board. Committee recommendations are given great weight in the deliberations of the Board.

F.1.c. The composition, reporting responsibilities, oversight responsibility and monitoring activities of the Applicant's CAC. Two CACs advise Advanced Health, one in Coos County and one in Curry County. Both CACs are organized (in terms of composition) and operated (in terms of duties) in accordance with ORS 414.627. A representative of the Curry County CAC is a member of the Advanced Health Board. Both CACs have timely completed each annual CHIP and CHA as contemplated by the statute. As discussed in more detail in Attachment 11, to complete an entirely new (2019) CHIP, the CACs in both Coos and Curry Counties are completing a scholarly and facilitated assessment of care integration. Each CAC has identified the best examples of care integration in their service area, and the greatest opportunities to improve care integration in those areas. As contemplated by the statute, the activities of the CAC also inform Advanced Health's strategic objectives and ultimately its resource allocation. For example, the Curry County CAC formed a Peer Advisory sub-committee to research and consider issues relating to the delivery of peer services in Behavioral Healthcare. Advanced Health provided a mini-grant to help facilitate that effort. A direct outgrowth of that work is the participation by that sub-committee in Advanced Health's review, selection and ongoing evaluation of successful bidders for Peer Delivered Services that is expected to occur in May, 2019. Advanced Health will build on such activities by expanding the role of these CACs during 2019, and clarifying their governance structures in accordance with new requirements of CCO 2.0 policy initiatives. Advanced Health will ensure that the CACs have a decisionmaking role in directing, tracking and reviewing spending on SDOH and health-related services spending. It will also invite each CAC to assist in meaningful ways in the selection of Advanced Health's State Health Improvement Plan priorities, the development of the new Health Equity Plan, and the process of ensuring the delivery of Culturally Responsive and linguistically appropriate healthcare.
Anna Warner
Executive Program Director
Western Oregon Advanced Health, LLC
("Advanced Health")
anna.warner@advancedhealth.com
Telephone: 541-269-4560

PROFESSIONAL EXPERIENCE

Western Oregon Advanced Health, LLC, abn Advanced Health, Coos Bay, Oregon
Executive Program Director, 2018 – Current
Directly responsible for implementing and monitoring elements of the Coordinated Care Organization's (CCO's) contract with the Oregon Health Authority (OHA) as those contract elements relate to Consumer Advisory Councils (CACs), Community Health Assessments (CHAs), Community Health Improvement Plans (CHIPs), Tribal Advisors, Equity, Social Determinants of Health (SDOH), Value-Based Contracting, and focused investments in building the capacity of non-clinical social service agencies that serve as strategic partners to the CCO.

Southwest Oregon IPA, Inc. (SWOIPA), Coos Bay, Oregon
Director of Quality, 2015 – 2019
Plan, implement, and evaluate quality management and improvement initiatives. Collaborate closely with quality improvement staff at community partner, Provider Network, and CCO delegate organizations as well as the Oregon Health Authority, Transformation Center, and other CCOs to achieve system-wide improvements and work toward the Triple Aim of improved health outcomes, improved patient experience of care, and cost efficiency.

South Coast Hospice, Coos Bay, Oregon
Manager of Human Resources, Quality, and Compliance, 2015
Managed human resource processes for the organization, including clinical and non-clinical staff. Implemented quality improvement project to ensure timely and accurate reporting and monitoring process for Uniform Data Set reporting requirements. Made recommendations for comprehensive policy and procedure update and implementation process to ensure compliance with federal requirements.

Hardin Optical Company, Bandon, Oregon
Quality Assurance Manager, 2011 – 2014
Oversaw implementation and maintenance of ISO 9001:2008 quality management system. Provided assistance to all functional areas of the company regarding ISO
compliance. Reviewed data and signed certificates of conformance for finished products. Maintained ITAR registration with the Department of State and ensured compliance of internal procedures. Assisted with OSHA and DEQ compliance. Directed project to install and implement new ERP software.

**Hardin Optical Company, Bandon, Oregon**
**Production Manager, Process Improvement Coordinator, 2005 – 2011**
Used lean manufacturing and six sigma tools to drive improvement and select projects. Supervised cross-functional project teams. Analyzed data and created custom reports to track success of improvement projects.

**EDUCATION AND CERTIFICATION**

**Certified Professional in Healthcare Quality (CPHQ) – 2018**
*National Association of Healthcare Quality (NAHQ)*

**Bachelor of Science, Mechanical Engineering – 1999**
*Rice University – Houston, Texas*
PROFESSIONAL EXPERIENCE

Western Oregon Advanced Health, LLC, abn Advanced Health, Coos Bay, Oregon
Chief Executive Officer, 2018 – Present
Accountable for assisting the Board of Directors of a Coordinated Care Organization providing Medicaid Managed Care in the development of strategic goals and objectives, and for developing and implementing all operational plans, reporting to the Board of Directors. Responsible for leading affiliates and community partners in transforming the local health system in a rural healthcare environment.

Southwest Oregon IPA, Inc. (SWOIPA), Coos Bay, Oregon
Chief Executive Officer, 2018 – Present
Accountable for assisting the Board of Directors of a 100-member independent practice association in the development of strategic goals and objectives, and for development and implementation of all operational plans, reporting to Board of Directors. Responsible for ensuring that Medicaid physical health benefit is delivered effectively and efficiently, and working collaboratively with Advanced Health and most healthcare organizations providing physical health services in the Southern Oregon Coast region.

Director of Quality, 2015 – 2018
Accountable for medical authorization implementation and oversight, external and internal quality standards and external quality reviews. Reduced medical authorization turnaround time by 20 days. Developed a quality incentive incubator fund, leading to further healthcare transformation in Coos and Curry Counties.

DOCS Management Services, LLC, Coos Bay, Oregon
Member, Board of Managers, 2018 – Present
Accountable for leading Board of Managers in the development of strategic goals and objectives and ensuring the delivery or effective and efficient administrative services for Advanced Health and other affiliates to allow delivery of Medicaid benefit in Coos and Curry Counties.
Chief Operations Officer, 2015 – Present
Accountable for the day-to-day operations, including authorizing and processing over $100 million in medical encounters, resulting in major improvements in timeliness of claims processing.

Asante Physician Partners, Medford Oregon
Practice Manager, 2014 – 2015
Responsible for the overall management and daily activities of outpatient medical practices in Medford and the providers within the ICU inpatient unit at Asante Rouge Regional Medical Center. Provided leadership and strategic direction for the physician enterprise, worked closely with physicians, Asante management on clinical, financial and administrative issues, ensuring outstanding customer service, and administered clinical and administrative processes that complemented the delivery of high quality, cost effective and customer-focused patient care.

Samaritan Health Services, Newport, Oregon
Clinics Manager, 2013 – 2014
Acquired and analyzed information to support strategic planning, business development and clinical operations for four high producing clinics (Samaritan Pacific Internal Medicine, Samaritan Pacific Surgical Associates, Samaritan Pacific Walk-In Clinic and Samaritan Pacific ENT and Allergy Clinic). Developed and implemented financial policy, performed financial analyses, and guided decision making based on financial indicators. Led development of feasibility studies, new technology assessments and created business plans for new and existing business opportunities. Worked with community and physician partners in achieving operational success.

FORMAL EDUCATION AND PROFESSIONAL CERTIFICATION

Certified Medical Practice Executive (CMPE) – 2014
American College of Medical Practice Executives

Master of Business Administration / Healthcare Administration – 2011
University of Phoenix – Phoenix, Arizona

Bachelor of Science, Business Administration / Management – 2001
Southern Oregon University – Ashland, Oregon
PROFESSIONAL EXPERIENCE

Western Oregon Advanced Health, LLC, abn Advanced Health, Coos Bay, Oregon
Chief Information Officer, 2019 – Current
Directly responsible for implementing and monitoring elements of the Coordinated Care Organization's (CCO's) contract with the Oregon Health Authority (OHA) as those contract elements relate to Health Information Technology (HIT), Health Information Exchange (access), annual attestation and progress reporting, compliance and monitoring of HIT programs and to monitor and negotiate HIT program MOU’s with contracted providers. Management and oversight of contracted physical, behavioral, and oral health providers' EHR adoption for use in care coordination, hospital event notification, maximizing health information technology services in CCO's TQS plan, and generating relevant data related to value based payment models.

Southwest Oregon IPA, Inc. (SWOIPA), Coos Bay, Oregon
Chief Information Officer, 2019 – Current
Assure the continuous operation and improvement of data systems, telecommunication and software and hardware systems. Plan, organize, and execute all Information Technology (IT) functions, including support, training, maintenance, planning, compliance, and advancement of all technologies. Develop and implement goals and objectives for information systems technology throughout the organization; contribute to general business planning regarding technology and systems required to maintain organizational operations and competitiveness.

Information Technology Manager, 2017 – 2019
Responsible for configuration of the network and hardware devices. Provide end-user support. Responsible for maintaining and upgrading Production and Report Databases. Plan and budget for organizational software and hardware, assuring timely upgrades, and scheduled replacement of hardware and software to maximize operational efficiencies. Monitor and evaluate compliance covering the privacy of, and access to, protected health information as outlined by HIPAA and other applicable federal and state laws and regulations requirements. Advise departments and staff on requirements. Ensure security best practices are
identified and integrated into all facets of projects including network, system
designs/configuration, and implementation. Contribute to general business
planning regarding technology and systems required to maintain organizational
operations and competitiveness.

**Data Analyst**, 2016 – 2017
Responsible for Business Support Requests. Assisted with Risk, Access, and
Incentive Metrics report creations. Responsible for building Tableau Dashboards.
Created reports to assist in determining payment errors. Assisted in solving
encounter data errors. Assisted in creating routes for 835 and 837 files.

**Coquille Valley Hospital**, Coquille, Oregon
Responsible for creating reports using Discern Analytics 2.0 in Cerner for data
analytics. Assisted in building Clinics virtually in Cerner. Responsible for building
charges in Cerner. Worked daily with Cerner Support to solve issues within the
system. Responsible for reviewing charge data. Achieved HIMSS Level 6 for the
Hospital.

**Health Informatics Class of Oregon Institute of Technology**, Klamath Falls,
Oregon
**Project Manager**, 2014
Oversaw team project to complete an Information Systems Audit in the review of
Transformation Wellness Center's (TWC) Electronic Health Record System.
Reported to TWC and facilitated product demonstration. Received regional
recognition through local media for community participation.

**EDUCATION AND CERTIFICATIONS**

**Certified HIPAA Security Professional (CHSP)** – 2018
4Med Professional Training and Certifications

**Master of Medical Science, Health Informatics** – 2017
*University of South Florida, Morsani College of Medicine* – Tampa, Florida

**Bachelor of Science, Information Technology – Health Informatics** – 2014
*Oregon Institute of Technology* – Klamath Falls, Oregon
PROFESSIONAL EXPERIENCE

Western Oregon Advanced Health, LLC abn Advanced Health, Coos Bay, OR
Chief Financial Officer, 2015 – Current
Representative duties and responsibilities of this position include: strategic planning of controlled financial growth; performing financial risk assessment and management; long-term financial sustainment planning; managing short- and long-term risk reserves; serving as a subject matter expert to the firm; providing fiscally-based decision support services; implementing internal controls; accurately and timely filing contractually required quarterly and annual reports; maintaining fiscal integrity and compliance; and, overseeing the company’s strategic framework for aligning infrastructure services with operational priorities.

Southwest Oregon IPA, Inc. (SWOIPA) Coos Bay, Oregon
Chief Financial Officer, 2015 – Current
Representative duties and responsibilities of this position include: providing fiscal oversight and revenue-cycle analyses for core contractual clinical services; evaluating financial and operational standards, policies and procedures; and, developing budgeting, forecasting and financial reporting processes.

Coquille Valley Hospital (CVH), Coquille, Oregon
Chief Financial Officer, 2014 – 2015
Representative accomplishments in this position included: building the revenue-cycle-side of the Cerner electronic health record; assisting the organization to meet all Medicare Meaningful Use requirements; and, effecting the implementation of the new Dynamics GP financial accounting and payroll systems.

Jefferson Healthcare (JH), Port Townsend, Washington
Controller, 2003 – 2014
Representative accomplishments in this position included: leading the budgeting process for 30 departmental directors; supervising accounting, payroll and accounts payable processes; developing accounting department improvement plans; and, lending leadership to a hospital-wide transition to the EPIC electronic health record.
EDUCATION AND CERTIFICATIONS

Master of Health Administration – 2014
Ohio University – Athens, Ohio

Bachelor of Science, Business Administration, major in Finance – 1991
Ohio University – Athens, Ohio

Licensed Certified Public Accountant (CPA)
Certified in West Virginia – 1995
Certified in Oregon – 2018
PROFESSIONAL EXPERIENCE

Western Oregon Advanced Health, LLC, abn Advanced Health, Coos Bay, Oregon
Chief Medical Officer, 2019 – Current
Directly responsible for the planning, development, implementation, management, ongoing support, and evaluation of the programs related to the integration and coordination of patients' physical, behavioral and oral healthcare. Programs include coordination of care, preventative healthcare, Network Provider management, health equity, quality improvements initiatives, and oversight of medical policies, medical service delivery and quality of care for Oregon Health Plan Members.

Southwest Oregon IPA, Inc. (SWOIPA), Coos Bay, Oregon
Chief Medical Officer, 2019 – Current
Responsible for the planning, development, implementation, management, ongoing support, and evaluation of the medical service programs in accordance with Medicare and Medicaid requirements and the Quadruple Aim. Responsibilities include concurrent review of inpatient care, prior authorization of referrals and procedures, review of member and provider appeals and complaints, case management activities, and pharmacy program oversight; quality improvement including quality assurance for daily activities within the company; initiatives and projects with staff, business partners, consumers and community members; and, oversight of medical policies, medical service delivery and quality of care for health plan members.

North Bend Medical Center, Inc., Coos Bay, Oregon
Physician, 1984 – Current
Physician for comprehensive family medicine practice. Provide inpatient and outpatient medical care for patients of all ages.

Coos County Health Department GYN Clinic / Family Planning, Coos Bay, Oregon
Physician, 1984 – 1986
Provided ambulatory gynecology services for patients referred by public health staff.
Redwood Coast Medical Services, Stewarts Point, California
Physician, 1983
Provided ambulatory services for urgent care. Provided chronic disease management services.

Aquarian Efforts Clinic, Sacramento, California
Staff Physician, 1999-2004
Provided STI care and contraception for a free clinic.

FORMAL EDUCATION AND TRAINING

Residency in Family Practice – 1983
University of California, – Davis, California

University of California, – Davis, California

Doctor of Medicine – 1980
Albany Medical College, – Albany, New York

Bachelor of Science in Biochemistry – 1976
University of California, – Davis, California

LICENSURE AND CERTIFICATION

Medical Licensure 14219
State of Oregon, Expires December 2019

American Board of Family Practice

Diplomate – 1983
National Board of Medical Examiners
Methodology – Capacity and Access

1. Describe the methodology used to establish provider capacity for physical, behavioral, and oral health providers. How does Contractor determine the minimum number of providers needed to ensure sufficient access? Advanced Health examines Member-to-Provider, and Population-to-Provider ratios, across all disciplines, to determine the minimum number of Providers needed to ensure adequate access, with the goal of maintaining Member-to-Provider ratios that are consistent with statewide norms. These data are subject to further analysis or refinement for such variables as zip code, foreign languages spoken, or areas of high diagnostic need.

2. Describe the process used to develop, maintain and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract. Advanced Health maintains a continuously updated Excel-based Delivery System Network spreadsheet. This document is reviewed quarterly by the Chief Medical Officer and Clinical Advisory Panel, with an eye toward monitoring Member-to-Provider ratios to ensure adequate access to all services provided by Advanced Health.

3. Describe how Contractor identifies and incorporates the needs of linguistically and culturally diverse populations within its community. Advanced Health is developing the capability of REAL+D data. Coos and Curry Counties are characterized by a paucity of ethnic diversity at 10.7 percent and 9.6 percent, respectively. Only 35 Member households are Spanish-speaking and local public schools have eliminated their migrant education and ESL programs. CAHPS scores for persons of minority status were found to be no different than those from the dominant Anglo population. In consultation with the Office of Equity and Inclusion, the greatest disparities were identified for persons with disabilities, and particularly persons with mobility disabilities. Advanced Health requires all personnel, Providers, and contractors to complete cultural and linguistically competence and health literacy training and has brought expert trainers and speakers to the community. Advanced Health is committed to providing culturally and linguistically appropriate services through the retention of translators and interpreters, print material available in Spanish, and the inclusion of Native American and Hispanic Providers within its network.
4. Describe how Contractor utilizes Grievance and Appeal data to identify and remedy member access issues by geographic area, by provider type, by special needs populations, and by subcontractor or subcontracted activity.

Access to care (wait times, travel distances, and subcontracted activities such as non-emergent medical transportation): Advanced Health’s grievance and appeals system works across all network disciplines, including physical health, oral health, Behavioral Health, and NEMT. On a quarterly basis, Advanced Health aggregates data from its grievance and appeals system, and dichotomizes those data based on access variables (wait times; travel distances). Data are converted to dashboards with quarterly plotted linear values. At a glance, Advanced Health’s data scientist can determine if there has been an uptick in access-related complaints, and easily dive a little deeper into the data to determine root cause. At a glance it can be determined if corrective actions placed into effect are producing desired downticks.

Network adequacy (including sufficient number of specialists, oral health and behavioral health providers). Using the same methodology set forth in 5.a, above, data are dichotomized by individual Providers and by Provider type and specialties to determine if wait times and travel distances are creating inadequacies within the network. Individual Providers receive quarterly dashboard that summarize access barriers reported by Members, and if a Provider’s dashboard is trending in a negative direction, the Provider is counseled accordingly. Advanced Health’s chief medical officer is charged with monitoring and addressing inadequacies within the network and, when necessary, disciplining or sanctioning Providers.

Appropriate review of prior authorized services (consistent and appropriate application of prior authorization criteria and notification of adverse benefit determination down to the subcontractor level). One salient reason for making the transition from delegation contracts to Privileged Provider contracts, is to continue to extend to some (but not all) Providers the authority to engage in credentialing, sub-contracting, panel management, and utilization management, and yet to permit Advanced Health to reserve solely for itself the authority to deny a prior authorization request. Privileged contractors may approve, but not deny, prior authorization requests. All prior authorization requests that privileged contractors contemplate denying must be referred to Advanced Health for final determination by medical and Behavioral Health experts. Notices of adverse benefit determination are issued only by Advanced Health; no Provider, contractor, or sub-contractor holds this authority.

5. Describe the data collection methods used to assess timely access to services including member, provider and staff feedback about the provider network and performance, and, when specific issues are identified, the
protocols for correcting them. In addition to Grievance and Appeals data, Advanced Health is implementing a procedure whereby an entry is made into the electronic health record on the date that a Member requests an appointment. This will provide Advanced Health will the ability to monitor wait times between the date of request and the date of the medical appointment.

Advanced Health provides every medical Provider with a quarterly dashboard that provides feedback on the Provider’s performance with respect to relevant quality incentive metrics and internal access metrics. This same document also provides a visual dashboard that compares each physician’s performance to a matched cohort of other physicians, through which each physician can measure his or her performance against the performance of his or her peers or specialty cohort. Performance information for contractors is shared through face-to-face operational meetings convened for the purpose of discussing contractual performance and barriers. These are two-way conversations in which contractors identify barriers or perceived lack of support from Advanced Health, and Advanced Health discusses interactions and performance. For example, when meeting with contracted hospitals, discussions may center on length-of-stay or hospital readmission rates. When meeting with the SUD contractor, discussions will focus on SUD engagement and SUD retention rates. When meeting with the mental health contractor, discussion will focus on SOC or psychiatric hospital utilization. All discussions are purposed at quality improvement.

**Addressing Deficiencies in Network Adequacy**

6. Provide an evaluation of the prior year’s Delivery System Network Capacity Report, identifying where network deficiencies were discovered, and provide a description of how those deficiencies are being remedied. In the response, please address the following:

6.a. The methodology used to identify barriers and network gaps: The primary methods used in 2018 to identify network deficiencies consisted of: an analysis of Member-to-Provider ratios, dichotomized by zip codes, across physical health, Behavioral Health, and oral health variables; an analysis of wait time dissatisfaction as reported through the Grievance and Appeals or CAHP surveys, dichotomized by ethnicity; an analysis of time-and-distance standards; and, an analysis of Members’ aggregate diagnostic conditions to determine adequacy of the network to meet those diagnoses. The following network gaps or deficiencies were noted:

- A shortage of dentists in Curry County;
- 35 of 86 mental health Providers within the network are unlicensed, and are practicing as qualified mental health professionals or qualified mental health associates;
14 percent of respondents to Health Insight’s survey reported that the geographic location of mental health services was not convenient;

The substance use disorder program under contract to ADAPT, Inc. (ADAPT) operates with 2.0 FTE licensed professionals and 16 CADCs, the majority of whom are certified at the CADC-I level;

Residential substance use disorder treatment services are not available in the local community, thereby necessitating an interruption of the family bond when parents of infants and toddlers are required to be absent from the home and community for 28-31 days;

Certain medical specialties are unrepresented in the local community, but one would not anticipate that those services would be available in a rural community: pediatric internal medicine; neonatology; neuroradiology; neurosurgery; and, vascular surgery.

Certain medical specialties and sub-specialties are under-represented within Advanced Health’s network and include: allergy and immunology; anesthesiology; cardiology; child psychiatry; dermatology; endocrinology; gastroenterology; hematology and oncology; infectious disease; nephrology; obstetrics and gynecology; pain medicine; psychiatry; radiology; rheumatology; thoracic surgery; urology; and vascular surgery; and,

Applied Behavioral Analysis is absent from the community as a strategy to address Members whose needs fall along the autism spectrum continuum.

6.b. Immediate short-term interventions to correct network gaps:

The shortage of dentists in Curry County is being addressed through locum tenens arrangements; and,

For those medical specialty and sub-specialty services that remain under-represented in the local community, SWOIPA contracts for those services from multi-specialty group practices located in Medford and Eugene and continues to recruit for new Providers.

6.c. Long-term interventions to fill network gaps and resolve barriers:

Over the course of CCO 2.0, Advanced Health will be sunsetting the participation of qualified mental health professionals and qualified mental health associates from its network panel and in a quality improvement effort, will transition to using only licensed mental health professionals. Advanced Health will offer scholarship assistance to current qualified mental health professionals who elect to complete a locally available MSW-to-LCSW course of studies.

Advanced Health is addressing access to locally available mental health services by expanding the number and location of Assertive Community Treatment Teams.

Over the course of CCO 2.0, Advanced Health will be sunsetting the participation of CADC-Is from its network panel and, in a quality
improvement effort, will credential only those individuals at the CADC-II level or higher.

- ADAPT is re-configuring its residential treatment services for substance use disorders, such infants and toddlers will be able to accompany their parents for parent-with-child residential treatment. For older children who are separated from parents for the duration of residential treatment, a reunification home will be established to permit parents to receive a briefer course of residential treatment, and to enter a housing-supported intensive day treatment program in the local community that provides drug-free housing supports to the entire family.
- Advanced Health has resolved deficiencies in certain medical specialties through the recruitment and retention of new Providers. This is true for allergy and immunology, dermatology, radiation oncology, and urology.
- Advanced Health is in the immediate process of recruiting a certified and licensed mental health professional to provide Applied Behavioral Analysis.

Outcome Measures for Evaluating the Efficacy of Interventions to Fill Network Gaps and Resolve Barriers: As Network gaps and barriers are resolved, Advanced Health would expect to see declining rates of Member complaints (through the Grievance and Appeals system), and this rate would be steadily decreasing over time. Advanced Health would also expect to see increasing rates of Member satisfaction as measured by the CAHP Survey, and this rate would be steadily increasing over time. Finally, Advanced Health would expect to see decreasing Member-to-Provider ratios, and that decrease would continue over time.

Projection of Changes in Future Capacity Needs: As Advanced Health has analyzed Member-to-Provider ratios, it has also analyzed Population-to-Provider ratios, understanding that Advanced Health’s network of Providers is not exclusive to Advanced Health and serves the entire community. All shortages or gaps identified for Members are also present for the general population. When Advanced Health makes an improvement for Members, it is also making an improvement for the entire population.

Ongoing Activities for Network Development Based on Identified Gaps and Future Need Projections: In addition to continuous Provider recruitment, Advanced Health is currently involved with Southwestern Oregon Workforce Development, and the board of directors for this entity has identified the healthcare workforce as a major priority. One such effort, in cooperation with Southwestern Oregon Community College, has been the development of an off-site master’s training program in clinical social work, offered by Portland State University through distance learning, but convened on the campus of Southwestern Oregon Community College. (A separate effort, has been to bring a certification program to the community for medical assistants.) To increase the rate of enrollment in the clinical social worker training program, and to improve the quality of Behavioral
Health services offered to Members, in 2020 and 2021, Advanced Health will offer financial assistance, in the amount of $5,000 per person, for a maximum of five candidates per annum, for those individuals who are currently working as qualified mental health professionals, or qualified mental health associates, within Advanced Health’s network, and who are desirous of matriculating through a degree program that leads to clinical licensure. Beginning in 2022, the same levels of financial assistance will be offered to any candidate who meets the entrance requirements to the clinical social worker training program, and who agree to remain in the community post-graduation.

Similarly, Advanced Health will offer financial assistance, in the amount of $2,500 per person, for a maximum of five candidates per annum, for those individuals who are currently working as at the CADC-I level within the Advanced Health’s network, with the goal of assisting these individuals to become certified at the CADC-II level, or beyond.

Southwest Oregon Community College evidenced multiple barriers to the development of a traditional health worker training program. The first cohorts in Coos and Curry Counties to be certified as community health workers were trained, at Advanced Health’s expense, at Rogue Community College in neighboring Jackson County. In 2017, Advanced Health provided the financial support needed by Southwestern Oregon Community College for the training of a faculty member who, in turn, could obtain the appropriate level of education required to permit Southwestern Oregon Community College’s traditional health worker program to become accredited. In both 2017 and 2018, Southwestern Oregon Community College enrolled 24 individuals in its community health worker training program. The first cohort of 24 students was comprised of individuals currently employed throughout Advanced Health’s network, and Advanced Health sponsored the full cost of the educational program for these employees. In 2018, Advanced Health subsidized all but $500 of tuition expenses for an additional cadre of 24 students, many of whom were drawn from the community.

In order to develop the 54 additional traditional health workers that are needed to meet the Behavioral Health care needs of Members, Advanced Health will provide financial assistance to Southwestern Oregon Community College to develop an accredited training program for personal health navigators. In addition, Advanced Health will sponsor at least two traditional health worker training programs at Southwestern Oregon Community College. If timely arrangements can be made, the first course will be offered in the fall of 2019, and the second course in 2020. Because employment vacancies will exist for all graduates of the program, employers will interview and pre-approve persons for participation. Upon graduation, the graduate will be employed by the pre-approving employers. Because Advanced Health Members have needs that
Advanced Health is keenly aware that its Members are requesting a more diverse and expanded program of peer-delivered services. To this end, Advanced Health will provide financial assistance to Southwestern Oregon Community College to develop an accredited training program for peer wellness specialists. It is envisioned that accreditation will be received during 2020. Until local accreditation is obtained, Advanced Health will provide qualified peer wellness candidates with options for out-of-area training.

Advanced Health’s most pressing Behavioral Health workforce development need is for psychiatric evaluators and prescribers. Southern Oregon State University (Ashland) offers an advanced degree for mental health/psychiatric advanced practice nurse practitioners. Advanced Health has a standing offer to provide up to $50,000 in financial assistance to any registered nurse who holds a bachelor’s of science degree in nursing, who can meet the entrance requirements to the mental health/psychiatric nurse practitioner training program at Southern Oregon University, and who will make a commitment to practice in Coos or Curry County upon graduation from the program.

The U.S. Department of Education provides federal TRIO grants to academic institutions (and other entities) purposed at identifying and providing educational services to individuals from disadvantaged backgrounds. The program originally included three distinct federal grant programs (hence the name, TRIO) but was expanded under the Obama administration to include eight programs, the most familiar of which are Educational Opportunity Centers, Student Support Services, Talent Search, and Upward Bound. Southwestern Oregon Community College is a recipient of an Upward Bound grant ($263,938 per annum) with 52 participants, and a Talent Search grant ($306,024 per annum) with 622 participants. Both the Talent Search and Upward Bound program identifies youth from disadvantaged backgrounds during high school, provides career counseling and tutoring, and, assist participants in completing high school and meeting college entrance requirements. Advanced Health will lend social capital to these two programs purposed at emphasizing healthcare careers, and especially local opportunities for careers in the Behavioral Health care field. Advanced Health can envision a program in which first-year college students who hold an interest in a health career, and who are enrolled in Talent Search or Upward Bound, complete training as community health workers, peer wellness specialists, or navigators. This would create a circumstance in which students would have access to family-wage employment while completing the balance of their academic goals, thereby alleviating the financial stressors that accompany higher education – particularly for those from disadvantaged backgrounds. At the same time, employment as a traditional health worker will provide student-employees with meaningful first-hand experience in the healthcare industry.
The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Workforce, offers a wide array of grant programs purposed at the development of health professionals, only three of which target Behavioral Health, and of those, two target training to address the opioid crisis. Nonetheless, the Bureau of Health Workforce has developed a series of well-researched grants that are effective in developing the nursing workforce and other allied health professionals (e.g., Nursing Workforce Diversity grants; Allied Health Professional grants; and Nurse Education, Practice, Quality, and Retention grants). Each of these evidence-based programs share structures that are similar to the U.S. Department of Education’s TRIO grants: identify students at the high school level; stimulate an interest in a health career (including those careers that require a formal college degree and those for which only certificates are required); provide academic advisement, tutoring, and mentoring; and assist with college entry requirements and applications. In some of these programs, students at the high school level earn stipends for participation in program activities (advisement; job shadowing; tutoring; mentoring; campus tours), and these stipends are deposited into a scholarship account on the students’ behalves.

The Health Resources and Services Administration (HRSA) has developed an evidence-based and innovative program entitled Kids Into Health Careers, which is particularly purposed at introducing middle and high school students (and their parents) to the vast array of careers that exist in the healthcare industry. The program has been extensively field-tested in rural communities. In most rural communities, Kids Into Health Careers has been a programmatic offering of Area Health Education Centers. The program is assembled in a kit and includes: guidance materials to use when working with local school systems; an operating instruction booklet; parent information; and presentation materials for students stratified by age. Parent education materials include thirty (30) sources of financial aid and a list of federally funded health facility contacts for additional information.

HOSA is an international student organization recognized by the U.S. Department of Education, and its two-fold mission is to promote career opportunities in the healthcare industry and to enhance the delivery of quality healthcare to all people. HOSA’s goal is to encourage all health science instructors and students to join and be actively involved in HOSA. HOSA is not a club to which a few students join. Rather, HOSA is a powerful instructional tool that works best when it is integrated into health sciences education at the high school level.

There are potentially multiple solutions purposed at developing a workforce pipeline in Advanced Health’s service area, but only one, the federal TRIO program, is in operation and its focus is not delimited to health careers or professions. Nonetheless, programs such as Bureau of Health Workforce initiatives, Kids Into Health Careers, and HOSA, represent evidence-based potential solutions for Coos and Curry Counties. Armed with knowledge about models that work, Advanced
Health will convene a summit during 2020, in partnership with the state and local educational and workforce development communities, to identify the best solution, or combination of solutions, to build a health workforce pipeline, beginning at least by the high school years. With its educational and workforce development partners, Advanced Health will commit social and financial resources to launch and sustain a defined workforce development pipeline.

**Description of the Delivery Network and Adequacy**

I.1 CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. The CCO may use geocoding and should include an analysis of how enrollees can access services, with supporting documentation, as needed.

**Overview:** Geocoding is the process of transforming a description of a location (such as an address, name of a place, or coordinates) to a location on the earth’s surface. Advanced Health’s methodology is superior to geocoding in that it uses multiple layers within Tableau analytic software to create interactive and programmable intelligence, presented in the form of raw data, graphs, and visual geographic mapping, to identify the physical location of enrollees, as well as the physical location of the Providers who serve these enrollees. In Advanced Health’s application, both enrollees and Providers are geocoded according to zip code, thereby permitting an impactful visual analysis of enrollee-to-Provider ratios across the wide range of rural zip codes served by Advanced Health. The data are updated quarterly and reviewed by senior management at the same intervals.

**Primary Health Care:** Because the data stored in Tableau is viewable in layers with interactive “mouse-over” text, the multi-layers of Tableau are difficult to print for inclusion in this report. However, a live demonstration of Advanced Health’s Tableau system is available on-site to the Oregon Health Authority and its External Quality Review Organization. A summary of tabular data from Tableau presents the following information:

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Community</th>
<th>Enrollees</th>
<th>PCP MD / DO</th>
<th>PCP NP/PA</th>
<th>PCP to Enrollee Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>97420</td>
<td>Coos Bay (Served Exclusively by Advanced Health)</td>
<td>7736</td>
<td>32</td>
<td>13</td>
<td>'1:172</td>
</tr>
<tr>
<td>97459</td>
<td>North Bend (Served Exclusively by Advanced Health)</td>
<td>3645</td>
<td>1</td>
<td>1</td>
<td>'1:1823</td>
</tr>
<tr>
<td>97411</td>
<td>Bandon (Served Exclusively by Advanced Health)</td>
<td>1731</td>
<td>3</td>
<td>5</td>
<td>'1:217</td>
</tr>
<tr>
<td>97423</td>
<td>Coquille (Served Exclusively by RFA 4690 - Advanced Health)</td>
<td>1624</td>
<td>6</td>
<td>1</td>
<td>'1:232</td>
</tr>
</tbody>
</table>
At first glance, the communities of Lakeside, North Bend, and Powers (in Coos County), along with the communities of Langlois, Sixes, Port Orford, and Agness (in Curry County) appear to be underserved, while the remaining communities appear to be overserved. To obviate this “first glance” interpretation, additional analysis is required:

- Lakeside, located in the northern portion of Coos County, is 13.6 miles from the population center of Coos Bay/North Bend to the south, and 12.4 miles from the population center of Reedsport to the north in Douglas County. Residents of Lakeside have the option of joining Advanced Health and traveling 13.6 miles to Coos Bay/North Bend to access any one of 54 Primary Care Providers or joining Trillium and traveling 12.4 miles to Reedsport to access the services of any one of six Primary Care Providers. Among those 54 Providers are options for Family Medicine, Internal Medicine, or Pediatrics, whereas Reedsport includes only Family Medicine. The preponderance of Medicaid-eligible persons in Lakeside (population 1,686) have elected to join Advanced Health. Non-Emergency Medical Transportation (NEMT) is available to provide transportation to and from scheduled appointments.

- There are two large, multi-specialty, group practices in Coos County: Bay Clinic and North Bend Medical Center (NBMC). The physical location of “North Bend Medical Center” is within the Coos Bay zip code, although it is...
located two blocks from the political boundary of the City of North Bend. Coos Bay and North Bend share a common political boundary and it is virtually impossible to detect where one ends and the other begins. In the larger sense, it is best to consider Coos Bay and North Bend as a single population center, consisting of 11,391 Medicaid enrollees who are served by 54 Primary Care Providers, resulting in a Provider-to-enrollee ratio of 1:211.

- The community of Powers is extremely remote and meets federal criteria for designation as a \textit{frontier area}. Approximately 35 years ago, residents of Powers created the Powers Health District and assessed themselves a moderate tax to attract and retain a Primary Care Provider. While this strategy worked for three decades, it failed when, despite its best recruitment efforts, no Primary Care Provider would agree to live in Powers nor to work in the substandard clinic that was owned by the Powers Health District (a 1920s era cabin that had served a logging camp and was transported down the mountain, to Powers, on skids). In an agreement, Waterfall Community Health Center, a federally qualified health center that had been operating a school-based health center in Powers, agreed to assume management responsibility for the Powers Health District. With the assistance of funding from the Health Resources and Services Administration (HRSA), Powers was added to the official scope of Waterfall CHC and federal resources were made available for the construction of a shared community- and school-based health center. Unfortunately, despite significant outreach efforts, the demand for services at the clinic was so low as to make continuing operations unsustainable. The press release officially announcing the closure indicated that visits for both medical services and mental health services were low, with the clinic seeing no patients at all on some days. The clinic will close on June 30, 2018, and Waterfall is working with their patients to facilitate their ongoing care, whether patients choose to travel to their main location in North Bend or seek care in the nearest communities of Myrtle Point or Coquille. Again, NEMT is available to any of those locations.

- The rural communities of Langlois, Sixes, Port Orford, and Agness (another community that meets HRSA’s frontier criteria) are located within a thirteen-mile stretch of one another along Highway 101. The communities are 33 miles to the south of Bandon, and 28 miles to the north of Gold Beach. At the time that Coast Community Health Center submitted its qualifying \textit{New Access Point} application to HRSA to become a federally qualified health center, the entity identified Bandon as its primary service site, and the communities of Langlois, Sixes, Agness, and Port Orford as locations for satellite clinics. Coast Community Health Center has purchased property in Port Orford and has plans to build a full-service clinic at that site. In the meantime, it has established a temporary office in Port Orford and operates a non-certified school-based health center in Port Orford, and staffs these two
locations, at a minimum, with .50 FTE Primary Care Providers. In addition, Dr. Pitchford, who is affiliated with a group practice in Gold Beach, also provides full-time support to a critical access clinic in Port Orford. With this collective effort, the aggregate 651 Medicaid beneficiaries in Langlois, Sixes, Agness, and Port Orford are served by 1.5 FTE Primary Care Providers, resulting in a Primary Care Provider to enrollee ratio of 1:434. NEMT services are available to provide transportation to and from scheduled medical and related appointments to Port Orford, Bandon, Gold Beach or beyond if needed. Of these 651 members, 2.8% have CCOG coverage (mental health and dental only through the CCO), 27% are seen by Providers affiliated with North Bend Medical Center in Gold Beach, Bandon, and Coos Bay; 26% are seen by Providers from Coast Community Health Center; 17% by Providers affiliated with Curry Health Network (half of those with Dr. Pitchford); 11% at Bay Clinic in Coos Bay, and 5% at Southern Coos Hospital’s primary care clinic. (Does not total 100%, as there are other Providers with small numbers.)

When examining issues of Network capacity, it is critical to examine not only the ratio of Providers who are available to serve the Enrollee population, but the general population, as well. Advanced Health contracts with Southwest Oregon IPA, Inc. (SWOIPA) for the services of its physician panel; in turn, SWOIPA contracts with nearly every practicing medical Provider in Coos and Curry County, except a single dermatologist who does not accept insurance of any kind, a psychiatrist who refuses to contract with the Oregon Health Plan and was recently sanctioned by the board of medicine, a solo podiatrist who has been contracted for years but allowed her credentialing file to expire despite multiple outreach attempts, an internist at the VA clinic, and a solo-practice adult nurse practitioner who does not meet PCP standards for 24/7 coverage and admitting plan to the hospital. Therefore, there are very nearly as many Primary Care Providers to meet the needs of the Enrollee population as there are to meet the needs of the general population.

Coos County is home to 63,761 residents, while Curry County is home to 22,713 residents (US Bureau of the Census, 2016 Update). SWOIPA contracts with 71 Primary Care Providers in Coos County and 18 Primary Care Providers in Curry County. For the general population in Coos County, the ratio of Primary Care Providers to persons is 1:898, while in Curry County this ratio stands at 1:1261. HRSA’s Bureau of Primary Health Care believes that medical underservice begins when there is less than one Primary Care Provider for every 1,641 members of the general population (HRSA, BPHC, Form 9, Need for Assistance Scoring, 2016). In both Coos and Curry Counties, the Primary Care Provider to population ratios are better than this standard. Although Coos County is currently classified by HRSA as a Health Professional Shortage Area (HPSA) for Low-Income and Homeless Persons (Designation 141999410R), HRSA proposed on November 10, 2016, that the
designation be withdrawn largely because of the expansion of the Affordable Care Act (ACA) and Advanced Health’s ability to adequately meet the primary healthcare needs of the targeted population. Curry County continues to hold a HPSA designation (Designation 1419994191), although the designation is lowly scored at 15.

**Dental Health Care Services:** Table 2 details the distribution of oral health Providers and provides a dental Provider to enrollee ratio for each zip code tabulation area.

### Table 2
**Dental Provider-to-Enrollee Ratios by Zip Code**

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Community</th>
<th>Shared?</th>
<th>Enrollees</th>
<th>Dentists</th>
<th>Other Oral Health</th>
<th>Service location in zip code</th>
<th>Ratio to Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>97420</td>
<td>Coos Bay</td>
<td>No</td>
<td>8143</td>
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<td>3</td>
<td>yes</td>
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<td>97459</td>
<td>North Bend</td>
<td>No</td>
<td>3827</td>
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<tr>
<td>97411</td>
<td>Bandon</td>
<td>No</td>
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<td>97423</td>
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<td>97458</td>
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<td>97415</td>
<td>Brookings</td>
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<td>97444</td>
<td>Gold Beach</td>
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<td>97414</td>
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<td>78</td>
<td>0</td>
<td>0</td>
<td>no</td>
<td>0:78</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>19701</strong></td>
<td><strong>19</strong></td>
<td><strong>10</strong></td>
<td></td>
<td><strong>1:679</strong></td>
</tr>
</tbody>
</table>

In the table, each zip code and the name of the community is listed with information whether that zip code is served exclusively by Advanced Health or shared with another CCO. Dentists are listed in one column, with hygienists and expanded-practice hygienists listed in the next column. Each professional is listed only in one community for the sake of calculations, but many of the Providers travel to many communities. The column labeled “Service location in zip code” reflects whether a zip code is served by an oral health Provider at least part time.

Advanced Health contracts with Advantage Dental to provide oral health services to our population. Advantage Dental has done a substantial amount of work to improve access to dental services in our region. Over the last several years, they have expanded the number of clinics in the service area as well as the number of
available Providers. They also have been a leader in using expanded-practice hygienists (labeled as EPP in the DSN report) in a variety of settings to meet enrollee’s special healthcare needs. As an example, an EPP provides dental sealants in the schools; a hygienist provides oral health evaluations for children entering DHS custody as part of the FEARsome Clinic, and hygienists also provide services at all WIC offices. Advantage utilizes a combination of local private practices and Advantage-owned clinics to ensure adequate access to services.

The overall ratio of oral healthcare Providers to enrollees is 1:671 with the ratio to the general population being 1:2982. This is not neatly divided between the counties, as many of the oral health Providers travel to a variety of locations. This provides flexibility in the network for cross-coverage when a Provider is away or when one leaves the area. This allows Advantage Dental to shift services to locations where the demand is highest and adjust staffing patterns to meet demands. This also has allowed Advantage Dental to meet the special healthcare needs of enrollees by providing services for homeless members at The Nancy Devereaux Center (a drop-in services location for people experiencing homelessness), at the Coos Health and Wellness offices for enrollees experiencing severe and persistent mental illness that prevents them from utilizing conventional service locations, and in the FEARsome Clinic for kids in DHS custody.

Nationwide, Oregon ranks 35th among all states with respect to the ratio of dentists to members of the population at .486 dentists per 1,000 persons (or, 1:2050). Advanced Health’s ratio of 1:2982 total population is less than Oregon’s average. Until 2012, Coos County held a Dental Health Professional Shortage Area (DHPSA) designation for all persons. That designation was retired in late 2012 and replaced with a DHPSA designation for only low-income persons. Curry County continues to hold a DHPSA designation for all persons (Designation 6419994185), meaning that the well-insured have as much difficulty in accessing a dentist as the uninsured. Overall, given our wide variety of service locations and ratio of oral health Providers to enrollees, Advanced Health feels our network is adequate.

Mental Health Services: Table 3 sets forth the number of Enrollees and mental health service Providers, by zip codes, and establishes the mental health Provider to enrollee ratio for each zip code.

**Table 3**

<table>
<thead>
<tr>
<th>Zip code</th>
<th>Community</th>
<th>Shared?</th>
<th>Enrollees</th>
<th>Providers</th>
<th>Ratio to Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>97420</td>
<td>Coos Bay</td>
<td>No</td>
<td>8172</td>
<td>62</td>
<td>1:132</td>
</tr>
<tr>
<td>97459</td>
<td>North Bend</td>
<td>No</td>
<td>3836</td>
<td>6</td>
<td>1:639</td>
</tr>
<tr>
<td>97411</td>
<td>Bandon</td>
<td>No</td>
<td>1858</td>
<td>3</td>
<td>1:619</td>
</tr>
<tr>
<td>97423</td>
<td>Coquille</td>
<td>No</td>
<td>1700</td>
<td>1</td>
<td>1:1700</td>
</tr>
</tbody>
</table>

**Mental Health Services:** Table 3 sets forth the number of Enrollees and mental health service Providers, by zip codes, and establishes the mental health Provider to enrollee ratio for each zip code.
Again, at first glance, it appears that some communities are overserved while other communities are underserved. To this end, additional analyses are required.

- Residents of Lakeside may travel 13 miles via Highway 101 to access mental health services in North Bend. If transportation is a barrier, NEMT is available at no cost.

- Although the Delivery System Network Excel document identifies each Provider with a “home address,” both Coos Health and Wellness and Curry Community Health out-station mental Providers in distant communities. Fully 20 percent of the 51 mental health workers who are employed by Coos Health and Wellness in North Bend (N = 10) are permanently assigned to a satellite clinic in the county seat of Coquille, and from that location serve residents of Coquille and Myrtle Point. Similarly, Curry Community Health maintains permanent offices in Gold Beach and Brookings where 17 mental health professionals are employed. Of those professionals, two are out-stationed on a permanent basis in Port Orford to serve the communities of Langlois, Sixes, Port Orford, and Agness. If transportation is a barrier, NEMT is available at no cost.

- Coos Health and Wellness, serving Coos County, also contracts with nearly every private practice counselor in the region who meets their standards.

- Integrated Behavioral Health care is becoming increasingly available across the service area. North Bend Medical Center has expanded to four Behavioral Health Consultants (BHCs)—two serving Family Medicine and Internal Medicine, two serving Pediatrics. The two BHCs serving pediatrics do not appear in the report or the counts because they are MSW degree holders who are receiving clinical supervision to become LCSWs. Waterfall CHC has two BHCs in addition to co-located mental health specialty care. Coast CHC and Southern Coos Hospital primary care share 2 BHCs in
Bandon, with approximately 1.5 FTE at Coast (918 members) and 0.5 FTE at Southern Coos (286 members.) Curry Health Network has one BHC serving Brookings and Gold Beach (619 members.)

When HRSA works to identify specific community needs, it does not include licensed professional counselors, qualified mental health professionals, or qualified mental health associates, which contribute substantially to our overall professional network. If these Provider types are included, Coos and Curry Counties would show a Provider to enrollee ratio of 1:220 and a Provider to population ratio of 1:972, which exceeds federal minimum recommendations of 1:1000.

Nonetheless, HRSA’s Catchment Area 14, which includes both Coos and Curry Counties, holds a federal Mental Health Professional Shortage Area designation (Designation 7419994114). The designation applies to the entire geographic population, irrespective of income or insurance status. The primary reason for the designation is not so much a shortage of recognized mental health professionals, but a weighted shortage of prescribers. Although the delivery network includes six psychiatric and mental health nurse practitioners and four psychiatrists, this not all these Providers are available full time or located physically in the service area. The FTEs worked by these Providers to treat our enrollees is flexible and changes based on the needs of the network. Still, we know that access to a psychiatrist of psychiatric nurse practitioner is more difficult for members of the community at large than it is for our enrollees, as the Community Behavioral Health entities have a mandate to serve our population as a priority. Because there are a limited number of Providers, NEMT is made available to patients to consult with non-participating psychiatric prescribers in Eugene and Medford when needed, primarily for second opinions. Prior authorization requests for out-of-panel or out-of-area consultations are rarely, if ever, denied; and, telemedicine is frequently used, particularly in Curry County, for ongoing psychiatric medication management.

The 89 mental health Providers in Coos and Curry Counties are described in Table 3.1. These Providers are reflected by their Provider taxonomy codes from the NPPES database. Of note, several Providers in this table have taxonomy codes in the OHA database that do not match their license or their known practice specialty. For example, Rochelle Tucker, an MD Psychiatrist, was categorized as “Behavioral Health and Social Service Providers: Psychologist.” Because we are a small CCO and we know our Providers, we were able to make some corrections. Although the taxonomy codes are not perfect descriptors of the types of work done by the Provider, this is one way to look at the range of mental health Provider types.
**Table 3.1**  
**Mental Health Provider by NPI taxonomy code**

<table>
<thead>
<tr>
<th>Taxonomy Description</th>
<th>Provider Count</th>
<th>Enrollees</th>
<th>Ratio to Enrollees</th>
<th>Ratio to Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health and Social Service Providers: Counselor: Mental Health</td>
<td>52</td>
<td>19936</td>
<td>1:383</td>
<td>1:1663</td>
</tr>
<tr>
<td>Behavioral Health and Social Service Providers: Counselor: Professional</td>
<td>18</td>
<td>19936</td>
<td>1:1108</td>
<td>1:4804</td>
</tr>
<tr>
<td>Behavioral Health and Social Service Providers: Social Worker: Clinical</td>
<td>14</td>
<td>19936</td>
<td>1:1424</td>
<td>1:6177</td>
</tr>
<tr>
<td>Behavioral Health and Social Service Providers: Counselor</td>
<td>9</td>
<td>19936</td>
<td>1:2215</td>
<td>1:9608</td>
</tr>
<tr>
<td>Behavioral Health and Social Service Providers: Marriage and Family Therapist</td>
<td>9</td>
<td>19936</td>
<td>1:2215</td>
<td>1:9608</td>
</tr>
<tr>
<td>Behavioral Health and Social Service Providers: Social Worker</td>
<td>9</td>
<td>19936</td>
<td>1:2215</td>
<td>1:9608</td>
</tr>
<tr>
<td>Behavioral Health and Social Service Providers: Counselor: Addiction (Substance Use Disorder)</td>
<td>7</td>
<td>19936</td>
<td>1:2848</td>
<td>1:12353</td>
</tr>
<tr>
<td>Behavioral Health and Social Service Providers: Psychologist: Prescribing (Medical)</td>
<td>4</td>
<td>19936</td>
<td>1:4984</td>
<td>1:21619</td>
</tr>
<tr>
<td>Behavioral Health and Social Service Providers: Psychologist</td>
<td>2</td>
<td>19936</td>
<td>1:9968</td>
<td>1:43237</td>
</tr>
<tr>
<td>Group: Single Specialty</td>
<td>2</td>
<td>19936</td>
<td>1:9968</td>
<td>1:43237</td>
</tr>
<tr>
<td>Physician Assistants and Advanced Practice Nursing Providers: Nurse Practitioner: Psychiatric/Mental</td>
<td>2</td>
<td>19936</td>
<td>1:9968</td>
<td>1:43237</td>
</tr>
<tr>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology: Psychiatry</td>
<td>1</td>
<td>19936</td>
<td>1:19936</td>
<td>1:86474</td>
</tr>
<tr>
<td>Behavioral Health and Social Service Providers: Psychiatrist: Clinical</td>
<td>1</td>
<td>19936</td>
<td>1:19936</td>
<td>1:86474</td>
</tr>
<tr>
<td>Behavioral Health and Social Service Providers: Social Worker: School</td>
<td>1</td>
<td>19936</td>
<td>1:19936</td>
<td>1:86474</td>
</tr>
<tr>
<td>Other Service Providers: Case Manager/Care Coordinator</td>
<td>1</td>
<td>19936</td>
<td>1:19936</td>
<td>1:86474</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1</td>
<td>19936</td>
<td>1:19936</td>
<td>1:86474</td>
</tr>
</tbody>
</table>

In 2016, on behalf of the Health Systems Division at OHA, Health Insight conducted a survey of adults and the parents/guardians of children who had
accessed mental health services between July and December of 2015 using Oregon Health Plan (OHP) benefits. For the survey variable, *location of services was convenient*, 70 (86 percent) respondents enrolled with Advanced Health (known as WOAH at that time) replied *agree* or *strongly agree*, while 11 (14 percent) replied *disagree* or *strongly disagree*. For the survey variable, *services were available at convenient times*, 74 (92.5 percent) respondents with WOAH replied *agree* or *strongly agree*, while 6 (7.5 percent) replied *disagree* or *strongly disagree*.

**Substance Use Disorder (SUD) Services:** Table 4 sets forth the number of Enrollees and substance abuse treatment Providers, by zip codes, and establishes the substance abuse treatment Provider to enrollee ratio for each zip code.

<table>
<thead>
<tr>
<th>Zip</th>
<th>Community</th>
<th>Shared</th>
<th>Enrollees</th>
<th>SUD Providers</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>97420</td>
<td>Coos Bay</td>
<td>No</td>
<td>7736</td>
<td>0</td>
<td>0:7736</td>
</tr>
<tr>
<td>97459</td>
<td>North Bend</td>
<td>No</td>
<td>3645</td>
<td>17</td>
<td>1:215</td>
</tr>
<tr>
<td>97411</td>
<td>Bandon</td>
<td>No</td>
<td>1731</td>
<td>0</td>
<td>0:1731</td>
</tr>
<tr>
<td>97423</td>
<td>Coquille</td>
<td>No</td>
<td>1624</td>
<td>0</td>
<td>0:1624</td>
</tr>
<tr>
<td>97458</td>
<td>Myrtle Point</td>
<td>No</td>
<td>1207</td>
<td>0</td>
<td>0:1207</td>
</tr>
<tr>
<td>97415</td>
<td>Brookings</td>
<td>All Care</td>
<td>681</td>
<td>13</td>
<td>1:53</td>
</tr>
<tr>
<td>97444</td>
<td>Gold Beach</td>
<td>All Care</td>
<td>593</td>
<td>7</td>
<td>1:85</td>
</tr>
<tr>
<td>97465</td>
<td>Port Orford</td>
<td>All Care</td>
<td>495</td>
<td>1</td>
<td>1:495</td>
</tr>
<tr>
<td>97449</td>
<td>Lakeside</td>
<td>Trillium</td>
<td>409</td>
<td>0</td>
<td>0:409</td>
</tr>
<tr>
<td>97466</td>
<td>Powers</td>
<td>No</td>
<td>302</td>
<td>0</td>
<td>0:302</td>
</tr>
<tr>
<td>97450</td>
<td>Langlois</td>
<td>All Care</td>
<td>119</td>
<td>0</td>
<td>0:119</td>
</tr>
<tr>
<td>97414</td>
<td>Broadbent</td>
<td>No</td>
<td>82</td>
<td>0</td>
<td>0:82</td>
</tr>
<tr>
<td>97476</td>
<td>Sixes</td>
<td>All Care</td>
<td>77</td>
<td>0</td>
<td>0:77</td>
</tr>
<tr>
<td><strong>Total enrollees</strong></td>
<td></td>
<td></td>
<td><strong>18701</strong></td>
<td><strong>38</strong></td>
<td><strong>1:493</strong></td>
</tr>
<tr>
<td><strong>Total Population</strong></td>
<td></td>
<td></td>
<td><strong>86,474</strong></td>
<td></td>
<td><strong>1:2276</strong></td>
</tr>
</tbody>
</table>

To a significant extent, addiction treatment services in Oregon are provided by Certified Alcohol and Drug Counselors (CADCs) (The CADC-I requires no formal degree and is issued after 150 hours of addiction counseling education and 1,000 hours of clinical supervision. The CADC-I credential is primarily intended for those individuals who are in recovery, who can verify at least two years of sobriety and abstinence, and who will largely serve as peer facilitators or recovery counselors. While the CADC-II credential requires 300 hours of counseling education and a bachelor’s degree, an associate degree is often accepted under waivers. The CADC-III credential requires a master’s degree.). ADAPT retains the services of 2.0 FTE licensed counselors/therapists and 16 CADCs, the majority of whom are certified at
the CADC-I level. These individuals provide the preponderance of out-patient substance abuse treatment services.

ADAPT has recently opened an intensive day treatment program (with housing supports) in Coos County that will operate under the supervision of a Licensed Clinical Social Worker. Also, under the supervision of a Licensed Clinical Social Worker is a residential treatment program located in neighboring Douglas County, in Roseburg. ADAPT also operates a Medication Assisted Treatment (MAT) program that accesses ongoing prescribing from a physician specializing in Addiction Medicine via telemedicine. Advanced Health’s enrollees have access to all these service elements. However, demand has been growing, resulting in a need to triage these services for those with the most acute needs, primarily those completing detox and residential treatment. As a result, more enrollees have chosen the higher-level interventions such as detox and residential treatment, substantially increasing the cost of services.

Recognizing the growing need for treatment in opioid use disorder, ADAPT applied for and was granted SAMHSA and OHA funds to open an Opioid Treatment Program (OTP) in North Bend. This will be located adjacent to the ADAPT offices, where other treatment is provided for various substance use disorders. The OPT is scheduled to open in July 2018, starting with the approximately 40 members who are currently receiving Suboxone treatment. It is anticipated that the program will serve 100-150 clients, with priority given to those enrolled in OHP. Advanced Health has provided substantial financial support to the program. As patients are stabilized on MAT, the goal is to encourage additional X-waivered Primary Care Providers so that some patients can graduate to fewer intensive levels of treatment. The OTP will also serve as an important resource for patients who are started on office-based opioid treatment (OBOT) that require the more intensive level of care that is provided in a fully-licensed OTP. The OTP also mitigates against the problem of multiple patients on OBOT scrambling for a Provider when an X-waivered Primary Care Provider leaves the community.

Advanced Health currently has four X-waivered Primary Care Providers (outside those affiliated with ADAPT.) However, these Providers are currently serving only 2 patients on Suboxone. We plan to support additional primary care and OB Providers in obtaining X waivers to expand the continuum of care for our members with opioid use disorder. We believe that once the OTP is running, we will be able to engage more PCPs in the hub-and-spoke model.

Advanced Health is also the only CCO to be the sponsoring organization for the OHA Prescription Drug Overdose Prevention (PDO) Coordinator, a grant-funded position intended to work across all sectors of the region to reduce the harms from prescribed opioids. The PDO coordinator has seated a multi-sector advisory panel, coordinated efforts already underway in the community spearheaded by Chief
Robert Kappelman of the North Bend Police Department, brought Institute for Healthcare Improvement (IHI) trainings in safe opioid use to groups of local Providers, and sponsored multi-disciplinary teams from local primary care offices to attend the statewide summit on Opioids, Pain, and Addiction Treatment in Eugene in May 2018. These activities serve as primary prevention of opioid use disorder, as most heroin users begin with prescription medications. They also serve as secondary prevention by training Providers to recognize opioid use disorder in their practice, and tertiary prevention of overdose in the form of increasing Naloxone rescue training and distribution.

Coos County, which is the most populous county in our service area, was recently awarded grant funding via Oregon House Bill 4143 to place peer support specialists in the emergency department to facilitate entry into treatment for patients presenting with opioid use disorder. This grant was awarded based on a combination of the opioid prescription burden in the region and the region’s readiness to increase access to treatment. Plans are in the early development phase, with funding slated to begin in 2019, but will likely involve a partnership between Advanced Health partners and Providers including: Coos Health and Wellness (Coos county’s mental health and public health agency) as the fiscal partner, Bay Area Hospital (who sees 73% of the emergency department visits in our entire service area) as the emergency department, Bay Area First Step (a local agency providing peer supports to recovery and clean and sober housing) as the peer support agency, ADAPT as the SUD treatment agency, and Emergency and hospitalist physicians as part of SWOIPA. Although this will be a substantial improvement in the system of care for SUD, this program will not necessarily be reflected by a significant increase in the number of Providers listed in the DSN spreadsheet.

I.2 CCO discusses how the network ensures that the time and distance standards for member access to health care are met.

In most of the United States, county geographies are relatively small and homogenous, so county-level data is widely used to analyze information. In Oregon, however, the 36 counties vary greatly in size, geography, and population, and thus an analysis of sub-county units more accurately represents community’s needs with respect to primary healthcare services. Among the established small geographic boundaries, postal zip code areas are the only ones that follow logical transportation and market patterns. Zip codes are also currently linked to a large amount of demographic, socioeconomic, and health status information – including hospital utilization and market-share data – that are continuously updated.

Within Oregon, there are 130 Oregon Primary Care Service Areas in all, 104 of which are rural in nature, using the Office of Rural Health’s definition: a geographic area, ten or more miles from the centroid of a city of 40,000 or more
persons. For purposes of comparative data, travel time to the nearest source of primary healthcare is used to account for a service area’s remoteness or proximity from a source of primary healthcare. Estimated travel time is calculated from the largest town or city within each zip code to the nearest source of primary healthcare, either within the same zip code, or if not available within the same zip code, in the closest neighboring zip code. Driving time and distance are calculated using the online driving directions at Google Maps. To avoid fluctuations in traffic depending on when the site is accessed, the time without traffic is used.

The mean travel time to the nearest source of primary healthcare for Oregon’s rural service areas is 23 minutes. The following rural communities in Oregon evidence the longest driving times, in descending order: North Lake (105); Fossil (79); Halfway (71); Jordan Valley (70); Condon (58); McKenzie/Blue River (56); Arlington (52); Oakridge (46); Maupin (42); and Powers (41 to Coquille). Powers was the only community in Coos or Curry Counties that is characterized by adverse travel times, and this situation will occur when Waterfall Community Health Center’s satellite location in Powers closes on June 30, 2018. At that time, the closest primary care offices will be in Myrtle Point (20 miles, 31 minutes) and Coquille (30 miles, 41 minutes.) For all other rural communities in Coos and Curry Counties, travel times are well within normal limits established by the Oregon Office of Rural Health (Oregon Office of Rural Health, 2016 Areas of Unmet Health Care needs in Rural Oregon).

In 2016, on behalf of the Health Systems Division at OHA, Health Insight conducted a survey of adults and the parents/guardians of children who had accessed mental health services between July and December of 2015 using Oregon Health Plan (OHP) benefits. For the survey variable, location of services was convenient, 70 (86 percent) respondents enrolled with WOAH replied agree or strongly agree, while 11 (14 percent) replied disagree or strongly disagree. For the survey variable, services were available at convenient times, 74 (92.5 percent) respondents with WOAH replied agree or strongly agree, while 6 (7.5 percent) replied disagree or strongly disagree.

In a fully rural service area, it is expected that some specialties may exist only outside of the region. Advanced Health partners with specialty Providers in the surrounding areas to ensure access to specialists that are not located within the service area. As expected, specialty services such as perinatology and neonatology are in the nearest tertiary-care centers with neonatal intensive care units. Complicated pregnancy or delivery is the most common reason for transfer to a hospital outside of the service area, with most transports going to Sacred Heart River Bend Hospital in Springfield, approximately 100 miles from Bay Area Hospital, or Asante in Medford, approximately 130 miles from Brookings or 150 miles (by ground transport) from Curry General Hospital in Brookings.
Specialties not located within the service area are reflected in the specialty overview table. In general, our regional specialists including perinatology, gastroenterology, and endocrinology are skilled at developing co-management plans that allow the PCP to manage between specialty visits, reducing the amount of travel for the member.

I.3 CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours per day, 7 days per week for all members.

**Physical Health:** SWOIPA has entered into contracts with all hospital emergency departments in its service delivery area for emergency and triage services: Bay Area Hospital, a tertiary facility serving the population center of Coos Bay and North Bend in Coos County; Coquille Valley Hospital, a Critical Access Hospital in eastern Coos County; Southern Coos Hospital, a Critical Access Hospital in southern Coos County; and Curry General Hospital, a Critical Access Hospital in Curry County that operates emergency departments in Gold Beach, the county seat, and Brookings at the California State Line. Bay Area Hospital also operates a locked adult psychiatric unit and accepts appropriate transfers from the critical access hospitals in the region, providing mental health emergency care as well.

Urgent care services are offered during traditional and non-traditional hours. Bay Clinic, North Bend Medical Center, Waterfall Community Health Center and Coast Community Health Center offer same-day urgent care appointing and non-traditional clinic hours, including Saturdays and evenings. In addition, Bay Clinic and North Bend Medical Center in Coos Bay offer urgent care to patients without a local PCP or those whose PCP cannot accommodate them with a same day appointment (e.g. when they are out of town or unexpectedly called to the hospital.)

As a primary source, Advanced Health analyzes access by closely monitoring its Grievance and Complaint Logs. Advanced Health, unlike most of its sister CCOs, follows a very broad definition of a grievance or complaint. Consistent with Oregon Administrative Rules and OHA guidance, Advanced Health defines a complaint as any expression of dissatisfaction howsoever delivered (e.g., written, or even a simple oral comment). All such grievances or complaints are recorded, and appropriate and timely follow-up action is taken. There are two results of Advanced Health’s broad interpretation of a complaint: (1) Advanced Health is often, and somewhat unfairly, signaled out as having the highest complaint rate among CCOs; and (2) Because Advanced Health responds to every expression of dissatisfaction and takes prompt and thoughtful remediation, its CAHPS access scores have been consistently good, despite our rural location and the community report that those with other insurance have difficulty accessing Providers. A major purpose of the Complaint and Grievance system is to be engaged in continuous quality improvement, and that has been the end-effect at Advanced Health. For 2017, the
most recent year for which data are available, Advanced Health’s CAHPS composite satisfaction score for access to care across all variables was 83.9%, just above the statewide average and statistically equivalent to previous scores. Advanced Health exceeded its targeted benchmark of 84.2 percent by two full percentage points in 2016, but then did not meet the improvement target set for 2017. This reflects expected statistical variation from survey data, and not clinically meaningful change.

Advanced Health will continue to assert that there is a direct and positive correlation between seemingly high complaint rates and ultimately high rates of satisfaction with access to care. Moreover, since the third quarter of 2016, Advanced Health has evidenced decreasing access-related complaints, which are the result of true improvements resulting from the continued focus and work led by Advanced Health’s RN Health Services Coordinator. This position was created in 2016 to focus on upstream interventions to improve the complaint and appeal process to get members the covered services that would meet their needs. Pertinent to increasing access, the Health Services Coordinator has improved processes for reviewing complaints weekly to identify trends, has created a PCP Assignment Workgroup to solicit key stakeholder information (e.g. care managers, customer service representatives), has improved the quarterly complaint report giving feedback to individual Providers, and trained Providers on tested methods to improve access and decrease complaints. Some of these changes were simple, such as giving offices the script to ask new patients, “Have you been assigned to us?” instead of automatically telling callers that they are closed to new members. (PCPs in our service area are frequently closed to new members but agree to accept new Advanced Health members in an equitable rotation.) Some changes have been more complex, including developing relationships for cross-coverage when a Provider is out of the office and messaging this to patients.

**Dental Health:** Advanced Health contracts with, and delegates responsibility for, Advantage Dental for the provision of dental and oral health services. Advantage Dental has established an urgent care system in which an early morning appointment is available each weekday from 8:00 to 9:00 AM for patients who contact Advantage Dental after hours or for those patients who present to a hospital emergency department with complaints of dental pain. A rotational system of on-call dentists is available to hospital emergency departments, particularly for oral trauma. Advantage Dental’s on-call arrangements also permit urgent care services on holidays, after hours, and weekends. Each of Advantage Dental’s clinics is open until 6:00 PM, thereby creating appointing options for enrollees who work until 5:00 PM.

Nationwide, Oregon ranks 35th among all states with respect to the ratio of dentists to members of the population at .486 dentists per 1,000 persons (or, 1:2050). Advanced Health’s ratio of 1:671 oral health Providers is adequate. The number of
dentists is lower in Curry County than in Coos County, but in both counties, dental access is much better for Enrollees than non-Enrollees. Nonetheless, Advantage Dental and Advanced Health are working to improve ratios and access in Curry County and, over the past two years, have increased the number of dentists, and dental locations, that are available to serve enrollees. Advantage Dental is reporting that, concurrent with the emphasis on financial incentive metrics that favor prevention, dental chairs are often occupied for preventive services, resulting in lower capacity for urgent and restorative care. Advantage Dental has recently adopted a risk stratification model for patient appointing that will help to assure that the needs of patients with higher risk scores are more expeditiously and appropriately served.

In addition to the risk stratification model, Advantage Dental has partnered with local organizations to respond to urgent and non-urgent needs in non-traditional venues. Advantage has partnered with Coos Health and Wellness and the Nancy Devereaux Center to offer an outreach clinic with a dental hygienist for enrollees experiencing homelessness or severe and persistent mental illness and dental conditions. Often these conditions can be addressed outside of the emergency department setting and, in a location, where the enrollee feels comfortable accessing services.

As a primary source, Advanced Health analyzes access by closely monitoring its Quarterly Grievance and Complaint Logs. Access-related complaints for dental health services have remained consistently low at less than three per quarter. In the last four quarters, there have been a total of five access complaints. As a secondary source, Advanced Health also analyzes annual consumer surveys regarding access. For 2017, Advanced Health’s CAHPS composite satisfaction score for access to care across all variables was 83.9%, above the state average of 83.1%. Advanced Health exceeded its targeted benchmark for access by two full percentage points in 2016 but did not meet the improvement target of 86.5% in 2017. This is within the expected statistical variation for a survey based on a sample of the population, and we feel it indicates a stable, high-performing state. In addition, to ensure compliance with contractually established access standards, at the suggestion of Health Insight, Advanced Health’s chief compliance officer engages in secret-shop-style telephone calls on an irregular basis to assess waiting periods for routine and urgent care.

Mental Health: Advanced Health contracts with, and delegates responsibility for, mental health services to Coos Health and Wellness (formerly, Coos County Mental Health) for services in Coos County, and Curry Community Health for services in Curry County. Both community mental health programs offer same-day walk-in options for urgent mental health crises wherein no appointment is required, and both programs operate 24/7 emergency and crisis response systems.
In Coos County, an innovative project, entitled MY CRU (Mobile Youth Crisis Response Unit), is available to respond to psychiatric emergencies for children and adolescents. This project is financially underwritten by Advanced Health and has been a tremendous success in diverting pediatric cases from hospitalization or transfers to institutionalization. MY CRU consists of a team of two persons who will travel to homes, schools, or the emergency department in the major population center. Most interventions are handled in the home, with present parents. Referrals to this program have been made by law enforcement, juvenile justice workers, educators, parents, and self-referrals from young persons. The goal is to obviate the need for care in the emergency department as well as hospital admission in favor of intervention and treatment in the community. In 2017, MY CRU responded to 344 calls, 15% of which were youth already in the emergency department. Although 96% of those originated in Coos county, 15 youth from Curry county, Douglas county, or other counties were seen after they had been transported to Bay Area Hospital for emergency department services. Most of these youth were insured by Advanced Health, but there were also a small number with private insurance, or no insurance found. Sixty percent of calls resulted in the youth remaining in the home. Of the others, nearly 20% received consultation in the emergency department that connected them to outpatient services, and only 10% required hospitalization.

Bay Area Hospital operates the only secure psychiatric care unit on Oregon’s south coast. Coos Health and Wellness retains these services under contract. Curry General Hospital does not operate a secure psychiatric unit and, at best, can only admit mental health patients to a medical ward with 24-hour nursing supervision. Generally, patients are transferred within 24 hours to either Bay Area Hospital or to Rogue Valley Medical Center in Medford. These facilities serve only adults, and access to inpatient or subacute care for children and youth is very limited. Advanced Health continues to work collaboratively with community mental health programs, local pediatricians, and local hospitals to provide local, outpatient services when appropriate to reduce the need for acute care and streamline the transfer process to out-of-area facilities when clinically appropriate.

As often occurs in isolated and rural communities with small population bases, urgent, emergent, and crisis services can be difficult to access in our remote rural portions of our service area. Curry County stretches for 75 miles along the Oregon coast. Highway 101 is sometimes impassable during harsh winter months and is frequently closed for reasons of mudslides or road bed erosion. Transit time from Brookings at the southern border, to Langlois at the northern border, requires 86 minutes when there are no traffic, weather, or construction delays. With revenue from only 2,200 Advanced Health Enrollees, Curry Community Health deploys 17 mental health workers to provide services for the population center in Brookings, the county seat and home of Curry General Hospital in Gold Beach, and outposts in Port Orford. Given the need to be on-call 24/7, this equates to 4.0 FTE available
each hour of the year – and these four individuals need to be distributed across a 75-mile range. In late 2016, Curry Community Health, in partnership with Advanced Health, applied for and received grant funding from OHA to establish an Assertive Community Treatment (ACT) program. This program has demonstrated fidelity and is now operational. Advanced Health recognizes that given the remote location, there is always some risk that the program could lose a key staff member and has supported our partner organization in training and recruiting efforts when needed.

See below in section I.10, continuum of care for mental health services, for further information about ACT and other services.

As a primary source, Advanced Health analyzes mental health access by closely monitoring its Quarterly Grievance and Complaint Logs. Mental-health-related access complaints remain low, despite efforts to ensure the capture of complaints in any form. There were very few access-related complaints, and those were generally from members wishing to access levels of service (e.g. residential treatment) felt not to be appropriate by the treatment team. As a secondary source, Advanced Health also analyzes annual consumer surveys regarding access. In 2016, on behalf of the Health Systems Division at OHA, Health Insight conducted a survey of adults and the parents/guardians of children who had accessed mental health services between July and December of 2015 using Oregon Health Plan (OHP) benefits. For the survey variable, location of services was convenient, 70 (86 percent) respondents enrolled with Advanced Health (then WOAH) replied agree or strongly agree, while 11 (14 percent) replied disagree or strongly disagree. For the survey variable, services were available at convenient times, 74 (92.5 percent) respondents with WOAH replied agree or strongly agree, while 6 (7.5 percent) replied disagree or strongly disagree. In addition, at the suggestion of Health Insight, Advanced Health’s chief compliance officer engages in secret-shopper-style telephone calls on an irregular basis to assess waiting periods for routine and urgent mental healthcare during both regular business hours and after hours.

**Substance Use Disorder Services:** For all substance use disorder treatment services except medical detoxification, SWOIPA contracts with, and delegates authority to, ADAPT, Inc. ADAPT maintains home offices in Roseburg (Douglas County), and full-service out-patient services in Reedsport (Douglas County), Grants Pass (Josephine County), and North Bend (Coos County). ADAPT, in turn, contracts with Curry Community Health for the provision of out-patient treatment services. Within Coos and Curry Counties, ADAPT either directly employs, or contracts for the services of, 18 Certified Alcohol and Drug Counselors (CADCs), resulting in a counselor-to-Enrollee ratio of 1:1102. ADAPT responds to urgent needs on a 24/7 basis.
ADAPT operates residential treatment programs in Roseburg for adults, women with infants, and adolescents, and these services are made fully available to Advanced Health’s Enrollees according to American Society of Addiction Medicine (ASAM) criteria. Social detoxification services are also available in Roseburg, and non-NEMT transportation services are arranged, as needed, on a case-by-case basis.

What had been lacking in Coos and Curry Counties was the availability of intensive out-patient treatment services, and the largest stumbling block had been housing arrangements, particularly for those who must travel from Curry County, or who, regardless of county, have no sober support systems within their current housing arrangements. To this end, ADAPT opened an innovative intensive out-patient treatment program with housing supports in Coos Bay. The program has the capacity to serve 16 adults in residence and is under the supervision of a clinical social worker.

Utilizing federal grant funds, and in partnership with Advanced Health, ADAPT will open an Opioid Treatment Program (OTP) in Coos County in July 2018. This program will create new treatment options using buprenorphine, naloxone, suboxone, Vivitrol, and methadone, which is particularly critical as Advanced Health’s Providers work earnestly to reduce the use of prescribed opioid pain medications. All licenses and permits have been obtained for the program. Currently, Medication Assisted Treatment (MAT) is available on a small scale. The Drug Addiction Treatment Act of 2000 (DATA 2000) permits physicians who meet certain qualifications to treat opioid addiction with certain medications that have been specifically approved for that purpose. This privilege was expanded to nurse practitioners and physician’s assistants in 2016. The waiver is designated on the prescriber’s DEA number with an “X,” therefore these prescribers are often referred to as “X-waivered.” They may be addictions specialists, but more often are Primary Care Providers. There are currently no X-waivered prescribers available to provide office-based opioid treatment (OBOT) in Coos County, although active recruitment is under way. Four Providers in Curry County have X waivers. To improve access to MAT, ADAPT is using a physician who is an addiction specialist affiliated with their program. Patients meet with the physician on a face-to-face basis for initial induction, then most follow-up visits are conducted via telemedicine. The telemedicine program is currently at capacity and serving 65 enrollees year-to-date in 2018. The program served 36 members over the same time period in 2017.

Bay Cities Ambulance reports naloxone administration to the Oregon Prescription Drug Monitoring Program to track overdose information. Bay Cities has partnered with Advanced Health to provide naloxone, both product and training in its use, to local law enforcement and other groups. The PDO Coordinator and Advanced Health Director of Pharmacy Services are working to expand access to naloxone and train community members to provide life-saving first-line treatment for opioid overdose. In addition, Coos County will receive grant funds in 2019 to develop peer
supports in the emergency department to connect enrollees with opioid overdoses to appropriate treatment. (Discussed in the SUD continuum of care, section I.11.)

As a primary source, Advanced Health analyzes addiction treatment services access by closely monitoring its Quarterly Grievance and Complaint Logs. Throughout 2016, Advanced Health received no access-related complaints for substance use disorder treatment services. As a secondary source, Advanced Health also analyzes annual consumer surveys regarding access. Advanced Health’s CAHPS composite satisfaction score for access to care across all variables was 83.9 percent and was above the statewide average. Advanced Health’s chief compliance officer engages in secret-shopper-style telephone calls on an irregular basis to assess waiting periods for routine and urgent addiction treatment.

**Emergency Transportation:** Advanced Health’s DSN Report spreadsheet does not reflect any contracted Providers of emergency transportation. This is because our local EMS Providers were advised in years past by their trade organization not to contract with the OHP plans. We receive excellent service from EMS Providers throughout our service area, including Bay Cities Ambulance, covering Coos Bay, North Bend, and Bandon; Coquille Valley Ambulance, serving Coquille; Myrtle Point Ambulance serving Myrtle Point and Powers; Port Orford Community Ambulance; and Cal-Ore Life Flight serving the area south of Port Orford to Brookings-Harbor.

**I.4 The CCO analyzes wait times for appointments with providers, including specialists.**

The methods employed by Advanced Health to assess access and wait times for physical health, dental, mental health, and addiction treatment services were specified in the prior section (1.3) and, in summary, include monitoring of the Grievance and Complaint System, analyzing survey data, and engaging in secret-shopper-style telephone calls. It is to be noted once again that Advanced Health’s CAHPS composite satisfaction score for access to care across all variables was 83.9 percent and was above the statewide average.

**Physical Health / Primary Health Care Services:** Panel management is the cornerstone for providing timely and appropriate care for patients with complex needs in the primary care setting. Often, panel management is the foundation to better-planned visits and fewer urgent and emergency care visits, while ensuring accountability in chronic disease management and improved care. For this reason, Advanced Health has invested significantly in a proactive risk modeling solution that assists Primary Care Providers in identifying patients for whom primary healthcare visits are needed. By working proactively with panel managers, patients are proactively recalled for visits. In addition to purchasing, maintaining, and updating the predictive risk modeling solution, Advanced Health has used its
incubator innovation grant program to support panel managers at those primary care practices that have requested this service. Panel managers review the predictive risk modeling solution’s data on a regular basis for two primary purposes: to engage in visit-planning for those patients who are scheduled to be seen that day; and to look for patients who should be scheduled but are not scheduled (i.e., patients who: have had a recent visit to an urgent care clinic or emergency department, have not had preventive care, have chronic conditions not adequately controlled, or who have failed to follow-through with scheduled diagnostic tests or ancillary services; etc.). Most primary care practices in the service area are closed to new patients or limit new patients who have other insurances. However, as contracted providers with Advanced Health, all our Primary Care Providers agree to accept an equitable number of patients into their panel and provide appropriate access to meet their needs. In short, in Coos and Curry Counties, Advanced Health’s Medicaid beneficiaries enjoy greater access with shorter wait times than do any other group of medical users.

Advanced Health’s RN Health Services Coordinator analyzes enrollee complaints weekly to quickly identify trends. If more than one access complaint is received in a month, she investigates by reaching out to the practice. Practices who are temporarily overwhelmed (e.g. new Providers, Providers with time out of the office, etc.) can request to be taken off the rotation of new patient assignments. This allows for immediate adjustments to connect enrollees to the practice that can best meet their needs in a timely fashion.

**Physical Health / Medical Specialty Services:** Please refer to Section I.6, below, for a detailed discussion.

**Dental Health:** To ensure compliance with contractually established access standards, including wait times, at the suggestion of Health Insight, Advanced Health’s chief compliance officer engages in *secret-shopper-style* telephone calls on an irregular basis to assess waiting periods for routine and urgent care. Wait-times for routine dental care appointments average twelve weeks for Enrollees, and up to six months for non-enrolled general community members and Medicare beneficiaries. The addition of additional dental Providers to the Advantage Dental panel, along with the adoption of risk stratified appointing protocols, will aid in decreasing wait times for routine care, while assuring that patients with high needs are more expeditiously appointed.

**Mental Health:** Mental health appointments are available on a same-day, walk-in, unscheduled basis. In 2016, on behalf of the Health Systems Division at OHA, Health Insight conducted a survey of adults and the parents/guardians of children who had accessed mental health services between July and December of 2015 using Oregon Health Plan (OHP) benefits. For the survey variable, *services were available at convenient times*, 74 (92.5 percent) respondents with Advanced Health
(then known as WOAH) replied agree or strongly agree, while 6 (7.5 percent) replied disagree or strongly disagree. For the survey variable, mental health staff were willing to see me as often as I felt necessary, 29 (91 percent) respondents with WOAH replied agree or strongly agree, while 3 (9 percent) replied disagree or strongly disagree. For the survey variable, mental health staff returned telephone calls within 24 hours, 25 (93 percent) of WOAH’s respondents replied yes, while 2 (7 percent) respondents replied no. For the survey variable, able to get all the services I thought I needed, 24 (83 percent) of the respondents affiliated with WOAH replied yes, while 5 (17 percent) replied no.

**Substance Use Disorder Services:** In Curry County, general Provider and community feedback, along with the results of secret-shopper-style telephone calls, confirm that same-day appointing is available for initial substance use treatment services. In Coos County, ADAPT retains a cadre of CADCs, but only the most senior and experienced of these is authorized to perform initial ASAM assessments, as it is the outcome of these assessments that determine the patient’s assignment to a level of care (e.g., out-patient; intensive out-patient; detoxification; residential).

Many of the primary care practices in Coos County have access to integrated Behavioral Health specialists who accept warm hand-offs from Providers whenever substance abuse is suspected. Each of these Behavioral Health specialists is well-versed in SBIRT (Screening, Brief Intervention, and Referral to Treatment) and Motivational Interviewing. Once a Motivational Interviewing session has been concluded, and the patient is motivated to enter substance abuse treatment, it is crucial that the referral to treatment be timely, if not immediate (Multiple professional literature sources document that the Referral-to-Treatment process within SBIRT is the model’s weakest link and, in many communities or settings, is simply not working.). In most cases, ADAPT offers an intake appointment within two days with a CADC who is authorized to perform the ASAM assessment. If the referral is made by a hospital emergency department, the assessment can almost always be accomplished within 24 hours. Nonetheless, Advanced Health understands that motivation can fade quickly and is working with ADAPT to increase the number of CADCs who are qualified to conduct an initial ASAM assessment to assure that all motivationally interviewed Enrollees can be seen the same day as, or within 24 hours of, the Motivational Interviewing session.

I.5 The CCO describes the ratio of members to providers for primary care providers, medical specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. The CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios to be adequate.
Primary Care Providers: Per Table 1, the Primary-Care-Provider to enrollee ratio for Advanced Health is 1:208. However, these Providers are shared with the general community. For the general population in Coos County, the ratio of Primary Care Providers to persons is 1:898, while in Curry County this ratio stands at 1:1261, including NPs and PAs who function in a PCP role. HRSA’s Bureau of Primary Health Care believes that medical underservice begins when there is less than one Primary Care Provider for every 1,641 members of the general population. In both Coos and Curry Counties, the Primary Care Provider to population ratios is better than this standard. Advanced Health considers these ratios to be adequate, but along with other leaders in the local medical community, would prefer to see a ratio that more closely approximates 1:1000 in Curry County.

Advanced Health is working with OHSU’s Rural Health Campus to increase the supply of Providers, and has contributed support to visiting medical, pharmacy, nurse practitioner, and physician assistant students. Data show that students trained in a rural location are more likely to practice in a rural location. Advanced Health is a partner with Bay Area Hospital, North Bend Medical Center, and Bay Clinic in physician recruitment activities and planning. Advanced Health leadership has consistently joined Bay Area Hospital in planning for recruitment and retention in needed disciplines. Most recently, Advanced Health convened a meeting with the pediatricians, who are feeling the increased burden of screening and documentation imposed by the OHA quality incentive metrics. Various options for providing additional coverage for hospital-based services (pediatric admissions, ER visits, and attendance at C-sections, etc.) have been discussed.

Medical Specialists: Please refer to Section I.6, below, for a detailed discussion.

Dental Providers: Per Table 2, the dental-professional-to-enrollee ratio for Advanced Health is 1:671 Nationwide, Oregon ranks 35th among all states with respect to the ratio of dentists to members of the population at .486 dentists per 1,000 persons (or, 1:2050). We consider the panel to be adequate.

Mental Health Providers: Per Table 3, the mental-health-Provider to enrollee ratio for Advanced Health is 1:220, which exceeds federal minimum recommendations of 1:1000. While we consider these ratios to be adequate overall, Advanced Health recognizes that there are still barriers in the community to timely access, and we continue to work to provide multiple routes to access mental health services in a variety of settings.

Substance Use Disorder Treatment Providers: Per Table 4, the substance-use-disorder-Provider-to-enrollee ratio for Advanced Health is 1:487. Regence Blue Cross Blue Shield of Oregon estimates that five percent of a given population will access substance abuse treatment services in an annual period. If this holds true with Advanced Health’s enrollees, then it could be anticipated that 1,000 enrollees
would annually seek substance use treatment services. If it is estimated that the average substance abuse counselor should serve a caseload of not more than 25 persons, and if each person is engaged in treatment for six months, then it would be estimated that each CADC could serve 50 unduplicated patients per year. With 18 CADCs available, and an average service capacity of 50 patients per CADC, Advanced Health’s addiction treatment network has the capacity to serve 900 unduplicated patients per annum, closely approximating the actuarial need estimates of Regence Blue Cross Blue Shield. With the off-site services of residential treatment programs, the addition of new FTE at the intensive day treatment program, and the addition of the OTP, Advanced Health’s addiction treatment network is adequate.

**Acute Care Beds:** Bay Area Hospital, a DRG facility, has 129 staffed beds with an annual occupancy rate of 57.5 percent, meaning that, on average, 55 beds are unoccupied on any given day. Coquille Valley Hospital, a Type B facility, has 25 staffed beds with an annual occupancy rate of 21.1 percent, meaning that, on average, 19 beds are unoccupied on any given day. Through 2016, Curry General Hospital, a Type A facility, had 24 staffed beds with an annual occupancy rate of 30 percent, meaning that, on average, 16 beds were unoccupied on any given day. Southern Coos Hospital, a Type B facility, has 19 staffed beds with an annual occupancy rate of 18 percent, meaning that, on average, 15 beds are unoccupied on any given day. In aggregate and on average, Coos and Curry Counties support 105 unoccupied hospital beds each day, resulting in an abundant (and costly) supply of staffed beds.

The exception to this supply is in the distribution of maternity care. Curry General Hospital has been unable to adequately staff its OB beds, resulting in women in Curry county needing to travel to Coos Bay or Crescent City for delivery. Although two Certified Nurse Midwives (CNMs) provide prenatal care and have a certified birthing center, they are unable to provide delivery services without hospital backup. Advanced Health continues to work with Curry General Hospital to ensure that maternity care is available in Curry County.

While there are no tertiary-care hospitals within our service area, Advanced Health coordinates with Sacred Heart River Bend in Springfield and Asante Rogue Regional Medical Center as well as OHSU for services limited to tertiary care facilities. The most common reasons for transfer are complications of pregnancy requiring delivery in a facility with neonatal intensive care, neurosurgical trauma, complex oncology care and cardiothoracic surgery.

**Ratios of Pediatric Providers to Infants, Children, Adolescents, and Young Adults:** Most of the children under 18 in our network are cared for by pediatricians. Our pediatricians provide excellent access and rarely limit their panel sizes to less than 700 Advanced Health patients, approximately half of their
patient panels. Our pediatricians also provide hospital coverage and specialized care while also caring for general pediatrics patients. This includes a fellowship-trained pediatric pulmonologist who cares for all our cystic fibrosis patients and many kids with complex respiratory diseases, a fellowship-trained pediatric endocrinologist, two pediatricians trained in forensic examination of suspected victims of abuse, and one pediatrician with advanced training in identification of autism. Our fellowship-trained pediatric cardiologist, who cared for many kids with congenital heart disease as well as general pediatrics patients, retired a few months ago. We have 11 pediatricians and 2 pediatric nurse practitioners, for a ratio of 1:526 Advanced Health members under 18 (to correspond with census-related age groups) and 1:1169 people in our service area who are under age 18. (Numbers based on US Census Bureau Quick Facts for Coos and Curry counties, population estimates of July 1, 2017, the most current date available as of June 2018.) Although most kids in our service area are treated by pediatricians, there are also several Family Physicians, as well as FNPs and PAs in Family Medicine, who treat children of varying ages. The proportion of the panel that is composed of enrollees under 18 varies widely among Providers in Family Medicine, so it is not easy to include them in the calculation of Provider ratios. However, they would only improve the overall ratio, which is already better than the Oregon ratio of 1:1622. Advanced Health feels that our network is adequate for the care of members under 18.

**Ratio of Primary Care Providers to Adult:** Advanced Health has 98 Providers in Family Medicine and Internal Medicine: 41 PAs or NPs, and 57 MDs or DOs. In our service area, most children are seen by the pediatricians, and the Family Physicians serve primarily adults. They serve approximately 13,329 members 21 and up, for a ratio of approximately 1:136. Most of the physicians in Coos County accept a panel of up to 280 Advanced Health members; PAs/NPs typically accept 150-180 members. In Curry county the panels are smaller, as the members are split with All Care. Advanced Health considers this panel adequate for our rural area, although we are consistently working to ensure an adequate or increasing supply of Providers in our service area.

**Ratio of Primary Care Providers to Seniors:** The number of enrollees over 65 is approximately 1,193. Of these, 45% have the CCOG benefit with mental health and dental coverage only. The remaining 650 members with physical health coverage are equally shared by both Family Medicine and Internal Medicine Providers, all of whom are proficient in the care of older adults. There is a total of 98 Providers in Family Medicine and Internal Medicine; 41 of those are nurse practitioners or PAs. Most older adults are assigned to 57 MD/DO physicians, resulting in a ratio of 1 physician to every 21 seniors. We consider this adequate, although again, we are consistently working with community partners to improve the supply of Providers.
Please note that the number of Providers specializing in Family Medicine and Internal Medicine described in this paragraph does not exactly match the number described in table 1 because some Providers specializing in Family Medicine or Internal Medicine (most often, the NPs or PAs) work in settings such as urgent care. While they do not function as PCPs for purposes of accepting a panel of patients that they manage over time, they do contribute to the overall capacity of the system for services to these age groups.

I.6 The CCO discusses how the network ensures time and distance standards for member access to specialists is met. The CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultation.

Medical Specialties, Capacity and Ratios: The composition of Advanced Health’s network of medical specialists is presented in Table 5.

<table>
<thead>
<tr>
<th>Medical Specialty</th>
<th>Dr. Count</th>
<th>Midlevel Count</th>
<th>Oregon Statewide Ratio*</th>
<th>Advance Health Ratio @ 19936 Members</th>
<th>Two-County Ratio @ 86557 Residents</th>
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<td>Dr. Count</td>
<td>Midlevel Count</td>
<td>Oregon Statewide Ratio*</td>
<td>Advance Health Ratio @ 19936 Members</td>
<td>Two-County Ratio @ 86557 Residents</td>
</tr>
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(**) Includes only those persons aged 18 and younger.

Note: A few of the numbers in the table do not match the DSN spreadsheet. These represent specialists who practice in the area and see Advanced Health enrollees but may not show as contracted because they work for a contracted entity. For example, four interventional cardiologists practice at, and are employed by, Bay Area Hospital. Not all contract directly with us, as some provide only inpatient services and are therefore credentialed and contracted under the auspices of the facility. Similarly, a cadre of anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) are employed by hospitals in the service area.

In the Table 5, above, Column 1 identifies the area of medical specialty. To form a basis for comparison, Column 4 provides Oregon’s statewide physician-to-population
ratio for each medical specialty identified in column 1. Column 3 includes nurse practitioners and physician assistants working in the indicated specialty. Column 5 sets forth Advanced Health’s Provider-to-enrollee ratio for each medical specialty and sub-specialty, while Column 6 establishes the physician-to-population ratio for each medical specialty for the entire population of Coos and Curry Counties. Advanced Health’s Provider panel is drawn from the local medical community, with a 99 percent participation rate. At the same time, Advanced Health shares this Provider panel with the entire population base.

Again, at first glance, it appears that, with a handful of exceptions, Advanced Health’s members are well-served by a diversity of medical specialists. However, when it is realized that Advanced Health’s members share this panel with the balance of the community, the data are not as satisfying:

- Certain medical specialties would not be anticipated for a community the size of Coos and Curry Counties. Those medical specialties include pediatrics/internal medicine (common in Midwest; uncommon in Oregon, where Family Medicine has greater representation), neonatology, perinatology, neuroradiology, neurosurgery, and vascular surgery. As need and circumstances arise, Advanced Health authorizes the provision of these services through non-participating Providers located in Medford and Eugene/Springfield (and when necessary, in Portland, Salem, and out-of-state).

- Certain medical specialties are well- or adequately-represented in Coos and Curry Counties. These include: pathology; emergency medicine; family medicine; internal medicine; dermatology; cardiology; general surgery; ophthalmology; orthopedic surgery; otolaryngology; pediatrics; rehabilitation medicine; plastic surgery; and, radiation oncology.

- The remaining medical specialties and sub-specialties are under-represented within the two-county community and include: child psychiatry; endocrinology; gastroenterology; hematology and oncology; infectious disease; nephrology; neurology; obstetrics and gynecology; psychiatry; rheumatology; thoracic surgery; urology; and vascular surgery.

- Several specialties may appear under-represented, as they do not appear in the DSN spreadsheet. Often, they are employed by hospitals and work inpatient only (anesthesiology), are available via telemedicine (neuroradiology and radiology), or the nature of the practice may not be represented in the specialty categorization (e.g. general surgeon who does a significant amount of vascular surgery, including carotid endarterectomy, AV fistula placement for dialysis, etc.)
Several of the community's internal medicine specialists have established sub-specialty expertise. For example, one internal medicine specialist has received advanced training in the insertion and application of insulin pumps, thereby offsetting apparent deficits in endocrinology, while another internal medicine specialist is qualified to read echocardiograms and interrogate pacemakers, thereby offsetting apparent shortages in cardiology. Several internists do upper and lower endoscopy, as do the general surgeons, providing some offset to the lack on gastroenterology. See also the description of pediatric sub-specialty expertise.

Until very recently, Advanced Health held a reciprocal contract with Trillium (previously LIPA), in neighboring Lane County. Through this agreement, Trillium gained access to SWOIPA’s medical specialists on behalf of its patient population in Reedsport, while Advanced Health gained access to the medical specialists affiliated with the former Lane Independent Practice Association (LIPA). While most of the medical specialists agreed to see Advanced Health’s patients at their practice locations in Eugene, a handful of medical specialists traveled to Coos County to make services more geographically available to Advanced Health’s members. However, with the reorganization of Trillium, following its buy-out by Centene, the LIPA agreement was rendered void. While the various Providers of medical specialty services who were previously associated with Lane Independent Practice Association continue to honor and accept Advanced Health’s referrals, there is no written agreement or contract to document the availability of these Providers, and thus they are excluded from our formal Delivery System Network calculations. To this end, Advanced Health is currently negotiating a contractual arrangement with Northwest Specialty Clinics, and through this agreement will contractually add to its participating Provider panel the following medical specialties: pulmonology (7); gynecology (20); neurology (5); urology (17); general, thoracic, neuro, and vascular surgery (12); nephrology (4); and, gastroenterology (9). These Providers, while accessible to all our enrollees, will be the most accessible to those residing in Coos County.

In Curry County, Provider referral patterns, as well as patients’ travel preferences, are more closely linked with the Rogue Valley than with the Willamette Valley. At the request of Providers and enrollees in Curry County, in late 2016, Advanced Health began a series of contractual negotiations with Prime Care, the independent practice association that serves Jackson County and the greater Medford area. All details of the legal arrangements between Advanced Health and Prime Care had been resolved by May 2017, when the Providers affiliated with Prime Care asked for assurances that Advanced Health would also include the Asante Health System and Providence Medford Medical Center among its contracted hospital facilities. Thus, the final inking of the contract with Prime Care was stalled. To this end, Advanced Health is now in direct contract negotiations with Asante Physician Partners. This arrangement will add cardiologists, dermatologists, endocrinologists, gastroenterologists, immunologists, neonatologists, nephrologists, neurologists,
neurosurgeons, ophthalmologists, oncologists, otolaryngologists, pain medicine specialists, pediatric oncology, pulmonologists, rheumatologists, thoracic surgeons, urologists, and vascular surgeons to Advanced Health’s contracted list of empaneled Providers. In the meantime, these Providers continue to see our enrollees.

**Time and Distance Standards:** When families elect to live in rural communities, they do not expect to have geographically proximal access to universities, shopping meccas, diverse museums, the opera, or ballet. They also do not expect to have immediate access to medical centers associated with schools of medicine or to a wide array of medical specialty and sub-specialty services. In short, rural residents expect to travel. The travel time from the population center of Coos Bay/North Bend to an array of medical specialists in Eugene/Springfield is 2 hours and 13 minutes over a span of 113 miles via Highway 101 and Oregon Route 38. The travel time from the population center of Brookings in Curry County, to Medford in Jackson County, is 2 hours and 41 minutes over a span of 126 miles via US-199 and Interstate 5. NEMT services are always available for scheduled medical appointments.

**Wait Times for Appointments:** Locally, the wait time for non-urgent medical specialty appointing is very reasonable. If the matter is more urgent, the local community of medical specialty physicians is always willing to aid referring Primary Care Providers by granting early access, even if it means that the medical specialist extends his or her work day. There is a spirit of collegiality among the members of SWOIPA and they work actively to lend aid and assist one another.

Wait times for out-of-area medical specialty appointing will be a little longer, but not unreasonably so generally accepted practice standards, although those patients who are unable to delay gratification may experience the wait times as being “too long,” (albeit whenever anyone is waiting for worrisome diagnostic test results, even hours, let alone days, feels “too long”). In truth, wait times are reasonable and in keeping with community norms, apart from neurology where wait times can be six months for a non-urgent consultation.

Technology has made it temporarily more difficult to conduct “secret shopper” evaluations of wait times. Referrals are placed electronically, so specialists’ office staff do not expect to offer appointment times to enrollees calling without a referral from the PCP. Unfortunately, the technology currently does not allow our clinics to reliably report time between referral and appointment. Through its Innovation Incubator Fund, Advanced Health has supported data analytics personnel and software at multiple clinics with the aim of making this type of data more widely available.

Wait times are also monitored informally in real time. Because we have close relationships with our Provider Network, staff call when local wait times are
unreasonable, usually due to limited supply in that specialty. When this occurs, utilization review staff approve referrals to out-of-area specialists as appropriate.

In several high-demand specialties, our specialists have noted that many of the referrals they receive have not been optimally evaluated by their PCP. To ensure the most high-value visits to those specialists, and to improve capacity for those enrollees who truly need the specialists’ services, Advanced Health staff have worked with those specialists to develop “Readiness to Refer” tools. Beginning with gastroenterology and hepatitis C, our care management staff worked with the specialty offices to develop checklist tools to guide the PCP. That way, initial steps can be handled locally by the PCP who has a working relationship with the patient. Once the preliminary steps are done, the tool can also serve as a checklist to ensure that staff provide all the pertinent information when making the referral. The readiness tools have been very well received by PCPs, who have suggested some additional specialties be added. The specialists are pleased to use their precious time on patients who are appropriately selected for referral. We currently use readiness tools for gastroenterology/hepatitis C, urology, ophthalmology (to differentiate medical eye from vision), and bariatric surgery.

The Application of Telemedicine: To address either Provider shortages or issues of time and travel, the following services are available by telemedicine:

- ADAPT makes the services of prescribing physicians available to patients who are being treated for substance use via medication-assisted treatment;
- Curry Community Health secures the services of consulting psychiatrists via telemedicine;
- Pediatricians affiliated with North Bend Medical Center secure consultations with Oregon Health & Sciences University;
- Oncologists affiliated with North Bend Medical Center and Bay Area Hospital secure consultations from Peace Health in Eugene and Oregon Health & Sciences University;
- Cardiologists affiliated with North Bend Medical Center and Bay Area Hospital secure consultations from Peace Health in Eugene and Oregon Health & Sciences University; and,
- Emergency department physicians at Coquille Valley Hospital and Bay Area Hospital have access to real-time medical consultations for stroke, cardiology, and head trauma through Oregon Health and Sciences University, and for burns through Doernbecher Children’s Hospital.
I.7 The CCO describes how traditional health care workers (by type) are incorporated into the delivery system network. The CCO should analyze and describe by type whether the CCO considers this adequate.

Oregon has a rich history of groundbreaking non-traditional health worker programs. The Indian Health Service in Oregon has employed Community Health Workers since the 1960s, and by the early 1980s, most federally qualified health centers were also deploying Community Health Workers. A component of the federally qualified health center program in Multnomah County, The Community Capacitation Center, became known as a regional expert on the use of non-traditional health workers. Many church groups developed Parish Nurse programs, and in the process, deployed Parish Health Promoters. La Clinica del Valle (Jackson County) was among the first in the State to employ Promatores and Doulas in service to migrant and seasonal farm workers.

Locally, and long before the age of “certification,” federally qualified health centers were among the early adopters of non-traditional health workers concepts. Waterfall Community Health Center employed its first non-traditional health worker in 2007 in a blended position entitled “Community Health Outreach and Eligibility Assistance Worker.” Several years later, it added a bilingual and bicultural individual in the same occupational classification. Concurrent with its admission to the national family of federally qualified health centers in 2013, Coast Community Health Center retained the services of a Community Health Outreach Worker for specific assignment to persons experiencing housing instability. Bay Area Hospital initiated the use of its first Personal Health Navigator when it retained the services of a registered nurse to serve as an oncology navigator.

**Community Health Workers:** By definition, a *Community Health Worker* is a certified individual who promotes health or nutrition within the community in which the individual resides, by: serving as a liaison between communities, individuals, and coordinated care organizations; providing health or nutrition guidance and social assistance to community residents; enhancing community residents’ ability to effectively communicate with health care providers; providing culturally and linguistically appropriate health or nutritional education; advocating for individual and community health; conducting home visits to monitor health needs and reinforce treatment regimens; identifying and resolving issues that create barriers to care for specific individuals; providing referral and follow-up services or otherwise coordinating health and social service options; and, proactively identifying and enrolling eligible individuals in federal, state, local, private or nonprofit health and human services programs. At Advanced Health, no employee, regardless of occupational classification, provides enrollment assistance, as doing so would be contrary to Advanced Health’s contract with OHA for CCO services.
The path toward attaining the services of Community Health Workers was a long and tedious one for Advanced Health. While many other CCOs were accessing certification training programs through their local community colleges, our local community college, Southwestern Oregon Community College, (SWOCC) offered no so options. When OHA made resources available to community colleges to develop curricula for Traditional Health Worker certification programs, SWOCC shared its resources with a consortium of other community colleges (including Lane Community College, Rogue Community College, and Chemeketa Community College). The curricula that was developed by the consortium was implemented at Lane and Rogue Community Colleges immediately upon accreditation, but not at Southwestern. Advanced Health began a formal advocacy effort with Southwestern as early as November of 2013, but to no avail. An application submitted by Southwestern in late 2015 was not met with accreditation by the Higher Education Coordinating Commission due to the absence of a qualified instructor. This decision rendered a serious blow to Advanced Health, as its Transformation Plan included a robust agenda of culturally appropriate educational, wellness, and outreach activities to be undertaken by newly-certified Community Health Workers, several of whom were intended to be bicultural, bilingual, and bi-literate.

Frustrated, Advanced Health still perceived the need and value in training a cadre of individuals as Community Health Workers. To achieve this end, we paid all costs for two of employees to travel to the greater Medford area, on a regular weekly basis, including Saturday sessions, to complete the Community Health Worker educational program at Rogue Community College. Of the individuals who completed the training: one is assigned to the Case Management Team in Coos County; and one is assigned to the Case Management Team in Curry County.

In 2017, Southwestern announced that it had formed a partnership with Oregon State University, and through this partnership would be offering a training program for Traditional Health Workers, commencing in April. The registration fees were somewhat prohibitive, because participants were being asked to offset the wages for both an instructor from OSU and an instructor-in-training from Southwestern (The goal was to have an individual from the local community co-facilitate the course with a seasoned faculty member from OSU, thereby building local capacity and developing a local instructor who would meet accreditation standards.). Despite unusually elevated tuition fees, Advanced Health jumped at the opportunity to finally have access to a Community Health Worker training program and purchased each of the twenty slots that were available and successfully advocated to add a twenty-first slot. These slots were then made available within our organization and to our community partners, Providers, and stakeholders. A cadre of nineteen newly-trained Community Health Workers graduated from SWOCC in June 2017. These Community Health Workers are directly employed by Advanced Health or by our contractors and delegates. The nineteen new graduates, coupled with the two previously trained Workers, creates a
team of 21 Community Health Workers who are deployed as follows: Advantage Dental (1); Bay Clinic (2); Coast Community Health Center (3); Coos Health and Wellness (2); Curry Community Health (3); North Bend Medical Center (1); Waterfall Community Health Center (2); and Advanced Health (4). An additional Community Health Outreach Worker was trained at Advanced Health’s expense and is employed on a part-time basis by the Devereux Center, which provides a range of advocacy and assistance services to persons who are homeless (250 of whom are Advanced Health members). In addition, one newly-graduating Community Health Worker was deployed to become an eligibility and enrollment assister for DHS’ local Office of Aging and Persons with Disabilities. The final newly-trained Outreach Worker provides support to the Curry Peer Advisory Council that works with that organization’s Recovery Community project.

Collectively, Advanced Health now has access to 21 Community Health Workers (pending certification for the nineteen new graduate). It is envisioned that these Workers will be retained within Care Coordination Teams at the various partnering organizations, and their specific position descriptions may vary somewhat from location to location. It is still too early to assess the efficacy and impact of this new workforce, or to comment about whether a workforce numbering 21 individuals is enough to be considered adequate. For certain, it represents an improvement over prior years and holds the potential for improved service delivery to enrollees. Advanced Health believes that the recommended guidance is one Community Health Worker for every 1,000 enrolled members, and if this guidance is accurate, then we would be appropriately staffed with 21 Community Health Workers serving an enrollee base of nearly 20,000 members.

**Peer Wellness Specialists:** For peer workers providing services in the field of Behavioral Health and addictions recovery, the State currently provides a definition for Peer Support Specialists: *those who provide peer-delivered services to an individual or family member with similar life experience, under the supervision of a qualified clinical supervisor.* A Peer Support Specialist must complete an Addictions and Mental Health-approved training program and be: a self-identified person currently or formerly receiving mental health services; or, self-identified person in recovery from a substance use disorder who meets abstinence requirements; or, a family member of an individual who is a current or former recipient of addictions or mental health services. Peer Wellness Specialists receive training focused specifically on reducing the levels of co-morbidity and shortened life span that are endemic among persons with Behavioral Health issues.

Coos Health and Wellness (formerly Coos County Mental Health) has long placed an emphasis on the services of Peer Wellness Specialists and currently employs approximately eight-to-twelve such individuals (although they are not included on the referenced Excel spreadsheets). Within this setting, Peer Wellness Specialists provide one-on-one assistance, co-facilitate certain group therapy sessions with a
licensed professional, and serve as a very active steering committee that provides a continual feedback loop in program development and improvement. In addition, Coos Health and Wellness’ Systems of Care (SOC) initiative has developed important roles for Peer Support Specialists, Family Support Specialists, and Youth Support Specialists as required by OHA’s Guidance Document for the SOC program. Coos County Health and Wellness enjoys the services of 2.0 FTE Youth Peer Support Specialists, 2.0 FTE Family Support Specialists, and 2.0 FTE Adult Peer Support Specialists. The organization is in the process of retaining an additional 2.0 FTE Adult Peer Support Specialists, and when fully staffed will have 8.0 FTE Peer Support Specialists. Shama House, a supported employment program also retains the services of 1.0 FTE Peer Support Specialist.

Curry Community Health operates the Clubhouse, which is a peer-delivered drop-in center designed to support individuals working on recovery from mental illness and addiction. Curry Community Health directly employs three Peer Wellness Specialists, who are bolstered by eight volunteer Peer Wellness Specialists, who work to assist enrollees in learning new skills, building friendships and alliances, obtaining support for recovery, and supporting others on their journey to wellness. The M.I.N.D.S. (Moving in New Directions) Clubhouse in Gold Beach is operated by both Peer Wellness Specialists and staff members, and is a two-story facility that features a kitchen, computer room, library, and greenhouse. The group has two vans for field trips, including a wheelchair lift, a stove for cooking, and a kiln for ceramics. Peer-directed activities include exhibiting members’ crafts at art fairs, group meals both on-site and at distant locations, sharing movies, or taking short field trips for enjoyment, such as bowling, historical sites, walks along the river, or picnic lunches. Peer Wellness Specialists, along with members of Advanced Health’s Curry County Community Advisory Council (CAC) participated in Peerpocalypse – a conference of leaders, emerging leaders, innovators, and peers who want to become more involved in the peer community. Advanced Health offsets all costs associated with the conference for local participants.

ADAPT employs two Peer Support Specialists. In addition, two addiction counselors who have direct experience with recovering family members, provide family peer support to the families of enrolled addiction patients (Because these two individuals are counted on the panel of direct service Providers, they are not double-counted in the following discussion as Peer Support Specialists.).

OHA incorporates significant changes in its contract with CCOs for OHP services in 2018. It is altogether well and good that OHA should adopt these revisions. The preponderance of professional literature confirms that consumer-operated mental health and addiction treatment services were equivalent to, or superior to, control services provided by licensed professionals (Paulson, et al., 1999; Solomon & Draine, 1999; Kaufmann, 1995; Edmunson, et al., 1982, and a host of researchers to follow). In clinical trials, consumer-delivered services resulted in overall increases in well-
being, stronger relationships with a recovery community, greater levels of empowerment, more timely and useful crisis services, greater promotion of self-care, shorter hospital stays, higher levels of employment, reductions in the use of seclusion and restraint, less frequent involvement with law enforcement, and less expensive costs.

Advanced Health turned to related professional literature to learn the correct ratio of peer support specialists to mental health and addiction treatment consumers. Most literature confirmed that Peer Support Specialists do not serve their own caseload, per se, but rather share a caseload with a qualified professional. In one study (Solomon), two teams, each comprised of a professional and a Peer Support Specialist, served a total of 96 patients, suggesting a ratio of 1:48. In a separate study (O'Donnell), three teams, each comprised of a professional and a Peer Support Specialist, served a total of 119 patients, suggesting a ratio of 1:40. In a third study (Clarke), three teams served a total of 164 patients, suggesting a ratio of 1:55, while in a fourth study (Davidson) three teams effectively served 260 participants, resulting in a ratio as high as 1:85. An average of the four studies would suggest that the correct Peer Support Specialist-to-consumer ratio is 1:55. Peer Support Services are not necessarily withdrawn at the conclusion of an episode of treatment, and may well serve as a supportive bridge between treatment episodes. If it is assumed that each Peer Support Specialist could address the needs of 55 consumers, then based on an average annual estimate of 2,500 Behavioral Health consumers, Advanced Health’s needs for Peer Support Specialists would equal 45 FTE. In a separate analysis of capacity, if it is assumed that one Peer Support Specialist is paired with every mental health and addiction counselor within Advanced Health’s Behavioral Health service delivery system, then the need for Peer Support Specialists would eclipse 104 FTE in 2018. At present, the community’s two mental health programs and substance abuse treatment program enjoy the benefit of approximately 20.5 FTE employed and volunteer Peer Support Specialists, which is significantly less than the number of Peer Support Specialists than would be required to meet the standards of above.

While Advanced Health believes that the system of care will benefit from additional peers, it will take some time to develop this workforce. In addition to supporting training for Peer Wellness Specialists, Advanced Health is beginning work in collaboration with Coos Health and Wellness, ADAPT, and Bay Area First step to add Peer Support Specialists to the emergency department at Bay Area Hospital for patients who present with opioid overdose. The goal is to improve engagement with treatment for substance use disorder. The amount of the funding has not yet been disclosed to us by OHA, but the grant (designated as part of HB 4143) is scheduled to begin in 2019.

**Personal Health Navigators:** A Personal Health Navigator is an *individual who provides information, assistance, tools, and support to enable a patient to make the*
best health care decisions in the person’s particular circumstance and in light of the patient’s needs, lifestyle, combination of conditions, and desired outcomes. Because a local training and certification program has not been developed for Personal Health Navigators, this category of non-traditional health worker is not represented in Advanced Health’s network, excluding the Oncology Nurse Navigator affiliated with Bay Area Hospital.

**Promotoras and Doulas:** Promotoras are non-traditional health workers who undergo 150 hours of comprehensive training purposed at addressing, navigating, and creating protective factors and systems to increase positive health outcomes in racial/ethnic (largely Hispanic) low-income communities. To a significant extent, a Promotora is to the Hispanic community as a Community Health Worker is to the dominant racial/ethnic community. Although two of the recent graduates of SWOCC’s Community Health Worker training program are bilingual and bicultural, within Advanced Health’s system of care, they are recognized as Community Health Workers and not as Promotoras. We anticipate the addition of additional Community Health Workers in future cohorts of SWOCC’s program.

A Doula is an assistant who provides physical as well as emotional support during childbirth and assists pregnant and post-partum women in a non-medical capacity and are well-recognized healthcare workers in Mexico. In 2014, the most recent year for which certified data are available, there were 624 births in Coos County and 145 births in Curry County. Currently, this occupational category is not represented in Advanced Health’s service delivery network. Bright Eyes Midwifery, staffed by Certified Nurse Midwives and located in Curry County, does provide the services of “birth assistants,” but both individuals are formally trained as registered nurses and are not considered to be Traditional Health Workers. Also, Bay Area Hospital (the only hospital in the service area currently providing inpatient maternity care) uses experienced OB nurses to staff its MOMS (Management of Maternity Services) program, which includes post-partum home visits to assist with breastfeeding, assess the newborn, and support new mothers. While these services are slightly different than those of a doula, they do provide women with some of the supports that a doula would provide. Bay Area Hospital also provides women with near-continuous labor support—another function of a doula. Advanced Health feels that this is adequate at this time.

**Eligibility and Enrollment Assisters:** Because Advanced Health’s contract with OHA for CCO services prohibits us from providing any form of eligibility assistance to prospective enrollees, we do not retain the services of Eligibility and Enrollment Assisters. However, Advanced Health remains mindful of the presence of these individuals within the community to direct inquirers to the most appropriate resource. Enrollment and Eligibility Assistance Workers are available within the community at Coast Community Health Center, Coos Health and Wellness, Curry Community Health, Oregon Coast Community Action, Waterfall Community Health
Center and local DHS Offices in Coos and Curry Counties. Bay Area Hospital also employs a Presumptive Eligibility worker who assists community members needing hospital services, both inpatient and outpatient. We feel that this is adequate at this time.

I.8 The CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate. Because there was no licensed transportation exchange in Coos or Curry Counties, Advanced Health was initially required to look beyond the counties' borders when seeking a non-emergency medical transportation (NEMT) vendor. After completing its due diligence, including pre-delegation reviews, Advanced Health initially selected Trans Link, a program operated by the Rogue Valley Council of Governments, as the NEMT Provider. Trans Link had provided NEMT for the region for years previously through a contract with OHA.

While Trans Link provided service in good faith, it had numerous hurdles to operate as the NEMT Provider in a service area outside of its local region. (See last year’s analysis for an in-depth discussion.) In the meantime, a business local to Coos Bay—Bay Cities Ambulance—began working with our neighbor CCO Umpqua Health Alliance to provide NEMT. After a year of working with UHA, Bay Cities Brokerage (the NEMT side of the business) had proven its ability to provide NEMT to UHA’s satisfaction. A goal of our organization has always been to support and develop local resources where possible, so partnering with Bay Cities Brokerage seemed a natural fit. Advanced Health began NEMT services with Bay Cities Brokerage on September 29, 2017.

Bay Cities Brokerage provides the full spectrum of NEMT needs, including mileage reimbursement, sedan, wheelchair van, stretcher van, etc. It utilizes CCAT (Coos-Curry Area Transit) when possible, but these services are limited. For example, North Bend Medical Center is only a stop on every-other circuit, even though a majority of outpatient medical services in the community are rendered there.

Complaints related to NEMT have decreased substantially since Bay Cities Brokerage began providing the service. However, we are still working on balancing service with costs, and encountering some patterns of use in our community that incur significant additional transportation costs. For example, two members travel to Roseburg (and previously to Eugene) round-trip daily to access methadone treatment. Substantially more of our members with end-stage renal disease are managed with hemodialysis (requiring transport every other day) than with peritoneal dialysis (which is performed at home) when compared with enrollees in UHA.
Advanced Health feels that our NEMT capacity is adequate, and that performance will continue to improve as we work with Bay Cities Brokerage as our partner.

I.9 The CCO addresses transportation and access for enrollees with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.

Transportation for Enrollees with Disabilities or Special Needs: All vehicles operated by Bay Cities Brokerage and CCAT are modern, respectful, fuel-efficient, and fully handicapped accessible, including hydraulic wheelchair lifts and lock-down platforms for persons seated in wheelchairs. CCAT drivers have been trained in lending aid to, and transporting, persons with disabilities, including mobility, visual, and hearing impairments. Bay Cities Brokerage provides NEMT services to those individuals who may need to be transported in a reclined position, as frequently occurs between Long-Term Care Facilities and Providers’ offices. Ambulances that are not equipped with Advanced Life Support are used for this purpose. When needed, ambulances equipped with oxygen support are also used for NEMT services. Bay Cities also operates several wheelchair-accessible vans, and they have been providing skilled transport of people with disabilities and special needs, especially elderly residents of long-term care facilities, in the community for years.

Although NEMT rules permit the transportation of the patient and a single accompanying family member or advocate, Advanced Health has frequently authorized the transportation of additional persons when doing so makes the transportation process easier or friendlier for the patient. When patients with disabilities or special needs prefer to provide their own transportation, and yet doing so would create a financial hardship, Advanced Health provides mileage reimbursement to enable patients with special needs to arrange their own transit.

Advanced Health’s Case Management and Care Coordination team is empowered to authorize a wide range of transportation services on a case by case basis, thereby assuring that uniquely individual needs are addressed. For each of these reasons, Advanced Health considers its NEMT program to be fully adequate for persons living with disabilities or special needs.

Access for Enrollees with Disabilities or Special Needs: Provider offices are assessed for access variables that are important to members with special healthcare needs. Assessment protocols include not only traditional ADA accessibility standards, but also consider issues related to HIPAA privacy. Patient comfort is an important variable, and for that reason the office assessment includes identifying those offices that provide a combination of chairs in the waiting area with and without arms, and access to high/low-rise bariatric examination tables. All
contracted local Providers’ offices are visited periodically to ensure that appropriate access exists.

I.10 The CCO demonstrates a continuum of care [adults/children, crisis, outpatient, intensive outpatient (e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)), residential, inpatient] for the treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate. Advanced Health’s mental health agencies have evolved a sophisticated array of evidence-based programming for enrollees of all ages.

Infants, Toddlers, and Young Children: Available outpatient services include Parent-Child Interactive Therapy (PCIT), infant massage, parenting education and support, and as appropriate, behavior modification therapies and individual and family therapy modalities. Available intensive outpatient services include a therapeutic classroom operated by South Coast Head Start as well as a psychiatric day treatment program for elementary age youth. Residential services are rarely required but are available through arrangements with the Southern Oregon Child Study and Treatment Center in Ashland and other state level resources. Crisis services are available through a 24/7 mental health crisis hotline as well as mobile crisis response teams (available for all ages). Coos Health and Wellness, in cooperation with Kairos, also operates a specific youth-oriented crisis team (MY CRU or Mobile Youth Crisis Response Unit) to help address psychiatric emergencies for children and adolescents. This project is financially underwritten by Advanced Health and has been a tremendous success in diverting pediatric cases from hospitalization or transfers to higher levels of care. MY CRU consists of a team of two persons who work within the primary population centers, providing community and home-based interventions, with present parents and supports. Referrals to this program have been made by law enforcement, juvenile justice workers, educators, parents, and self-referrals from young persons. For young children with autism, Applied Behavioral Analysis (ABA) is made available in the home setting and is often coordinated with Targeted Case Management programs operated by the public health sector. ABA is appropriate for children aged 1 to 21. Advanced Health partners in Coos County have had a difficult time recruiting an ABA therapist after their employee who was pursuing certification left the area. We recognize this as an ongoing area of need.

Adolescents and Young Adults: Available outpatient services include age-appropriate psychotherapies including cognitive behavioral interventions, DBT, EMDR and other evidenced based approaches. Other standard care includes psychiatric care, community-based skills training, as well as peer-delivered and family support services. School based mental healthcare is also the norm with mental health counselors present in most of the school districts within the region.
Additional positions are being added for three additional school-based therapists. Care is trauma-informed and involves the youth and family in treatment planning. A team approach, involving the youth, family, formal and natural supports works to tailor services to the needs of the youth at the time of assessment. Ongoing assessment assures that services are adjusted on an individualized basis. Services are flexible and can occur in an office setting, or be delivered “in-place,” e.g., school, home, or community. Applied Behavioral Analysis (ABA) is also available in the home setting as above.

Fidelity-level System of Care/Wraparound services are also available to all eligible members. System of Care (SOC) and Wraparound services represent philosophies of care rather than programs with clearly specified elements of treatment. SOC recognizes the importance of family, school, and the community in a child’s overall health. Accordingly, SOC initiatives comprise the informal and formal supports and services available in each community as an integral component. Wraparound services are one approach to working with families using a SOC philosophy. Wraparound “wraps” services in the community around the child and family, according to individualized and self-selected needs. Wraparound has a specifically defined clinical and theoretical orientation and is concerned with the process of how a child and family are engaged to create a strength-based and culturally competent service plan. Coos and Curry Counties work collectively to deliver SOC and Wraparound through the Coastline Systems of Care workgroup. Coos County is funded for 40 SOC slots, and Curry County for five.

Intensive day treatment options for this age segment include innovative psychiatric day treatment. This program is jointly ventured by Coos Health and Wellness, the North Bend School District, and Kairos. Coos Health and Wellness determines eligibility for placement, while also working closely with community partners to explore whether this highest level of psychiatric care for children and adolescents within the county is the best fit for the youth and his or her family. Sites are available for both elementary and middle-school students, and a special education teacher is employed to assure that participants do not fall behind academically. Psychiatric day treatment includes, as appropriate: medication management; family and group therapy; social skills training; life skills training; speech and occupational therapy; and an array of support services. Using current evidence-based practices, a Wraparound process empowers the family to meet their needs and those of the children in their care. The entire day treatment team is training in, and dedicated to the use of, Collaborative Problem Solving (CPS). CPS informs the over-arching treatment philosophy and guides everyone to be mindful of both strengths and lagging skills.

An array of residential treatment services is available for those aged 11 to 24, including the New Beginnings Psychiatric Residential Treatment Program (11-17), Three Bridges Psychiatric Residential Treatment Program for Young Adults (17-
24), Cadenza Residential Treatment Home for Young Adults (17-24), Momentum Residential Treatment Home for Young Adults (17-24), and Tempo Residential Treatment Home for Young Adults (17-24). Evidence-based models employed in these settings include Collaborative Problem Solving (CPS), Therapeutic Community Visits (TCV), Cognitive-Behavioral Therapy, Cognitive Restructuring, Neurosequential Model of Therapeutics (NMT) and Early Psychosis interventions (EASA). MY CRU is available to respond to the crisis needs of the age segment.

**Adults:** The community mental health programs offer a full array of adult mental health services. Crisis services are available as described above with a 24/7 crisis line, mobile response teams and available clinic walk-in services. If needed, acute psychiatric hospitalization is available through Bay Area Hospital, but whenever possible, patients are diverted to Crisis Respite Beds at the Coos Crisis Resolution Center – a six-bed, licensed, short-term residential treatment facility. This program is in a residential neighborhood and yet is situated directly across the street from Bay Area Hospital and conveniently close to other community services. Crisis treatment usually entails a combination of Milieu Therapy, psychotropic medications, Assertive Case Management, and Motivational Interviewing. These services are provided 24/7 under the direct supervision of a psychiatric nurse practitioner and licensed mental health professional.

Traditional outpatient mental health services for adults include individual, family and group therapy, psychiatric services, case management and skills training. Services are available both through Community Mental Health Programs as well as an array of independent Providers, allowing for maximum choice for members. Evidenced based approaches include Cognitive Behavioral approaches, Solution-Focused Therapy, DBT, EMDR, Motivational Interviewing and others. Supported employment services are well established for members and peer-delivered services are becoming increasing available for all.

For those who suffer from severe and persistent mental illness additional services are available including intensive case management services, supported housing, financial supports, skills training, peer services, and assertive community treatment. Both Community Mental Health Programs also manage the Choice Model state contracts, helping to link and support individuals that utilize or may utilize state level resources including the Oregon State Hospital and step-down levels of care.

The model of choice for the provision of the most intensive outpatient services is Assertive Community Treatment (ACT). ACT Planning Grants were awarded in both Coos and Curry County and have helped to improve upon the ACT-like services that previously existed. Both Curry Community Health and Coos Health and Wellness are provisionally certified and are on track to meet Fidelity metrics as determined by the ACT Center for Excellence.
Specific services are also available to individuals with legal or forensic involvement. A mental health court is in operation within the Coos District Courts and a Corrections Counselor delivers and coordinates care both with the local Parole and Probation department as well as the Coos County Jail. Increasing emphasis is also placed on assisting individuals that are being assessed as being unable or potentially able to aid in their own defense with the additional goal of being able to support such individuals to successful community integration.

A range of residential treatment options is available, including Licensed Residential Treatment. Following treatment, members have access to Fully Integrated Supported Housing, and Transitional Housing. Cedar Bay is a five-bed, licensed, residential treatment home in North Bend and serves adults who are discharged from the Oregon State Hospital. Bell Cove was built in 2013 and specifically designed as a five-bed licensed residential treatment home located in Brookings. This facility is designated for Psychiatric Security Review Board individuals. Driftwood Lodge, located in Gold Beach, is a beautiful eight-bed mental health residential facility converted from an old fishing lodge. Treatment approaches include Dialectical Behavior Therapy (DBT), Milieu Therapy, and Cognitive Behavioral Therapy.

For a community the size of Coos and Curry Counties, Advanced Health judges the array of children’s and adult’s mental health treatment programs to exceed the adequate range. While the array of services is adequate, the number of mental health counselors in the community is not currently where we would like it to be. Although local clinics are developing integrated Behavioral Health, Providers trained in the model have proven difficult to recruit. In several circumstances, clinics hiring Providers trained in the traditional specialty model of care have found themselves offering co-located services, but not truly integrated services. Advanced Health has provided ongoing support to clinics hoping to advance integration of services by way of grant funding, funding to support recruiting efforts, and technical assistance. In addition to supporting the development of Behavioral Health in primary care, Advanced Health is supporting Coos Health and Wellness in the development of primary care services integrated into their Behavioral Health clinics. Advanced Health sees that there is an ongoing need to develop integrated services.
I.11 The CCO demonstrates a continuum of care (adult, child, detox, outpatient, intensive outpatient, residential) for the treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate. For all substance use disorder treatment services except complex medical detoxification, SWOIPA contracts with, and delegates authority to, ADAPT, Inc. ADAPT maintains home offices in Roseburg (Douglas County), and out-patient services in Reedsport (Douglas County), Grants Pass (Josephine County), and North Bend (Coos County). ADAPT, in turn, contracts with Curry Community Health for the provision of out-patient treatment services.

Within Coos and Curry Counties, ADAPT either directly employs, or contracts for the services of, a total of 38 Certified Alcohol and Drug Counselors (CADCs) and other SUD treatment Providers, resulting in a Provider-to-Enrollee ratio of 1:487. ADAPT responds to urgent needs on a 24/7 basis. Outpatient treatment services are made available to persons 12 and over, but with differing clinical approaches. For adolescents, a combination of evidence-based approaches is used including the Adolescent Community Reinforcement Approach (A/CRA), Community Reinforcement and Family Training (CRAFT), and other cognitive therapies. Services include individual therapy, group therapy, the treatment of co-occurring disorders, case management, and gambling treatment. A salient feature of ADAPT’s service delivery system is its operation of a federally qualified health center, enabling ADAPT to offer fully integrated primary and Behavioral Health services. For enrollees under 12, a variance from the state is required to provide treatment. For these enrollees, services would either be offered via another program holding a specialized license, or the variance could be requested.

ADAPT operates residential treatment programs in Roseburg for adults, women with infants and children 5 and under, and adolescents. These services are made fully available to Advanced Health’s Enrollees according to American Society of Addiction Medicine (ASAM) criteria. Social and medical detoxification services are also available in Roseburg, and transportation services are arranged, as needed, on a case-by-case basis.

What had been lacking in Coos and Curry Counties was the availability of intensive out-patient treatment services, and the largest stumbling block has been housing arrangements, particularly for those who must travel from Curry County, or who, regardless of county, have no sober support systems within their current housing arrangements. To this end, ADAPT has opened an innovative intensive out-patient treatment program with housing supports in Coos Bay. The program has the capacity to serve 16 adults in residence and is supervised by a CADC II.

Utilizing federal grant funds, and in partnership with Advanced Health, ADAPT will open an Opioid Treatment Program (OTP) in Coos County in July 2018. This
program will create new treatment options using buprenorphine, naloxone, suboxone, and methadone, which is particularly critical as Advanced Health’s Providers work earnestly to reduce the use of prescribed opioid pain medications. All licenses and permits have been obtained for the program. Currently, Medication Assisted Treatment (MAT) is available on a small scale. The Drug Addiction Treatment Act of 2000 (DATA 2000) permits physicians who meet certain qualifications to treat opioid addiction with certain medications that have been specifically approved for that purpose. This privilege was expanded to nurse practitioners and physician’s assistants in 2016. The waiver is designated on the prescriber’s DEA number with an “X,” therefore these prescribers are often referred to as “X-waivered.” They may be addictions specialists, but more often are Primary Care Providers. There are currently no X-waivered prescribers available to provide office-based opioid treatment (OBOT) in Coos County, although active recruitment is under way. Four Providers in Curry County have X waivers. To improve access to MAT, ADAPT is using a physician who is an addiction specialist affiliated with their program. Patients meet with the physician on a face-to-face basis for initial induction, then most follow-up visits are conducted via telemedicine. The telemedicine program is currently at capacity and serving 65 enrollees year-to-date in 2018. The program served 36 members over the same time period in 2017.

Recognizing the growing need for treatment in opioid use disorder, ADAPT applied for and was granted SAMHSA and OHA funds to open an Opioid Treatment Program (OTP) in North Bend. This will be located adjacent to the ADAPT offices, where other treatment is provided for various substance use disorders. The OTP is scheduled to open in July 2018, starting with the approximately 60 members who are currently receiving Suboxone treatment. It is anticipated that the program will serve 100-150 clients, with priority given to those enrolled in OHP. Advanced Health has provided substantial financial support to the program. As patients are stabilized on MAT, the goal is to encourage additional X-waivered Primary Care Providers so that some patients can graduate to fewer intensive levels of treatment. The OTP will also serve as an important resource for patients who are started on office-based opioid treatment (OBOT) that require the more intensive level of care that is provided in a fully-licensed OTP. The OTP also mitigates against the problem of multiple patients on OBOT scrambling for a Provider when an X-waivered Primary Care Provider leaves the community.

Advanced Health is also the only CCO to be the sponsoring organization for the OHA Prescription Drug Overdose Prevention (PDO) Coordinator, a grant-funded position intended to work across all sectors of the region to reduce the harms from prescribed opioids. The PDO coordinator has seated a multi-sector advisory panel, coordinated efforts already underway in the community spearheaded by Chief Robert Kappelman of the North Bend Police Department, brought Institute for Healthcare Improvement (IHI) trainings in safe opioid use to groups of local Providers, and sponsored multi-disciplinary teams from local primary care offices to
attend the statewide summit on Opioids, Pain, and Addiction Treatment in Eugene in May 2018. These activities serve as primary prevention of opioid use disorder, as most heroin users begin with prescription medications. They also serve as secondary prevention by training Providers to recognize opioid use disorder in their practice and refer to treatment, and tertiary prevention of overdose in the form of increasing Naloxone rescue training and distribution.

Coos County, which is the most populous county in our service area, was recently awarded grant funding via Oregon House Bill 4143 to place peer support specialists in the emergency department to facilitate entry into treatment for patients presenting with opioid use disorder. This grant was awarded based on a combination of the opioid prescription burden in the region and the region’s readiness to increase access to treatment. Plans are in the early development phase, with funding slated to begin in 2019, but will involve a partnership between Advanced Health partners and Providers including: Coos Health and Wellness (Coos county’s mental health and public health agency) as the fiscal partner, Bay Area Hospital (who sees 73% of the emergency department visits in our entire service area) as the emergency department, Bay Area First Step (a local agency providing peer supports to recovery and clean and sober housing) as the peer support agency, ADAPT as the SUD treatment agency, and emergency and hospitalist physicians as part of SWOIPA. Although this will be a substantial improvement in the system of care for SUD, this program will not necessarily be reflected by a significant increase in the number of Providers listed in the DSN spreadsheet.

With the caveat that there is a need to identify additional prescribers to work with the Medication Assisted Treatment program, Advanced Health judges the comprehensive array of substance use treatment services to be adequate.

I.12 The CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees. Advanced Health’s registry of Delivery System Network Providers includes three acupuncturists (two LACs and one MD acupuncturist), two chiropractors, three occupational therapists, and fourteen physical therapists. Over the past several years, Advanced Health has been hard at work to decrease the number of patients for whom opiates are prescribed. As we have done so, the need to create alternatives for pain management has become apparent. In addition to authorizing encounters with acupuncturists, chiropractors, and physical therapists, Advanced Health has also created programs to assist patients living with pain and those with other special healthcare needs. For patients who are working on weight-loss programs through Healthy Eating and Active Living initiatives, Advanced Health pays for memberships in local fitness centers or gyms and memberships in dietary support groups such as TOPS (Take Off Pounds Sensibly) through flexible services funding.
Medical funds also cover consultations with registered dieticians where appropriate. Advanced Health makes every reasonable effort to meet the unique and individualized health-related needs of enrollees and is receptive to alternative therapies and the insightful recommendations of patients and their providers.

When the Health Evidence Review Board added benefits for back and neck pain, Advanced Health Primary Care Providers expressed a need for help in navigating the available resources and in determining which patients might be appropriate for either surgical or non-surgical interventions. To this end, Advanced Health entered into a contractual agreement with Dr. Alex Curcin, an orthopedic spine specialist. Under this initiative, physicians were provided with a quality referral option to the Spine Care Program for all patients suffering from back pain. In turn, the program sought to add the services of an Orthopedic Physician Assistant and a Patient Navigator, and developed a range of protocols for non-opioid treatment options, including acupuncture, chiropractic services, spinal manipulation by an osteopathic physician, physical therapy, exercise therapy, weight management, massage, nutrition counseling, and yoga. Based on medical assessments and individual needs, these services are made available for all patients who suffer from back pain and who are assessed by the Spine Care Program. Unfortunately, recruiting a physician assistant has proven a barrier over the last year, limiting the number of enrollees who could be assessed by the program. The program continues to recruit. The Patient Navigator has enrolled in Community Health Worker training to improve her skills in care coordination and patient coaching.

Advanced Health has recognized several limitations to its network adequacy in this arena. First, acupuncturists and chiropractors have been difficult to enroll as OHP Providers. Many enjoy the cash business model and are not interested in carrying the required malpractice to meet OHA standards. Some struggle with the basics of the allopathic-focused healthcare system such as authorizations and correct billing. We have provided extensive assistance to acupuncturists and chiropractors in our service area in this regard, with the aim to improve access. Massage therapy continues to have significant limits, as massage therapists cannot independently bill for their services due to OHP rules. We have several willing independent massage therapists who are unable to bill us. Advanced Health has tried to foster partnerships between our independent massage therapists and billing Provider types, such as physical therapy practices or the Spine Care Program. Advanced Health also recognized that Living Well with Chronic Disease programs were not well received by our members. To meet the needs of our members with chronic pain, we developed our own program: Life Skills for Long Term Pain. This is led by our RN case manager who also has a BS in kinesiology and partners closely with the Spine Care Program. The elements are evidence-based practices and include an introduction to programs available in the community at no charge to our members, including yoga for people with limited mobility, Tai Chi, mindfulness, Walk With Ease, and other resources.
Multiple community programs are available to our enrollees at no charge. Advanced Health has long included in our contract with Bay Area Hospital that our members could access any of their community education offerings at no charge to the member. These offerings include Mindfulness-based stress reduction, Chair exercise classes, CBT-based “Train your Brain to overcome Pain,” and many other classes. Other community programs include yoga at multiple levels, including chair-based yoga for the least mobile; tai-chi; pool aerobics; and more.

While we feel that our array of alternative therapies is adequate, we feel that the community would benefit from additional resources. However, it is important to Advanced Health that those services are evidence-based and follow clear standards. Although we have not turned away any willing Providers at this time, we are cautious to partner only with those alternative therapy Providers that we are certain will provide high-quality services.

Advanced Health has experienced a relative shortfall of physical therapy services to adequately meet the needs of the community. While Advanced Health contracts with all the physical therapy offices in the service area, all of them have experienced shortages of PTs recently. Exacerbating this problem is the fact that the offices resort to using traveling Providers to fill their gaps, but these Providers are not able to obtain DMAP ID numbers in a timely manner, and therefore cannot bill us or serve our members. Also, with the expanded benefit for back pain, the PT offices have seen a substantial increase in the number of referrals. However, many of the patients with chronic pain are not motivated to participate in PT services. As a result, the PTs experience a high rate of missed appointments, further exacerbating the limits in availability. While we continue to work with them to resolve these issues, some (such as the timeliness of DMAP ID numbers) are outside of our control.

II. Description of Enrollees

II.1 The CCO describes its process for considering enrollee characteristics when making provider assignments: (a) CCO provides analysis of the language and cultural needs of enrollees; (b) CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.

General: Advanced Health’s participating Providers have agreed to accept OHP beneficiaries according to a reasonably equitable assignment basis. This means that the average primary care physician agrees to serve up to 280 of Advanced Health’s members, and the average pediatrician agrees to serve 700 Advanced Health members. When a new member is assigned to us by OHA, Advanced Health contacts the member to inquire if the member has any preference in assignment to a Primary Care Provider or has a pre-existing relationship with one. Members are
queried about geographic preferences, cultural or language preferences, special needs (i.e., wheelchair transportation; American Sign Language; TDY capacities), and whether they had previously established care with a Provider with whom they would elect to continue care. Members may request a specific Provider by name, and if that Provider is accepting new members, the patient is assigned to the Provider of choice (Even if the Provider is not accepting new members, Advanced Health will contact the Provider and request that the Provider accept this specific enrollee, based on the enrollee’s request or previously established patient-Provider relationship.). Members who do not respond to Advanced Health’s requests regarding Provider preference are assigned at the beginning of the following month to a geographically proximal Primary Care Provider who can meet any additional special needs (i.e., cultural, linguistic, accessibility). Enrollees may request a change in Primary Care Providers for any reason, up to twice per year.

For those enrollees who do not express a preference, Advanced Health uses an automated system to distribute new enrollees among Primary Care Providers according to their location and panel size. This improves access by ensuring that enrollees are assigned where there is capacity. This system also automatically assigns a returning member to the last known PCP, regardless of the time they have been off our rosters. For example, during the rapid increase in enrollment in 2014 as a result of the affordable care act, our PCPs noted that some of their newly assigned patients had been established patients up to a decade prior but had not received care while uninsured since that time. As a result, many new enrollees started with a familiar Provider despite years without coverage.

**Language and Cultural Needs:**

Current demographic data identifies the following enrollee characteristics:

**Race and Ethnicity**

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<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>14,863</td>
<td>56.3%</td>
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<tr>
<td>Not Provided</td>
<td>9,915</td>
<td>37.6%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>796</td>
<td>3.0%</td>
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<tr>
<td>American Indian/Alaskan</td>
<td>407</td>
<td>1.5%</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>131</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other Race or Ethnicity</td>
<td>129</td>
<td>0.5%</td>
</tr>
<tr>
<td>Black</td>
<td>100</td>
<td>0.4%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>35</td>
<td>0.1%</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>13</td>
<td>0.05%</td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
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<td>0.004%</td>
</tr>
</tbody>
</table>

**Languages Spoken in the Home**

<table>
<thead>
<tr>
<th>Language</th>
<th>Count</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>English</td>
<td>25,561</td>
<td>96.9%</td>
</tr>
<tr>
<td>Other/Undetermined</td>
<td>512</td>
<td>1.9%</td>
</tr>
<tr>
<td>Spanish</td>
<td>317</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Within Advanced Health’s physician network, there are multiple bilingual Providers who speak a multiplicity of foreign languages: Nepali (1); Hindi (1);
Spanish (5); German (2); and Russian (1). All enrollees who speak a foreign language are offered the option of being assigned to a Primary Care Provider who speaks their native language, if that language is represented among the panel of Providers. If the patient’s native language is not represented by a member of Advanced Health’s panel, then telephone interpretive services are made available. Advanced Health has found that this service is rarely, if ever, required.

Within the mental health and addiction treatment system, there is a single therapist who is fluent in Spanish, and a second who is fluent in American Sign Language. The individual who is fluent in American Sign Language is available on an “on call” basis to accompany enrollees to medical appointments, when requested. There is no foreign language capability within Advantage Dental’s Provider panel. Advanced Health retains the services of a single certified Spanish Language Interpreter, and contracts with the local Education Service District for additional interpreters and American Sign Language professionals. Essential patient documents are available in Spanish, and for those who are visually impaired, in large type and audio recording.

In 2017, Advanced Health added the Coquille Indian Tribal Clinic to our network. The Coquille Tribe has been an excellent community partner since the inception of the CCO, participating in our original Community Heath Assessment, sending a representative to our CAC, and participating in several community-wide events such as the South Coast Opioid Summit. Because of the wrap-around payments received by tribal clinics, most had no incentive to join CCOs, relying on the FFS benefit. However, this meant that many of their enrollees had difficulty accessing specialists. When they joined the CCO, the Tribal Clinic has been offered some special considerations: enrollees are only assigned to the clinic as their PCP if they request it or are established patients; the clinic has allowed their patients to choose whether or not to enroll in the CCO; and we have added their clinic pharmacy to our pharmacy network, providing technical assistance to them. Although the number of enrolled members remains small, we look forward to a long and productive partnership.

In 2016, Advanced Health requested equity consultation and technical assistance through the Transformation Center and OHA’s Office of Equity and Inclusion who, in turn, provided the services of Ignatius Bau. Advanced Health was originally presented with an Excel spreadsheet that provided raw data, dichotomized by ethnicity, for a variety of the variables surveyed through the CAHPS process or included in metric performance measures. Advanced Health examined this raw data and conducted statistical tests to determine if there were any significant differences among the racial and ethnic classifications of enrollees for each variable. There were no significant differences. Nonetheless, there are a handful of “apparent disparities,” (e.g., circumstances under which the trend line for persons of racial and ethnic minority status are somewhat less favorable than for the
population as a whole): (1) Rates for SBIRT positive screening of Asian members and those who reside in Spanish-speaking households; (2) Elevated rates for hospital emergency department utilization by African-American enrollees; and, (3) Rates for dental sealants among children from Spanish-speaking households. Of note, for two of these variables, the rates are not elevated for all persons of Hispanic origin, but only for those from Spanish-speaking households, suggesting that a language barrier is interfering with both the SBIRT and dental sealant processes. Perhaps the written parental consent for pediatric dental sealants are not appropriately understood when translated to Spanish. SBIRT materials are available in Spanish, but not Chinese (5 adult members) or Vietnamese (3 members.) These may not be the best measures for eliminating disparities since the numbers of members from diverse racial and ethnic backgrounds is so small, and data show that these groups generally fare well in many quality measures: e.g. developmental screening (Spanish speakers at 88% vs. 82% for English speakers), adolescent well visits (Spanish speakers at 62% vs. 55% for English speakers), or colorectal cancer screening (Spanish speakers at 62% vs. 55% for English speakers).

To achieve greater parity, Advanced Health offset all costs associated with enrolling a staff member with the Office of Equity and Inclusion’s DELTA program in 2016, only to have that employee transfer to another health-related work setting upon program completion. In 2017, Advanced Health sent another employee through the program. In addition, Advanced Health has added persons of underrepresented racial and ethnic groups to its Community Advisory Council.

**Needs of Members with Disabilities:** Rolling, twelve-month demographic data for Advanced Health’s enrollees finds that 2,269 (9.0 Percent) are individuals who could be classified as persons with disabilities. As set forth earlier in this section, members with disabilities are assigned, with their consent, to Providers who are best equipped to address not only the medical disability, but who can also provide the supports and structures that the disability requires (i.e., high/low-rise bariatric exam tables; American Sign Language; amplification devices for the hard-of-hearing; mobility aid and wheelchair access). A mental health professional who is fluent in American Sign Language is available on an “on call” basis to accompany enrollees to medical appointments, when requested. Advanced Health contracts with the local Education Service District for additional American Sign Language professionals as well as alternative interpretation aids for enrollees with auditory or visual impairments.

When Advanced Health received the technical consultation in health equity described above, apparent disparities were found in emergency department utilization and the application of dental sealants, and while comparative data for both variables is in the wrong direction, the findings are not statistically significant. Of interest, however, it was discovered that there is a disparity in the rate of effective contraceptive use among women who are disabled. Advanced Health has
adopted the *One Key Question* protocol for all primary care and obstetrical offices and is monitoring to assure that women with disabilities are equitably included in tabulated data from this protocol. Although persons with disabilities have always been included on Advanced Health’s Community Advisory Council, those individuals are being increasingly empowered to speak up for, and thereby represent, other enrollees who are similarly situated.

II.2 The CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.

**Children:** At Advanced Health, the most common reasons that children come to the attention of healthcare professionals, in descending order, are:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Upper Respiratory Infections, Non-Chronic</td>
<td>44.4%</td>
</tr>
<tr>
<td>Otitis Media and Related Conditions, Non-Chronic</td>
<td>32.6%</td>
</tr>
<tr>
<td>Other Lower Respiratory Disease, Non-Chronic</td>
<td>22.5%</td>
</tr>
<tr>
<td>Liveborn</td>
<td>21.3%</td>
</tr>
<tr>
<td>Viral Infection, Non-Chronic</td>
<td>17.8%</td>
</tr>
<tr>
<td>Superficial Injury – Contusion</td>
<td>14.8%</td>
</tr>
<tr>
<td>Other skin disorders – Non-Chronic</td>
<td>12.4%</td>
</tr>
<tr>
<td>Other Gastrointestinal Disorders, Non-Chronic</td>
<td>12.4%</td>
</tr>
<tr>
<td>Other injuries and conditions due to external causes</td>
<td>12.3%</td>
</tr>
<tr>
<td>Asthma</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

Almost entirely, these conditions can be well-managed by pediatricians in the primary care setting. Of note, among Advanced Health’s pediatricians: Dr. LaGesse is fellowship-trained in pediatric pulmonology; Dr. Henken is fellowship-trained in non-interventional pediatric cardiology (retired in March); Dr. DeLeon and Dr. Moore are trained in the forensic evaluation of child abuse; Dr. Yost has received advanced training in the evaluation of autism; and Dr. Rastogi is a fellowship-trained pediatric endocrinologist. All of them practice general pediatrics in addition to care related to their special training.

**Adults:** Among Advanced Health’s adult members, the most common reasons for consulting a healthcare professional, in descending order, are:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Connective Tissue Diseases, Non-Chronic</td>
<td>29.7%</td>
</tr>
<tr>
<td>Spondylosis, Intervertebral Disc, &amp; Other Back Problems</td>
<td>29.6%</td>
</tr>
<tr>
<td>Substance-Related Disorders, Chronic</td>
<td>28.2%</td>
</tr>
<tr>
<td>Mood Disorders, Chronic</td>
<td>27.6%</td>
</tr>
<tr>
<td>Anxiety Disorders, Chronic</td>
<td>27.0%</td>
</tr>
<tr>
<td>Essential Hypertension</td>
<td>25.6%</td>
</tr>
<tr>
<td>Other Non-Traumatic Joint Disorders, Non-Chronic</td>
<td>24.7%</td>
</tr>
<tr>
<td>Other nutritional; endocrine; and metabolic disorders – Chronic</td>
<td>23.6%</td>
</tr>
<tr>
<td>Other Nervous System Disorders, Chronic</td>
<td>22.2%</td>
</tr>
<tr>
<td>Other Lower Respiratory Disease, Non-Chronic</td>
<td>22.2%</td>
</tr>
</tbody>
</table>
(Includes patients dependent on opioids who do not have a substance use disorder and some patients who screen positive on SBIRT, but may fall into the lower-risk categories, such as women reporting one episode in the last year of drinking 4 drinks in a day.)

While most of these disorders will first come to the attention of a Primary Care Provider, and most can indeed be addressed in the primary care setting, a milieu of referral options is available within Advanced Health’s Provider panel:

- A specialized Spine Care program has been developed for spondylosis and other back problems and is operated by South Coast Orthopedics, and Advanced Health’s specialty panel boasts eight orthopedic surgeons who can provide specialty care if needed for other non-traumatic joint disorders.

- The “other connective tissue diseases” category includes a disparate group of conditions including fibromyalgia, chronic pain syndromes, and various minor injury and symptom codes, most in the purview of primary care.

- Hypertension is addressed as an OHA Quality Incentive Measure. Related heart disease is managed by 5 cardiologists and internal medicine and family medicine Providers.

- Collectively, Coos Health and Wellness and Curry Community Health, retain the services of 86 mental health professionals who can address mood and anxiety disorders. In addition, a PhD clinical psychologist and three additional Behavioral Health consultants (master’s level or higher) are embedded at North Bend Medical Center’s multi-specialty physician practice in North Bend. Waterfall and Coast Community Health Centers also provide integrated Behavioral Health, and Waterfall also provides co-located traditional counseling services.

- Substance-related disorders can be treated by a wide array of local programming, recently expanded to include intensive out-patient services and medication-assisted treatment.

If an examination is made of the number of adult patients who are diagnosed with chronic disease states, the following figures emerge:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Disease</td>
<td>5,786</td>
</tr>
<tr>
<td>Psychiatric Disorders</td>
<td>5,065</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td>3,963</td>
</tr>
<tr>
<td>Skeletal Disorders</td>
<td>3,940</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td>2,870</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td>1,885</td>
</tr>
<tr>
<td>Dermatologic Conditions</td>
<td>1,638</td>
</tr>
</tbody>
</table>
Medical-specialty-physician-to-patient ratios were previously provided in Table 5. Advanced Health’s Provider network is adequate to meet these needs except as noted in analysis above. Shortages are evident in pulmonology, gastroenterology, neurology, endocrinology, rheumatology and nephrology, primarily related to geography. Three, soon to be four interventional cardiologists are available in Coos County, a fifth consulting cardiologist is regularly available in Curry County. A single local neurologist is available, but wait times are unacceptable. Gastroenterology and endocrinology are not present in the local community, but available to enrollees through highly functioning referral relationships. Again, it is noted that many of Advanced Health’s internal medicine specialists have received advanced training and developed additional specialized expertise, including emphasis areas that include gastroenterology and endocrinology. We also recognize that not all cardiovascular disease requires a cardiologist, and not all metabolic disorders require an endocrinologist. Our local PCPs are proficient in the primary care of these types of conditions.

II.3 The CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed. Case managers, care coordinators, panel managers, and in some circumstances, navigators, school nurses, and discharge planners (hereafter, simply referred to as case managers), are employed throughout the greater medical and social services community. Medically-related case managers are employed at Bay Area Hospital, Coquille Valley Hospital, Curry General Hospital, Southern Coos Hospital, Bay Clinic, North Bend Medical Center, Curry Health Network, Coast Community Health Center, Waterfall Community Health Center, South Coast Orthopedics, Bright Eyes Midwifery, South Coast Educational Service District, ADAPT, Coos Health and Wellness, and Curry Community Health. Non-medical case managers are employed by DHS child protective services, DHS Aging and Persons with Disabilities, Community Living, Oregon Coast Community Action (that operates Head Start and the local Regional Early Learning Hub), Coos and Curry County Juvenile Justice, Coos and Curry County Adult Probation and Parole, South Coast Educational Service District, and the Student Support Services Team at Southwestern Oregon Community College.

In turn, Advanced Health retains the services of three case management nurses, one case management licensed professional, and two community health workers (four of whom serve Coos County, and two of whom serve Curry County). This team of Super Case Managers accepts referrals from all other community-based case managers and serves those enrollees for whom the efforts of community-based case managers have been unsuccessful. The manager of Advanced Health’s case
management program, Yvette Grabow, RN, convenes regularly monthly meetings of all community-based case managers, and assumes responsibility for the inter-agency coordination of these individuals. She and her team also participate in case conferences at locations throughout the community, whenever the case conference pertains to a health-related issue for an Advanced Health member. In Southern Oregon, as in most communities, staff shortages within educational systems and skilled care facilities, increased demand for services created by expanded enrollment under the Affordable Care Act and a locally aging population, and patient acuity and complexity, have created situations in which community-based care managers have limited experience to contribute to challenges in achieving continuity of care across the care continuum. For this reason and over the years, Ms. Grabow and her team have become the community’s “go-to” professionals for the most challenging cases. It is within this context that enrollee needs for continuity of care, and transitions between levels of care, are contemplated, assessed, and implemented.

While continuity of care, as a distinct concept, remains elusive in professional literature, and other terms such as coordination of care, case management, and discharge planning are often used interchangeably, there is a shared understanding among the community’s case managers that continuity of care is defined by two core elements: care over time (past, present, and future); and a focus on the individual enrollee’s health needs and personal context. Continuity of care is often viewed as an outcome, while case management and care coordination are the approaches used to attain this outcome. Under the direction of Ms. Grabow, Advanced Health’s approach is one that falls within the nursing scope of practice: registered nurses use critical thinking skills and evidence-based judgment to assess an enrollee’s unique needs in a holistic context. With this knowledge, Advanced Health’s Case Management Team plans, communicates, and delivers the most appropriate transitions in care by collaborating with enrollees, members of their families, advocates, other care Providers, and Primary Care Providers. Using their broad understanding of available community resources, Advanced Health’s Case Management Team implements the plan of care to meet enrollee needs appropriately. A continuous process of monitoring, re-assessment, and evaluation of outcomes informs timely future decisions regarding next steps in continuity of care and transitions in care.

In addition to the care management resources above, Advanced Health’ medical director has done much to promote continuity of care and safe transitions throughout the system. As a practicing hospitalist, he has worked with the physician community to improve the process of discharge from the hospital, to standardize and make timelier discharge summaries, and to promote effective Provider-to-Provider communication about patients.
In the mental health realm, Advanced Health has met the quality metric for follow up after mental health hospitalization for the past several years. Advanced Health met the 2017 benchmark of 82.7% of members receiving follow up in 7 days, above the state average of 78.7%. Also, to promote continuity with primary care and transition to specialty Behavioral Health when appropriate, Shay Stacer, PhD, has guided the development of integrated Behavioral Health across the community and established good working relationships with the specialty Behavioral Health system for effective transitions when patients require specialty mental healthcare.

ADAPT, despite the constraints of 42 CFR privacy rules, has worked to ease continuity of care and effective transitions for its clients who complete residential SUD treatment and return to their home communities. They provide outpatient MAT via telemedicine after discharge from detox or residential treatment, and they encourage appropriate release of information for communications with a client’s PCP.

As part of its Transformation Grant, Advanced Health provides access to Milliman’s PRM Analytics Care Coordinator Reports to all PCPs and to their designated care managers. This tool includes patient-level data including specialists seen and dates, hospitalization dates and diagnoses, information regarding chronic diseases, and gaps in care on quality metrics. In accordance with Oregon rule and OAR supporting sharing of Behavioral Health information with primary care, Behavioral Health care information (number of visits, rendering Provider) is included. Unfortunately, SUD treatment information is excluded due to federal regulation related to 42 CFR. Advanced Health feels this is a barrier to continuity and safe transitions, but we do not have the ability to change the rules.

III. Additional Analysis of the CCO's Provider Network to Meet Enrollee Needs

III.1 The CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult, family, and child mental health surveys, and CAHPS. The CCO needs to describe how it uses the input from its Community Advisory Council.

Complaint and Grievance System: Advanced Health’s complaint and grievance system is the primary methodology through which Advanced Health receives and incorporates enrollee feedback into network adequacy decisions, primarily because it is a process that provides continuous feedback loops throughout the year. The other feedback methods, such as yearly CAHPS surveys, occur only episodically and do not provide the opportunity for rapid change cycles. The complaint and grievance system are under the supervision of Advanced Health’s Chief Medical Officer, Kenton Sharman, M.D. Dr. Sharman personally reviews and responds to
complaint and grievance information regularly. However, she recognized that in order to make solid, upstream and systematic interventions resulting in true improvement, additional resources were required.

In October of 2016, Advanced Health created the position of RN Health Services Coordinator (HSC). This position is tasked with analyzing patterns of complaints and making system-level interventions. She is in the customer service department, so she can provide real-time assistance to our customer service representatives. The HSC is also an experienced nurse case manager, has training in LEAN process improvement methods, and is also an Adverse Childhood Events Study (ACES) master trainer. She applies all these skills in combination to help individual members with their unique concerns, identify trends and appropriate interventions to result in real improvements, and to provide a trauma-informed approach in our systems. As a result of her interventions with Providers and their staff, as well as our own system, Advanced Health has seen a gradual, steady decline in the rate of access complaints, to nearly half of our previous rate. Complaints are reviewed weekly, and if any Provider receives two access complaints within a month, staff reach out to identify any problems. Providers experiencing temporary difficulties in capacity have a process for pausing the addition new enrollees to their panel. Providers’ office staff have also learned best practices for speaking to enrollees and obtaining cross-coverage when their Provider is out of the office. As an example, customer service representatives observed that when enrollees would call to make an appointment with their newly-assigned PCPs, some staff would say that the physician’s office was not open to new patients, despite agreeing to take new Advanced Health enrollees on rotation. The HSC made the simple suggestion to ask callers if they had been assigned to the practice. No other insurer assigns enrollees in our service area, so that simple question allowed staff to easily determine that this was a newly-assigned Advanced Health enrollee. This allowed staff to avoid asking about insurer, which is sometimes interpreted by OHP enrollees as discriminatory against them, when in fact it is in their favor.

Mental Health Surveys: Child, Family, and Adult Mental Health Surveys were made available to Advanced Health (then operating as WOAH in early June of 2017. Overall, most responses received from WOAH’s members were positive; i.e., in aggregate: 86 percent of respondents found that the location of services was convenient; 92.5 percent of respondents found that services were available at convenient times; 96.5 percent of respondents confirmed that they had a Primary Care Provider; 90.6 percent of respondents believed that they were seen as often as they felt necessary; 92.6 percent of respondents reported receiving return telephone calls within 24 hours; 83 percent of respondents believed that they had received all needed mental health services; and 80 percent of respondents stated that they were able to see a psychiatrist if they wanted to do so. No doubt, there is room for improvement, particularly regarding enrollees receiving the full range of mental
health services that they desire and access to psychiatrists (for which there is a confirmed shortage).

Advanced Health was pleased to know that the 2016 version of the mental health survey included questions about trauma-informed care and housing instability. Only 66 percent of respondents confirmed that the mental health assessment included questions about history of trauma, albeit 86 percent of respondents who had experienced trauma found that their trauma-related issues had been adequately addressed by mental health staff. As a component of its Transformation Plan, Advanced Health provided no-cost, full-day, training to all partnering organizations in Trauma-Informed Care, and since that time has been working to assure that ACE (Adverse Childhood Experience) assessment protocols are occurring throughout the system.

Advanced Health has long understood that Coos and Curry Counties suffer from housing shortages at all levels. The homeless population is disproportionate to other rural communities. The wait period for Section 8 Housing Vouchers for low-income families and seniors exceeds two years. No new Section 8 housing options have been developed in over two decades. By self-report, the local public housing authorities are understaffed, barely able to process and verify Section 8 housing eligibility and have had no time in which to develop any applications for HUD-supported housing. Children who have been taken into protective custody sometimes spend their first nights in custody with child service workers in hotel rooms because the community lacks adequate capacity in its foster care system. Finally, the medical community’s professional recruitment activities are placed in jeopardy when newly-recruited physicians and executive are unable to find suitable housing, regardless of cost. It has been commonly believed within the community that the housing shortage is a function of deficits in land, labor, and loans. Advanced Health believes that, to these deficits, one could also add leadership and laws (because ever-expanding regulatory and building codes are driving up the cost of new construction). (In California, one house of the legislature just approved a bill that would suspend some regulatory building and zoning codes in those communities that have high rates of homelessness.)

Advanced Health is determined to lend leadership to the community’s housing crisis, and is a major contributor to a proposed, long-overdue, and comprehensive Housing Needs Assessment Study. The study was modeled after one that was completed in Tillamook County in which the authors not only assessed needs but established sequential solutions and identified the resources to support each solution. In the development of our most recent Community Health Assessment (CHA), social determinants of health, including housing, are addressed. The Community Health Improvement Plan based on this new CHA will soon be forthcoming.
CAHPS: The CAHPS survey is limited due to its yearly cadence and limited sample of respondents but is a valuable source of information from our population of enrollees.

The CAHPS survey administered in 2014 (and released in 2015) found that only 51 percent of respondents confirmed that they had a regular dentist. This was of concern to Advanced Health and to Advantage Dental. During the intervening time, Advantage Dental worked to add dental capacity, both by opening a new clinic in Curry County, and by adding additional Providers to its panel. The CAHPS survey administered in early 2017 confirmed that the number of enrollees who could personally identify a regular dentist had increased by five percentage points, to 56 percent. 2018 CAHPS Banner Book data has not yet been analyzed.

Starting seven years ago, Advanced Health engaged in a continuing and concerted effort to reduce the rate of chronic and high dose opioid prescriptions. In the 2014 CAHPS survey, 71 percent of patients stated that their Providers counseled with them about reasons not to take these medications. By 2017, this value increased by twelve percentage points, to 83 percent. It was important to Advanced Health to not only reduce the number of opioid prescriptions, but to concurrently assist patients in understanding why they might want to avoid these medications. The strategy of asking and training physicians to take quality time to communicate with patients regarding prescription complications is working.

Community Advisory Councils: In February of 2016, Advanced Health retained the services of a Chief Transformation Officer, and assigned this individual, along with 1.0 additional FTE, the responsibility for better focusing, empowering, and engaging the two Community Advisory Councils (one each in Coos and Curry Counties). Although this resulted in a significant financial investment for Advanced Health, it is returning significant dividends in terms of providing consumers with a voice in the healthcare delivery system. The following are a series of representative activities that have been undertaken at the specific request and guidance of the Community Advisory Councils (CAC):

- The Coos County CAC, concerned by a series of recent suicides, recommended that call boxes be placed on the North Bend Bridge through which persons in distress could make emergency contact with suicide prevention experts. Advanced Health, in partnership with Coos Health and Wellness, purchased the call boxes and acquired needed clearances from the Oregon Department of Transportation and Oregon Historical Council.

- The Curry County CAC, also concerned by an elevated rate of suicide among youth and young adults, recommended that there be more suicide response recognition training in a diversity of settings. Advanced Health has provided
multiple Mental Health First Aid training sessions that were extremely well attended, and most CAC members also completed the training.

- The Curry County CAC conducted a survey of food banks and found there to be a paucity of fresh fruits and vegetables. Advanced Health responded by providing financial assistance to the Oregon Coast Community Action Agency to purchase a refrigerated truck, such that fresh produce could be transported and supplied to Curry County’s food banks. CAC members have met with Agricultural Extension staff to learn more about greenhouse and nutrition education options. Advanced Health will support these efforts.

- The Coos County CAC expressed concern about the number of disengaged adolescents, particularly those who are not faring well academically or involved in extracurricular school and community activities. Coos Health and Wellness worked with CAC members and external consultants to design a drop-in center that would appeal to these adolescents, and Advanced Health provided financial support for the drop-in center that opened in July 2017 and has shown continuous growth in the number of youths served.

- The Curry County CAC has engaged in strong lobbying and advocacy for a Peer Recovery Community model. While peer-delivered services exist in Gold Beach, they were not available in the population center of Brookings. Advanced Health has provided training for Peer Wellness Specialists and assisted in developing a peer-operated drop-in center in Brookings.

- Female members of the Coos County CAC, once they learned about the One Key Question program, asked that this program be adopted in all primary and obstetrical practices. Advanced Health made a mini-grant available to train Providers and prepare patient education materials to support the program. Advanced Health also made an incubator grant award to support this work in Curry County.

- Both CACs continue to express concern that information about the milieu of available social services is lacking in Coos and Curry Counties. Advanced Health became one of three partners funding the local 211 System and is bolstering that system with printed resource materials in Curry County.

**Performance Improvement Projects (PIPs):** Although many PIPs are not structured in ways that encourage or facilitate consumer input, several of Advanced Health’s PIPs have been used in this regard. For the Statewide PIP related to opioids, and in response to feedback from members experiencing chronic pain, Advanced Health has developed new community programs including a self-management support group called Life Skills for Long-Term Pain. This pilot program is led by an Advanced Health RN care manager with a BS in kinesiology,
who developed the curriculum in accordance with evidence-based practices and incorporating local resources.

Although not one of the four PIPs on which Advanced Health reports to OHA, Advanced Health’s Transformation Plan includes a PIP that is purposed on the integration of dental and Behavioral Health. Enrollees who participate in this program, most of whom are homeless, are given options to rate the program and make recommendations for improvement.

**South Coast Oral Health Coalition:** Advanced Health underwrites the cost of a contractor to lend leadership to the all-volunteer South Coast Oral Health Coalition (a division of the Oregon Oral Health Coalition). This Coalition completed an oral health needs assessment which combines the input of patients, oral health Providers, and cross-sector focus groups.

**Housing and Homelessness Coalitions:** Similarly, Advanced Health underwrites the cost of a contractor to lend leadership to housing and homelessness coalitions in both counties. Consumers are frequent participants at these coalition meetings and the various summits that have been convened by the coalitions – providing yet another opportunity for consumers’ voices to be heard.

**III.2 The CCO describes how it uses technology to deliver team-based care and other innovations.** Health care is facing rapid-fire change which requires broad reforms in healthcare delivery. Changing demographics, increasing rates of chronic disease, advances in medical science, health information technology’s ability to make care safer and more efficient, skyrocketing costs, and the short- and long-term impacts of the Patient Protection and Affordable Care Act (ACA) are all strong drivers for reform of the entire system. As the Institute for Healthcare Improvement established in 2007, improving healthcare delivery in the United States requires a focus in three areas, which has become known as the Triple Aim. As healthcare financing moves from volume-based to value-based payments, clinicians will be required to work in inter-professional teams, coordinate care across settings, utilize evidence-based practices to improve quality and patient safety, and promote greater efficiency in care delivery. Advanced Health’s healthcare system is responding by supporting these changes and incentivizing Providers to acquire new competencies and work more closely together than before.

One way in which Advanced Health has responded has been in the implementation of its predictive risk stratification and population health tool in collaboration with Milliman. The PRM Analytics Care Coordinator Reports are available to all Advanced Health PCPs and their designated care managers. In a working model of team-based care, every member of the team will be working at the top of his or her license. This means that physicians don’t perform functions for which nurses have been trained, and nurses don’t perform functions for which medical assistants have
been trained. Yet each of these, physician, nurse, and medical assistant is a valued member of the healthcare team with very specific functions to perform. Advanced Health has supported practices in creating panel manager/care manager positions as integral members of the primary healthcare team. Panel managers, in turn, are charged with consulting the predictive risk stratification software regularly for a multiplicity of purposes: identifying patients who should be scheduled for visits but who are not scheduled, identifying gaps in preventive care, and seeing what other Providers are involved in the patient’s care. This information is then communicated by the panel manager to the Primary Care Provider and is particularly helpful in helping to focus encounters for patients scheduled that day or in reaching out to members. Advanced Health has also supported the implementation of PreManage to assist in identifying members needing follow up after an emergency department visit or to record a care recommendation for members with frequent ED visits.

Today’s new models of healthcare delivery are driven by health quality metrics. To collect needed data, Providers have invested in electronic medical records, while organizations, such as Advanced Health, have invested in population health tools for the purposes of documentation, billing, data aggregation, identifying high-cost or high-risk patients, and tracking quality metrics that provide feedback to Providers. These efforts are purposed at absorbing the costs and processes of documentation, thereby permitting the physician to work at the top of his or her license. When implemented in a team-based setting, Provider satisfaction improves, Provider retention improves, and Provider burn-out is diminished. Early after the implementation of the CCO quality metrics, Advanced Health realized that none of the meaningful-use-certified electronic health records (EHR) were able to successfully report the electronic clinical quality metrics (eCQMs). Advanced Health partnered with Milliman to extract the necessary data from the EHR to both meet the reporting requirements and give timely, accurate, actionable data to Providers. The Care Coordinator Reports allow Providers to pull “gap lists” of patients missing needed care so that they may do targeted outreach.

Another effective intervention that Advanced Health has provided is its Innovation Incubator Grant Program. Under this program, delegates, contractors, and Providers can request financial assistance to undertake innovative ideas without having to bear one hundred percent of the costs and risks alone. Through these Innovation Incubator projects, Advanced Health has provided support for new programs including panel managers, case managers, and health psychologists. Advanced Health has partnered with its network to provide community paramedicine and home visiting, drop-in centers for disenfranchised youth, Provider recruitment strategies, focused outreach activities to persons who are homeless, and programs designed to reduce hospital re-admissions, among many others. Each funded project must identify clearly articulated and measurable outcome objectives that align with quality measures. Advanced Health requires that funds also be invested by the applicant, and that successful projects develop sustainability plans.
III.3 The CCO describes procedures to ensure that enrollees with special health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health. In its first several years as a certified CCO, Advanced Health made the evidence-based self-management educational curriculum, Living Well, available to all enrollees, upon referral, who were living with chronic disease states. Despite using instructors who were certified by Living Well, and closely following the evidence-based instructor's manual and participant's text books, the program failed. Fully 80 percent of program participants dropped out after the first or second session, and there were very few program completers. Concerned, Advanced Health undertook a survey of former participants and learned that participants had little appetite for a program that was delivered in a classroom setting, complete with text books, work sheets, and homework. Since that time, Advanced Health has instituted other evidence-based self-management programs, including DEEP: Diabetes Education and Empowerment Program, and is piloting Life Skills for Long-Term Pain—a program developed in-house but based on other evidence-based principles of self-management programs. These have been very well received by our members, as they incorporate much more hands-on, experiential activities. Our DEEP nurse instructor has now demonstrated success with several cohorts, and after seeing our success, several local clinics will begin offering the program soon.

In addition to our own offerings, Advanced Health has historically partnered with other community programs. Bay Area Hospital offers an array of patient education programs through its Community Education Center. The monthly list of programs is published on Advanced Health’s web site, and all programs are made available to Advanced Health’s members at no cost. A representative sample of educational programs available in June and July 2018, includes:

- Maternity and Well Baby Classes and Breastfeeding Support
- Support and Educational Groups for Those Undergoing Dialysis
- Diabetes Education
- Pre-Op Classes, including: “Moving Forward,” for those having joint replacement surgery
- Cancer Treatment Support and Education Groups
- Depression and Anxiety Support Group (Also Available at the Devereux Center)
- Stop Tobacco Use
- Parkinson’s Support and Education Group
- Bariatric Surgery Support and Education Group
- Stroke Support and Education Group
- Multiple Sclerosis Support and Education Group
- Alzheimer's and Dementia Education and Support Group
- *Darkness to Light* Stewards of Children Education and Support Group
• Body Awareness (A gentle exercise class to assist in relaxation, muscle strengthening and toning, and improved balance and posture)
• Didgeridoo Club (for people with lung disorders)

Our Health Eating Active Living group has hosted nutrition classes for those on a limited income and for healthy foods that fight inflammation, in conjunction with the Oregon State University Extension office and let by a registered dietician. This was very well received and attended by most of the consumer members of our CAC.

Coos Health and Wellness’ Peer Support Program also offers a modified Living Well program that is tailored to the unique needs and interests of persons who are living with chronic and persistent mental illness. The program addresses chronic disease states, both physical and mental and operates as a slow-open group – meaning that there is no formal start date or end date. Enrollees may enter the program at any point and exit the program when they have taken from it what they want. This program is exceptionally well attended.

III.4 The CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network. At the highest governance levels within the organization, there is a commitment to diversity. Advanced Health’s board of directors has sought to include members of diverse racial and ethnic groups as well as a consumer member.

At the leadership level, Advanced Health’s Chief Transformation Officer has helped the organization maintain a focus on culturally and linguistically appropriate care. Advanced Health has sought to educate our workforce on ethnic disparities, trauma-informed practices, the culture of poverty, diverse linguistic and cultural needs, and the overt practice of cultural humility. By consistently working in this way, the organization has raised awareness of culturally relevant and linguistically appropriate needs which, in turn, has spawned needed service improvements.

Within Advanced Health’s physician network, there are multiple bilingual Providers who speak a range of foreign languages: Nepali (1); Hindi (1); Spanish (5); German (2); and, Russian (1). All enrollees who speak a foreign language are offered the option of being assigned to a Primary Care Provider who speaks their native language, if that language is represented among the panel of Providers. If the patient’s native language is not represented by a member of Advanced Health’s panel, then telephone interpretive services are made available.

Within the mental health and addiction treatment system, there is a single therapist who is fluent in Spanish, and a second who is fluent in American Sign Language. The individual who is fluent in American Sign Language is available on
an “on call” basis to accompany enrollees to medical appointments, when requested. There is no foreign language capability within Advantage Dental’s Provider panel. Although Advanced Health offset all costs associated with training two certified Spanish Language Interpreters, one has since moved from the community and only one remains in Coos County. Curry Community Health retains the services of a second certified Spanish Language Interpreter to meet the needs of that community. In addition, Advanced Health contracts with the local Education Service District for additional interpreters and American Sign Language professionals. Essential patient documents are available in Spanish, and for those who are visually impaired, in large type and audio recording.

In 2016, Advanced Health requested equity consultation and technical assistance through the Transformation Center and OHA’s Office of Equity and Inclusion who, in turn, provided the services of Ignatius Bau. Advanced Health was originally presented with an Excel spreadsheet that provided raw data, dichotomized by ethnicity, for a variety of the variables surveyed through the CAHPS process or included in metric performance measures. Advanced Health extracted this raw data and conducted statistical tests to determine if there were any significant differences among the racial and ethnic classifications of enrollees for each variable. There were no significant differences. Nonetheless, there were a handful of “apparent disparities,” (e.g., circumstances under which the trend line for persons of racial and ethnic minority status are somewhat less favorable than for the population as a whole): (1) Rates for SBIRT positive screens of Asian members and those who reside in Spanish-speaking households; (2) Elevated rates for hospital emergency department utilization by African-American enrollees; and, (3) Rates for dental sealants among children from Spanish-speaking households. Of note, for two of these variables, the rates are not elevated for all persons of Hispanic origin, but only for those from Spanish-speaking households, suggesting that a language barrier may be interfering with both the SBIRT and dental sealant processes. See section II.1 above for additional discussion of considerations for culturally and linguistically appropriate services for all enrollees, including those with special healthcare needs.

IV. Coordination of Care

IV.1 The CCO describes relationships (including any memoranda of understanding) with: and

IV.2 The CCO discusses coordination with the following stakeholders:

Aging and Persons with Disabilities: In June 2016, Advanced Health (then WOAH) and the regional office of Aging and Persons with Disabilities (APD) renewed their longstanding Memorandum of Understanding (MOU) for care coordination with Long-Term Care (LTC) members for the performance period July 1, 2016 through June 30, 2017. Unlike the previous MOUs negotiated between the
parties, that MOU included a clearly established schedule of case conference meetings along with a handful of performance indicators. On September 30, 2016, the local APD supervisor contacted Advanced Health and asked if it would be possible to discontinue the every-other-month case conference sessions, because APD personnel were: (1) huddling every weekday morning at Bay Area Hospital (BAH) to discuss cases in common with both Advanced Health and BAH; and, (2) meeting monthly at Advanced Health in the Care Management Committee with a wide variety of community-based case managers. This seemed a reasonable request and on October 5, 2016, the parties agreed to modify the MOU by attaching a copy of an email chain between the parties.

In March 2018, Advanced Health began to discuss proposed changes to become effective July 1, 2018. That MOU is complete and reflects current practice. The changes were not substantive overall and included change in reporting requirement and language identifying enrollees as having “Long-Term Services and Supports” (LTSS), which was previously described as enrollees in “Long-Term Care” (LTC).

Local Public and Mental Health Authorities: In 2011, the local public health and mental health authorities in Coos County were merged into a single entity, then-titled Coos County Public Health and Mental Health. In 2015, the name was changed to Coos Health and Wellness. Ms. Ginger Swan, MS, LPC, serves as the director of Coos Health and Wellness, while David Geels, MA, LMFT, serves as the manager of Behavioral Health services, and Ms. Florence Pourtal-Stevens, MPH, serves as the manager of public health services. The board of Coos County Commissioners retain status as the official public health and mental health authorities, and one county commissioner, Ms. Melissa Cribbins, serves on Advanced Health’s governing board.

In Curry County, in 2012, the board of county commissioners surrendered control over local public health and mental health programs to the State of Oregon, who in turn, contracted with a newly-emerged, private, not-for-profit corporation, Curry Community Health, for the provision of local public health and mental health services. Curry Community Health acts as the local health authority in Curry County. Mr. Kenneth Dukek serves as the chief executive officer and represents the interests of Curry County public health and mental health on Advanced Health’s board of directors. Ms. Erin Porter, MS, LCSW, is the director of Behavioral Health services. Public health services are limited to those mandated by rule, or for which State funding is available, and include maternal-child health, contagion control, vital statistics, and oversight of public health emergency reporting. Although Curry Community Health also provides primary care services at its Brookings location.

Advanced Health has entered into substantial and formal contractual agreements with both Coos Health and Wellness and Curry Community Health, and delegates to each certain responsibilities to administer, oversee, and provide mental health
services. The working relationships between the parties is excellent. Care coordination, communication patterns, and feedback loops are open and fluid, and begin at the governance level where all parties are represented. The members of Advanced Health’s executive team are in near-daily contact with Coos Health and Wellness and Curry Community Health. Advanced Health convenes regular monthly meetings with its delegates and major Provider groups for the purposes of networking, information-sharing, quality improvement, and compliance in-service training. Curry Community Health and Coos Health and Wellness are fastidious in their attendance at these meetings and assume leadership roles and provide content expertise. This working relationship has been facilitated since the completion of the new Coos Health and Wellness building, which is on the same lot as Advanced Health’s offices. This completes a vision of a social services campus with Oregon Coast Community Action (a local social supports program), South Coast Head Start, the South Coast Regional Early Learning Hub, South Coast Food Share (supporting food pantries throughout the region), and Coos County CASA (Court-Appointed Special Advocates).

At the service delivery level, the manager of Advanced Health’s case management program, Yvette Grabow, RN, convenes regularly monthly meetings of all community-based case managers, including those affiliated with local public health and mental health programs, and assumes responsibility for the inter-agency coordination of these individuals. She and her team also participate in case conferences at local public health and mental health locations throughout the community, whenever the case conference pertains to a health-related issue for an Advanced Health member.

Advanced Health has been a willing partner to address identified needs within the local public health departments, often offering moderate grant assistance to offset the costs of certain health education and promotion, or providing community-wide in-service training on such topics as the social determinants of health, trauma-informed practices, or bridges out of poverty.

In the past, Advanced Health contracted with the local public health agencies to provide significant technical assistance in the development of the Community Health Assessment. As a result, Advanced Health’s Community Health Assessment mirrored the mandatory health assessment protocols that local public health agencies are required to develop. In turn, the Community Health Improvement Plans tended to focus primarily on matters of public health concern. Advanced Health has recently completed work on Community Health Assessments that will fall due in March of 2018. Development was done in cooperation with representatives from all sectors that are required to engage in community health assessing (i.e., four hospitals; two federally qualified health centers; two public health agencies; two local mental health authorities; two mental health advisory committees; two public health boards; a single coordinated care organization; a local
Indian Health Services Clinic, and the Local Alcohol and Drug Planning Committee). An extensive spreadsheet was developed detailing the requirements for the needs assessments that each entity type is obligated to perform, and consensus was reached regarding the points of intersection. A consultant was retained by the involved groups to assist in the production of the assessments for both Coos and Curry counties. Through these efforts, Advanced Health not only played a leadership role in coordinating the community health assessment process but is relieving local public health agencies and small rural hospitals of significant financial and social capital burdens.

**Indian Health Services and/or Tribal Clinics:** In 2014, the Coquille Indian Tribe’s Tribal Health Clinic approached Advanced Health (then WOAH), asking for assistance in accessing WOAH’s panel of medical specialty Providers. WOAH believed that the simplest way to assist the Tribe would be to broker an agreement between the Tribe and the multi-specialty practice located at North Bend Medical Center (NBMC). However, when officials with NBMC reviewed the required contractual addenda that has been prepared by personnel at OHA who oversee Tribal 638 and Indian Health Services programs, NBMC balked. To that end, WOAH provided a draft agreement to the Coquille Indian Tribe, using language common to all WOAH’s Provider services agreements. Under the proposed agreement: American Indians who chose to join the CCO could do so; the Tribal Health Clinic would serve as the Primary Care Provider for all Native Americans, unless they elected otherwise; and Tribal members would have access, through their Primary Care Provider, to medical specialty services. The draft contract was passed back-and-forth between the attorneys for both entities, with the Tribal 638 mandatory addenda serving as the major stumbling block between the parties. Frustrated, any attempts at a contractual solution became stalled in mid-2015.

In May 2016, Coos County Commissioner Melissa Cribbins, who previously served as the attorney-of-record for the Coquille Tribe, approached WOAH with a plea to assist the Indian Health Service Clinic in accessing medical specialty services. An initial meeting was promptly convened with Commissioner Cribbins, the director of the Indian Health Clinic, and WOAH’s executives. The parties amicably and rapidly came to consensus about how a working agreement could be structured, with Tribal officials expressing extreme willingness to abandon some of the language included in OHA’s mandatory contractual addenda for Tribal contracts. The parties agreed that, rather than passing a contractual document back-and-forth between their attorneys, that the attorneys would meet, work from scratch, and jointly and collaboratively develop the contractual agreement. That work was completed, but WOAH was advised by operations officials at OHA that it could not enter into a contractual agreement with the Tribal Clinic until OHA had reviewed the document and taken certain other (poorly understood by WOAH) steps to establish enrollment and authorization processes. The contractual agreement was been stalled at OHA for many months. In 2017, Advanced Health was finally able
to execute a contract with the tribal clinic. At this time, patients at the clinic are asked if they wish to enroll in the CCO and assisted by the clinic in doing so. We have had an excellent working relationship so far, although the number of enrollees has been small. The Indian Health Service Clinic reports no access barriers to dental services and uses the services of Coos Health and Wellness for Behavioral Health referrals. The director at Coos Health and Wellness is a member of the Cherokee Nation and has designed traditional healing programs that are syntonic to Tribal members.

IV.3 The CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmissions and emergency department usage.

Interdisciplinary care teams exist in several practice settings within Advanced Health’s service delivery network: North Bend Medical Center; Coast Community Health Center; and Waterfall Community Health Center. In these three settings, that collectively serve approximately of 60% of Advanced Health enrollees, Primary Care Providers are paired with Behavioral Health specialists and use a seamless warm hand-off system to achieve care integration and coordination. The North Bend Medical Center integrated Behavioral Health program is led by a PhD psychologist trained in integrated Behavioral Health and includes an LCSW and two MSW counselors working toward their LCSW. Waterfall and Coast Community Health Centers are staffed by licensed professional counselors and LCSWs.

Case managers, care coordinators, panel managers, and in some circumstances, navigators, school nurses, and discharge planners (hereafter, simply referred to as case managers), are employed throughout the greater medical and social services community. Medically-related case managers are employed at Bay Area Hospital, Coquille Valley Hospital, Curry General Hospital, Southern Coos Hospital, Bay Clinic, North Bend Medical Center, Curry Health Network, Coast Community Health Center, Waterfall Community Health Center, South Coast Orthopedics, Bright Eyes Midwifery, South Coast Educational Service District, ADAPT, Coos Health and Wellness, and Curry Community Health. Non-medical case managers are employed by DHS child protective services, DHS Aging and Persons with Disabilities, Oregon Coast Community Action (that operates Head Start and the local Regional Early Learning Hub), Coos and Curry County Juvenile Justice, Coos and Curry County Adult Probation and Parole, South Coast Educational Service District, and the Student Support Services Team at Southwestern Oregon Community College.

In turn, Advanced Health retains the services of three case management nurses, one case management licensed professional, and two community health workers (four of whom serve Coos County, and two of whom serve Curry County). This team
of Super Case Managers accepts referrals from all other community-based case managers and serves those enrollees for whom the efforts of community-based case managers have been unsuccessful. The manager of Advanced Health’s case management program, Yvette Grabow, RN, convenes regularly monthly meetings of all community-based case managers, and assumes responsibility for the inter-agency and interdisciplinary coordination of these individuals. She and her team also participate in case conferences at locations throughout the community, whenever the case conference pertains to a health-related issue for an Advanced Health member. In Southwestern Oregon, as in most communities, staff shortages within educational systems and skilled care facilities, increased demand for services created by expanded enrollment under the Affordable Care Act and a locally aging population, and patient acuity and complexity, have created situations in which community-based care managers have limited experience to contribute to challenges in achieving care coordination across the continuum of care. For this reason and over the years, Ms. Grabow and her team have become the community’s “go-to” professionals for the most challenging and irretractable of cases. It is within this context that enrollee needs for care coordination, continuity of care, and transitions between levels of care, are contemplated, assessed, and implemented.

Advanced Health’s Case Management Team plans, communicates, and delivers the most appropriate interdisciplinary care coordination by collaborating with enrollees, members of their families, advocates, other care Providers, medical and behavioral specialists, and Primary Care Providers. Using their broad understanding of available community resources, Advanced Health’s Case Management Team implements the plan of care to meet enrollee needs appropriately. A continuous process of monitoring, re-assessment, and evaluation of outcomes informs timely future decisions regarding next steps in continuity of care and transitions in care. Advanced Health considers its interdisciplinary care coordination strategies to be adequate to reduce hospital re-admission, as evidenced by our re-admission rates which consistently meet the state benchmark.

Efforts to reduce emergency room utilization include providing direct financial underwriting for after-hour urgent care clinics operated by Bay Clinic and North Bend Medical Center. However, emergency room utilization rates have been more difficult to impact. Our local hospitals have sought to advertise low wait times to attract more non-emergent visits, and our local urgent care clinics have been more likely than most to divert patients to the emergency department. Advanced Health has implemented PreManage and is supporting our local clinics in doing this also. Bay Clinic and North Bend Medical Center are focusing on reducing emergency room visits also as part of CPC+. Advanced Health has also adopted a new Performance Improvement Project (PIP) to work on reducing unnecessary emergency department utilization. Advanced Health feels that the teams are in place to do the needed work, the tools are getting developed, but that the processes we use could still benefit from improvement.
IV.4 The CCO describes its process for identifying and assessing all enrollees for special health care needs. Advanced Health’s care management team utilizes a basic needs assessment that addresses needs such as housing, food, transportation, physical health, Behavioral Health, and oral health. Members who have multiple healthcare needs, multiple chronic conditions, mental illness, or substance use disorders, and members experiencing health disparities or barriers to care are prioritized to receive intensive case management (ICM) or care coordination services. An individualized care plan is developed for those members agreeing to receive ICM services. This care plan takes into consideration cultural and linguistic considerations, social determinants of health, and barriers that may exist to optimal health or accessing clinically appropriate services. The care team at Advanced Health works closely with care management teams across the community and continuum of care, as many enrollees with special healthcare needs have a pre-existing relationship with care managers in mental health, Aging and People with Disabilities, case managers affiliated with the PCPCH, etc. The care manager with the existing successful relationship with the enrollee typically remains as that enrollee’s primary contact and advocate.

Advanced Health also equips our PCPs with the Milliman PRM Analytics risk stratification tool. This tool is used both by CCO staff and PCPs and staff to easily identify those enrollees most at risk of hospitalization, emergency department utilization, or avoidable costs in the form of exacerbations of ambulatory care sensitive conditions. In addition to providing the CCO with an overview of our population or the PCP an overview of her panel, the tool provides patient-specific information, including likelihood of hospitalization or ER use in the next 6 months, history of utilization from all Providers (except substance use disorder treatment), medication fill history, and avoidable costs (such as from preventable emergency department utilization.) The tool also identifies gaps in care, such as screenings, tobacco cessation, and other quality activities that are due. The biggest limitation of the tool is that it is based largely on claims information, so is of limited benefit when an enrollee is new to the CCO. It does, however, create a continuous three year look back, even when eligibility has been interrupted for a period.

In addition to these tools, Advanced Health uses every authorization review as an opportunity to coordinate care and identify enrollees with special healthcare needs. Utilization review staff are trained to notice if referrals are coming from a Provider that is not the PCP of record (to correct and coordinate when needed), if multiple specialists are seeing a member without coordination of care, if PCPs are having difficulty accessing necessary services for a member, or if there appears to be under- or over-utilization of services. The Advanced Health utilization review staff frequently make referrals to ICM services.
Advanced Health customer service representatives are also trained to identify and assist enrollees with special healthcare needs. They are familiar with local services, work to assist local care managers in partner organizations, and are tireless patient advocates. They utilize the Grievance and Appeals system to identify barriers to care and enrollee needs that are not being met and find ways to meet them. They assist enrollees in “telling the story” when they experience a barrier or make an appeal, and they refer frequently to ICM. To complement this culture of service, the Nurse Health Services Coordinator (HSC) sits side-by-side with the customer service representatives to provide input using her nursing and case management background. The HSC is also an ACES Master Trainer and all customer service representatives have received training in health literacy, trauma-informed practices, the impacts of poverty, and culturally and linguistically appropriate care.

IV.5 The CCO describes how it uses electronic health records to coordinate health care, including preventive health care, for all enrollees across the continuum of care. While most of Advanced Health’s medical, dental, and Behavioral Health Providers are using some form of electronic health record, they are not using the same system, and thus interoperability among systems is limited. Some entities have invested heavily in state-of-the-art electronic health record systems, such as EPIC, while others are working with systems that are far less robust. A community-wide work group was convened by Bay Area Hospital and has been working for over a year on a community-wide solution. When Bay Area Hospital replaces its Electronic Health Record (EHR), the goal is that most of our community Providers will join in moving to the same platform. Obviously, this will come at substantial expense and require significant work to achieve. Advanced Health has participated throughout the process with the goal of helping to support a unified record for the community.

Knowing that a single EHR across all community Providers would be a long way away, Advanced Health (then WOAH) established a subsidiary named South Coast Oregon Technology Innovations as an entity to promote tools for health information exchange (HIE). While the community was still wary after a failed attempt at an HIE, Advanced Health was able to implement a project which became the Milliman PRM Analytic platform. Originally envisioned to include information about all patients seen by all entities represented in the CCO, Advanced Health eventually had to scale back plans and include only our OHP enrollee claims data. While we still envision a future state where all patients of our CCO partner entities could be represented, we have enjoyed the capability it provides to identify enrollees at risk of avoidable exacerbations of disease, to identify common high-risk conditions, to collect information about care across the continuum of Providers, and to identify opportunities for screenings and quality measures. Our three largest PCPCH clinics—North Bend Medical Center, Bay Clinic, and Waterfall Clinic—also provide an interface to their EHR that populates electronic clinical quality measures (eCQMs). These are updated with clinical data every two weeks and provide
individual patient data that is actionable for clinicians. We have discovered that this is much more advanced reporting than any other CCO has been able to produce.

Going forward, as Advanced Health engages in data aggregation with other Oregon payers in the CPC+ program, we may find that the Milliman solution becomes obsolete, or that it cannot support the costs of both the Milliman tool and a shared data aggregation system with other payers. At the same time, as the community continues to move in a forward decision-making direction regarding the potential implementation of a community EHR, it may be found that our current ability to report eCQMs and risk-stratify patients is better than that of other vendors.

V. Performance on Metrics

V.1 The CCO describes its efforts to build network capacity for those metrics where the CCO’s performance is below baseline. OHA’s 2017 Final Metrics Report was released only several days ago. Advanced Health met only 11 of the 17 possible performance metrics, and all three of the challenge pool metrics. This was a huge disappointment, as we have received over 100% of our quality funds each year since the inception of the program. The metrics that were not met are as follows:

- Emergency Department Utilization, attaining a value of 53.0/1000 mm against a target of 52.8/1000 mm, reflecting 55 visits over the target with a total numerator of 11,905;

- Timely prenatal care, missed by 1 member out of 256, for a rate of 90.6% under the target of 91%;

- Controlling High Blood Pressure, attaining a score of 64.7% against a target of 65.2%, reflecting 10 patients;

- Diabetes Poor Control, with 25.8% of patients not controlled, above the goal of 22.8% (reflecting 30 patients)

- CAHPS Access to Care, at 83.9%, compared to a statewide average of 83.1% and the benchmark of 86.5%;

- CAHPS Satisfaction with Care at 84.6%, below the target of 87.3%;

The Satisfaction with Care metric does not measure enrollee satisfaction with the care they receive, but rather “Always” or “Usually” answers to the question: “How often, when you call your health plan, are you treated with respect?” This score is based on the answers of a sample of about 300 adults and the parents of about 300
children. It is not known how many of those surveyed called our CCO; many of them called state enrollment hotlines and were required to hold for excessive times, or they may have based their answer on their experience with other state agencies. Nevertheless, our score reflects a consistently high performance that is within the usual statistical margin of error—essentially the same as previous years. Only half of the CCOs met this metric, consistent with normal statistical variation around a stable, high-performing rate. We want our enrollees to feel that they are always treated with respect and have engaged our customer service team in extensive training over the years, including trauma-informed practices, health literacy, and the cultural effects of poverty.

CAHPS Access to Care also reflects expected statistical variation. Our entire medical community has worked to expand the number of medical professionals available in the region, but we experienced some Provider retirements around the time of the survey. As noted previously, our entire medical community, with very few exceptions, participate in the care of OHP enrollees. Access for our members is routinely better than for others in the community. Still, Advanced Health has maintained a focus area in our Coos County Community Health Improvement Plan around improving access by promoting team-based care. Advanced Health utilizes value-based payments incentivizing PCPs to reduce access complaints and accept substantial patient panels. All our ongoing monitoring is showing improvement in access since 2015, when the full effects of increased demand from the ACA expansion were seen.

We feel that the Diabetes Poor Control measure and Hypertension Control measure were true missed opportunities. Waterfall Community Health Center participated in the Health Hearts Northwest (H2N) initiative but had significant staff turnover and gains from the previous year were lost. Workflows like those promoted by (H2N) were adopted by some practices at NBMC, which showed significant improvement, but not enough to meet the CCO target. Although we fell 10 members short of the goal, 15 members had a blood pressure of 140/90 exactly, and were not rechecked to see if it would fall below. Offices that have embraced the new workflow of rechecking all elevated blood pressures are now seeing substantial improvements. North Bend Medical Center care managers created diabetes standing orders to address missed opportunities, but this met with significant Provider resistance throughout the year. Standing orders were ultimately adopted, but despite this, the clinic had over 50 patients with controlled HgA1cs in 2016, but who were never tested in 2017. Analysis suggests that many of these patients were diet controlled. Twenty-five patients had HgA1cs over 9 before September 2017 but were not retested. Standing orders have now been adopted, and we believe that we will improve in 2018.

The Timely Prenatal Care metric is an example of a metric that has likely reached peak performance. Of the 256 women that met the denominator requirements, 24
missed care in the first trimester. Of these, on chart review it was found that 7 had a visit within 2 weeks of the end of their first trimester. Two were seen for substance use treatment in their first trimester but were unaware that they were pregnant at the time. Five were enrolled during their entire first trimester, but lost eligibility in the second trimester, re-enrolled, and had care within 42 days of re-enrollment. Several were documented at delivery as having no prenatal care due to substance use issues or previous involvement with DHS. One reported that she’d previously had healthy pregnancies, so didn’t think early prenatal care would be important for her. Advanced Health provided testimony to the Metrics and Scoring Committee about setting appropriate benchmarks for measures where CCOs are performing well, but consistently scoring 100% is not realistic. Inappropriately high benchmarks risk losing Provider support and increase burnout when Providers feel that they are held to an unreasonable standard. Still, we are working to capture those last few women in the first trimester. First, all the OB offices need to treat the initial prenatal visit as urgent. Second, we are recommending to ADAPT that women being treated for SUD be screened for pregnancy when they are screened for drugs of abuse and counseled using One Key Question. One Key Question is already in use in most PCP offices, so we plan to change our “Pregnancy notification form” to a guide for PCPs to accomplish an initial prenatal visit with risk screening, basic counseling, establishment of due date, and warm handoff to the maternity care Provider on the date of a positive pregnancy test.

Emergency Department utilization has been a difficult metric for us to tackle. First, the OHA data has been unreliable. It is presented as a 12-month rolling look-back with a 5-month lag for claims runout, and no dates of service are provided for data validation throughout the year. When Advanced Health realized that we were 55 visits away from the target, we used the dates of service provided by during the month of data validation and identified that at least 80 (likely many more) visits spanning midnight had been counted twice, although there was only one visit in the medical record and only one claim. Even though this method of counting does not conform to HEDIS specifications, we were told that OHA is unwilling to change its method of calculation. In 2015, our ED utilization rate had been trending above the target, but then suddenly dropped precipitously. We immediately notified OHA that we thought there was an error and offered to work with them to identify the problem. We also asked that the falsely low rate not be published as our actual score, but we were told that the results were final. This kind of unreliable data makes it impossible to determine real change.

Advanced Health supports extended after-hours urgent care clinics in Coos Bay and North Bend. Both Coast and Waterfall Community Health Center provided non-traditional clinic hours, for both walk-ins and scheduled appointments, during the evening and on Saturday. Most of our patients are seen in Patient-Centered Primary Care Homes (PCPCH), and these practices join with practices planning to certify as PCPCH in a monthly workgroup convened by Advanced Health staff.
There is significant focus on access to care, including urgent appointments and follow up after emergency department utilization. Despite all these interventions, we have not seen meaningful reductions in ED utilization. Advanced Health has not directly incentivized PCPs who have low rates of ED utilization in their panels, as we found that these rates were almost entirely correlated with the medical complexity of the panel. There was no incentive that did not run the risk of encouraging Providers to drop high-utilizing members from their panels. Instead, we have incentivized Providers to maintain low rates of access complaints, PCPCH status, cross-coverage of patients when the Provider is away, and education of patients regarding what constitutes an emergency. We have supported to programs to increase case management, integrated Behavioral Health, team-based care, and all the processes that correlate with lower ED utilization. Unfortunately, we do not have the cooperation of our largest hospital. Although Bay Area Hospital is paid by capitation and does not benefit financially from increased numbers of visits from our members, they have had a consistent strategy of encouraging use of the ED for urgent, but non-emergent care. The emergency medicine group, California Emergency Physicians, is paid on a fee-for-service basis that encourages increased utilization, and they have been unwilling to enter a value-based payment that encourages follow-up with the PCP instead of in the ED.

V.2 The CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization. The OHA Quality Measures, both the incentive and the non-incentive measures, provide a method to compare and benchmark on several utilization measures. While Advanced Health has emergency department utilization above the state average, it also has a higher percentage of enrollees who are disabled, older, or have chronic health conditions. The HEDIS ambulatory care outpatient utilization provides a balancing measure, in which we see that Advanced Health enrollees also use other outpatient services (e.g. office visits) at rates higher than the state average, suggesting lack of outpatient access is not the reason for the rate of ED utilization. Also, avoidable ED visits are, proportionately, much closer to the state average than ED visits overall. Advanced Health scores above state averages on adolescent well care, SBIRT screening, childhood immunization, dental sealants, developmental screening, effective contraception use, follow-up after mental health hospitalization, and well child visits. We have actively worked with our community partners to improve all of these.

With regards to dental services, preventative care is overutilized in proportion to restorative care, which is a goal, but also reduces time available for restorative treatments. Advantage Dental is working to improve access by rolling out a risk stratification and prioritization model for use in its dental practices. If the model is successful, and there is every reason to believe that it will be, Advantage Dental will achieve greater balance between preventative and restorative care.
With regards to Behavioral Health services, it is undeniable that addiction treatment services are underutilized. A comparison of numbers of enrollees with substance use disorder diagnoses ($N = 1,844$) is substantially higher than the number of enrollees entering substance use disorder treatment. When Advanced Health re-negotiated its delegation contract with ADAPT for addiction treatment services in February 2016, it included performance improvement language focused on increasing the numbers of patients receiving substance use disorder treatment. For the non-incentive metric, *Initiation of Alcohol or Other Drug Treatment*, ADAPT attained a score for calendar year 2016 of 37.9 percent, which was down nearly two percentage points from the 2015 score of 39.7 percent, although the score was spot-on with Oregon's mean score for CCOs. For the non-incentive metric, *Engagement in Alcohol or Other Drug Treatment*, ADAPT's score for 2016 was 13.2 percent, down significantly from its 2015 score of 22.7 percent. This means that, of all enrollees who presented at ADAPT for an initial assessment, only 13.2 percent kept two or more visits within the next thirty days. None of Oregon's CCOs are performing well on this metric: only two CCOs demonstrated improvement, and for them the rates remained relatively low at 15.8 and 16 percent, respectively. 2017 data are not yet available. Because this is not an incentive measure, OHA has not focused on the details of what this represents. (Details of how the data is collected are important. For example, in 2013, we were told that only about 35% of our enrollees were receiving timely prenatal care. This was because the claims-based measure at the time excluded women whose services were billed as part of a complete OB package, and therefore focused only on women who had changed Providers or had incomplete care. Subsequent iterations of the measure specifications came closer and closer to the true experience of our members, until in 2016, chart review data with reliable due dates showed that 92% of women received timely care, despite no real change in access in our Provider network. Similarly, OHA touted that “only 35% of women of childbearing age were using effective contraception,” when this number represented the percent of women who had a visit to a Provider for the express purpose of receiving contraception in that year. This number failed to represent the large number of women who had previously chosen permanent sterilization or long-acting reversible contraception (LARC) that had been placed in a prior year.) It is possible that an increased number of people are being diagnosed with risky use of substances through the SBIRT screening process, while not meeting the definition of substance use disorder, nor the need for specialty care. We feel further analysis of this problem is needed.

Advanced Health does recognize that we have not had adequate resources to treat opioid use disorder, leading us to support the development of the Opioid Treatment Program (OTP). We feel this will substantially improve access to treatment for those abusing opioids. Advanced Health also houses the Prescription Drug Overdose Prevention Coordinator, who works with multiple community stakeholders to reduce harms from prescription opioids, ensure access to treatments and rescue agents, and to improve community capacity to respond to the opioid
We have also participated in a four CCO collaborative PIP to reduce the prescribing of high doses of opioids. We will also partner to institute a program of peer supports in the ED to improve connections to treatment after opioid overdose. The OTP and related activities, however, does not address the primary substances of abuse in our region, which are alcohol and stimulants. Methamphetamine remains the major drug of choice other than alcohol, and Oregon public health data show stimulant-related deaths on the rise statewide. We will continue to watch for best practices to reduce stimulant abuse and death.

Monitoring of Hepatitis C treatment shows that there is still underutilization of treatment with direct-acting antivirals due to a combination of limited access to gastroenterology specialists and members not optimized for treatment. Advanced Health employs a care manager focused on Hepatitis C, and she has improved care overall for our members with the disease. However, we still have several members who have not attempted to access treatment.

Use of the Milliman PRM Analytic tool allows Advanced Health to identify members with patterns of overutilization of ED services and/or underutilization of PCP services. One click will identify all enrollees that have not had a visit with their current PCP of record in the calendar year. One click will identify frequent ED users, as well as the confluence of the two. The uses of the tool are described in multiple sections above.

In addition to these tools, Advanced Health is growing a robust analytics department that provide detailed analysis of many types of utilization. Use of Tableau software allows many users to easily visualize utilization data to determine where to institute controls to limit overutilization and where services may be underutilized. This allows us to intervene at the appropriate level to ensure the most appropriate utilization of limited resources in order to get the best possible health outcomes.

Advanced Health has developed a robust collection of strategies to address both under- and overutilization. We continue to monitor and adjust those strategies to meet the needs of our community.

Notes regarding the data used in this analysis:

Data for this analysis were gleaned from a variety of sources, depending on the section of the report and the element. Every effort has been made to use the same or similar data sources when possible; however, differing sources are used when one source provides more useful data for analysis. Although I have attempted to use consistent language in the report, “practitioner” and “Provider” may be used interchangeably; also “member” and “enrollee” and “patient” may be used interchangeably.
For overall enrollment, numbers are based on eligibility files as of June 19, 2018. Our number of enrollees has been stable over the last year, so a “point in time” measurement was felt to be appropriate.

Provider numbers are based on credentialing information from Advanced Health and our community Providers or delegates, including Coos Health and Wellness, Curry Community Health, and ADAPT. In some cases, these are supplemented by our local knowledge about Providers practicing within organizations that may not require direct credentialing and contracting with Advanced Health (such as anesthesiologists and CRNAs directly employed by Bay Area Hospital.)

Numbers of members with specific clinical conditions (asthma, diabetes, etc.) are taken from the Milliman PRM Analytics Care Coordinator Report, which included enrollee and PCP-assignment information through May 2018 and claims information paid through April 2018, with a three-year look-back as the source for its analysis. Because of the phenomenon of enrollee “churn,” in which enrollees may lose eligibility briefly and then return to the plan, this tool includes all enrollees who have been eligible in the preceding three months, dropping enrollees from the report if they have had a continuous three-month lapse in eligibility. For this reason, the total membership represented in these reports appears larger than the total membership at any one point in time.

The term “community partners” includes equity partner organizations in Advanced Health as well as organizations in the community with whom we routinely work together in formal or informal partnerships.
**Background:** Western Oregon Advanced Health, LLC (abn *Advanced Health*) was initially certified by the Oregon Health Authority (OHA) as a Coordinated Care Organization (CCO) in the first wave of CCO applicants in 2012. For the past seven years, Advanced Health has been meeting the healthcare needs of 18,477 Members in Coos County and 2,230 Members in Curry County, for a combined total of 20,707 Members, in the southwestern-most corner of Oregon. Advanced Health shares Curry County with AllCare CCO, Inc. (AllCare), and primarily serves residents in the more northern portions of Curry County (e.g., Port Orford and Gold Beach), while AllCare serves approximately 3,000 residents, drawn largely from the more populous southern community of Brookings.

Coos and Curry Counties are federally classified as *rural*, while the communities of Powers and Agness carry federal designations as *rural-remote* or *frontier*. To that end, Advanced Health's Community-based service delivery system is unlike that of metropolitan or urban CCOs, in that it seeks to engage all healthcare Providers throughout a 3,227 square-mile area. Collectively Coos and Curry Counties support a population base of 85,790 persons, or 26.5 persons per square mile. Over one-half of the service area is federally characterized as *sparsely populated*.

Under CCO 1.0, Advanced Health delegated all physical health and Substance Use Disorder (SUD) services to Southwest Oregon IPA, Inc. (SWOIPA), an Affiliate. In turn, SWOIPA delegated SUD services to ADAPT, Inc. (ADAPT). ADAPT has been certified by OHA for the provision of in-patient, residential (adult and adolescent), intensive out-patient, out-patient, detoxification, and medication-assisted treatment (MAT) services. With the onset of CCO 2.0, Advanced Health will enter into a Privileged Provider Subcontract with SWOIPA for the full integration of physical and Behavioral Health services under a Global Budget. *Privileged Provider Subcontracts* differ from delegation contracts in that there are certain privileges that may or may not be awarded to a Subcontractor, depending on the Subcontractor's capabilities and prior performance. *Privileges* include, but are not limited to, credentialing, sub-contracting, and utilization management.

Through SWOIPA, Advanced Health contractually secures the services of 105 physicians who practice at 23 discrete addresses in practice configurations that range from solo private practice to fifty-member multi-specialty group practices. The area is served by a single DRG Hospital (Bay Area Hospital) and three Rural Critical Access Hospitals in Gold Beach, Bandon, and Coquille.

Similarly, under CCO 1.0, Advanced Health delegated all dental and oral health services to Advantage Dental, with caveats that Advanced Health held the right to
empanel additional oral health Providers if Advantage Dental was unable to meet the full array of Members' needs. Under CCO 2.0, Advanced Health will no longer use a delegation model, and instead will enter into Privileged Provider Subcontracts, or cooperative agreements in which Advanced Health retains significant involvement in oral healthcare.

In both counties, the boards of county commissioners retain status as the Local Mental Health Authority (LMHA). In Coos County, Coos Health and Wellness, a division of county government, is certified by OHA as the Community Mental Health Program (CMHP), while in Curry County that designation is held by Curry Community Health, which is independent from county government and organized as an Oregon not-for-profit corporation that enjoys tax-exempt status pursuant to IRS 501(c)(3). Under CCO 1.0, Medicaid-supported mental health benefits were delegated by Advanced Health to the two CMHPs. Under CCO 2.0, Advanced Health will no longer use a delegation model.

1. Governance and Organizational Relationships
1.a.(1) Please describe the proposed governance structure, consistent with OAR 414.625. Advanced Health is manager-managed and its central governance document is called an operating agreement. The operating agreement establishes a Board of Directors (the Board) that serves as Advanced Health's manager. The Board is responsible for ensuring that Advanced Health establishes appropriate objectives and achieves them. The Board is comprised of 17 Directors, all of whom are individuals. Each of the owners of the membership interests in Advanced Health (equity owners) has contributed capital and remains liable for future capital calls. The equity owners appoint the majority of Directors through a process of voting by the percentage ownership that each equity owner owns. The Board as a whole elects all other Directors (the elected directors), who serve three-year staggered terms. The elected directors include, at this time, one member of the Curry County CAC. The Nominating Committee of the Board is accountable for identifying potential Directors to ensure compliance with ORS 414.625 and all applicable OHA rules, and helps to ensure that elected directors represent the Community served by Advanced Health.

The operating agreement requires that all Directors be appointed in a manner that ensures that the composition of the Board complies with ORS 414.625 and all applicable OHA rules. The Board meets regularly to discuss Advanced Health business and make decisions, and complies with recent legislation regarding open meetings. Certain major decisions for Advanced Health must be approved by 60% or 75% of the equity owners. Given the ownership of Advanced Health, the 75% threshold means that the 60% equity owner cannot control these decisions but must instead seek cooperation from other owners. For example, major decisions such as merger, liquidation, major contracts, conflict of interest transactions, distributions to equity owners, and similar matters require 75% equity owner approval. When
consent is sought, the equity owners may consent or return the matter to the Board for more deliberation, but may not change the resolution submitted by the Board to the equity owners.

The Executive Committee, which is made up of the officers of the Board, is responsible for oversight of the Chief Executive Officer (CEO), appointment of Committee members, development of Board meeting agendas that address all aspects of Advanced Health's operations as well as its policy decisions, the exercise of financial oversight between Board meetings, and assisting the CEO with thorny personnel or other issues as needed. Members of the Executive Committee typically serve on other committees as well. The Compliance Committee is responsible for ensuring that Advanced Health's operations (including policies, procedures and operations) comply with federal and State law, regulations and best practices in healthcare governance. The Board has the authority to appoint ad hoc committees as it desires. All Board committees report to the Board as a whole, and committees do not have independent authority to act unless action is specifically delegated by the Board. Committee recommendations are given great weight in the deliberations of the Board. Non-directors may participate on committees, but may not chair a committee.

1.a.(2) Please describe the proposed Community Advisory Council (CAC) in each of the proposed Service Areas and how the CAC was selected consistent with OAR 414.625. Advanced Health operates two Community Advisory Councils (CAC), one in Coos County and one in Curry County. Each CAC is purposed at ensuring that the healthcare needs of consumers and the Community are being addressed. Each CAC is comprised of one representative of county government and multiple Community stakeholders, but most representatives are consumer-Members. Initially, CAC members were selected by a committee composed of an equal number of county representatives and members of the governing body of Advanced Health. Over time, the boards of county commissioners asked to be excused from this function and delegated their decision-making regarding appointments to the CAC to their respective Community Mental Health Programs (CMHPs). To this end, CAC membership is now jointly determined by the governing board of Advanced Health and the respective CMHP. A disadvantage to this model is that the consumer-Members of the CAC are disproportionately representative of adult Members who are diagnosed with Severe and Persistent Mental Illness (SPMI), but the offsetting advantage assures that adults with SPMI have a clear voice in the operation of the CCO.

1.a.(3) Please describe the relationship of the governance structure with the CAC, including how Applicant will ensure transparency and accountability for the governing body's consideration of recommendations from the CAC. The governance structure for Advanced Health includes participation on the Board by a consumer-Member from the CAC. However, going
forward, to improve transparency and create the opportunity for greater CAC and Community voices, beginning in May or June of 2019, Advanced Health will seat an Aggregate Panel of Advisors. The Aggregate Panel of Advisors will be comprised of two representatives from each CAC (for a total of four persons, one of whom must be representative of persons with severe and persistent mental illness (SPMI), and one of whom must be representative of Members receiving DHS Medicaid long-term care, or long-term services and supports), a Tribal representative, an equity representative, a representative from the Clinical Advisory Panel, a Quality Improvement representative, and a compliance representative.

Under its current practices, for each agenda item that appears on the governing Board's monthly meeting, staff members prepare a one-page summary that states the background for the issue, the reason the issue is coming before the Board, and a recommendation for action tendered by executive personnel. Executive staff will continue to develop these one-page Agenda Items but will do so seven-to-ten days in advance of each Board meeting. The Aggregate Panel of Advisors will convene a meeting within that time frame and will be encouraged to submit their recommendations to the Board, such that the agenda packet contains the following information:

![Figure 1](image)

**Figure 1**

**AGENDA ACTION ITEM FOR THE BOARD OF DIRECTORS**

<table>
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<tr>
<th>BOARD ACTION ITEM</th>
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<tr>
<td><strong>Background:</strong></td>
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<td><strong>Current Issue or Question:</strong></td>
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<td><strong>Recommendation of Executive Staff:</strong></td>
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<td><strong>Recommendation of Consumer Advisors:</strong></td>
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<td><strong>Recommendation of Compliance Personnel:</strong></td>
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<td><strong>Recommendation of Quality Personnel:</strong></td>
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At the time that each monthly meeting of the Aggregate Panel of Advisors is convened, the advisors will be asked one additional question: *Is there any matter*
that you would like to see brought to the attention of the Board of Directors? Any affirmative response to this question will be for inclusion in the next monthly meeting of the Board, thereby assuring that the Board of Directors will take under advisement or action, any matter brought to them by CACs, other advisory bodies, or appointed advisors. Under newly adopted open meeting rules governing CCOs, members of the Aggregate Panel of Advisors, their advocacy groups, and other interested parties from the general public have new avenues for addressing and influencing the decision-making of the Board.

1.a.(4) Please describe how the CCO governance structure will reflect the needs of Members with severe and persistent mental illness and Members receiving DHS Medicaid-funded LTC services and supports through representation on the governing board or CAC. In both Coos and Curry Counties, the CACs include disproportionate representation from adults with severe and persistent mental illness (SPMI) (as noted in 1.a.(2), earlier), and each CAC also includes at least one individual who receives Medicaid-funded long-term services and supports. From the discussion in 1.a.(3), it is evident the composition of the Aggregate Panel of Advisors also includes these individuals.

1.b.(1) An Applicant is encouraged but not required to establish a Clinical Advisory Panel as a means of assuring best clinical practices across the CCO's entire network of providers and facilities. If a Clinical Advisory Panel is established, describe the role of the Clinical Advisory Panel and its relationship to the CCO governance and organizational structure. From the time of its inception, Advanced Health has seated and supported the workings of an extremely active Clinical Advisory Panel (CAP). Working in collaborative concert with the Chief Medical Officer, the primary role of the CAP is to assure the adoption of best clinical practices and to establish clinical standards. The CAP meets two times per month, is chaired by Advanced Health's Chief Medical Officer, and includes among its membership multiple physicians (both primary care and medical specialties), a dentist, a SUDs specialist, a clinical psychologist, and Advanced Health's Director of Quality and accountability. With a great degree of frequency, the Board of Directors of Advanced Health refers specific questions or assignments to the CAP, and with the same degree of frequency the CAP makes recommendations to Advanced Health's Board of Directors.

1.b.(2) If a Clinical Advisory Panel is not established, the Applicant should describe how its governance and organizational structure will achieve best clinical practices consistently adopted across the CCO's entire network of providers and facilities. Not applicable.

1.c.(1) Describe Applicant's current status in obtaining MOUs or contracts with Type B Area Agencies on Aging, or DHS local APD office. Coos and Curry Counties are unserved by a Type B Area Agency on Aging. Advanced Health
has long held a written Memorandum of Understanding (MOU) with DHS's regional Aging and Persons with Disabilities office. The MOU has been periodically amended with the mutual consent of the parties.

1.c.(2) IF MOU or contracts have not been executed, describe Applicant's efforts to do so and how the Applicant will obtain the MOU or contract. Not applicable.

1.d.(1) To implement and formalize coordination, CCOs will be required to work with local mental health authorities (LMHA) and community mental health programs (CMHP) to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving mental health services. Describe the Applicant's current status in obtaining MOUs or contracts with LMHAs and CMHPs throughout its proposed Service Area. Advanced Health holds current contracts with the CMHPs in both Coos and Curry Counties, i.e., with Curry Community Health in Curry County, and with Coos Health and Wellness in Coos County.

1.d.(2) If MOUs or contracts have not been executed, describe the Applicant's efforts to do so and how the Applicant will obtain the MOUs or contracts. Not applicable.

1.d.(3) Describe how Applicant has established and will maintain relationships with social and support services in the Service Area: DHS Child Welfare and Self-Sufficiency Field Offices: Administrative and clinical personnel from DHS Child Welfare hold influential seats on Advanced Health's Children's System of Care/Wraparound executive committee, and in that role, direct service delivery and spending for the System of Care and Wraparound programs. At the request of DHS Child Welfare, Advanced Health has made grant funds available to the Every Child program to provide supports to children who are involved in the child welfare system, and to work ardently within the Community to identify and recruit new foster care providers. Advanced Health's commitment to the Every Child program is long-term in nature and is considered a Community benefit activity. Advanced Health has established a collaborative working relationship with the local DHS Self-Sufficiency Field Office. Navigators employed by Advanced Health make referrals to the Self-Sufficiency Office for matters regarding a Member's eligibility, and accept referrals from the Self-Sufficiency Office for Members who have unique needs that cannot be met by that office, e.g., diapers, food items at the end of the month after a Member's Oregon Trail card has been depleted, or Intensive Care Coordination services.

Oregon Youth Authority (OYA) and Juvenile Departments: Executive leaders from OYA and local juvenile departments are invited to serve on Advanced
Health's Children's System of Care/Wraparound executive committee, and in that role, direct service delivery and spending for these programs. Beginning with the onset of CCO 2.0, Advanced Health is committed to placing a designated adolescent therapist in the Coos County Juvenile Department, and if there is enough need, to place a System of Care Team within the Juvenile Department. Advanced Health is motivated to work with OYA and juvenile justice officials to determine if there is enough local need to launch proctor schools or therapeutic classrooms or establish intensive day treatment programs in educational settings. My CRU (Crisis Response Unit), a 24/7 rapid response unit for adolescent mental health crises and suicide prevention, is often accompanied by law enforcement personnel who have been cross-trained with members of the My CRU team.

**Department of Corrections:** Advanced Health's partner, Coos Health and Wellness, provides the clinical services needed to support a Mental Health Court. All local law enforcement agencies are active partners in Advanced Health's opioid project and in addition have participated in mental health crisis de-escalation training. Advanced Health provided funding to offset the initial costs of Naloxone training for law enforcement (and other first responders). Under CCO 2.0, Advanced Health envisions developing a highly specialized Assertive Community Treatment Team whose caseload will be devoted to Members who are diagnosed with SPMI and involved in the criminal justice system.

**School Districts, Education Service Districts, and Higher Education:** Advanced Health's partners sponsor two school-based health centers (SBHCs) on the campuses of Marshfield High School in Coos Bay, and Brookings-Harbor High School in Curry County. Collectively, Advanced Health's network of Behavioral Health Providers (including two CMHPs and two federally-qualified health centers) provide Behavioral Health counselors in nearly all elementary, middle, and high schools in the two-county region. The local Education Service District operates an intensive case management and Care Coordination program for students with severe physical health impairments. Advanced Health, through SWOIPA, underwrites most of the costs for the school nurse associated with this program, and all costs for the program's pediatrician. In 2017, SWOIPA contributed $1 million to the construction of a new health sciences facility on the campus of Southwestern Oregon Community College (SOCC). Construction will begin later in 2019 and when completed will double the size of the school of nursing. Advanced Health has also worked arm-in-arm with SOCC to attain accreditation for its Traditional Health Worker education program and offset all faculty costs for the first two cohorts of participants in this program.

**Developmental Disabilities Program:** There is a paucity of local resources for individuals diagnosed with intellectual or developmental disabilities (I/DD). The local Office of Aging and Persons with Disabilities (ADP) provides "community living case management," but for those individuals with concurrent I/DD and
Behavioral Health disorders, there are no resources at all. Advanced Health is aware of the residential Stabilization and Crisis Units (SACUs) that are available for Members with concurrent I/DD and acute Behavioral Health services needs – all located along the I-5 corridor and at or north of Eugene but has never been able to access these facilities for its Members through the regional or county community developmental disabilities program.

**Tribes, Tribal Organizations:** Advanced Health was the first CCO to enter a formal, OHA-approved, contractual mechanism wherein members of the Coquille Tribe may elect to receive their Medicaid benefits either through the CCO or through their federally recognized Coquille Indian Tribe Community Health Center. Advanced Health recognizes Coquille Indian Tribe Community Health Center as a Primary Care Provider (PCP) within its network, and the PCPs affiliated with the Tribal Health Center are free to make Referrals throughout Advanced Health's Provider Network for the full complement of services, including Behavioral Health services. Additional detail is provided in the response to 12.d.(1), later in this narrative.

**Housing Organizations:** In Coos County, the Coos County, City of Coos Bay, and City of North Bend Housing Authorities have been merged into a single Authority. Over the span of the last three decades, this Authority has not advanced a single federal housing development application to HUD, nor has it applied for housing development funds through Oregon's Community Development Block Grant program. Instead, the local housing authority focuses primarily on administering HUD's Section 8 Housing Voucher program. The local community action agency, Oregon Coast Community Action (ORCCA), that has had long-term access to Community Development Block Grant and HUD funding, primarily provides "assistance programs aimed at helping individuals and families obtain stabilization through housing programs designed to assist such persons in maintaining or transitioning into permanent housing." When specialized housing grant resources were historically made available to CMHPs, Coos Health and Wellness "stood aside," and deferred their options to Columbia Care – an out-of-county program that now owns and operates the handful of (beautiful) residential facilities in the local community. As the result of decades of inaction, Coos and Curry Counties suffer from acute shortages of all housing types. There is no supported housing, and anything once-designed as "transitional housing" has become permanent housing, as there is no shelter to which to transition. While local housing groups have complained that their efforts are unsuccessful because there is a shortage of Land, Loans, and Labor, Advanced Health believes otherwise.

Advanced Health believes that there has been an absence of Leadership, and to this end in 2018, provided the lion’s share of costs associated with retaining an independent consulting firm to develop separate housing needs assessment studies in both Coos and Curry Counties. This effort brought together the leadership from
both counties and involved county commissioners, city managers and councilors, housing authorities, business leaders, social service agencies, and advocates. Long after the needs assessment studies were completed, the housing leadership group has continued to remain engaged and is developing innovative solutions, including re-zoning and the potential creation of a local community housing trust fund. To facilitate these continuing efforts, Advanced Health paid the full cost of retaining a consulting firm to work with the local housing leadership group in developing a strategic plan for housing. This strategic plan (scheduled for completion by December 2019), among other strategies, will specifically advise Advanced Health about needs, investments, and strategies related to supported housing. Separately, SWOIPA owns a one-square-block of commercial space in which its offices were previously located, and the consultant will advise whether this facility could be cost-effectively converted to supported housing. Subject to the continuing approval of the Community Advisory Councils and Aggregate Panel of Advisors, it is Advanced Health's intent to invest fully one-half of all Social Determinants of Health (SDOH) spending in sorely needed supported housing, subject to any restrictions that may be imposed by CMS or OHA on capital investments.

Community-Based Family and Peer Support Organizations: Through the Curry County CAC, Advanced Health made seed money available to a sub-committee purposed at developing additional peer-directed peer support programs in that community. As a result of that group's planning and advocacy, Advanced Health will issue a solicitation in May 2019 to stand-up additional peer support programs in Curry County. Coos Health and Wellness operates a successful and well-received peer program. An independent entity, Bay Area First Step, is a recovery community initiative, but operates exclusively with lay personnel who work without clinical supervision. While Advanced Health appreciates the strides that Bay Area First Step has made, it is unable to affiliate with that program.

Other Social and Support Services Important to Communities Served: Advanced Health contributed $250,000 over the past two years to initiate an Adverse Childhood Experiences (ACEs) work group; that entity will now organize separately from Advanced Health yet continue to benefit from an ongoing commitment of social and capital resources. At the request of advocates in Curry County, Advanced Health contributed all facility costs associated with establishing a one-stop community integrated service program in Gold Beach and has pledged ongoing support. For five years, Advanced Health has increased its support of the Devereux Center – and outreach program for persons who are unstably housed – and has pledged its continuing support under CCO 2.0. Through an innovative partnership, Advanced Health is assisting the United Way of Southwestern Oregon in its re-launch efforts, contributing $100,000 to their operating costs in 2019, with the goal of expending $180,000 in 2020 and $160,000 in 2021. Similarly, Advanced Health has been a long-term financial supporter of the Boys and Girls Club, and the Kids Hope Center – a program for children who have been sexually abused.
Advanced Health funded one-half of the costs for the purchase of a refrigerated truck to transport fresh commodities from ORCCA's warehouse in Coos County to Curry County food banks.

2. Member Engagement and Activation
2.a. Describe the ways in which Members (and their families and support networks, where appropriate) are meaningfully engaged as partners in the care they receive as well as in organizational quality improvement activities. Most primary care services are delivered by patient-centered primary care homes (PCPCHs). The PCPCH model emphasizes team-based care in which the Primary Care Provider, Behavioral Health specialist, registered nurse, medical assistant/panel manager, and primary-care case managers work collectively to meet the needs of each patient. Within Advanced Health's model, all PCPCHs are trained to place the Member at the center of the team – meaning that the Member is the most important player. This model of care, while not always ensuring that every Member is meaningfully engaged in care, holds the best promise to increasingly engage Members as partners in the care they receive.

Advanced Health consults with its Members, through the Community Advisory Council, to identify Member engagement activities that are consumer-nominated as being meaningful. (These are discussed at greater length in the Community Engagement Plan that is appended to Attachment 10, Social Determinants of Health.) The engagement activities that were advanced by the Community Advisory Council, and approved by Advanced Health for implementation in 2019-2020, include: housing; adverse childhood experiences; prescription drug overdose prevention; improved access to Behavioral Health services; suicide prevention; healthy eating and active living; and kindergarten preparedness. A variety of consumer engagement activities are planned, or under development, for this array of initiatives, including: purposeful planning for supported housing; purposeful planning for the development of a parent-with-child drug-free reunification home following discharge from residential SUD treatment; implementing strength-based resiliency activities for persons affected by ACEs; continuing the popular Naloxone training throughout the community, including distant Rural sites; identifying strategies that will incentivize Members to engage in preventative care; using Community-based (rather than office-based) models for the delivery of Behavioral Health services; providing more ASIST training to address suicide; offering inviting and interesting courses on nutrition as medicine and cooking classes; and, parenting education. Each of these activities is designed with and for Members to increase Member engagement and participation, and each is evaluated for the degree to which it contributes to quality improvement.

2.b. Describe how Applicant will ensure a comprehensive communication program to engage and provide all Members, not just those Members accessing services, with appropriate information related to the benefits
and accessing physical health, Behavioral Health, and oral health services, including how Applicant will:

**Encourage Members to be active partners in their health care, understanding to the greatest extent feasible how the approach to activation accounts for the social determinants of health.** Under optimal circumstances, a new Member's first appointment at the Primary Care Provider's practice will be with a Traditional Health Worker who is reflective of the target population and a member of the case management team. This initial meeting provides the occasion for screening for health risk factors, cultural preferences, linguistic needs, ACEs, and SDOH. The Member does not simply complete a variety of screening tools, but concurrently is engaged in a verbal exchange that includes motivational interviewing. The Traditional Health Worker provides feedback regarding the screening results, and seeks to understand how the primary care practice can best meet the Member's unique needs (i.e., through same-day appointing; Saturday appointing; appointing when a Spanish language health interpreter is present; appointing with a same-gender Provider; *special handling* to prevent re-traumatization; and a great many other Member-centric customizations). If the Member screens positive for ACEs or SDOH, now is the time to frankly discuss these elements of the Member's history and identify ways in which the Member's ongoing care will be trauma- and SDOH-informed. This initial session also provides the occasion to discuss team-based care and introduce the Member to his or her team. This discussion occurs verbally, but the Member is also provided with a brochure on team-based care, as well as contact information for each member of the team. Now is also the occasion to enforce that the Member is the most important member of the team.

**Educate Members on how to navigate the coordinated care approach and ensure access to advocates including peer wellness and other Traditional Health Worker resources.** At the initial intake session (discussed in the paragraph above), the Member will meet a Traditional Health Worker, who will educate the Member about the PCPCH model, team-based care model, and coordinated care model. The Traditional Health Worker may share a little about his or her background to assist in forming an alliance with the Member, based on shared life experiences. The Traditional Health Worker will provide information about services available through navigators or peer wellness specialists, and will introduce the Member to those personnel, or assure that those personnel are included as members of the Member's primary-care case management team. Information provided by the Traditional Health Worker is further re-enforced by printed information in the *Member Handbook*, and telephonic and in-person information provided by Advanced Health's navigators (formerly, customer service representatives).
Encourage Members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate. Based on each Member's screening results, primary care plans of care will be developed for those Members that could benefit from enhanced wellness resources or efforts. Using motivational interviewing, Members will be asked to agree to the plan of care. If Members are unable to provide their agreement, consideration will be given to whether the lack of agreement is culturally or linguistically-based or is the result of some other barrier that the primary care team will work to overcome. Advanced Health makes an array of wellness, prevention, and lifestyle programs available to Members, and Members are directed to these resources. When unique needs are identified, flexible services funds may be used to address those needs consistent with the Member's plan of care.

Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities. Advanced Health publishes a plan language document summarizing Members' rights and responsibilities. The document is included in the Member Handbook, posted to Advanced Health's web site, and made available in reception rooms for reference. Members are encouraged to direct any question about their rights and responsibilities to any member of their primary care team, or to navigators at Advanced Health.

Meaningfully engage the CAC to monitor and measure patient engagement and activation. Advanced Health consults with its Members, through the Community Advisory Council (CAC), to identify Member engagement activities that are consumer-nominated as being meaningful. A variety of consumer engagement activities are planned, or under development, by the CAC including: purposeful planning for supported housing; purposeful planning for the development of a parent-with-child drug-free reunification home following discharge from residential SUD treatment; implementing strength-based resiliency activities for persons affected by ACEs; continuing the popular Naloxone training throughout the Community, including distant Rural sites; identifying strategies that will incentivize Members to engage in preventative care; using Community-based (rather than office-based) models for the delivery of Behavioral Health services; providing more ASIST training to address suicide; offering inviting and interesting courses on nutrition as medicine and cooking classes; and, parenting education. Each of these activities is designed with and for Members to increase the likelihood of Member engagement and participation, and each is evaluated for the degree to which it contributes to Quality Improvement. In specific, time-framed and measurable outcome objectives are established for each activity. Advanced Health's internal Quality Improvement team provides the analytics for some outcome measures, while an independent and external evaluator provides the analytics for other, Community-based, measures for programs performed by non-clinical social
service partners. CAC members are encouraged to become involved in the evaluation process, and through that effort, learn about rigorous evaluation techniques and methods. Because the CAC will become increasingly responsible for the expenditure of larger sums under the SDOH initiatives that will be rolled out in 2021, it becomes essential to develop discerning evaluation skills among CAC members.

3. Transforming Models of Care
3.a.(1) Patient-Centered Primary Care Home: Describe Applicant's PCPCH delivery system. Advanced Health has long been a champion of the Patient-Centered Primary Care Home (PCPCH) model. Today, 87 percent (17,147 of 19,705) of Advanced Health's Members are served through OHA-recognized PCPCHs. Advanced Health's largest PCPCHs include North Bend Medical Center, Bay Clinic, and Waterfall Community Health Center in Coos County, and Coast Community Health Center and Curry Health Network in Curry County. PCPCHs are primary healthcare clinics that are recognized by the OHA for their commitment to providing high-quality, patient-centered care. At its heart, the PCPCH model of care fosters strong relationships with patients and their families to better care for the whole person. Primary care homes reduce costs and improve care through the early identification of problems, focusing on prevention, wellness, and managing chronic conditions. PCPCHs are the most salient vehicle for delivering the right care, in the right place, at the right time.

3.a.(2) Describe how Applicant's PCPCH delivery system will coordinate PCPCH providers and services with DHS Medicaid-funded LTC providers and services. Advanced Health requires its Primary Care Providers to develop a written plan of care for every Member that is participating in DHS' Medicaid-funded programs of long-term care or long-term services and supports. If the Member experiences a triggering event or undergoes transitions in care that cannot be managed in the PCPCH, a fast-track and immediate Referral system exists for these Members to be Referred to Intensive Care Coordination/Exceptional Needs Care Coordination (ICC/ENCC) services. Primary Care Providers are expected to continue to be the Primary Care Provider for Members who are in long-term care, and to make visits to those facilities.

3.a.(3) Describe how the Applicant will encourage the use of Federally Qualified Health Centers (FQHCs), Rural health clinics, migrant health clinics, school-based health clinics, and other safety net providers that qualify as Patient-Centered Primary Care Homes. Advanced Health is served by two FQHCs: Waterfall Community Health Center serves greater Coos County; and Coast Community Health Center (that also holds a designation as a health center for persons who are homeless) serves southern Coos County (Bandon) and northern Curry County (Port Orford). Both FQHCs are certified as PCPCHs, and both are under contract to Advanced Health. North Bend Medical Center's
immediate care clinic, and its practices in Bandon and Myrtle Point, are federally recognized as Rural Health Centers, as is the Oak Street Clinic in Brookings. All four enjoy state recognition as PCPCHs and are included in Advanced Health's network. Technically, Curry Family Medical Clinic in Port Orford is classified as a Critical Access Clinic but enjoys the same benefits as a Rural Health Center. It, too, is recognized as a PCPCH and a member of Advanced Health’s network. Two school-based health centers (SBHCs) exist in the Service Area, on the campus of Marshfield High School in Coos Bay, and Brookings-Harbor High School in Curry County. The SBHC at Marshfield High School is recognized as a PCPCH because of its affiliation with Waterfall Community Health Center. The PCPCH at Brookings-Harbor High School does not offer 24/7 services and is only open during academic months and is therefore not a member of Advanced Health’s network. Advanced Health recognizes Coquille Indian Tribe Community Health Center as a Primary Care Provider within its network. There are no migrant clinics or black lung clinics in the Service Area.

3.b.(1) If Applicant proposes to use other models of patient-centered primary health care in addition to the use of PCPCH, describe how the Applicant will assure Member access to Coordinated Care Services that provide effective wellness and prevention services, facilitates the coordination of care, involves active management and support of individuals with Special Health Care Needs, is consistent with a patient and Family-centered approach to all aspects of care, and has an emphasis on whole-person care in order to address a patient's physical, oral and Behavioral Health care needs. Coos Health and Wellness is in the process of developing a Community Behavioral Health Clinic, and Advanced Health is contributing to this effort. The Behavioral Health center is in its earliest days of implementation, and open only two half-days per week. As the Behavioral Health center matures, and can offer relatively full-time services, Advanced Health will require it to become recognized by OHA as a Community Behavioral Health Center.

3.b.(2) Describe how the Applicant’s use of this model will achieve the goals of Health System Transformation. Community Behavioral Health Centers (CBHCs) were created through Section 223 of the Protecting Access to Medicare Act, which established a demonstration program based on the Excellence in Mental Health Act. Oregon is one of eight states participating in the federally funded demonstration program, and the Behavioral Health center being developed by Coos Health and Wellness is consistent with the Oregon model for CBHCs. The National Council for Behavioral Health has concluded that CBHCs can transform access to care in their communities and are: increasing access to mental health and addiction treatment; expanding capacity to address the opioid crisis; collaborating with partners in Hospitals, jails, prisons, and schools; and attracting and retaining qualified staff who offer science-based, trauma-informed services.
4. Network Adequacy
4.a.(1) How does Applicant intend to assess the adequacy of its provider network? Please include specific data points used to inform the assessment and the methodology for how adequacy will be evaluated.

And

4.a.(2) How does Applicant intend to establish the capacity of its provider network? Please include specific data points used to inform the assessment and the methodology for how capacity will be evaluated.

The responses to these two questions will be addressed concurrently and will begin with the presentation of several mid-2018 data sets (Tables 1 and 2). These data are specifically used to inform adequacy and capacity.

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Community</th>
<th>Enrollees</th>
<th>PCPs</th>
<th>PCP to Enrollee Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>97449</td>
<td>Lakeside (Community Shared with Trillium)</td>
<td>380</td>
<td></td>
<td>0:380</td>
</tr>
<tr>
<td>97459</td>
<td>North Bend (Served Exclusively by AH)</td>
<td>3,723</td>
<td>2</td>
<td>1:1861</td>
</tr>
<tr>
<td>97420</td>
<td>Coos Bay (Served Exclusively by AH)</td>
<td>8,374</td>
<td>42</td>
<td>1:199</td>
</tr>
<tr>
<td>97423</td>
<td>Coquille (Served Exclusively by AH)</td>
<td>1,765</td>
<td>4</td>
<td>1:441</td>
</tr>
<tr>
<td>97411</td>
<td>Bandon (Served Exclusively by AH)</td>
<td>1,838</td>
<td>5</td>
<td>1:368</td>
</tr>
<tr>
<td>97458</td>
<td>Myrtle Point (Served Exclusively by AH)</td>
<td>1,284</td>
<td>3</td>
<td>1:428</td>
</tr>
<tr>
<td>97466</td>
<td>Powers (Served Exclusively by AH)</td>
<td>265</td>
<td></td>
<td>0:265</td>
</tr>
<tr>
<td>97450</td>
<td>Langlois (Community Shared with AllCare)</td>
<td>147</td>
<td></td>
<td>0:147</td>
</tr>
<tr>
<td>97476</td>
<td>Sixes (Community Shared with AllCare)</td>
<td>67</td>
<td></td>
<td>0:67</td>
</tr>
<tr>
<td>97465</td>
<td>Port Orford (Shared with AllCare)</td>
<td>471</td>
<td></td>
<td>0:471</td>
</tr>
<tr>
<td>97406</td>
<td>Agness (Community Shared with AllCare)</td>
<td>13</td>
<td></td>
<td>0:13</td>
</tr>
<tr>
<td>97444</td>
<td>Gold Beach (Shared with AllCare)</td>
<td>658</td>
<td>9</td>
<td>1:73</td>
</tr>
<tr>
<td>97415</td>
<td>Brookings (Community Shared with AllCare)</td>
<td>850</td>
<td>7</td>
<td>1:121</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>19,835</strong></td>
<td><strong>72</strong></td>
<td><strong>1:275</strong></td>
</tr>
</tbody>
</table>

At first glance, the communities of Lakeside, North Bend, and Powers (in Coos County), along with the communities of Langlois, Sixes, Port Orford, and Agness (in Curry County) appear to be underserved, while the remaining communities appear
Table 1 includes only primary care physicians. These physicians are supported by a cadre of eight nurse practitioners and twenty-six physician assistants, most of whom also function as Primary Care Providers. These mid-level practitioners significantly expand primary healthcare capacity.

Lakeside, located in the northern portion of Coos County, is 13.6 miles from the population center of Coos Bay/North Bend to the south, and 12.4 miles from the population center of Reedsport to the north in Douglas County. Residents of Lakeside have the option of joining Advanced Health and traveling 13.6 miles to Coos Bay/North Bend to access primary care or joining Trillium and traveling 12.4 miles to Reedsport to access the services of any one of six Primary Care Providers. The preponderance of Medicaid-eligible persons in Lakeside (population 1,686) have elected to join Advanced Health.

There are two large, multi-specialty, group practices in Coos County: Bay Clinic and North Bend Medical Center (NBMC). The physical location of "North Bend Medical Center" is within the Coos Bay zip code, although it is located two blocks from the political boundary of the City of North Bend. Coos Bay and North Bend share a common circuitous political boundary. In the larger sense, it is best to consider Coos Bay and North Bend as a single population center, consisting of 12,097 Medicaid Enrollees who are served by 44 Primary Care Providers, resulting in a Provider-to-Enrollee ratio of 1:275.

The community of Powers is extremely remote and meets federal criteria for designation as a frontier area. Waterfall Community Health Center provides telemedicine primary care to Powers in concert with the Powers Rural Health District. With this adjustment, the actual Primary Care Provider-to-Enrollee ratio is 1:530.

The rural communities of Langlois, Sixes, Port Orford, and Agness (another Community that meets HRSA's frontier criteria) are located within a thirteen-mile stretch of one another along Highway 101. The Communities are 33 miles to the south of Bandon, and 28 miles to the north of Gold Beach. Coast Community Health Center has purchased property in Port Orford and will build a full-service clinic at that site. Advanced Health is lending $1 million in financial assistance to this effort.

When examining issues of Network capacity, it is critical to examine not only the ratio of Providers who are available to serve the Enrollee population, but the general population, as well. Advanced Health contracts with SWOIPA for the services of its physician panel; in turn, SWOIPA contracts with every practicing medical Provider in Coos and Curry County. Therefore, there are precisely as many Primary Care Providers to meet the needs of the Medicaid Enrollee population as there are to meet the needs of the general population.
Coos County is home to 63,761 residents, while Curry County is home to 22,713 residents (US Bureau of the Census, 2016 Update). SWOIPA contracts with 56 Primary Care Providers in Coos County and 16 Primary Care Providers in Curry County. For the general population in Coos County, the ratio of Primary Care Providers to persons is 1:1139, while in Curry County this ratio stands at 1:1420. HRSA's Bureau of Primary Health Care believes that medical underservice begins when there is less than one primary care Provider for every 1,641 members of the general population (HRSA, BPHC, Form 9, Need for Assistance Scoring, 2016). In both Coos and Curry Counties, the Primary Care Provider to population ratios are better than this standard. Although Coos County is currently classified by HRSA as a Health Professional Shortage Area (HPSA) for Low-Income and Homeless Persons (Designation 141999410R), HRSA proposed on November 10, 2016, that the designation be withdrawn largely because of the expansion of the Affordable Care Act (ACA) and Advanced Health’s ability to adequately meet the primary healthcare needs of the targeted population. Curry County continues to hold a HPSA designation (Designation 1419994191), although the designation is lowly scored at 15.

<table>
<thead>
<tr>
<th>1. Medical Specialty</th>
<th>2. Oregon Statewide Ratio*</th>
<th>3. Advanced Health Ratio @ 20,000 Members</th>
<th>4. Two-County Ratio for N = 86,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy and Immunology</td>
<td>1:116,722</td>
<td>1: 20,000</td>
<td>1: 86,400</td>
</tr>
<tr>
<td>Anatomic/Clinical Pathology</td>
<td>1: 25,614</td>
<td>1: 6,666</td>
<td>1: 28,797</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>1: 6,424</td>
<td>1: 5,000</td>
<td>1: 21,600</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1: 20,360</td>
<td>1: 20,000</td>
<td>1: 86,400</td>
</tr>
<tr>
<td>Dermatology</td>
<td>1: 27,008</td>
<td>1: 20,000</td>
<td>1: 43,200</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1: 5,779</td>
<td>1: 588</td>
<td>1: 2,540</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>1: 49,628</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine/General Practice</td>
<td>1: 2,172</td>
<td>1: 800</td>
<td>1: 3,456</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1: 23,354</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td>1: 10,233</td>
<td>1: 2,857</td>
<td>1: 12,342</td>
</tr>
<tr>
<td>Hematology and Oncology</td>
<td>1: 22,817</td>
<td>1: 10,000</td>
<td>1: 43,200</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>1: 52,937</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>1: 2,369</td>
<td>1: 800</td>
<td>1: 3,456</td>
</tr>
<tr>
<td>Internal Medicine / Pediatrics</td>
<td>1: 107,304</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatology/Perinatology</td>
<td>1: 92,331</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nephrology</td>
<td>1: 40,930</td>
<td>1: 20,000</td>
<td>1: 86,400</td>
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<tr>
<td>Neurological Surgery</td>
<td>1: 44,609</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td>1: 21,577</td>
<td>1: 20,000</td>
<td>1: 86,400</td>
</tr>
</tbody>
</table>
### Table 2

<table>
<thead>
<tr>
<th>Medical Specialty</th>
<th>1. Oregon Statewide Ratio*</th>
<th>2. Advanced Health Ratio @ 20,000 Members</th>
<th>3. Two-County Ratio for N = 86,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics and Gynecology</td>
<td>1: 7,115</td>
<td>1: 2,857</td>
<td>1: 12,342</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1: 15,448</td>
<td>1: 4,000</td>
<td>1: 17,280</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>1: 13,643</td>
<td>1: 2,500</td>
<td>1: 10,800</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>1: 28,359</td>
<td>1: 6,667</td>
<td>1: 28,801</td>
</tr>
<tr>
<td>Pediatrics (Persons &lt;22 Yrs of Age)</td>
<td>1: 1,622</td>
<td>1: 783</td>
<td>1: 1,707</td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation</td>
<td>1: 39,309</td>
<td>1: 10,000</td>
<td>1: 43,200</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>1: 55,919</td>
<td>1: 10,000</td>
<td>1: 43,200</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1: 8,086</td>
<td>1: 5,000</td>
<td>1: 21,600</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>1: 86,310</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>1: 62,035</td>
<td>1: 10,000</td>
<td>1: 43,200</td>
</tr>
<tr>
<td>Radiology &amp; Diagnostic Radiology</td>
<td>1: 11,344</td>
<td>1: 5,000</td>
<td>1: 21,600</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>1: 60,155</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>1: 31,510</td>
<td>1: 20,000</td>
<td>1: 86,400</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>1: 90,233</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In Table 2, above, Column 1 identifies the area of medical specialty. To form a basis for comparison, Column 2 provides Oregon's statewide physician-to-population ratio for each medical specialty identified in Column 1. Column 3 sets forth Advanced Health's physician-to-Enrollee ratio for each medical specialty and sub-specialty, while Column 4 establishes the physician-to-population ratio for each medical specialty for the entire population of Coos and Curry Counties. Advanced Health's Provider panel is drawn from the local medical Community, with a 99% participation rate. At the same time, Advanced Health shares this Provider panel with the entire population base. Advanced Health's preferred standard is to attain equal or better specialist-to-population ratios than Oregon's statewide norms.

Again, at first glance, it appears that, with a handful of exceptions, Advanced Health's members are well-served by a diversity of medical specialists (Column 3). However, when it is realized that Advanced Health's Members share this panel with the balance of the Community, the data are not as satisfying (Column 4):

- Certain medical specialties would not be anticipated for a Community the size of Coos and Curry Counties. Those medical specialties include pediatric internal medicine, neonatology, neuroradiology, neurosurgery, and vascular surgery. As needs arise, Advanced Health authorizes the provision of these services through Providers located in Medford and Eugene (and when necessary, in Portland, Salem, and out-of-state).
Certain medical specialties are well- or adequately-represented in Coos and Curry Counties. These include: pathology; emergency medicine; general surgery; ophthalmology; orthopedic surgery; otolaryngology; pediatrics; rehabilitation medicine; plastic surgery; and, radiation oncology.

The remaining medical specialties and sub-specialties are under-represented within the two-county Community and include: allergy and immunology; anesthesiology; cardiology; child psychiatry; dermatology; endocrinology; family practice; gastroenterology; hematology and oncology; infectious disease; internal medicine; nephrology; neurology; obstetrics and gynecology; pain medicine; preventive medicine; psychiatry; radiology; rheumatology; thoracic surgery; urology; and vascular surgery.

Shortages in family practice and internal medicine are not as significant as they appear in Table 2 due to the services of eight nurse practitioners and 26 physician assistants. Similarly, a cadre of five advanced practice nurses, with specialties in oncology infusion and anesthesia, serve to offset the apparent shortages of physicians in oncology and anesthesiology. Several of the Community's internal medicine specialists have established sub-specialties. For example, one internal medicine specialist has received advanced training in the insertion and application of insulin pumps, thereby offsetting apparent deficits in endocrinology, while another internal medicine specialist is qualified to read echocardiograms, thereby offsetting apparent shortages in cardiology.

4.a.(3) How does Applicant intend to remedy deficiencies in the capacity of its Provider Network? Advanced Health remedies deficiencies in the capacity of its Provider Network through a continuing effort at Provider recruitment and by entering into contractual agreements with neighboring medical specialists. Advanced Health has negotiated a contractual arrangement with Northwest Specialty Clinics, and through this agreement added to its Participating Provider panel the following medical specialties: pulmonology (7); gynecology (20); neurology (5); urology (17); general, thoracic, neuro, and vascular surgery (12); nephrology (4); and, gastroenterology (9).

4.a.(4) How does Applicant intend to monitor Member wait times to appointment? Please include specific data points used to monitor and how that data will be collected. In times past, Advanced Health's primary method for monitoring Member wait times was through complaints received in its Grievance and Appeals System. Advanced Health is now requiring Providers throughout its network to make an entry in the electronic health record for every Member-initiated or Provider-Referral appointment request, noting the date of that request. Advanced Health is working to develop a methodology for capturing appointment-request dates in claim and encounter submission protocols, thereby creating continuous electronic monitoring of wait times. Should this not be possible through
the claims process, Advanced Health will monitor wait times as a function of chart auditing.

4.a.(5) How will Applicant ensure sufficient availability of general practice oral health providers and oral health specialists, such as endodontists? Please provide details on how the full-time-equivalent availability of providers to serve Advanced Health's prospective Members will be measured and validated. Advanced Health contracts with Advantage Dental for the provision of oral health services. Advantage Dental makes the services of 28 dentists available in Coos County to meet the needs of approximately 17,000 Members, resulting in a dentist-to-Member ratio of 1:607. Nationwide, Oregon ranks 35th among all states with respect to the ratio of dentists to members of the population at .486 dentists per 1,000 persons (or, 1:2,050). Advanced Health's ratio of 1:607 is significantly better than Oregon's norm. Advantage Dental includes in its network a variety of dental specialists, including dental anesthesiology, endodontics, oral and maxillofacial surgery, and periodontics. These services are available in population centers via NEMT. One local oral surgeon has been admitted to SWOIPA's panel of Providers, rendering oral surgery locally available. Advanced Health has begun to track full-time equivalency (FTE) in its delivery system network accounting and is becoming better able to track Provider-to-patient ratios on an FTE basis.

In Curry County, Advantage Dental makes the services of three dentists available, all located in the Brooking-Harbor area. One dentist was brought to Curry County on a locum basis. Advanced Health is working collaboratively with AllCare (a CCO that shares a portion of the Curry County population) to identify and engage additional dental professionals. Curry County is a federally declared dental health professional shortage area (DHPSA) for all persons (Designation 6419994185), meaning that the well-insured have as much difficulty in accessing a dentist as the uninsured.

4.a.(6) Describe how Applicant will plan for fluctuations in provider capacity, such as a provider terminating a contract with Applicant, to ensure that Members will not experience delays or barriers in accessing care. For dental services, Advanced Health previously engaged Advantage Dental under a delegation contract but going forward will remove some delegation provisions and enter into a Privileged Provider Subcontract in which not all authorities will be delegated or held by Advantage Dental. Advanced Health's current contract permits Advanced Health to contract with additional independent dentists if Advantage Dental cannot meet Members' needs. Future contractual arrangements will continue to give Advanced Health the latitude to add additional independent dental Providers.
Advanced Health will similarly enter into a Privileged Provider agreement with SWOIPA for the provision of fully integrated physical and Behavioral Health services under a single Global Budget. For physical health services, SWOIPA contracts with approximately 105 individual physicians, rather than to contract with large practice groups such as North Bend Medical Center or Bay Clinic. Under this arrangement, no Primary Care Provider serves more than 300 adult Members. (Pediatricians average 700-800 child Members). If any single Provider leaves the network, Advanced Health can quickly re-assign 300 Members who represent less than 1.5 percent of all Enrolled Members.

4.b. Requested Document: The completed DSN Provider Report is appended, as required.

5. Grievance and Appeals
5. Please describe how Applicant intends to utilize information gathered from its Grievance and Appeal System to identify issues related to each of the following areas:

5.a. Access to care (wait times, travel distances, and subcontracted activities such as Non-Emergent Medical Transportation): Advanced Health's Grievance and Appeals System works across all network disciplines, including physical health, oral health, Behavioral Health, and NEMT. On a quarterly basis, Advanced Health aggregates data from its Grievance and Appeals System, and dichotomizes those data based on access variables (wait times; travel distances). Data are converted to dashboards with quarterly plotted linear values. At a glance, Advanced Health's data scientist can determine if there has been an uptick in access-related complaints, and easily dive a little deeper into the data to determine root cause. At a glance it can be determined if Corrective Actions placed into effect are producing desired improvements.

5.b. Network adequacy (including sufficient number of specialists, oral health and Behavioral Health Providers). Using the same methodology set forth in 5.a, above, data are dichotomized by individual Providers and by Provider type and specialties to determine if wait times and travel distances are creating inadequacies within the network. Individual Providers receive quarterly dashboard that summarize access barriers reported by Members, and if a Provider's dashboard is trending in a negative direction, the Provider is counseled accordingly. Advanced Health's chief medical officer is charged with monitoring and addressing inadequacies within the network and, when necessary, designing Corrective Actions, disciplining or sanctioning Providers.

5.c. Appropriate review of prior authorized services (consistent and appropriate application of Prior Authorization criteria and notification of Adverse Benefit Determination down to the Subcontractor level). One
salient reason for making the transition from delegation contracts to Privileged Provider Subcontracts, is to continue to extend to some (but not all) Providers the authority to engage in credentialing, sub-contracting, panel management, and utilization management, and yet to permit Advanced Health to reserve solely for itself the authority to deny a Prior Authorization request. Privileged Subcontractors may approve, but not deny, Prior Authorization requests. All Prior Authorization requests that Privileged Providers contemplate denying must be referred to Advanced Health for final determination by medical and Behavioral Health experts. Notices of Adverse Benefit Determination are issued only by Advanced Health; no Provider or Subcontractor holds this authority.

6. Coordination, Transition and Care Management
6.a. Care Coordination Overview: In advance of answering specific evaluation questions related to Care Coordination, Advanced Health sets forth this overview of its Care Coordination model, in the belief that this will enhance the readers' understanding and provide helpful insights as to why the model has been developed in a unique and innovative way. All case management services will exist at the primary care level, including the management of mental health diagnoses that are less severe than SPMI (for adults) or SED (for children). Accordingly, PCPs and PCPCHs inherit the responsibility for implementing case management services consistent with policies and procedures promulgated by SWOIPA. Primary-care case management services (PCCM) are separate and qualitatively different from Care Coordination services. SWOIPA will pay a per-member-per-month (PMPM) fee to PCPs and/or PCPCHs to provide both case management and integrated Behavioral Health services. Multiple case management models are available (strengths-based case management; clinical case management; acute care case management; disease-focused case management; supportive case management; nursing model case management; self-determination case management).

At its most simple elements, PCP practices will screen all assigned Members, both within 30 days of the date of assignment, and annually thereafter, using approved tools, for issues related to physical health risks, mental and emotional health, appropriate development, adverse childhood experiences, history of trauma, oral health needs, SUDs, SDOH, and health equity. Members who screen positive will be enrolled in PCCM. Members who are determined to be among priority populations, or at high risk, SPMI or SED, criminally involved, experiencing a triggering event, or having Special Health Care Needs, will be referred for Intensive Care Coordination (ICC) or Exceptional Needs Care Coordination (ENCC) (collectively, ICC/ENCC).

Members whose physical, social, emotional, behavioral, housing, and financial needs cannot be addressed through PCCM will be served through Intensive Care Coordination (ICC) or Exceptional Needs Care Coordination (ENCC). (The terms are used interchangeably and mean the same thing, hence the abbreviation,
**ICC/ENCC.** Certain populations are **required** to be enrolled in ICC/ENCC, unless the Member refuses ICC/ENCC services. Those populations are: pregnant and parenting women with SUD or mental health disorders; IV drug users; persons with opioid use disorders; veterans with SUD; all SED and SPMI; parents at risk of losing children to state custody; children aged 0 to 5 with ACEs and (defined) exacerbating events; Members on wait list for Oregon State Hospital; MAT participants; individuals at risk of first-episode psychosis (included in SED population); persons with intellectual and developmental disabilities (I/DD); juveniles involved in the justice system (likely included in SED); adult corrections population; children identified with clinically low levels of resilience, and, persons who are unstably housed.

By regulation, ICC/ENCC is the responsibility of the CCO. Advanced Health accepts this responsibility and will retain the services of a full-time, masters-level, licensed mental health professional, who is directly responsible for overseeing all ICC/ENCC services, howsoever delivered. This individual will be a direct employee of the CCO, and the functions assigned to this position will not be delegated or subcontracted. Because of the extensive administrative requirements placed on this position, the position will be further assisted by the full-time services of a registered nurse, thereby placing both behavioral and healthcare experts at the head of the ICC/ENCC program. Under Advanced Health’s Care Coordination Plan, Care Coordination responsibilities will follow most patients to their treatment settings, as follows: (1) To ADAPT for pregnant and parenting women with SUD; IV drug users; opioid use disorders; veterans with SUD; parents at risk of losing child custody or otherwise involved in the child welfare system with SUD; MAT participants; persons who are unstably housed with SUD; (2) To ACT Teams (bolstered by two ICC/ENCC Care Coordinators per team) for SPMI and corrections-involved populations, including veterans with SPMI; SPMI in residential and inpatient care; pregnant and parenting women with mental health issues; parents involved in the child welfare system with mental health diagnoses; adult corrections population; SPMI who are unstably housed; and (3) To the contracted Provider for System of Care (SOC) and/or Wraparound Services for the pediatric population that is SED involved, including: individuals at risk of first-episode psychosis; children aged 0 to 5 with ACEs, children involved in the child welfare system, youth involved in the juvenile justice system who are diagnosed with SED; children with clinically low levels of resilience or an absence of protective factors; and children evidencing other exacerbating factors.

Remaining Members needing ICC/ENCC services will receive those services through Care Coordinators who are directly employed by the CCO. Populations to be served by directly-employed personnel include: persons with intellectual or developmental disabilities; persons with exceptional needs other than Behavioral Health that cannot be managed in the primary care setting (i.e., persons with communication disabilities; persons who are blind; children with significant...
physical or learning disabilities); pregnant or parenting women who are homeless; pregnant and parenting women for whom SPMI and SUD have been obviated; and, Members receiving long-term care (LTC) or long-term services and supports (LTSS) from Aging and Persons with Disabilities, either who cannot be managed by the Primary Care Provider, or during transitions in care.

6.a.(1) Describe how Applicant will support the flow of information between providers, including DHS Medicaid-funded LTC Providers, mental health crisis services, and home and community-based services, covered under the State's 1915(i) State Plan Amendment (SPA) for Members with severe and persistent mental illness, as well as Medicare Advantage plans serving Fully Dual Eligible Members, in order to avoid duplication of services, medication errors, and missed opportunities to provide effective preventive and primary care. Primary-care case managers and ICC/ENCC Care Coordinators are required to extract treatment plans from Primary Care Providers, inclusive of medication lists and include this information in each Member's plan of care. The plan of care will further identify all Network Providers, LTC Providers, and Providers of essential home- and Community-based services who play a role in, or are assigned to, the Member. All plans of care exist in Advanced Health's Pre-manage/Community EHR system, are updated on the occasion of every case management or Care Coordination contact with the Member and can be electronically and remotely accessed by any Provider, case manager, or Care Coordinator, LTC facility, or crisis team, in a HIPAA-compliant, need-to-know basis. If the Member has given written consent for specifically-identified individuals, in compliance with HIPAA regulations, to access his or her plan of care, that information will be readily shared and made available at the Member's request.

At this time, Advanced Health is neither the sponsor of a Medicare Advantage plan nor affiliated with a sponsor of such a plan. Over the past seven years, Advanced Health has coordinated benefits and care for the 1,200 Fully Dual Eligible Members in its Service Area, working with the variety of Medicare Advantage (and other Medicare) plans that operate in this Service Area. Because precisely the same panel of physical health, oral health, and Behavioral Health Providers and Provider Organizations serve these Members for their Medicaid and Medicare care, Advanced Health is in a favorable position to ensure a seamless coordination of care and benefits for this population of Members who are aged/indigent or Members who are disabled. Recognizing the new requirements of the 2020 CCO Contract, Advanced Health is in the process of selecting an appropriate plan with which to have a formal contractual arrangement, which requires an analysis of which plan(s) are most widely used by Members assigned to Advanced Health. This contract will be in place by the time of the Readiness Review. In the likely event that not all Fully Dual Eligible Members in the Service Area will be served by the selected plan, Advanced Health will enter into arrangements with the other Medicare Advantage
plans to ensure that it continues to coordinate care and benefits for the Members served by other Medicare Advantage plans.

6.a.(2) Describe how the Applicant will work with its providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and Community prevention and self-management programs. Advanced Health has consistently collaborated with an extensive array of Community-based social and support services, including child welfare, adult and juvenile justice, educational systems, family partners, youth partners, advocacy organizations, and myriad Community-based social service agencies (tutors, mentors, coaches, athletic programs, summer camps, faith-based organizations, music programs, dance programs, art programs, outdoor education programs, youth development programs, wellness and fitness programs, chronic disease self-management programs, Community prevention programs, and others). Advanced Health was a significant contributor to the Community's effort to establish a 211 Resource Directory and makes that information available to case managers and Care Coordinators who seek to access specific resources on a Member's behalf. Advanced Health's CAC, CHIP, and SDOH initiatives will serve to further develop partnerships between the CCO and Community-based social and support services.

6.a.(3) Describe how the Applicant will develop a tool for Provider use to assist in the culturally and linguistically appropriate education of Members about Care Coordination, and the responsibilities of both Providers and Members in assuring effective communication. At the initial intake session (discussed in 2.b, bullet 1) the Member will meet a Traditional Health Worker, who will educate the Member about the PCPCH model, team-based care model, the coordinated care model, and the role of Care Coordination. The Traditional Health Worker will provide information about the responsibilities of both Members and Providers, and about services available through navigators or peer wellness specialists. Information provided by the Traditional Health Worker is further re-enforced by culturally and linguistically appropriate printed information in the Member Handbook, and telephonic and in-person information provided by Advanced Health's navigators (formerly, customer service representatives).

6.a.(4) Describe how Applicant will work with Providers to implement uniform methods of identifying Members with multiple diagnoses and who are served with multiple health care and service systems. Primary care practices are required to initially, and then annually, screen all Members for risks across the biopsychosocial realm and to advance to intensive Care Coordination (ICC/ENCC) those Members who are involved in multiple healthcare and social service systems. Members may also be referred to ICC/ENCC from all portals of entry, whenever complex care needs or non-compliance with prescribed medical protocols present, or at the occasion of triggering events.
6.a.(5) Describe how Applicant will implement an intensive Care Coordination and planning model in collaboration with the Member's PCPCH and other service providers such as Community Developmental Disability Programs and brokerages for Members with developmental disabilities, that effectively coordinates services and supports for the complex needs of Members. Primary-care case managers and ICC/ENCC Care Coordinators are required to extract treatment plans from Primary Care Providers, inclusive of medication lists and include this information in each Member's plan of care. The plan of care will further identify all Network Providers, LTC Providers, and Providers of essential home- and Community-based services who play a role in, or are assigned to, the Member. Advanced Health's case management and Care Coordination policies, procedures, and standards articulate the expectation for plans of care that are collaborative and specific across all network and Community systems. The Senior ICC/ENCC Executive reviews 75 percent of all care plans on a monthly basis to ensure completeness, collaboration, and compliance with these standards.

6.a.(6) Describe how Applicant will meet state goals and expectations for coordination of care for Members with severe and persistent mental illness receiving home- and Community-based services covered under the State's 1915(i) and Members receiving DHS Medicaid-funded LTC services, given the exclusion of DHS Medicaid-funded LTC service from Global Budgets. Advanced Health is cognizant of the OHA's accessibility standards and time-frames, as articulated in OAR 410-141-3220, and particularly for priority or special populations, in part comprised of: pregnant women; Members who are IV drug or opioid users; veterans and members of their families; women parenting children aged 0 to 5; all children aged 0 to 5; Members diagnosed with I/DD; Members receiving long-term care (LTC) or long-term services and supports (LTSS); Members who are diagnosed with a Serious Emotional Disturbance (SED) or Severe and Persistent Mental Illness (SPMI); Members with special healthcare needs; Members involved in the juvenile or adult criminal justice system; and Members, family members, caregivers and guardians of children who are involved in the child welfare system. All health service contracts issued by Advanced Health or SWOIPA make direct reference to OAR 410-141-3220 and reiterate timeliness and accessibility standards. Although the specific costs for LTC are excluded from the Global Budget, medical and Behavioral Health services costs for individuals residing in LTC are not. Advanced Health understands its obligations to provide and coordinate care for Members receiving LTC and long-term services and supports. These provisions are further enforced through vigilant contract monitoring performed by directly-employed compliance personnel.

6.a.(7) Describe the evidence-based or innovative strategies that Advanced Health will use within its delivery system network to ensure coordinated
care, including the use of Traditional Health Workers, especially for Members with Care Coordination needs, and those experiencing health disparities. For the large part, Members who are singularly diagnosed with SPMI, or who are dually diagnosed with concurrent physical health needs and SPMI, will receive Care Coordination services through Assertive Community Treatment (ACT) Teams, a well-researched, Evidence-Based strategy. Each ACT Team will be staffed by a licensed clinician, a fractional registered nurse, a fractional prescriber for psychotropic medication, a fractional skills trainer/supported employment developer, and – in a local twist – two Traditional Health Workers who are reflective of the target population of Members. Traditional Health Workers will assist with Care Coordination and navigation and may also serve as peer wellness specialists. An effort will be made to align a Member with an ACT Teams in which the peer wellness specialist experiences or experienced health disparities similar to those of the Member's.

6.a.(8)(a) Assignment of responsibility and accountability: The Applicant must demonstrate that each Member has a Primary Care Provider or primary care team that is responsible for coordination of care and transitions. Describe the Applicant's standards that ensure access to care and systems in place to engage Members with appropriate levels of care and services beginning not later than 30 days after Enrollment with the CCO. As a matter of policy and practice, all new Members are contacted within seven (7) days of Enrollment and assisted in the assignment to a Primary Care Provider. Members are always asked if they have currently established care with a network Primary Care Provider, and if so, and it is agreeable to the Member, the assignment will be made to that Primary Care Provider. Members will also be asked about their preferences: gender; geographic proximity to the Member's home; foreign languages spoken; handicapped accessibility. Every effort is made to accommodate the Members' preferences and it is rare when those preferences cannot be accommodated. A primary-care case management team is embedded in every primary care practice, and among many other functions, ensures coordination during transitions in care.

6.a.(8)(b) Describe how Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for Members to assess individual care needs or to determine if a higher level of care is needed. A new Member's first appointment at the Primary Care Provider's (PCP's) practice will be with a Traditional Health Worker who is reflective of the target population and a member of the case management team. This initial meeting provides the occasion for screening for health risk factors, cultural preferences, linguistic needs, ACEs, and SDOH. The Member does not simply complete a variety of screening tools, but concurrently is engaged in a verbal exchange that includes motivational interviewing. The Traditional Health Worker provides feedback regarding the screening results, and seeks to understand how the
primary care practice can best meet the Member's unique needs (i.e., through same-
day appointing; Saturday appointing; appointing when a Spanish language health
interpreter is present; appointing with a same-gender provider; special handling to
prevent re-traumatization; and a great many other Member-centric customizations).
If the Member screens positive for health risks, those risks will be assessed to
determine if the Member is best served in the primary care setting, or if Referrals
and coordination for higher levels of care are needed.

6.a.(9)(a). Comprehensive Transitional Care: The Applicant must ensure
that Members receive comprehensive transitional care so that Members' experiences
and outcomes are improved. Care Coordination and Transitional Care should be culturally and linguistically appropriate to
the Member's need. Describe Applicant's plan to address appropriate Transitional Care for Members facing admission or discharge from Hospital, hospice or other palliative care, home health care, adult foster care, skills nursing care, residential or outpatient treatment for mental health or substance use disorder, the Oregon State Hospital, or other care settings. This includes transitional services and supports for children, adolescents, and adults with serious Behavioral Health conditions facing admissions or discharge from residential treatment settings and the state Hospitals. In Advanced Health's model, it is anticipated that most Members who
may experience a transition-in-care have already been identified and are participating with an ICC/ENCC team. Under these circumstances, the ICC/ENCC team will have been involved with the Member, and the Member's Representatives
and Providers, at the earliest onset of the transition-in-care. Hopefully, most transitions-in-care will have been thoughtfully contemplated and be consistent with
the Member's written care plan. The Member, and Member's Representatives, will
be assisted by the ICC/ENCC team through each step of the transition-in-care,
including discharge planning. Discharge planning will commence concurrent with
the onset of the transition-in-care, will be Member- and family-focused, and will
result in planful, ego syntonic, and trauma-informed transitions that are purposed
at meeting each Member's unique needs.

Under isolated circumstances, a Member who is not served by an ICC/ENCC team
may experience conditions that result in emergent episodes of care or transitions-in-
care (e.g., acute health crisis; unanticipated early onset of psychosis). These Members, and their Representatives, will receive immediate assistance from Advanced Health’s Senior Care Management Executive until their Care Coordination needs can be transferred to an ICC/ENCC Care Coordinator. Such Members will be prioritized for access to an ACT or SOC team, if there is concurrent SPMI or SED.

For Members who are entering or exiting in-patient or residential services, and
particularly for those Members who have been placed in facilities that are outside of
the service delivery area, ICC/ENCC Care Coordinators shall have contact with the Member at least two times per month prior to discharge, and two times during the week prior to discharge. Every effort will be made to assure that these contacts occur on a face-to-face basis. If appropriate, the ICC/ENCC Care Coordinator will arrange a Warm Handoff for Members if they will be transferred to another relevant care Provider during the transition-in-care. For Members in acute care, ICC/ENCC Care Coordinators will have contact with the Member, preferably on a face-to-face basis, within one business day of admission, and two times per week until discharge. Per ICC/ENCC standards, Members will be timely reassessed in the event of triggering criteria.

6.a.(9)(b) Describe Applicant's plan to coordinate and communicate with Type B AAA or APD to promote and monitor improved transitions of care for Members receiving DHS Medicaid-funded LTC services and supports, so that these Members receive comprehensive Transitional Care. Advanced Health has entered into an MOU with DHS' Regional APD Office for the provision of Exceptional Needs Care Coordination (ENCC) for Members receiving Medicaid-funded long-term care (LTC) and long-term services and supports (LTSS). Three ICC/ENCC Care Coordinators are retained to serve this specific population, with an emphasis on transitions-in-care as described in the immediately preceding question's response.

6.a.(9)(c) Describe Applicant's plan to develop an effective mechanism to track Member transitions from one care setting to another, including engagement of the Member and Family Members in care management and treatment planning. Individual plans of care are developed for all Members receiving ICC/ENCC Care Coordination, and this will include most Members who are in transition from one care setting to another (excluding normal Hospital discharges for Members who are not included in priority populations, or SPMI-SED- SUD- or APD-involved). For each such Member, the Care Coordinator, together with the Member and the Member's Family, prepares a written plan of care that is effectively tracked through Advanced Health's electronic Pre-manage/Community EHR programs, visible to all Providers affiliated with the Member's care.

6.a.(10)(a) Describe Applicant's standards and procedures that ensure the development of individualized care plans, including any priorities that will be followed in establishing such plans for those with intensive Care Coordination needs, including Members with SPMI receiving home- and Community-based services covered under the State's 1915(i) SPA. Advanced Health uses the Evidence-Based Assertive Community Treatment (ACT) as an innovative strategy within its delivery system to ensure coordinated and integrated person-centered care for all Members, including those with SPMI or other chronic conditions who receive home- and Community-based services under
the State's 1915(i) State Plan Amendment. Advanced Health documents that each Member has a PCP and, when indicated, a primary-care case manager or ICC/ENCC Care Coordinator that is responsible for coordination of care and transitions. Individual care plans are used to address the supportive, therapeutic, cultural, and linguistic health of each Member, particularly those with ICC health needs. Through a process that includes the monthly review of 75 percent of all care plans, Advanced Health ensures that care plans reflect Members', families', and caregivers' preferences and goals.

6.a.(10)(b) Describe Applicant's universal screening process that assesses individuals for critical risk factors that trigger intensive Care Coordination for high-needs Members, including those receiving DHS Medicaid-funded LTC services. Universal screening occurs in the primary care practice, both within thirty (30) days of Enrollment, and annually thereafter, and includes an assessment of health risks, social and emotional wellbeing, ACEs, and SDOH-HE. Members found to be at moderate levels of risk, and who can be safely managed in the primary care setting, receive primary-care case management services. Those Members who are found to be included in special populations, or diagnosed with SPMI or SUD, or who present with high needs, are referred for ICC/ENCC services. This will include most Members who receive DHS Medicaid-funded LTC and LTSS services, particularly during times of transition. Advanced Health is aware that additional triggers can occur between annual screening assessments, provides information about these triggers in its Provider Handbook and policies, and makes arrangement for the immediate assignment of any Member to an ICC/ENCC team, if not already assigned at the time of the triggering event. For Members already assigned to an ICC/ENCC team, the Senior ICC/ENCC Executive ensures that the team responds to the Member immediately, and updates its plan of care within one work day.

6.a.(10)(c) Describe how Applicant will factor in relevant Referral, risk assessment, and screening information from local Type B AAA and APD offices and DHS Medicaid-funded LTC Providers, and how they will communicate and coordinate with Type B AAA and APD offices. Advanced Health has established a seven-year history of working with care managers at the regional APD office to meet the medical needs of Members receiving Medicaid-funded LTC and LTSS. APD's case managers and LTC Providers have access to Advanced Health's Pre-manage/Community EHR systems, through which they can reference plans of care, recent updates to the plans of care, and risk assessment and screening information. APD's case managers and Providers have direct contact information for Advanced Health's ICC/ENCC Care Coordinators and call upon those coordinators whenever there is a medical need, or change in the Members' circumstances, or actual or contemplated transition in care. These contacts prompt an immediate huddle among DHS and Advanced Health Care Coordinators. In addition, Advanced Health's ICC/ENCC Care Coordinators meet with APD's case
managers on a regular weekly basis and co-participate in Hospital and facility discharge planning meetings.

6.a.(10)(d) Describe how Applicant will reassess high-needs Members at least semi-annually or when significant changes in status occur to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner. Advanced Health's ICC/ENCC Care Coordinators are required to update plans of care on a monthly basis and more frequently if indicated. Advanced Health's policies, procedures, and standards establish expectations that Care Coordinators' assessments of high-needs Members will be continuous and ongoing, and that plans of care will be updated to reflect the Member's current status. Advanced Health's Senior ICC/ENCC Executive reviews 75 percent of all care plans on a monthly basis to ensure that assessment is a continuing process, and that care plans are up-to-date and reflective of Members', families', and caregivers' preferences and objectives.

6.a.(10)(e) Describe how individualized care plans will be jointly shared and coordinated with relevant staff from Type B AAA and APD and with DHS Medicaid-funded LTC Providers and Medicare Advantage Plans serving Fully Dual Eligible Members. Individualized plans of care are entered into Pre-manage/Community EHR systems, made electronically to all clinical personnel affiliated with a Member's care, in a HIPAA-compliant manner. End-users, including APD and LTC Providers and physicians providing care to Medicare Advantage Enrollees may also make entries to Pre-manage/Community EHR, thereby creating continuous feedback loops among all parties involved in each Member's care.

6.a.(11) Describe Applicant's plan for coordinating care for Member oral health needs, prevention and wellness, as well as facilitating appropriate Referrals to oral health services. Under new practice standards that will be forthcoming from the Clinical Advisory Panel, all Primary Care Providers will be required to perform limited oral health assessments during all well-child and well-adult office visits. When unaddressed oral health needs are identified, Referrals are made, and if the Member is participating in primary-care case management or ICC/ENCC Care Coordination, an entry regarding the need and Referral are made to the plan of care to ensure appropriate follow-up by case managers and Care Coordinators. Advanced Health's Clinical Advisory Panel has been charged with developing a more robust model for the integration of oral health services in the primary care setting, and their recommendations are anticipated by August 2019.

6.a.(12) Describe Applicant's plan for coordinating Referrals from oral health to physical health or Behavioral Health care. Oral health Providers have access to Pre-manage/Community EHR. If oral health Providers become aware of physical or Behavioral Health needs, they make entries to the alert system.
within Pre-manage/Community EHR and enter the nature of their concern. The "alert" will flag the plan of care to the attention of the assigned case manager or Care Coordinator who will make appropriate follow-up provisions in concert with the Member.

6.b.(1)(a) Describe Applicant's plan for ensuring the delivery of oral health services are coordinated among systems of physical, oral, and Behavioral Health care. Care Coordinators, through plans of care, are responsible for coordinating all aspects of a Member's care, including physical, oral, and Behavioral Health services, as well as housing, financial, legal, ACEs, and SDOH-HE needs. The primary communication tool among all parties involved in Members' care is the Pre-manage/Community EHR plan of care that is accessible throughout the system. On a monthly basis, the Senior ICC/ENCC Executive reviews 75 percent of all active plans of care to ensure that Care Coordinators are fulfilling these responsibilities and to identify lapses or gaps that may contribute to a lack of coordination. Lapses and gaps become the focus of in-service training, additional policy development, individual counseling with Care Coordinators, or corrective action.

6.b.(1)(b) Describe Applicant's plan for ensuring that preventative oral health services are easily accessible to Members to reduce the need for urgent or emergency oral health services. Preventative oral health needs are included in case management care plans and serve to prompt both case managers and Members that dental preventative exams need to be scheduled. Advantage Dental maintains one open walk-in appointment each morning, to ensure that any urgent dental need arising the previous night can be addressed in the absence of an ED visit.

6.b.(2)(a) Adequate, timely and appropriate access to Hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of the patient-centered primary care home. Describe how Applicant's agreements with its hospitalists and specialty care Providers will address coordination with a Member's Patient-Centered Primary Care Home or Primary Care Provider. The contractual agreement describes the healthcare delivery system as one that is "coordinated care" and requires all Hospitals and medical specialists under contract to coordinate Members' care with Primary Care Providers.

6.b.(2)(b) Describe Applicant's processes for PCPCH or Primary Care Provider to refer for Hospital admission or specialty services and coordination of care. Advanced Health's Primary Care Providers are permitted to make all in-network, and most out-of-network, medical specialty Referrals without Prior Authorization. Prior Authorization is required from the medical specialist if additional services will be provided after the initial consult. Primary
Care Providers may make direct Referrals for Hospital admission for all urgent and emergent needs. Prior Authorization is required for elective surgeries and procedures.

6.b.(2)(c) Describe Applicant's performance expectations for communication and medical record sharing for Hospital and specialty treatment, at the time of Hospital admission or discharge, for after-Hospital follow-up appointments. All Members are discharged from the Hospital with a scheduled after-Hospital visit, which may be with the medical specialist who attended the Members' needs during Hospital confinement, or with the Members' Primary Care Provider. An alert system notifies Primary Care Providers that their patients have been hospitalized. Discharge planners provide Primary Care Providers with electronic discharge records at the time of discharge, and coordinate scheduling the after-Hospital visit with the Primary Care Provider's office.

6.b.(2)(d) Describe Applicant's plan for achieving successful transitions of care for Members, with the PCPCH or Primary Care Provider and the Member in central treatment planning roles. When transitions in care are contemplated, the individualized plan of care attends to the details of that transition and includes both medical objectives from the Primary Care Provider, and Member preferences. No voice is greater than the others, and Members are always free to decline treatment, services, or medical recommendations.

6.c.(1)(a) Describe how the Applicant will effectively provide health services to Members receiving DHS Medicaid-funded LTC services whether served in their own homes, Community-based care, or Nursing Facility and coordinate with the DHS Medicaid-funded LTC delivery system in the Applicants Service Area, including the role of Type B AAA or the APD office. All Members receiving DHS Medicaid-funded LTC services, regardless of setting, are assigned to a Primary Care Provider who is ultimately responsible for the Member's medical needs. These individuals are also enrolled in ENCC. In Coos and Curry Counties, this numbers approximately 200 persons. Each Member receiving ENCC services is contacted at least one time per week to determine if there are any unaddressed needs or contemplated transitions. The Member's APD Care Coordinator, or caregiver, or home or residential facility is also contacted at least one time per month, and more frequently if indicated, for the purposes of updating the care plan. Advanced Health is contemplating implementing in-home and in-home bi-weekly and on-demand nursing rounds to better identify and address the needs of Members who are shared with Medicaid-funded LTC service providers.

6.c.(1)(b) Describe how the Applicant will use best practices applicable to individuals in DHS Medicaid-funded LTC settings including best practices
related to Care Coordination and transitions of care. Advanced Health is aware of the successes of the House Calls program in Portland, and the growing evidence-base for that program, and has considerable interest in adopting this model, using nurse practitioners, in its Service Area. Until that program can be launched, Advanced Health will operate a House-Call-like program that uses ENCC Care Coordinators who work under the supervision of a registered nurse.

6.c.(2)(a) Describe how Applicant will use or participate in any of the following models for better coordinating care between the health and DHS Medicaid-funded LTC systems, or describe any alternative models of care, including 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. While not on a full-time basis, ENCC Care Coordinators are on-site at each LTC facility each week, similar to co-location. For adult Members diagnosed with SPMI, Behavioral Health specialists affiliated with the Member's ACT Team are on-site in the LTC facility, group home, or Member's home (with consent) at least two times per week. In Curry County, Advanced Health has contributed to the development of a one-stop integrated Community services site at which APD representatives and Advanced Health Care Coordinators and Behavioral Health specialists will be co-located.

6.c.(2)(b) Describe how Applicant may use team approaches in which Care Coordination positions, jointly funded by the DHS Medicaid-funded LTC and health systems, or team approaches such as a multidisciplinary care team including DHS Medicaid-funded LTC representative. Advanced Health plans to deliver ENCC Care Coordination using a team approach that is comprised of professionals (nurses or licensed Behavioral Health specialists) and Traditional Health Workers. Similarly, Advanced Health will deliver all ENCC services to adult Members with SPMI through ACT Teams that are comprised of mental health professionals, registered nurses, skill trainers/job developers, Traditional Health Workers, and a fractional prescriber. Advanced Health will explore with its APD partners any interest in participating as members of these formalized teams.

6.c.(2)(c) Describe how Applicant may deliver 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). In 2018, Advanced Health engaged Advantage Dental and a single LTC nursing facility to test a model of providing on-site oral health screening for Medicaid-funded LTC residents. The pilot project was a phenomenal success! Members appreciated receiving preventative oral health screening and the early detection of dental problems that could have become painful or urgent over time. LTC staff members appreciated the pro-active approach that saved them from...
transporting fragile individuals to dental offices, or worse, to emergency departments for emergent dental problems that could have been earlier detected. Advantage Dental benefitted by being able to pro-actively arrange restorative dental care for LTC Members, rather than having to respond to emergencies. Advanced Health will replicate this model in LTC nursing homes throughout its Service Area.

6.c.(2)(d) Describe how Applicant may deliver clinician/home-based programs. Advanced Health is aware of the successes of the House Calls program in Portland, and the growing evidence-base for that program, and has considerable interest in adopting this model, using nurse practitioners, in its Service Area.

6.d.(1) Describe how Applicant will perform the following utilization management activities tailored to address the needs of diverse populations including Members receiving DHS Medicaid-funded LTC services, Members with Special Health Care Needs, Members with intellectual and developmental disabilities, adults who have SPMI, and children who have serious emotional disturbance (SED). How will the authorization process differ for Acute and ambulatory levels of care? When a Provider identifies a Prior Authorization request as being STAT, urgent, or emergent, this triggers an expedited review that will occur within 72 hours. If the Provider does not request a STAT review, Advanced Health's utilization management team will check to determine if the Member is included in a priority or special population, and if so, will mark the Prior Authorization request as STAT. All Prior Authorization requests that are flagged as STAT indicate to the reviewer that an expedited review is required. To assure that STAT requests are moved to the top of the inbox, STAT reviews are sent to reviewers through email-alert and Skype notifications.

If a Member of a special or priority population has been hospitalized, the Prior Authorization request related to length-of-stay is initiated within 24 hours of notification from the attending provider or admitting facility. Each approved length-of-stay is followed by the receipt of additional information if an extension is requested, or by a discharge summary. Extensions to length-of-stay requests are reviewed within 24 hours.

6.d.(2) Describe the methodology and criteria for identifying over- and under-utilization of services. Advanced Health currently is using the quality measures as its primary means of identifying over- and under-utilization. These are the externally validated metrics identified by the OHA as quality performance measures, some of them are also included in the CCO Quality Incentive program. Advanced Health monitors the utilization data in aggregate for trends. It also monitors for potential disparities in sub-populations, for example: race; ethnicity; gender; age; disability status; chronic conditions; zip code. These metrics are regularly reviewed at the Interagency Quality Committee. Pharmacy utilization is
reviewed by the Pharmacy and Therapeutics committee. Advanced Health has addressed identified under- and over-utilization concerns through the Performance Improvement Process (PIPs) and other improvement initiatives appropriate to the identified concern. It has also highlights some areas of under- and over-utilization in the Transformation and Quality Strategy, including data analysis to identify the issue and our action plan for improvement. Specific measures include:

- Adolescent Well Care Visits
- Colorectal Cancer Screening
- Emergency Department Utilization (for all Members)
- Emergency Department Utilization (for Members with mental illness)
- Well Visits in the First 15 months of life
- Developmental Screening (age 0 – 3)
- Dental Sealants on permanent molars for children
- Oral Health Evaluations for Adults with Diabetes
- Effective Contraceptive Use
- Childhood Immunization Status
- Adolescent Immunization Status

7. Accountability
7.a. Describe any quality measurement and reporting system that Applicant has in place or will implement in Year 1. Advanced Health has a demonstrated track record of collecting all data necessary to report CCO accountability metrics and to make improvements to meet benchmarks. Advanced Health has highly qualified and experienced staff in data analytics, quality management, and health information management systems. These staff members monitor the CCO accountability metrics and provide monthly feedback to clinics and Providers to pinpoint opportunities for improvement and evaluate champions and best practices. Advanced Health uses systematic performance improvement processes and Evidence-Based best practice models to promote improvement and achieve benchmarks. Advanced Health staff work closely with quality improvement staff embedded within the Provider Network to make improvements to systems and workflows to improve quality of care and efficiency of service delivery.

7.b. Will Applicant participate in any external quality measurement and reporting programs (e.g., HEDIS reporting related to NCQA accreditation, federal reporting for Medicare Advantage lines of business)? Advanced Health is in the very early phases of exploring NCQA accreditation as a Managed Care Entity. Advanced Health does participate in external quality measurement and reporting for the Medicare CPC+ Program.

7.c. Explain Applicant's internal quality standards or performance expectations to which Providers and Subcontractors are held? By contract, Advanced Health requires its Providers and Subcontractors to: work diligently
toward the attainment of HEDIS metrics, whether included in the Quality Pool or not; comply with practice standards promulgated with their respective professional associations and academies; treat Members with dignity and respect; respond to Members in ways that are Culturally Responsive and linguistically informed; provide services in a manner that attends unconscious/implicit bias; operate offices and practices that are trauma-informed; and maintain appropriate levels of access for Members.

7.d. Describe the mechanisms that Applicant uses for sharing performance information with Providers and contractors for quality improvement. Advanced Health provides every medical Provider with a quarterly dashboard that provides feedback on the Provider's performance with respect to relevant quality incentive metrics and internal access metrics. This same document also provides a visual dashboard that compares each physician's performance to a matched cohort of other physicians, through which each physician can measure his or her performance against the performance of his or her peers or specialty cohort. Performance information for contractors is shared through face-to-face operational meetings convened for the purpose of discussing contractual performance and barriers. These are two-way conversations in which contractors identify barriers or perceived lack of support from Advanced Health, and Advanced Health discusses interactions and performance. For example, when meeting with contracted Hospitals, discussions may center on length-of-stay or Hospital readmission rates. When meeting with the SUD contractor, discussions will focus on SUD engagement and SUD retention rates. When meeting with the mental health contractor, discussion will focus on SOC or psychiatric Hospital utilization. All discussions are purposed at quality improvement.

8. Fraud, Waste and Abuse Compliance
8.a. Please describe how Applicant currently engages in activities designed to prevent and detect Fraud, Waste, and Abuse. A number of mechanisms are currently in place to prevent and detect Fraud, Waste and Abuse (FWA). Advanced Health has in place a robust policy and set of procedures regarding FWA, and it requires each Provider and Subcontractor to also have such policies and procedures in place, which by contract must be acceptable to Advanced Health. Advanced Health compliance staff attends regular training on FWA detection and prevention, and they also serve as a resource for Network Providers and Subcontractors when they have questions or concerns. FWA detection and prevention issues are addressed regularly at compliance committee meetings at the Board of Directors, management and staff levels. With respect to specific services, the Utilization Review Team reviews Prior Authorization requests to ensure that proposed treatment plans are Medically Appropriate and no FWA red flags are identified. Once services are provided, inbound claims pass through a number of verification and validation steps which are designed to identify potential FWA issues. Advanced Health has developed monitoring tools such as analytic reports and
electronic dashboards to detect anomalies, which are subsequently investigated, to ensure that none of its Providers or Subcontractors is engaged in FWA activities.

8.b. Please describe how Applicant plans to monitor and audit its Provider Network, Subcontractors, and delegated entities for potential Fraud, Waste, and Abuse activities. Advanced Health has retained the services of one, and has access to a second, certified medical coder. These individuals have the skills to perform medical claims auditing to verify that medical claims (encounters) precisely and accurately match with medical records and processes and other documentation (such as claims verification by the Member), to result in a valid claim for services actually delivered that is neither up-coded nor down-coded. If needed, Advanced Health’s capacity to perform Provider audits can be increased through contractual agreements with independent medical auditing firms. Beginning in 2019, Advanced Health will use both algorithm and randomization to select claims and encounter data for auditing and will deploy personnel and contracted auditors to perform this function.

9. Quality Improvement Program
9.a. Please describe policies, processes, practices, and procedures you have in place that serve to improve Member outcomes, including evidence-based best practices, emerging best practices, and innovative strategies in all areas of Health System Transformation, including patient engagement and activation. Advanced Health maintains a robust quality management and quality improvement system, including, but not limited to, processes for performance evaluation and improvement, adoption and dissemination of Evidence-Based clinical practice guidelines, utilization review, quality measure monitoring and reporting, a comprehensive member grievance system, and strong organizational leadership commitment to quality. Advanced Health supports quality improvement capacity development within the Provider Network through regular meetings, technical assistance and training, performance improvement projects, as well as initiatives like the PCPCH Learning Collaborative. Advanced Health also has several initiatives centered around integration of care; integration of Behavioral Health into primary care, integration of physical health into a Behavioral Health setting, and integration of oral healthcare into primary care and Behavioral Health settings.

9.b. Please describe your experience and plan to emphasize and implement wellness and health improvement activities and practices within your organization for Members and staff, including partners and contracts in place to strengthen this aspect of health care. Advanced Health promotes healthy eating and activity for Members, staff, and the Community. A sample of some of Advanced Health’s current initiatives:
Advanced Health's office is part of a non-smoking campus in partnership with Coos Health and Wellness, Oregon Coast Community Action, and Early Head Start, all located on the same campus.

Advanced Health offers fresh, healthy options for catered lunch meetings such as Member classes and Community Advisory Council meetings.

As part of the Community Health Improvement Plan, Advanced Health supports the Healthy Bytes initiative, which publishes and distributes materials monthly highlighting a specific food with information about health benefits and recipes to try.

Advanced Health sponsored a free swim at the North Bend Municipal Swimming Pool each day during spring break in 2019 and will continue to sponsor a weekly free swim to promote healthy activity for the Community.

9.c. Outline your experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data that will be required for meeting regular performance benchmarks to evaluate the value of health services delivered by your CCO. Describe how CCO accountability metrics serve to ensure quality care is provided and serve as an incentive to improve care and the delivery of services. Advanced Health has a demonstrated track record of collecting all data necessary to report CCO accountability metrics and to make improvements to meet benchmarks. Advanced Health has highly qualified and experienced staff in data analytics, quality management, and health information management systems. Advanced Health monitors the CCO accountability metrics and provides monthly feedback to clinics and providers to pinpoint opportunities for improvement and evaluate champions and best practices. Systematic performance improvement processes and Evidence-Based best practice models are used to promote improvement and achieve benchmarks. Advanced Health staff work closely with quality improvement staff embedded within the Provider Network to make improvements to systems and workflows to improve quality of care and efficiency of service delivery.

9.d. Describe your policies and procedures to ensure a continuity of care system for the coordination of care and the arrangement, tracking, and documentation of all Referrals and Prior Authorizations. The Medical Services Department includes Utilization Review and Intensive Case Management functions. This team reviews Prior Authorizations to ensure that treatments follow the Prioritized List of Health Services and the associated guidelines to assure that services are Medically Appropriate. The Medical Services Department monitors performance to ensure that requests are handles in a timely and consistent manner. A data dashboard is in place to allow monitoring of number of authorization requests, average time to completion (for standard and expedited requests), percent approved or denied, and the types of requests received. Members in need of assistance to accessing appropriate care can be referred to Intensive Case
Management by their PCP or specialist Providers, by other members of the CCO team or Provider Network, or at the Member's or Family's request.

10. Medicare/Medicaid Alignment
10.a. Is Advanced Health under Enrollment and/or Marketing sanctions by CMS? **No.**

10.b. Is Applicant currently Affiliated with a Medicare Advantage Plan? If no, how will Applicant ensure they are contracted or affiliated with a Medicare Advantage Plan prior to the Effective Date of the Contract? Yes. Advanced Health's privileged contractor for physical and Behavioral Health services, SWOIPA, holds a contract with Pacific Source for its Medicare Advantage Plan in Coos and Curry Counties through which all physical and Behavioral Health services are coordinated.

11. Service Area and Capacity

11.a. List the Service Area(s) the Applicant is applying for and the maximum number of Members the Applicant is proposing to accept in each area based upon Applicant's Community health assessment and plan for delivery of integrated and coordinated health, mental health, and substance use disorder treatment services and supports and oral health services.

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<td>SERVICE AREA TABLE</td>
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11.b. Does Applicant propose a Service Area to cover less than a full County in any County? **No.**

12. Standards Related to Provider Participation
12.a. Standard #1 – Provision of Coordinated Care Services

INSTRUCTIONS: Submit the information about each Provider or facility using the DSN Provider Report Template in Excel for all Provider or facility types in Applicant's Provider Network. The Excel DSN Provider Report Template is submitted, as requested.

12.b. Standard #2 – Providers for Members with Special Health Care Needs
From those Providers and facilities identified in the DSN Provider Report Template (Standard #1 Table), identify those Providers and specialists that have special skills or sub-specialties necessary to provide a comprehensive array of Medical Services to the elderly, disabled population, children and youth in substitute care, Members who have high health-care needs or multiple chronic conditions, Members who are diagnosed with a mental illness, and Members who are diagnosed with substance use disorder. In narrative form, describe their qualifications and sub-specialties to provide Coordinated Care Services to these Members. Advanced Health has a long tradition of utilizing the expertise of its Providers in providing the wide array of Medical Services in a coordinated care fashion to our more vulnerable Members. Several our Primary Care Providers have additional training needed in serving a Rural medical Community, or they have additional certification in specialized care. (1) Dr. J. Deleon, Pediatrics, provides specialty care in the assessment and treatment of victims of child abuse. This is work performed in a multidisciplinary team, involving several agencies in a single location. (2) Dr. C. McKelvey, Pediatrics, has a long-term commitment and experience with foster children/families and school-based provision of services. (3) Dr. R. Gerber, Family Medicine, has provided specialized care for inpatient adult psychiatric services. In addition, he serves in a consultative fashion for elderly Members with cognitive/behavior impairment. (4) Dr. J. Yost, Pediatrics, has additional expertise in evaluation and management of children with features of pervasive development delay. (5) Dr. W. Haack, Internal Medicine, has additional expertise through her experience in managing highly complex vulnerable Members, with a focus of problems in and out of the ICU settings. She developed a coordinated care service line with Bay Cities Ambulance, providing in-home care/assessment resulting in a demonstrable decrease in ED utilization and readmission. (6) Dr. J. Ospina, Family Medicine, has additional certification and training in addiction medicine. In addition to a full spectrum family medicine practice, he provides Suboxone treatment in an integrated model, working with ADAPT and care management. (7) R. Stappler, ANP, Internal Medicine, provides full spectrum internal medicine care and has additional certification in pain management. She provides consultation for other Providers and she works closely with the care management team and integrated behavior management team in her multispecialty clinic. (8) Dr. P. Pareek, Child/Adult Psychiatry, provides care across the spectrum of ambulatory and inpatient care. He and his patients benefit from the coordinated care services across the available mental health, Behavioral Health, and social service delegates. (9) Dr. P. Lund, Internal Medicine, who is also bilingual in the Spanish language, provides specialty wound care at the district Hospital. In coordinating care with a patients’ PCP and with care management, several hospitalizations have been avoided. (10) Dr. W. Croson, Family Medicine, has longstanding expertise and specialty certification in invasive procedure management of pain. All these Providers are a source of information and support for their primary care and specialty colleagues. They are readily available and the
network of Providers, given the sizes of Advanced Health's Service Areas, know their areas of expertise.

12.c. Standard #3 – Publicly-Funded Public Health and Community Mental Health Services. NOTE: Applicant has submitted the required table within its DSN report, in Excel format, detailing its involvement with publicly-funded healthcare services.

12.c.(1) Describe how Applicant has involved publicly-funded providers in the development of its integrated and coordinated Application. Coos Health and Wellness serves as the publicly funded public health department, and publicly funded Community Mental Health Program (CMHP) in Coos County and holds an active seat on Advanced Health's Board of Directors. Board meetings for the past six months have focused primarily on anticipated, and then actual, changes between CCO 1.0 and CCO 2.0, and planning for those changes. Coos Health and Wellness has been directly involved in the development of this situate integrated and coordinated Application.

12.c.(2) Describe the agreement with counties in the Service Area that achieve the objectives in ORS 414.153(4). If any of those agreements are under negotiation, the Applicant must submit the executed agreement prior to OHA issuing the CCO contract. ORS 414.153(4) requires CCOs to recognize the responsibility of counties to operate Community mental health programs by requiring a written agreement between each CCO and the local mental health authority. Advanced Health holds current agreements with the LMHA and CMHP in Coos County, and with the CMHP in Curry Counties. These agreements expire on December 31, 2019 and will be replaced with updated agreements to be effective January 1, 2020 that capture new requirements for CCO 2.0. Advanced Health will enter into a Privileged Provider Subcontract in Coos County, and into a standard Provider contractual agreement in Curry County for the provision of: management of children and adults at risk of entering or who are transitioning from the Oregon State Hospital or residential care; Care Coordination of residential services and supports for children and adults; management of the mental health crisis system; management of some Community-based specialized services; and, management of specialized services to reduce recidivism of individuals with mental illness in the criminal justice system.

12.c.(3) If Applicant does not have signed agreements with counties, as providers of services or as required by ORS 414.153(4), describe good faith efforts made to obtain such agreements and why such agreements are not feasible. Not applicable.

12.d. Standard #4 – Services for the American Indian/Native Alaska Population (AI/AN)
12.d.(1) Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population. Two recognized Tribes exist in Advanced Health's Service Area: The Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (located in Coos, Curry, Lincoln, Douglas, and Lane Counties); and the Coquille Indian Tribe (with 538 Tribal members dispersed across Coos, Curry, Douglas, Jackson, and Lane Counties, 350 of whom reside in Coos County). Advanced Health was the first CCO to enter a formal, OHA-approved, contractual mechanism wherein members of the Coquille Tribe may elect to receive their Medicaid benefits either through the CCO or through their federally recognized Coquille Indian Tribe Community Health Center. Advanced Health recognizes Coquille Indian Tribe Community Health Center as a Primary Care Provider within its network, and the PCPs affiliated with the Tribal Health Center are free to make Referrals throughout Advanced Health's network for the full complement of services, including Behavioral Health services. In some cases, Tribal members elect to maintain their Enrollment with the Tribal Clinic, but then when the need exists for services beyond the scope or capability of the Tribal Clinic, transfer their Medicaid Enrollment to Advanced Health. Advanced Health is entirely comfortable with this arrangement, even though it results in some adverse selection at the greatest moment of need (and cost). Responsibility for care, and Care Coordination is managed either at the Tribal Clinic (for Tribal members who elect to Enroll with the Clinic), or by Advanced Health for those Tribal members who elect to Enroll with the CCO.

In Coos County, Advanced Health has reached a similar agreement with the Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians. This confederated Tribe does not enjoy the benefit of a Native American Health Center, and Tribal members are provided with the option of maintaining their existing Medicaid benefits (largely through open cards) or Enrolling in the CCO. Tribal leaders encourage Enrollment in Advanced Health's CCO, although no pressure is applied to Tribal members to make any Enrollment decision.

There are two Rancherias (Elk Valley and Resighini) and two Tribes present in Del Norte County in northern California, at the southern border of Curry County: Tolowa Dee-ni Nation; and Yurok Tribe of California. Of these, the Yurok is the largest, and many of its Tribal members reside in the Brookings-Harbor area of Curry County. This Tribe operates a Native American Health Center in Crescent City, California. Advanced Health has engaged in outreach efforts to the Yurok Tribe, and while no formal agreement has been reached, there is interest on both sides.

12.e. Standard #5 – Indian Health Services (IHS) and Tribal 638 Facilities
12.e.(1) From among the Providers and facilities listed in the DSN Provider Report Template, please identify any that are Indian Health Service or Tribal 638 facilities. The Coquille Indian Tribe Community Health Center is a recognized Indian Health Service provider.

12.e.(2) Please describe your experience working with Indian Health Services and Tribal 638 facilities. Include your Referral process when IHS or Tribal 638 facility is not a participating panel Provider. Include your Prior Authorization process when the Referral originates from an IHS or Tribal 638 facility that is not a Participating Provider. All Indian Health Service Providers operating in Coos and Curry Counties are Participating Providers. The standards for making and receiving Referrals, or for requesting Prior Authorization, are identical to those for any other in-panel Participating Provider.

12.f. Standard #6 – Pharmacy Services and Medication Management

12.f.(1) Describe Applicant's experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs. Advanced Health has experience providing a prescription drug benefit as a covered service to Oregon Health Plan Members. Advanced Health has a formulary of covered drugs developed to provide a least costly alternative first line agents to treat most conditions funded by the Health Evidence Review Commission Prioritized List of Health Services. Mental health medications that are in Standard Therapeutic Class 7 and 11 are excluded from coverage along with Medicare Part D drugs when the patient is Fully Dual Eligible as outlined by Oregon Administrative Rule. If a medication has a high propensity for treatment of non-funded conditions or for off-label/experimental use the medication may require a Prior Authorization to ensure use is Medically Appropriate and for treatment of a covered condition. The Advanced Health formulary is available publicly on the Advanced Health website organized both alphabetically and by therapeutic class in a manner easily accessible to Members and the public. When applicable, Advanced Health utilizes the Prioritized List of Health Services Guideline Notes to ensure appropriate coverage of treatment options. Advanced Health utilizes high quality evidence sources to develop coverage criteria for medications requiring Prior Authorization. The Advanced Health Pharmacy and Therapeutics Committee and DUR Board meet every other month to review drug use criteria, make recommendations for formulary changes, and assure that prescription medications are Medically Appropriate and not likely to result in adverse medical results. MedImpact Healthcare Systems provides Pharmacy Benefit Management services through contact with Advanced Heath's physical health Subcontractor. These services include pharmacy network management and pharmacy claims payment.
12.f.(2) Specifically describe the Applicant's: (i) Ability to use a restrictive formulary as long as it allows access to other drug products not on the formulary through some process such as Prior Authorization; (ii) Formulary development that includes FDA approved drug products for each therapeutic class and at least one item in each therapeutic class of over-the-counter medications sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the providers of Pharmaceutical Services, e.g. pharmacies; (iii) Development of clinically appropriate utilization controls; and, (iv) Ability to revise a formulary periodically and a description of the evidence-based review processes utilized (including how information provided by the Oregon Pharmacy & Therapeutics Committee is incorporated) and whether this work will be subcontracted or performed internally. Advanced Health uses a restrictive formulary to create access to least costly medications used to treat conditions funded for coverage by Oregon Health Plan. If a non-formulary medication is required to treat a Member's health condition, a Prior Authorization should be submitted for consideration of coverage. Prior Authorization requests are reviewed to ensure the condition being treated is funded for coverage by Oregon Health Plan or meets the covered comorbid rule, that least costly formulary agents have been trialed or contraindications exist, and that use of the requested agent is consistent with FDA approved prescribing information and is not off-label or experimental as restricted by Oregon Administrative Rule.

The Advanced Health formulary includes FDA approved drug products from each therapeutic class, and at least one item from each therapeutic class of over the counter medications. Drug products that are on formulary are available through the pharmacy benefit with a valid prescription from a Provider registered with the State to serve Oregon Health Plan members. Prior Authorization may be required for some formulary agents to ensure medical appropriateness. Prescriptions must be dispensed from a network pharmacy registered with the State to serve Oregon Health Plan Members. Exceptions may be made for emergent situations. Any medication not listed on the formulary may be requested through the Prior Authorization process.

The Advanced Health Pharmacy and Therapeutics Committee and DUR Board meet every other month. The Advanced Health Pharmacy and Therapeutics Committee is comprised of local practicing pharmacists and physicians. The Committee reviews and approves all drug utilization controls to ensure each are Evidence-Based and medically appropriate. Formulary changes may be recommended and approved at Advanced Health Pharmacy and Therapeutics Committee meetings.

Advanced Health utilizes the Oregon State University Drug Use Review and Management evidence reviews, clinical guidelines, FDA approved prescribing
information, and other high-quality literature sources to develop clinically appropriate utilization controls for medications.

The Advanced Health Pharmacy and Therapeutics Committee meets every month to review drug use criteria, formulary placement, DUR reports, and make recommendations for formulary changes depending on pharmacy trends identified in PBM reporting materials, price changes, OHA guidance, and best practice changes. This work is performed internally by the Advanced Health Pharmacy department. Advanced Health aligns drug utilization controls with FFS when evidence and cost support alignment.

12.f.(3) Describe Applicant's ability to ensure an adequate pharmacy network to provide sufficient access to all enrollees and how Applicant will communicate formulary choices and changes to the network and other medical professionals and how to make non-formulary, i.e. Prior Authorization, requests. Under the contractual arrangements described in more detail in Q12.f.(6), MedImpact Healthcare Systems provides for Advanced Health with PBM services, including maintenance of an adequate pharmacy network to provide sufficient access to all Advanced Health Members for pharmacy benefit services. Advanced Health Members have access to 587 pharmacies in Oregon, each of which are Enrolled in the State Medicaid program. The locations of the pharmacies meet the access needs of Advanced Health's rural CCO membership. Walgreen's is currently excluded from the pharmacy network to ensure the highest financial performance. MedImpact Direct Specialty pharmacies are also available to dispense high cost specialty medications to Advanced Health Members through a mail delivery system.

Advanced Health communicates formulary choices and changes to the pharmacy network and other medical professionals through Advanced Health's website, fax blasts, and distribution of written materials through Advanced Health's Provider Relations team. Information regarding Prior Authorization submission is located on the Advanced Health website and in the Advanced Health Provider Manual. All new Providers receive orientation that includes education about the Advanced Health formulary and how to submit Prior Authorization requests for medications.

12.f.(4) Describe Applicant's capacity to process pharmacy claims using a real-time Claims Adjudication and Provider reimbursement system and capture all relevant clinical and historical data elements for claims paid in their entirety by the CCO and when the coordination of benefits is needed to bill Third Party Liability (TPL) when the CCO is the secondary coverage. Under the contractual arrangements described in more detail in Q12.f.(6), MedImpact Healthcare Systems provides a contracted network of pharmacies electronically linked for real-time pharmacy claims adjudication. MedImpact participates actively in the National Council for Prescription Drug
Programs (NCPDP) to ensure compliance with industry standards for use of real-time, point-of-service technology across healthcare segments. Information captured with claims submission includes the necessary clinical and historical data elements for which a health plan may use for case management, formulary management and quality initiatives such as diabetic and asthma medication adherence. In addition, the information captured at the pharmacy is used to create the monthly encounter data files sent to the State.

Electronic coordination of benefits (eCOB) occurs at the point of sale as well. The purpose of an eCOB program is to allow pharmacies to seamlessly process secondary coverage claims at the point of service. The eCOB process is as follows:
1) The pharmacy electronically transmits the claim to the primary payer. 2) The primary payer will return an electronic confirmation of charges approved for payment and the remaining unpaid balance. 3) The pharmacy then transmits the remaining charges electronically to the secondary payer. 4) The secondary payer approves payment. 5) The secondary electronic claim is then processed, and the pharmacy is paid.

For eCOB to work most effectively, the health plan provides the appropriate COB eligibility information and network pharmacies must be willing or contractually obligated to participate. The ability for a pharmacy to participate can be dependent on the capabilities of the pharmacy's claim submission software. The eCOB program is fully compliant with NCPDP 5.1 standards for claim submission; however, some pharmacies are still unable to participate due to constraints. Network pharmacy providers are reimbursed via a bi-weekly cycle.

12.f.(5) Describe Applicant's capacity to process pharmacy Prior Authorizations (PA) within the required timeframes either with in-house staff or through a Pharmacy Benefits Manager and the hours of operation that prescribers or pharmacies will be able to submit PAs. Advanced Health processes Prior Authorizations for medications with a staff of clinical pharmacists, physicians, and certified pharmacy technicians provided through Southwest Oregon IPA, Inc. Medication Prior Authorizations are processed within 24 hours unless additional clinical information is required to render a decision, in which case up to 72 hours may be required pursuant to OAR 410-141-3225(9)(b-C). Advanced Health's business hours are Monday through Friday 8am to 5pm, with pharmacy staff on call for all holidays and weekends to ensure pharmacy and Provider administered drug Prior Authorization requests are completed within timeframe. Prior Authorization requests may be submitted at any time that is convenient for the provider office.

A five-day emergency supply of any medication prescribed at emergency, Hospital, or urgent care discharge may be approved by the MedImpact Pharmacy Helpdesk.
with a call from the dispensing pharmacy. The MedImpact Pharmacy Helpdesk is available 24 hours per day 7 days per week including holidays and weekends.

Advanced Health handles all Member and Provider calls during office hours, as well as processes all medication Prior Authorization requests. The MedImpact Pharmacy Helpdesk is available to handle pharmacy calls 24/7, but only handles Member or Provider calls after Advanced Health business hours. MedImpact may enter clinical or operational overrides into the pharmacy system under the direction from authorized personnel at Advanced Health. These individuals are authorized to approve any request that falls outside the standard procedures during and after plan business hours when calling MedImpact's Pharmacy Help Desk for assistance. Any individuals making a request that are not identified as authorized personnel will be advised to have an authorized personnel contact MedImpact for assistance.

Clinical Authorizations include the following:

- Clinical-Age Restrictions
- Clinical-Medical Exceptions
- Clinical-Non-Formulary
- Clinical-Prior Authorization Required
- Clinical-Quantity Restrictions
- Clinical-Physician/Specialty
- Clinical-Step Care Therapy
- Clinical-Excluded Drugs
- Clinical-DAW Difference
- Clinical-Co-pay Exceptions

Specific to Natural Disasters, MedImpact will enter a one-time refill-too-soon override, per medication, if the pharmacy states the Member has had to evacuate due to a disaster. The override may include quantity restrictions, if there is no lifetime or yearly limit on the medication and the quantity does not exceed the limit allowed per month as defined in the Member's benefit.

12.f.(6) Describe Applicant's contractual arrangements with a PBM, including:

The contractual discount percentage(s) from Average Wholesale Price (AWP) or the percentage above Wholesale Acquisition Cost (WAC) the Contractor will receive from the PBM including rebate and incentive agreements or other funds received from the PBM by the CCO or any other type of any pricing arrangements between the CCO and PBM not based on a percentage discount from AWP or the percentage above WAC. Advanced Health has contracted with Southwest Oregon IPA, Inc. (SWOIPA) for the delivery of physical health services by SWOIPA to the Members assigned to Advanced Health, including the delivery of pharmacy health benefits. In accordance with its
obligations under the its agreement with Advanced Health, SWOIPA has entered into a Service Agreement with MedImpact Healthcare Systems, Inc., a California corporation ("MedImpact"), dated March 1, 2008, as amended by the Amendment to the Service Agreement dated August 1, 2012, Amendment to the Service Agreement dated September 1, 2013, and Amendment to the Service Agreement dated August 17, 2018 (as amended, the "PBM Agreement"), pursuant to which MedImpact provides PBM services for Members assigned to Advanced Health. The pricing arrangements provided in the PBM Agreement, including the discount percentages that SWOIPA receives from AWP, are as follows:

The dispensing fees associated with each category or type of prescription (for example: generic, brand name, mail order, retail choice 90, specialty). The retail brand and generic dispensing fees under the PBM Agreement are both $0.70. The PBM Agreement does not provide a dispensing fee for Specialty Pharmacy. Accordingly, no dispensing fee is charged by MedImpact.

Excelsior Solutions validates the aggregate dispensing fees related to each claim file for all Advanced Health pharmacy claims and aggregates such pharmacy claims to ensure the PBM Agreement dispensing fees are not being exceeded. Annually, Excelsior reconciles the aggregated pharmacy claims, and related dispensing fees, to the PBM Agreement dispensing fees on an annual basis. Excelsior issues an alert when the aggregated dispensing fees exceed the PBM Agreement dispensing fees on an annual basis, informing SWOIPA of the excess amount.

The administrative fee to be paid to the PBM by CCO on a quarterly basis including a description of the associated administrative fee for each category or type and a description of the amount and type of any other administrative fees paid to PBM by Contractor.
12.f.(7) Describe Applicant's ability to engage and utilize 340B enrolled Providers and pharmacies as a part of the CCO including: (i) Whether Applicant is currently working with FQHCs and Hospitals; and if so; (ii) How Applicant ensures the 340B program is delivering effective adjunctive programs that are being funded by the delta between what CCOs pay for their drugs and their acquisition costs; and (iii) How the Applicant is evaluating the impact of these adjunctive programs whether they are generating positive outcomes. Advanced Health has two local FQHCs contracted to serve our CCO membership. Each of the FQHCs have an onsite 340B pharmacy contracted with MedImpact Healthcare Solutions to participate in the Advanced Health pharmacy network to dispense medications to our Advanced Health membership. Advanced Health does not have any cost sharing agreements with any 340B entities.

12.f.(8) Describe Applicant's ability and intent to use Medication Therapy Management (MTM) as part of a Patient-Centered Primary Care Home. Advanced Health intends to contract with local Patient-Centered Primary Care Homes to embed clinical pharmacists to provided Medication Therapy Management services to our Advanced Health members. This model of embedded clinical pharmacists has been demonstrated to improve patient health outcomes. Our initial goal is to focus on members utilizing ten or more medications, recent asthma or COPD exacerbation, or diabetics with uncontrolled hemoglobin A1c. Each member will receive a Comprehensive Medication Review that will be shared with the Primary Care Provider and outpatient pharmacy. Identified medication related problems will be reported to the Primary Care Provider for consideration. The embedded clinical pharmacist will also be available to the clinical team to address medication related questions including adherence strategies, medication safety, drug interactions, and proper drug disposal. A telephonic Medication Therapy Management program is also available through MedImpact and may be considered for Advanced Health members.
12.f.(9) Describe Applicant's ability to utilize E-prescribing and its interface with Electronic Medical Records (EMR). Advanced Health does not currently utilize an e-prescribing platform that interfaces with the EMR due to cost and implementation challenges. However, if utilizing an e-prescribing platform is required for CCO contracting in 2020, Advanced Health will contract with MedImpact to operationalize their electronic solution, MedPrescription®, to furnish providers with formulary, benefit and medication history information to support e-prescribing accuracy and efficiency. MedImpact developed MedPrescription® to provide prescribers with "pre-prescribing" services. These services include patient-specific prescription eligibility, medication history and basic formulary information for consenting patients in both inpatient and outpatient settings.

MedPrescription interfaces with Surescripts, MedImpact's e-prescribing connectivity vendor, to deliver pre-prescribing services to providers of contracted clients. Providers may access patient-specific information securely using their practice's e-prescribing technology. The e-prescribing technology must have passed the certification requirements of the e-prescribing connectivity vendor. MedPrescription's IT infrastructure supports any connectivity vendor provided the vendor conforms to industry standards.

12.f.(10) Describe Applicant's capacity to publish formulary and Prior Authorization criteria on a public website in a format usable by Providers and Members. Advanced Health's formulary is published publicly on the Advanced Health website organized alphabetically and by therapeutic class. The format is streamlined to be easily accessible by Members and Providers. Our Advanced Health Pharmacy and Therapeutics Committee reviews the formulary annually. Advanced Health is in the process of having all Prior Authorization criteria reviewed by the Advanced Health Pharmacy and Therapeutics Committee for publishing to the Advanced Health website.

Standard #7 – Hospital Services

12.g.(1) Describe how Applicant will assure access for Members to inpatient and outpatient Hospital services addressing timeliness, amount, duration, and scope equal to other people within the same Service Area. Advanced Health, through SWOIPA, enters into value-based contracts with all Hospitals present in the two-county service delivery area: Bay Area Hospital (a DRG facility in Coos Bay); Coquille Valley Hospital (a Rural, critical access, Type A and B facility in Coos County); Southern Coos Hospital (a Rural, critical access, Type A and B facility in Bandon, in Coos County), and Curry General Hospital (a Rural, critical access, Type A and B facility in Gold Beach, in Curry County). Exactly the same Hospitals that serve Advanced Health's Members also serve all other persons accessing Hospital services in Coos or Curry County, howsoever insured or not insured. The written contractual agreements with these four
Hospitals require that they provide inpatient and outpatient services to Advanced Health's Members according to the exact same timelines, and in the exact same amount, duration, and scope, as would be provided to persons with private healthcare insurance.

Multiple Hospital-based services are not available in the local Community, most notably invasive cardiac surgery, heart-lung transplant surgery, all surgeries involving neonates, neonatal intensive care, and neurosurgery. In anticipation of these needs, SWOIPA enters into written agreements with out-of-area Hospitals for the orderly provision of these services to its Members. On isolated occasion, a situation arises in which a Member has a unique or challenging need that cannot be met by either an in-network or out-of-area contracted Hospital. When this occurs, SWOIPA identifies any facility that can meet the Member's need and authorizes the service at that facility pursuant to a written contract.

SWOIPA has entered into contracts with out-of-state Hospitals, most notably with a facility in California for the provision of highly specialized pediatric invasive heart surgery, and with a Hospital in Crescent City, California, because it is the most geographically proximal facility to Members residing in Brookings at the Oregon-California border.

While Advanced Health's process for monitoring equal access of Members to inpatient and outpatient Hospital services could appear rather rudimentary, it works well because of the close connections between Advanced Health and its Providers. The Chief Medical Officer is always aware of Members who are receiving services from Referral Hospitals, and simply uses best clinical judgment to weigh whether the service provided to a Member was similar or equal to the services that the facility may have provided to a privately insured person and following up as needed.

12.g.(2) Describe how Applicant will educate Members about how to appropriately access care from Ambulance, Emergency Rooms, and urgent care/walk-in clinics, and less intensive interventions other than their Primary Care home. Specifically, please discuss:

What procedures will be used for tracking Members' inappropriate use of Ambulance, Emergency Room, and urgent care/walk-in clinics, other than their Primary Care home? Advanced Health subscribes to the Milliman Risk-Stratification Solution that, based on encounter data, furnishes every Primary Care Provider with a synopsis of all utilization. Frequent or inappropriate utilization of any resource can be quickly identified. These data sets can be viewed by Primary Care Providers, panel managers, case managers, ICC/ENCC Care Coordinators, and staff members at Advanced Health who are charged with monitoring system-wide performance or quality improvement.
Procedures for improving appropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics: Member education concerning the appropriate and preventative use of medical resources begins with the Member Handbook that provides clear guidelines about when to call for an Ambulance and when to report to an Emergency Department. If Members have questions about the appropriate use of services, a 24-Hour Nurse Call Line is available to assist. When Members keep their initial, and then annual, screening appointments at the primary care practice, oral education is provided to supplement information provided in the Member Handbook. This is the right time and setting to discuss preventative healthcare and to address those conditions that could lead to unscheduled urgent or emergent health needs. If Members persist in the inappropriate use of medical resources, they are provided with primary-care case management services, or in more protracted circumstances, with ICC/ENCC Care Coordination services. The goal is to seek to understand the Members' barrier to inappropriate utilization, remove those barriers, and use strength-based approaches to guide Members toward thoughtful and appropriate utilization. Because there is never an allowable negative consequence for wasteful and inappropriate utilization, there are times when even the best efforts of motivational interviewers fail.

12.g.(3) Describe how Applicant will monitor and adjudicate claims for Provider Preventable Conditions based on Medicare guidelines for the following: Adverse Events; and Hospital Acquired Conditions. Advanced Health's Medical Director participates on Hospital safety committees, and those committees engage in safety monitoring as a surveillance tool aimed at identifying adverse events and Hospital Acquired Conditions. Local Hospitals have implemented procedures consistent with the Medicare Patient Safety Monitoring System and through surveillance mechanism have access to specific adverse event and Hospital Acquired Condition information for all patients – not just Medicare patients. Conditions that are the focus of local surveillance include: object inadvertently remaining after surgery; air embolism; blood incompatibility; catheter-associated urinary tract infection; decubitus ulcer; vascular catheter-associated infection; surgical site infection; all in-facility falls and traumas; certain manifestations of poor control of blood sugar levels while an inpatient; and, deep vein thrombosis or pulmonary embolism following certain joint replacement procedures.

The Medical Director's participation on the safety committee assures that surveillance information will flow to the Medical Director on a need-to-know basis for all Members. Advanced Health's claims processing system flags for any diagnosis or procedure related to the locally surveilled focus list and pulls those claims for further analysis by the Medical Director. Like Medicare, Advanced Health simply does not honor those claims submitted for Provider-Preventable Conditions, Adverse Events, or Hospital Acquired Conditions.
12.g.(4) Describe the Applicant's Hospital readmission policy and how it will enforce and monitor this policy. All four of Advanced Health's contracted local Hospitals are participating with Medicare, and as such, monitor and report on Medicare readmission rates. Advanced Health requires the Hospitals to similarly report on Medicaid readmission rates.

12.g.(5) Please describe innovative strategies that could be employed to decrease unnecessary Hospital utilization. Advanced Health has undertaken an analysis of the causal factors that locally contribute to Hospital readmissions, and the most salient findings include difficulty in arranging home-health care following discharge and confusion regarding medication management. With some degree of frequency, Members being discharged from the Hospital needed home-health services and that capacity simply did not exist in the Community. For these Members, SWOIPA entered into a contract with Bay Cities Ambulance for the provision of community paramedic services. Community paramedics provide a home-health assessment within one or two days of discharge, and weekly thereafter or as prescribed by the Primary Care Provider. Primary Care Providers receive same-day notification of paramedic visits, status reports, and outcomes. New processes have also been placed into action to initiate medication reconciliation with Members, and Members' caretakers, at the time of discharge.

12.g.(6) Please describe how you will coordinate with Medicare providers and, as applicable, Medicare Advantage Plans to reduce unnecessary ED visits or hospitalization for potentially preventable conditions and to reduce readmission rates for Fully Dual Eligible Members. The same efforts that Advanced Health has described throughout this Section 12 for its Medicaid Members (to reduce unnecessary Emergency Department visits or hospitalizations or readmissions) will be applied to Advanced Health's Members who are Fully Dual Eligible for Medicare. Advanced Health works with all primary care and medical specialty Providers in the Community. The exact same Providers who are serving Medicaid Members are also serving Medicare beneficiaries, and thus, coordination with Medicare providers is inherent within Advanced Health's Provider Network.
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## Time and Distance Standards

- Primary Care Providers-Adult
- Primary Care Providers-Pediatric
- PCPCH
- OB/GYN
- Behavioral Health/Mental Health-Adult
- Behavioral Health/Mental Health-Pediatric
- Behavioral Health/SUD-Adult
- Behavioral Health/SUD-Pediatric
- Hospital
- Pharmacy
- Dental-Adult
- Dental-Pediatric
- Specialists-Adult
- Specialists-Pediatric

## Description of the Delivery Network and Adequacy

*(Please address an integrated delivery network in your response)*

CCO describes the geographic distribution of all providers compared with the geographic distribution of enrollees. The CCO may use geocoding and should include analysis of how enrollees can access services, with supporting documentation, as needed.

CCO discusses how the network ensures that the time and distance standards for member access to health care are met.
CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.

CCO analyzes wait times for appointments with providers, including specialists.

CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.

CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.

CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.

CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.

CCO addresses transportation and access for enrollees with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.

CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.

CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.

CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of enrollees.
3 **Description of Enrollees** *(Please submit a description that reflects integration of care for all enrollees)*

CCO describes its process for taking into account enrollee characteristics when making provider assignments.
- CCO provides analysis of the language and cultural needs of enrollees.
- CCO provides analysis of the needs of enrollees with disabilities and enrollees with special health care needs.

CCO provides analysis of the prevalence of diseases that require access to specialists among the enrollee population.

CCO describes how enrollee needs for continuity of care and transition between levels of care are assessed.

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4 **Additional Analysis of the CCO’s Provider Network to Meet Enrollee Needs** *(Please address how the CCO’s integrated network is mobilized to deliver care for all enrollees)*

CCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.

CCO describes how it uses technology to deliver team-based care and other innovations.

CCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.

CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.

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5 **Coordination of Care** *(Please address how the CCO provides integrated care coordination for all enrollees)*
CCO describes relationship (including any memoranda of understanding) with:
- Aging and Persons with Disabilities
- Local public health authority
- Local mental health authority
- IHS and/or Tribal Health Clinics

CCO discusses coordination with above stakeholders.

CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.

CCO describes its process for identifying and assessing all enrollees for special health care needs.

CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.

**Performance on Metrics** *(Please describe how the CCO uses performance on its metrics to influence network adequacy decisions)*

CCO describes its efforts to build network capacity for those metrics where the CCO’s performance is below the baseline.

CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.
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OAR 410-141-3220
Background: Western Oregon Advanced Health, LLC (abn Advanced Health) was initially certified by the Oregon Health Authority (OHA) as a Coordinated Care Organization (CCO) in the first wave of CCO applicants in 2012. Since that time, Advanced Health has been a leader in the adoption of alternative payment models (APMs). Advanced Health recognizes that it is of critical importance for the U.S. health system to minimize the pay-for-production payment model, in favor of a system that rewards Providers for efficiency, quality, and Member engagement. Therefore, Advanced Health has worked to introduce APMs wherever practical.

Advanced Health has incorporated several APMs into its contracts; indeed, in 2017, nearly half of Advanced Health's health services spending was paid using capitated arrangements. Advanced Health pays Subcontractors using percent of premium and per-member-per-month (PMPM) models, including its dental and transportation Providers. Advanced Health's Subcontractors have also embraced APMs. The largest Hospital in Advanced Health's service area is paid almost exclusively on a fully capitated basis. Nearly all primary care Providers are paid PMPM with bonus payments for the performance of certain incentive services. Many outpatient mental health services are also paid on a PMPM basis.

These contracts, and the APMs Advanced Health has implemented through them, have contributed to Advanced Health's ability to limit unwarranted growth in health spending. Between 2014 and 2017, Advanced Health's 3-year non-annualized rate of growth was -2.8% as compared to the total CCO rate of growth of 24.6%. By leading CCOs in the implementation of capitated payment model APMs, Advanced Health is contributing to the sustainability of the Oregon Health Plan (OHP).

Advanced Health will continue its VBP efforts in restructuring of significant contracts in 2019 and beyond. An important aspect of doing so will be a new requirement in major Subcontracts that Subcontractors' arrangements with downstream Providers demonstrate progress toward this goal. In addition, Advanced Health will ensure that contracts address quality (through performance measures and incentives) and Member engagement, as well as the efficiencies that VBP arrangements envision.
Advanced Health has had great success in transitioning Providers away from the fee-for-service model. Advanced Health's Providers recognize the importance of value-based compensation and trust Advanced Health to design payment contracts in a way that is collaborative and fair. Advanced Health will reach the goal of 70% value-based payments by 2024 by continuing to move contracts away from fee-for-service payment structures and by modifying existing APM-based contracts to meet CCO 2.0 standards.

C.1. Submit two variations of the information in the supplemental baseline RFA VBP Data Template: a detailed estimate of the percent of VBP spending that uses the Applicant's self-reported lowest Enrollment viability threshold, and a second set of detailed and historical data-driven estimate of VBP spending that uses the Applicant's self-reported highest Enrollment threshold that their network can absorb. Attached.

Advanced Health will begin the CCO 2.0 contract period with over 20% of projected Provider payments in VBPs by requiring the Subcontractor that is responsible for physical health and integrated Behavioral Health, Southwest Oregon IPA, Inc., an Affiliate of Advanced Health, to structure contracts in accordance with the CCO 2.0 guidelines. It has committed to doing so and has indicated that it will focus on Hospital and substance use contracts to implement this directive.
Estimates of Contract Values and Performance Against the 2020 VBP Target: Advanced Health estimates 23.6% of 2020 health-related payments will fall into LAN Category 2C or higher. This estimate applies to both the highest and lowest enrollment thresholds and rests upon several assumptions. Each assumption has been selected to be reasonable and, wherever possible, conservative; that is, assumptions have been selected to bias Advanced Health's estimate to be lower than expected. This ensures Advanced Health's final estimate is conservative and it can expect its 2020 VBP rate to be higher than 23.6%.

Table 2 provides an estimate of the amounts that will be spent under the contracts provided thereon for 2020. These are conservative estimates because trend will be considered when setting spending targets and PMPM rates in 2020, so one should
expect contract values to be even higher. These estimates are also conservative because Advanced Health's best estimate of 2020 revenue using current enrollment is much higher than 2018 revenue. Therefore, by using Table 2's values as estimates for 2020, it is assumed that, even though Advanced Health's OHP revenue will increase, none of that increase will result in larger payments to these Providers referenced on Table 2.

These contract spending estimates are produced using 2018 spending data and enrollment levels. Therefore, these estimates can be compared to estimates of 2020 revenue and health-related service spending at current enrollment levels to arrive at an estimated VPB percentage (this attachment will use "current enrollment" and "2018 enrollment" interchangeably. Advanced Health enrollment since 2016 has been stable).

This MLR estimate can be applied to estimated 2020 revenue—using current enrollment—to obtain an estimate of Advanced Health's 2020 health services spending. This value can then be used to estimate performance against the 20% VPB requirement.

By assuming Advanced Health maintains its high MLR, the estimated 2020 health services spending described herein is biased toward higher spending. This will bias the estimated percent of VBP spending downward, resulting in a conservative estimate.
Assumption 3: As Advanced Health enrollment scales to the highest and lowest enrollment thresholds, revenue, health services spending, and expected contract values of PMPM-developed VBPs scale linearly.

It is reasonable to expect Advanced Health to maintain current MLR with higher and lower enrollment. It is conceivable that Advanced Health could lose membership disproportionately in a small area within its service area, but that is difficult to predict.

Because revenue, health services spending, and PMPM VBPs scale with enrollment, we can produce estimates of 2020 VBP spending rates with Advanced Health's lowest and highest enrollment values.

C.2. Provide a detailed estimate of the percent of the Applicant's PMPM LAN category 2A investments in PCPCHs and the plan to grow those investments.

Applicants must submit the following details:
   a. Payment differential across the PCPCH tier levels and estimated annual increases to the payments
   b. Rational for approach (including factors used to determine the rate such as Rural, Urban, or social complexity)

Advanced Health will implement a case management PMPM payment for PCPCHs prior to 2020. This payment will support PCPCH provision of Primary Care Case Management (PCCM) services and the annual screening and reassessment of Members for social determinants of health and health risk factors. This payment will meet the criteria for LAN Category 2A (Foundational Payments for Infrastructure & Operations).

To determine how these funds should be distributed by tier for 2020, it is necessary to gauge the cost variation for case management services across PCPCH tiers. To
do this, Advanced Health surveyed service area PCPCH administrators for case management cost estimates. Advanced Health requested PCPCHs provide estimates of the costs of case management services at their current respective tiers along with estimates of these costs at respective previous and future tiers. Previous tier estimates were excluded for years prior to the start of the five-tier PCPCH system.
C.3. Describe in detail the Applicant's plan for mitigating any adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; lesbian, Gay, Bisexual, transgender and queer (LGBTQ) people; persons with disabilities; people with limited English proficiency; immigrants or refugees and Members with complex healthcare needs as well as populations at the intersections of these groups. Mitigation plans could include, but shall not be limited to:

a. Measuring contracted Provider performance against their own historical performance rather than national benchmarks when patient mix is more complex;

b. Use of risk-adjustment models that consider social and medical complexity within the VBP; and

c. Monitoring number of patients that are "fired" from Providers.

Advanced Health recognizes that transitioning away from the fee-for-service model requires careful planning. It is critical that—in attempting to improve efficiency and quality of care—CCOs do not create perverse incentives or otherwise compromise Member health outcomes, especially for priority populations.

Advanced Health's VBPs will consist mostly of APM-based contracts such as risk sharing and PMPM-based capitation contracts. A common pitfall APMs of these types is the potential for Providers to curtail appropriate care in order to avoid penalties, earn shared savings, or increase their margin against capitation. Unintended consequences are considered at every stage of Advanced Health's value-based payment process.

Advanced Health's mitigation process begins at VBP conception. Each VBP arrangement concept and any associated quality metrics are scrutinized by Advanced Health's leadership team. This team includes Advanced Health's Medical Director, Director of Quality, Chief Financial Officer, Chief Executive Officer, and Director of Financial Planning and Analysis. Each team member brings a unique perspective that can be used to search for unintended consequences. Team members place themselves in the shoes of their contractor counterparts. They consider how they could behave under the contract to maximize reward and how those actions will impact Member care and outcomes, including their specific impact on priority populations. Any perverse incentives or potential adverse effects are noted.

A similar vetting process will be performed with Community partners and Advanced Health Members. Advanced Health participates in a Community Equity Coalition. This group is comprised of a diverse selection of Advanced Health
Members, Advanced Health partners, and other Community members. The group works to identify service area disparities and to ensure services are accommodating priority population needs. This step exposes the planned VBP to scrutiny from a group that represents the diversity of backgrounds present in Advanced Health's Community.

The data from the previous steps are compiled by Advanced Health leadership and reviewed. A VBP concept can be abandoned at this point but often potential unintended consequences can be guarded against. A common approach is to incorporate into the VBP contract a complementing measure that negates specific perverse incentives. For example, the Hospital shared risk and capitation VBPs described in section C.1. of this attachment will, without intervention, create a perverse incentive for the contracting Hospitals to reduce appropriate care in order to increase their margin against the spending target. Including an incentive around Hospital readmissions helps to negate this perverse incentive. Hospital readmission rate is a lagging indicator for appropriate care. If a Hospital cuts appropriate care by, for example, inappropriately reducing the length of inpatient stays, the cuts will likely have a negative impact on their readmission rate and will result in a negative financial outcome.

Adverse effects of VBPs on priority populations are often best detected by concurrent and retrospective review of disparity data. Advanced Health's population health management (PHM) tools, custom dashboards and reports are used to assess the impact of VBPs on priority populations. One example of Advanced Health's PHM tools is Advanced Health's Quality Dashboard Suite, which allows users to review key quality and utilization measures. The dashboards can be filtered by Provider organization and Member demographic information, including ethnicity, language, medical complexity, and other population characteristics. These reports can be tailored to any adverse outcome risks identified in the vetting process. As an example of a uses-case for Advanced Health's PHM tools, Advanced Health uses its PHM tools to track Hospital utilization and Hospital readmission rates with filters for available demographic and priority population variables. These reports will be reviewed at least quarterly over the contract period to detect any disparate or negative health-related outcomes.

Once identified using reports, Advanced Health's analytics team reviews any potential disparity or negative outcome for statistical significance. If verified, Advanced Health acts by reviewing the data with the contractor, amending the contract to mitigate the negative outcome (for example, the introduction of a countering incentive), and/or eliminating the value-based payment.
C.4. Describe in detail the new or expanded, as previously defined, care delivery area VBPs the Applicant will develop in year one and implement in year two. The two new VBPs must be in two of the following care delivery areas: Hospital care, maternity care, children's healthcare, Behavioral Healthcare, and oral healthcare; noting which payment arrangement is either with a Hospital or focuses on maternity care, as required in 2021. The description will include the VBP LAN category 2C or higher, with which the arrangement aligns; details about what quality metrics the Applicant will use; and payment information such as the size of the performance incentive, withhold, and/or risk as a share of the total projected payment. Advanced Health has a strong history of VBPs in Hospital care, Behavioral Health, and oral healthcare. Over the contract period, Advanced Health will expand these existing VBPs to achieve compliance with LAN Category 2C or higher. Advanced Health will implement VBPs in all remaining care delivery areas, as specified in OHA's schedule.
C.5. Provide a detailed plan for how the Applicant will achieve 70% VBP by the end of 2024, taking into consideration the Applicant's current VBP agreements. The plan must include at a minimum information about:

a. The service types where the CCO will focus their VBPs (e.g. primary care, specialty care, Hospital care, etc.)

b. The LAN categories the CCO will focus on for their payment arrangements (e.g. mostly pay for performance, shared savings and shared risk payments, etc.)

Advanced Health will rapidly expand its use of VBPs over the CCO 2.0 contract period. The especially rapid implementations we outline here are possible because of Advanced Health's strong history of APM implementation and support. Many of Advanced Health's contracts fall into LAN Category 4N. Therefore, much of the work of transitioning Provider organizations away from fee-for-service has already been performed.

Advanced Health's most recent year-end financial results are useful for understanding the landscape of Advanced Health's health-related spending. The data in Table 6 comes from Report L13 of Advanced Health's 2017 Exhibit L submission. For simplicity, service categories have been consolidated. Advanced Health's 2017 explicit quality expenses are excluded to ensure conservative final estimates.
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<tr>
<th>Column 1</th>
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RFA 4690 – Advanced Health
General Instructions

Complete all yellow highlighted cells, if applicable, on the "Data_template" tab, the "Data_narrative" tab, the Include payments associated with VBPs on an incurred basis (as opposed to a paid basis). If any payment arrangements have a specified quality incentive payment, estimate the size of the payment for calendar year 2020 Include all payments to providers or contracted entities for which the payment aligns with one or more of the HCP-LAN categories for VBP. See the "HCP-LAN Framework" tab for definitions of the categories. In order for a payment arrangement to qualify as a value-based payment, there must be a quality component. Arrangements without any quality component should be listed under fee-for-service, category 3N, or category 4N For payments that span multiple HCP-LAN categories, use the most advanced category. If for example you have a contract that includes a shared savings arrangement with a pay-for-performance component - such as a quality incentive pool - then you should put the total value of the annual contract in Category 3A for shared savings. Multiple data_template tabs have been provided so that you can provide at least two models showing how your CCO will meet the 20% minimum VBP threshold for 2020. On the "data_template" tabs, submit two variations of the information: a detailed estimate—based on historical data—of the percent of VBP spending that uses the Applicant’s self-reported lowest enrollment viability threshold, and a second set of detailed and historical data-driven estimate of VBP spending that uses the Applicant’s self-

You are required to complete at least two "data_template" tabs. Completing a third is optional. For additional guidance, see the RFA and other resource documents such as the VBP categorization document.
## CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

### CONTRACTOR/CCO NAME:
**Advanced Health**

### REPORTING PERIOD:
1/1/2020 - 12/31/2020

### Definitions:
- **Column c** "Total dollars paid for provider contracts and/or arrangements, excluding contracts that are exclusively FFS": Enter the sum of all contracts by VBP category. These totals reflect the entirety of the contract, even if a portion of the contract is based on fee-for-service. For multi-model contracts that span multiple VBP categories, attribute all payments for that contract to the most advanced category.
- **Column f** "Total dollars paid for provider contracts and/or arrangements": Enter the sum of all contracts that are not VBPs because they are wholly fee-for-service arrangements or have no link to quality.

### Optional - describe any relevant details about your predicted VBPs - using terminology from LAN categories - for 2020. (50 words or less)

### Table: Value-Based Payment Category and Examples

<table>
<thead>
<tr>
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CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

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REPORTING PERIOD: 1/1/2020 - 12/31/2020

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Describe the kinds of services/providers/populations your CCO focuses on for VBPs (e.g. primary care, maternity care, hospital-based care, oncology, etc.). Briefly list as many as are applicable. Limit your response to 100 words or less.
Enter the per-member-per-month dollar amount you intend to pay clinics participating in the Patient Centered Primary Care Home (PCPCH) program. If the PMPMs vary for a given tier, you may enter a range. Otherwise, enter a single dollar amount.

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<tr>
<th>PCPC Tier</th>
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<th>Question</th>
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<th>APM Types - Subcategories</th>
<th>Brief description of:</th>
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<td>Select all that apply by putting an X in Column C in each applicable row</td>
<td>A) Type of providers/services involved; AND if applicable B) contracts with multiple APMs, where plan determined 'dominant APM' and C) future APM payments based on performance in this period not reflected here, such as future shared savings/risk arrangements. Please describe if and how these models take into account racial and ethnic disparities. Please also describe how models have considered individuals with complex health care needs.</td>
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<td>Foundational spending to improve care</td>
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<td>2C</td>
<td></td>
<td></td>
<td>FFS plus Pay for Performance (no penalties, upside only)</td>
<td></td>
</tr>
<tr>
<td>2C</td>
<td></td>
<td></td>
<td>FFS plus Pay for Performance (potential for penalties)</td>
<td></td>
</tr>
<tr>
<td>2C</td>
<td></td>
<td></td>
<td>FFS plus Pay for Performance (potential for incentives and penalties)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>FFS-based Shared Savings</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>X</td>
<td>FFS-based Shared Risk</td>
<td></td>
</tr>
<tr>
<td>3 or 4*</td>
<td></td>
<td></td>
<td>Procedure-based Bundle/Episode Targets or Payments</td>
<td></td>
</tr>
<tr>
<td>3 or 4*</td>
<td></td>
<td></td>
<td>Condition-Specific Bundle/Episode Targets or Payments</td>
<td></td>
</tr>
<tr>
<td>3*</td>
<td></td>
<td></td>
<td>Population-based Targets (not condition-specific)</td>
<td></td>
</tr>
<tr>
<td>4*</td>
<td></td>
<td>X</td>
<td>Population-based Payments (condition-specific)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>Full or % of Premium Population-based Payment (prospective payment)</td>
<td></td>
</tr>
</tbody>
</table>

* = whether these APMs are in Category 3 vs. Category 4 depends in part on whether the provider payments are made using a FFS architecture with retrospective reconciliations (3) or made prospectively based on subcapitated payments/budgets. See "Definitions" worksheet for more details.
<table>
<thead>
<tr>
<th>CATEGORY 1</th>
<th>CATEGORY 2</th>
<th>CATEGORY 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEE FOR SERVICE - NO LINK TO QUALITY &amp; VALUE</td>
<td>FEE FOR SERVICE - LINK TO QUALITY &amp; VALUE</td>
<td>APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
</tr>
<tr>
<td><strong>A</strong> Foundational Payments for Infrastructure &amp; Operations (e.g., care coordination fees and payments for HIT investments)</td>
<td><strong>A</strong> APMs with Shared Savings (e.g., shared savings with upside risk only)</td>
<td><strong>A</strong> APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td>
</tr>
<tr>
<td><strong>B</strong> Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</td>
<td><strong>B</strong></td>
<td></td>
</tr>
<tr>
<td><strong>C</strong> Pay-for-Performance (e.g., bonuses for quality performance)</td>
<td><strong>C</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3N</strong> Risk Based Payments NOT Linked to Quality</td>
<td><strong>3N</strong></td>
<td><strong>3N</strong></td>
</tr>
</tbody>
</table>
CATEGORY 4
POPULATION-BASED PAYMENT

A
Condition-Specific Population-Based Payment
e.g., per member per month payments for specialty services, such as ology or mental health)

B
Comprehensive Population-Based Payment
e.g., global budgets or ill/percent of premium payments)

C
Integrated Finance & Delivery System
e.g., global budgets or ill/percent of premium payments in integrated systems)

4N
Capitated Payments
CTT Linked to Quality
<table>
<thead>
<tr>
<th>Category 2A</th>
<th>Foundational spending to improve care, e.g., care coordination payments, PCPCH payments, and infrastructure payments.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2B</td>
<td>Payments for reporting on performance measures.</td>
</tr>
<tr>
<td>Category 2C</td>
<td>Pay-for-performance (P4P) rewards to improve care, such as provider performance to population-based targets for quality such as a target HEDIS rate.</td>
</tr>
<tr>
<td>Category 2C</td>
<td>Pay-for-performance (P4P) penalties where providers miss target rates on select performance measures.</td>
</tr>
<tr>
<td>Category 3A</td>
<td>Providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets if quality targets are met. Cost target may be for a comprehensive set of services (total cost of care) or for a limited episode/bundle.</td>
</tr>
<tr>
<td>Category 3B</td>
<td>Providers have the opportunity to share in a greater portion of the savings that they generate against a cost target or by meeting utilization targets if more quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met.</td>
</tr>
<tr>
<td>Category 4A</td>
<td>Providers receive prospective-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice (e.g., partial capitation or episode).</td>
</tr>
<tr>
<td>Category 4B</td>
<td>Providers receive prospective population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care for a comprehensive set of services that covers all of an individual's health care.</td>
</tr>
<tr>
<td>Category 4C</td>
<td>Payments to a highly-integrated finance and delivery system.</td>
</tr>
</tbody>
</table>
Background: Western Oregon Advanced Health, LLC (abn Advanced Health) provides the following information to the Oregon Health Authority (OHA) which will form the basis of Advanced Health's Health Information Technology (HIT) Roadmap for the next five years. The plan detailed in this document builds upon Advanced Health's current success in the areas of healthcare IT, data exchange, and regional alignment.

Over 90% of Providers and Provider Organizations in Advanced Health's Service Area (Coos and Curry County) currently use a certified electronic health records (EHR) system. All local Hospitals use a certified EHR. Moreover, the rate of office-based physician EHR adoption in this Service Area is a full 15 percentage points above the 2017 national average rates of certified EHR adoption. This is an exceptional rate of EHR adoption for a small, Rural healthcare Community.

All Hospitals in Advanced Health's region are connected to the Emergency Department Information Exchange (EDie), the web application that provides a State-wide comprehensive snapshot of high risk, high need individuals in real time. Additionally, 83% of Advanced Health's Members are empaneled with a Primary Care Provider using PreManage, EDie's complementary program that notifies Coordinated Care Organizations (CCOs) and Provider groups of Emergency Department utilization by their Members.

In large part, Advanced Health's success is a product of the region's unique environment; a small and highly integrated Community of physical, behavioral, and oral health Providers, Hospitals, ambulatory care clinics, and other specialists all dedicated to regional alignment. In this Rural Community, the Providers collaborate daily—as they must if patients are to be well served. The sparse population and relatively remote geography of this region actually supports Providers in knowing each other well and reaching out to each other. After all, they are as likely to bump into one another at the high school basketball game as in the halls of a Hospital. As a result, clinical and administrative questions and problems are resolved face-to-face or with a quick phone call or inter-Provider message. Larger Community-wide issues can be resolved on a foundation of mutual trust.

In building on current successes in HIT and achieving the goals of its HIT Roadmap, Advanced Health will continue to rely on the collaborative nature of its Provider Network. When Advanced Health says, for example, it will have “in-person” meetings with Providers, it means exactly that: Advanced Health will invite Providers to its offices and will be visiting on-site with Providers and other
participants in the CCO 2.0 effort. This is the way collaborative work gets done in this Rural Community.

The Advanced Health Network Providers have already proved themselves willing to invest substantial amounts of time, money and effort to promote better health through better care at a lower cost. In particular, Bay Area Hospital, Bay Clinic, Bay Eye Clinic, Coquille Valley Hospital, Curry Health Network, North Bend Medical Center, South Coast Orthopedic Associates, Southern Coos Hospital, Coast Community Health Center, Waterfall Community Health Center, and Southwest Oregon IPA (the Key Stakeholders) have helped to drive this success.

This successful collaboration was shown in 2017, when the Key Stakeholders, representing more than 60% of Network Providers, engaged in a successful initiative to identify a single EHR solution that would be suitable for Community-wide adoption. A single Community EHR system is the most effective and straightforward way to exchange Member records among disparate Providers. While it is notoriously difficult to get broad agreement on such matters, that was not the experience in Advanced Health's Service Area. Advanced Health's Key Stakeholders demonstrated a high level of commitment and collaboration, which allowed them to evaluate options and select a solution that best meets the needs and requirements of their Community.

After conducting an evaluation process to select a reliable, market-leading EHR system, the Key Stakeholders agreed on the Epic EHR system, a system which includes physical health, Behavioral Health, oral health, and population health management (PHM) utilities. The choice of Epic EHR also aligns this Community with the State's emphasis on VBP arrangements, as Epic EHR includes advanced VBP capabilities.

To implement its HIT Roadmap, Advanced Health will also continue to utilize the experience of its Chief Executive Officer, who was previously involved with Sky Lakes Medical Center's Epic EHR installation and implementation. In addition, many other leaders throughout Advanced Health's Community have previously held key positions in organizations that have designed and implemented similar systems, and those individuals are enthusiastically engaged in the collective vision for implementation of a Community-wide Epic EHR system.

**Section A. HIT Partnership**

**A.1.a. What challenges or obstacles does Applicant expect to encounter in signing the 2020 HIT Commons MOU and fulfilling its terms?**

As a Rural CCO that is always looking to learn from others, Advanced Health has found tremendous value in the HIT Commons. Advanced Health has used
information provided to the Health Information Technology Advisory Group (HITAG), such as the OHIT Data Reporting for electronic health records (EHRs) and health information exchanges (HIEs), to establish internal benchmarks and focus its resources on common goals. Advanced Health is committed to continued participation in the HIT Commons and values its collaborative nature. Advanced Health's CEO is currently serving on the HIT Commons Governance Board, while Advanced Health's CIO serves on HITAG.

While Advanced Health does not foresee any substantial difficulties in fulfilling its obligations under the 2020 HIT Commons MOU, it recognizes that productive participation will require a commitment of time by senior staff. Given Advanced Health's relatively remote location, travel to the HITAG and Governance Board meetings present challenges, but Advanced Health is confident that these challenges will be overcome and mitigated through advance planning. In-person participation in HIT Commons activities is a priority for Advanced Health.

Section B. Support for EHR Adoption

Background: Advanced Health has been successful in supporting EHR usage in its Service Area, as evidenced by that fact that currently all of the Provider group practices and Hospitals in Advanced Health's Service Area, including physical, behavioral, and oral Provider organizations, currently employ an EHR system. Building on this success, Advanced Health has set a goal to move beyond disparate EHR usage and promote greater Community alignment, increased Care Coordination, and enhanced interoperability and data exchange through deployment of the Epic EHR system.

Beginning in 2017, Advanced Health's Key Stakeholders - Bay Area Hospital, Bay Clinic, Bay Eye Clinic, Coquille Valley Hospital, Curry Health Network, North Bend Medical Center, South Coast Orthopedic Associates, Southern Coos Hospital, Coast Community Health Center, Waterfall Community Health Center, and Southwest Oregon IPA - engaged in an initiative to identify a single EHR solution. Because of the Key Stakeholders' substantial patient overlap, they strongly believed (and continue to believe) that a single, Community-wide EHR system provides the best avenue to achieve better access to data and care, robust Referral management, and greater clinical integration and support for VBP arrangements.

To show their commitment to the Epic EHR initiative, Bay Area Hospital, Bay Clinic, and North Bend Medical Center have signed a memorandum of understanding, confirming their intent to complete the initiative. Over 60% of Members are cared for by Primary Care Providers at Bay Clinic and North Bend Medical Center. The Key Stakeholders have jointly conducted an evaluation process to identify a market-leading system to serve the Community's needs. During this process, the requirements of all Providers in the Community, including
physical, behavioral and oral health Providers, were taken into account. Signaling their financial commitment to the vision and implementation of the Epic EHR, two Key Stakeholders, Bay Area Hospital and Southwest Oregon IPA, Inc., have agreed to make significant financial contributions to subsidize the capital and one-time costs for Providers that wish to implement Epic EHR. Both Southwest Oregon IPA, Inc. and Bay Area Hospital are equity owners of Advanced Health, and this demonstrates their joint commitment to Community-wide EHR as a component of Advanced Health's continued success.

The Key Stakeholders have coalesced around the Epic EHR system, a system which includes physical health, Behavioral Health, oral health, and population health management (PHM) utilities. Advanced Health, along with the Key Stakeholders is actively looking for an Epic EHR vendor. While originally Legacy was identified as a suitable partner, ultimately this did not result in a contract. The Key Stakeholders now meet at least monthly to continue the search for a vendor. Advanced Health recognizes that selecting an Epic EHR vendor and finalizing a contract with that vendor must be a priority.

Advanced Health understands that not every Provider (physical, behavioral, and oral) will join in the Epic EHR implementation. A few Providers in Advanced Health's region are not associated with a group practice and may not believe that they have the financial or technological capacity to implement a new EHR system without a negative impact on their Patients and practices. Ignoring such Providers in favor of group practice Providers would be inconsistent with Advanced Health's values. Advanced Health is committed to supporting these Providers, and discusses in later Questions in this Attachment 9 how it will continue to support those Providers that choose not to implement Epic EHR.

I. Evaluation Questions

B.1.a. How will Applicant support increased rates of EHR adoption among contracted physical health Providers?

Just over 95% of Advanced Health's contracted physical health Providers currently use an EHR system. All Hospitals in the Service Area use such a system. Over the next two years, Advanced Health will focus its efforts on supporting all physical health Providers, who are currently using different EHR products, in moving to a single, Community-wide EHR, which is anticipated to be the Epic EHR system. Physical health Providers are an integral part of Advanced Health's Epic EHR initiative. These Providers were represented in the solution selection process and provided valuable insight and guidance by identifying the requirements unique to Hospitals, Primary Care Providers, and specialty physical health Providers. As Advanced Health continues to facilitate and lead the efforts towards implementing the Epic EHR, the requirements of physical health Providers will guide the
customization of operational workflows, physician templates, and training material to meet these Providers' needs

In addition, Advanced Health recognizes that meeting the needs of physical health Providers after implementation of the Epic EHR system is essential. To that end, Advanced Health has been working to develop plans for an inclusive governance structure consisting of a board and a number of functional committees to provide physical health Provider organizations an avenue for ensuring their needs are met by the Epic EHR system.

As part of this initiative, Advanced Health will conduct in-person meetings and interviews with all physical health Providers to assess their current EHR tools' capability in the following areas:

- Patient portal and patient engagement capabilities;
- Operational performance and financial reporting;
- Ingestion of lab results, tests, radiology exams, and other outside information into a patient chart;
- Export and exchange records and CCDs; and
- Other key capabilities for enhancing Care Coordination in the region.

Advanced Health will work with physical health Providers that choose not to implement Epic EHR, to improve and optimize their use of their current EHR tools and ensure connection with the Community-wide system whenever possible.

Advanced Health recognizes that there are just a few physical health Providers (who are not associated with group practices or Hospitals) who have not yet implemented EHRs. Ignoring these Providers in this process would be inconsistent with Advanced Health’s values. Advanced Health has identified these Providers and plans to reach out to them in person to discover exactly what their concerns are with adopting an EHR system and provide support targeted to those specific concerns. It is Advanced Health’s hope that these Providers will move to the Epic EHR system along with other Providers.

Finally, as described in Attachment 11 to the Application, Advanced Health anticipates integrating Behavioral Health and physical health by co-locating Behavioral Health services in physical health locations, and co-locating physical health Providers in Behavioral Health settings. As this restructuring occurs, Advanced Health will provide technical support for Providers to ensure that the current EHR systems in place accommodate the unique needs of Behavioral Health Providers and that the perspectives of integrated Behavioral/physical health Providers are represented on EHR governance bodies.
B.1.b. How will Applicant support increased rates of EHR adoption among contracted Behavioral Health Providers?

Both of Advanced Health's Behavioral Health Subcontractors currently use an EHR system. Over the next two years Advanced Health will focus its efforts on supporting these Subcontractors in moving to a single, Community-wide EHR, which is anticipated to be the Epic EHR system. Behavioral Health Providers are an integral part of Advanced Health's Epic EHR initiative. One of the current Subcontractors for Behavioral Health was represented in the solution selection process and provided valuable insight and guidance by identifying the many requirements of an EHR system that are unique to Behavioral Health. As Advanced Health continues to facilitate and lead the efforts towards implementing the Epic EHR, the requirements of these experienced Subcontractors will help guide the customization of operational workflows, treatment templates, and training materials to meet these Providers' needs.

The integration between Behavioral Health and physical health is an important part of Advanced Health's strategy. As described in Attachment 11 to the Application, Advanced Health is planning to increase both the co-location of Behavioral Health and physical health Providers and the mobility of Behavioral Health Providers into Community settings. Advanced Health will work with Behavioral Health Providers to improve and optimize their use of their current EHR tools in these environments and ensure that the requirements for an EHR system take these structural changes into account.

As part of this initiative, Advanced Health will conduct in-person meetings and interviews with Behavioral Health Providers to assess their current EHR tools' capability in the following areas:

- Patient portal and patient engagement capabilities;
- Operational performance and financial reporting;
- Ingestion of lab results, tests, radiology exams, and other outside information into a patient chart;
- Export and exchange records and CCDs;
- Other key capabilities for enhancing Care Coordination in the region; and
- Support for co-location and mobile devices.

As discussed in Attachment 11 to the Application, the restructuring of Behavioral Health services will likely result in Advanced Health contracting with a larger number of Behavioral Health Providers than in CCO 1.0. As part of its selection process for such Providers, Advanced Health will communicate its expectations that such Providers have a plan for availability of an EHR system and that they ultimately adopt the Community-wide Epic EHR when it becomes available.
B.1.c. How will Applicant support increased rates of EHR adoption among contracted oral health Providers?

Advanced Health's oral health Subcontractor currently uses an EHR system. Over the next two years, Advanced Health will focus its efforts on supporting this Subcontractor in moving to a single, Community-wide EHR, which is anticipated to be the Epic EHR system. In the amendment and restatement of Advanced Health's agreement with this Subcontractor, milestones and targets for adoption of EHR by all of the Subcontractor's downstream Providers will be articulated. As Advanced Health continues to facilitate and lead the efforts toward implementing the Epic EHR, the requirements articulated by this experienced oral health Subcontractor will help guide the customization of operational workflows, treatment templates, and training material to meet the needs of oral health Providers who provide services. An important aspect of this customization will be requirements that oral health be more fully integrated with physical health and Behavioral Health.

B.1.d. What barriers does Applicant expect that physical health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?

Since all Advanced Health's contracted physical health Provider Organizations already use EHR systems, the barriers exist with a very small number of physical health Providers. These specific Providers represent less than 5% of Advanced Health's contracted physical health Providers. Advanced Health has recognized that the physical health Providers that have not yet implemented an EHR may be facing different barriers than the oral or Behavioral Health Providers. Advanced Health plans to overcome these barriers by meeting with the Providers individually to determine their reasons for not adopting EHRs. Once Advanced Health has collected and analyzed this data, it will work with the Providers to help them understand the need for, and benefits of, EHRs for Members and Providers. Also, with the in-person meetings, Advanced Health will be able to create a plan with the Provider on how to implement an EHR that will benefit the Provider and provide a pathway to adoption of the Community-wide EHR. These in-person meetings with individual Providers will begin in 2019. Advanced Health has also recognized that some physical health Providers may still choose to not implement EHRs. Advanced Health plans to continue to educate Providers on the benefits of EHR adoption.

Advanced Health also recognizes the following potential barriers that may impact physical health providers joining the Epic EHR initiative:

- Provider reluctance to transition to a new EHR system due to the implementation effort, cost, and operational disruption and their years-to-retirement; and
- The perception that the Epic EHR system will not be able to address the unique needs of individual Providers with specialty panels of Members, especially in very small clinics.

Advanced Health will overcome these barriers by:

- Developing and distributing a business case and value proposition promoting the benefits of the Epic EHR which will address clinical, operational, and regional benefits overall, as well as the associated costs and potential financial benefits;
- Engaging in a structured EHR implementation guided by industry best practices, including ample time for testing, training, and go-live support;
- Initiating a series of in-person meetings to share the value proposition and address Provider concerns as they come up;
- Arranging meetings with peer physical health organizations that have implemented similar Epic EHR arrangements to learn from their successes and challenges;
-包括Community Providers（物理、行为和口腔）作为Epic EHR的治理结构的一部分，以确保每种Provider类型的独特需求得到满足；和
-提供第二选项给那些不愿意加入Epic EHR的Community Providers，这将包括帮助他们在直接加入Reliance协作（在后续答案中更详细地讨论）和优化现有EHRs方面。

B.1.e. What barriers does Applicant expect that Behavioral Health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?

Both of Advanced Health's Behavioral Health Subcontractors currently already use EHR systems. As discussed above, their challenges will be in moving to a Community-wide EHR, but as they have been deeply involved with the Community effort in selecting Epic EHR, Advanced Health understands that they have considered the barriers and are making plans to overcome these barriers.

As discussed in Attachment 11, the restructuring of Behavioral Health services will likely result in Advanced Health contracting with a larger number of Behavioral Health Providers. Some of these Providers may be familiar organizations but not yet Providers in the Advanced Health Network. Advanced Health's commitment to restructuring to achieve integrated Behavioral Health requires attention to the practical HIT issues that arise to minimize disruption. As part of its selection process for such Providers, Advanced Health will communicate its expectations that such Providers have a plan for availability of an EHR system and that they agree to adopt the Community-wide EHR when it becomes available. Advanced Health
recognizes that the cost of selecting and installing a new EHR -- in terms of confusion, money and time -- can be a daunting barrier for any Provider. It will assist such Providers with technical assistance, including the business case for EHR, sharing knowledge gleaned about the various vendors developed during the Community-wide selection process. If there is sufficient need, Advanced Health will provide assistance to allow OCHIN or a similar organization to provide EHR services to pods of similarly situated new Providers.

Advanced Health believes that there may be other barriers to adoption of an EHR system (whether interim or Community-wide) for such Behavioral Health Providers, such as a belief (founded or otherwise) that such a system will simply not work for the kind of treatment the Behavioral Health Provider intends to provide (such as Assertive Community Treatment Teams). However, Advanced Health cannot assume that it has perfect understanding of these barriers for Providers who have never contracted directly with Advanced Health. Advanced Health plans to discover these barriers by meeting with the Providers in-person to seek their perspectives. Once Advanced Health has collected and analyzed this data, Advanced Health will work with the Providers to understand how Advanced Health or other Key Stakeholders can assist in overcoming the identified barriers. Also, with the in-person meetings, Advanced Health will be able to begin to create a plan with Providers on how to implement an EHR system that will benefit Members and the Providers. These in-person meetings will begin in 2019 after the selection of new Behavioral Health Providers, and the data will be analyzed by the time of the Readiness Review. Advanced Health has also recognized that some Behavioral Health Providers may still choose to not implement EHRs. Advanced Health plans to continue to educate Providers on the benefits of EHR adoption. As part of the education process for all new Providers not currently on an EHR system, Advanced Health expects to help overcome barriers by:

- Developing and distributing a business case and value proposition promoting the benefits of the EHR generally, and Epic EHR specifically, which will address clinical, operational, and regional benefits overall, as well as the associated costs and potential financial benefits;
- Engaging in a structured EHR implementation guided by industry best practices, including ample time for testing, training, and go-live support;
- Initiating a series of in-person meetings to share the value proposition and address Provider concerns as they come up;
- Arranging meetings with peer organizations in the Behavioral Health realm that have implemented similar EHR arrangements to learn from their successes and challenges;
- Including Behavioral Health Providers as part of the Epic EHR's governance structure to ensure the unique needs of each Provider type are addressed; and
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- Providing a second option to joining the Epic EHR for the Community Providers who choose not to join Epic EHR, which will include assistance in joining Reliance individually and optimizing current EHRs.

B.1.f. What barriers does Applicant expect that oral health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?

Since Advanced Health's oral health Subcontractor currently uses an EHR system, Advanced Health's focus with this Subcontractor will be on joining the Community-wide Epic EHR and ensuring that its downstream Providers are fully utilizing the current EHR systems and will be able to connect with the Epic EHR system. The amended and restated contract with this Subcontractor will contain milestones and timeframes for these goals.

Table B.1. Table Showing EHR Adoption Roadmap and Milestones.

The activities described in responses to Questions B1a through B1f will occur over the next five years. The specific timeline for those activities, including milestones, is shown in the following table.

[Table B.1. Begins on next page]
## TABLE B.1.
### EHR ADOPTION ROADMAP

<table>
<thead>
<tr>
<th>Year</th>
<th>Current EHR Usage Optimization</th>
<th>Epic EHR Implementation</th>
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</table>
| **2019** | • Conduct in-person meetings and interviews with Providers to understand gaps and challenges with their current EHR systems.  
• Conduct in-person meetings with all individual Providers who have not implemented any EHR to understand each barrier to implementation.  
• Communicate with new Behavioral Health Providers regarding EHR expectations and discover barriers  
• Ensure Subcontractor and Provider agreements appropriately address EHR expectations.  
**Milestone:** Targets will be set with each Subcontractor Provider on EHR usage optimization based on data from in-person meetings. | • Continue interviews with potential Epic Community Connect Hosts.  
• Establish regional support and governance structure.  
• Ensure all Providers and Provider Organizations are invited to participate.  
**Milestone:** Finalize contract with new Epic EHR Provider. |
| **2020** | • Develop and deliver education sessions for Providers showing best practices in EHR utilization to optimize EHR performance.  
• Re-visit individual Providers who have not implemented any EHR to determine if the barrier to implementation can be mitigated.  
**Milestone:** Education sessions delivered to the Community and tailored to the needs of each Provider type. | • Begin Epic EHR implementation with signatories of the memorandum of understanding.  
• Develop Epic EHR value proposition and business case to provide to deliberating Providers.  
**Milestone:** Commence Epic EHR implementation. |
| **2021** | • Conduct in-person meetings and interviews with Providers to understand gaps and challenges with their current EHR systems.  
**Milestone:** Targets will be set with each Provider on EHR usage optimization based off in-person meetings. | • Continue implementation.  
• Ensure proper training of Epic EHR system users.  
**Milestone:**  
• Epic EHR fully installed  
• Provide deliberating Providers Epic EHR value proposition and business cases. |
<table>
<thead>
<tr>
<th>Year</th>
<th>Current EHR Usage Optimization</th>
<th>Epic EHR Implementation</th>
</tr>
</thead>
</table>
| 2022 | • Develop and deliver education sessions for Providers showing best practices in EHR utilization to optimize EHR performance.  
• Re-visit individual Providers who have not implemented any EHR to determine if the barrier to implementation can be mitigated.  
**Milestone:** Education sessions delivered to the Community and tailored to the needs of each Provider type. | • Continue implementation.  
• Ensure proper training of Epic EHR system users. |
| 2023 | • Conduct in-person meetings and interviews with Providers to understand gaps and challenges with their current EHR systems.  
**Milestone:** Targets will be set with each Provider on EHR usage optimization based off in-person meetings. | • Sustain results and performance level.  
• Ensure proper training of Epic EHR system users.  
**Milestone:** All Epic EHR memorandum signatories are live on the Epic EHR. |

**B.2.a. What assistance would you like from OHA in collecting and reporting EHR use and setting targets for increased use?**

Advanced Health requests assistance in educating individual Providers and very small group practices on the benefits of EHRs and how they can implement these in a cost-effective way. Advanced Health would also benefit from assistance from OHA in promoting the transition to a Community-wide HIT ecosystem. Specifically, Advanced Health would like OHA’s assistance with the following:

- Convening relevant symposia and conferences;  
- Sharing dashboards and reports to inform the performance of CCOs across the State;  
- Sharing OHA’s expectations of EHR usage for physical, behavioral, and oral health Providers;  
- Sharing of best practices (and known problems to avoid) from other physical, behavioral, and oral health Providers for use of EHR;  
- Setting targets for regional data exchange, not limited to EHR usage, to assist Advanced Health in its focus on achieving regional HIT consolidation; and
B.2.b. Please describe your initial plans for collecting data on EHR use and setting targets for increased use by contracted physical health Providers. Include data sources or data collection methods.

Advanced Health collected data regarding EHR use and functional requirements in 2017 when the Key Stakeholders determined that the Epic EHR was the best approach for the Community. These activities have informed Advanced Health's Epic EHR selection and implementation process. Advanced Health has used, and will continue to use, the natural strength of the region's tight-knit, Rural Community, where Providers regularly collaborate and interact in person, to gather data on EHR use and future implementation of the Epic EHR.

Advanced Health will conduct in-person meetings with representatives from each Network Provider and Provider Organization (including Hospitals and clinics) to better understand current EHR gaps and limitations, as well as the capabilities that Providers need and want in the Epic EHR. Advanced Health hypothesizes that Providers may not be taking advantage of the full suite of capabilities of current EHR systems; this hypothesis will be tested in this process. Each physical health Provider may have different needs or gaps in their current EHR; Advanced Health can work with the Providers to find solutions that will improve care for Members.

Advanced Health will use the data collected to support the initiatives described in its answers to Questions B.1.a. through B.1.f. Specifically, Advanced Health will use the data to:

- Inform the Epic EHR initiative by incorporating the data and the resulting analysis into Advanced Health's more robust list of requirements for the Epic EHR implementation and using that data and analysis to inform the choice of vendor and customization and build process of the Epic EHR; and
- Optimize and improve the usage of current EHR tools through Advanced Health's provision of in-person information sessions to share EHR utilization best practices.

The in-person meetings that Advanced Health will have with each physical health Provider, Clinic, and Hospital will allow insight on what gaps and barriers the contracted physical health Providers may be experiencing. Advanced Health will use a mixture of OHA's assistance, and the data discovered in the gap analysis to set EHR usage targets. These targets will be based on:

- Patient portal and patient engagement capabilities;
- Operational performance and financial reporting;
- Ingestion of lab results, tests, radiology exams, and other outside information into a patient chart;
• Export and exchange records and CCDs;
• OHA's expectation of EHR usage;
• Meaningful use; and
• Other key capabilities for enhancing Care Coordination in the region.

B.2.c. Please describe your initial plans for collecting data on EHR use and setting targets for increased use by contracted Behavioral Health Providers. Include data sources or data collection methods.

Advanced Health recognizes that there is a significant difference between oral health, Behavioral Health, and physical health Providers in relation to data on EHR use. While Advanced Health will provide the same opportunities to all Providers in its region, plans and targets will be based on the need and capabilities of each type of Provider.

Advanced Health will conduct in-person meetings with representatives from each contracted Behavioral Health Provider to better understand current EHR gaps and limitations, as well as the capabilities that Providers need and want in the Epic EHR.

Advanced Health will use the data collected to support the initiatives described in its answers to Questions B1a through B1f above. Specifically, Advanced Health will use the data to optimize and improve the usage of current EHR tools. Advanced Health will also use the data, along with OHA's expectations, to set EHR utilization goals. With all contracted Behavioral Health Providers already utilizing EHRs, the targets will be based on how Behavioral Health Providers currently use, and can potentially use, their respective EHRs. These targets will be created based on how the EHRs can benefit and promote the Triple Aim of better health, better care, and lower costs.

As discussed in Attachment 11 to the Application, Advanced Health's plan to move away from delegation model for Behavioral Health in favor of integrated and Community-based Behavioral Health will likely result in it contracting with a more diverse group of Providers. In the selection process, Advanced Health will set targets for EHR use that will be informed by the information gathering process described above. Different targets may be required for different types of Providers, and will be geared toward their specific circumstances. Advanced Health is committed to minimizing the disruption of these changes while ensuring that EHR systems are used to best serve Members.

B.2.d. Please describe your initial plans for collecting data on EHR use and setting targets for increased use by contracted oral health Providers. Include data sources or data collection methods.
Advanced Health will conduct in-person meetings with representatives from its oral health Subcontractor (and the downstream Providers with whom it works) to better understand current EHR gaps and limitations, as well as the capabilities that the Subcontractor and its downstream Providers are currently effectively utilizing.

Along with OHA's suggestions on EHR use targets, Advanced Health will also use the data collected to create targets specifically for oral health Providers based on how oral health Providers use their respective EHRs. These targets will be created based on how the EHRs can benefit and promote the Triple Aim of better health, better care, and lower costs and further integration of oral health into physical health and Behavioral Health systems.

**Section C. Support for Health Information Exchange (HIE)**

**Background:** In 2017, the Key Stakeholders came together in 2017 to pursue greater regional alignment and healthcare information sharing through an initiative focused on implementing a single, Community-wide shared EHR system.

Advanced Health has recognized that physical, behavioral, and oral Providers have very specialized needs when it comes to Member information being shared. Advanced Health has taken the approach of a parallel roll-out plan for health information exchange (HIE) initiatives based on tools that will be most beneficial for each Provider and will assist in providing uninterrupted, quality care for Members.

Building upon the Epic EHR as one of the keystones of its regional alignment and collaboration strategy, Advanced Health is pursuing two additional tightly integrated initiatives to achieve greater HIE across Coos and Curry Counties.

The first initiative is increasing the effective deployment of the PreManage tool by Primary Care Providers serving Members. All Hospitals in Advanced Health's region are already connected to EDie, the State-wide tool that alerts Emergency Department (ED) Providers of patients with a history of multiple ED visits. In addition, 83% of Advanced Health's Members are currently covered by PreManage, EDie's complementary tool that notifies Providers of ED utilization by their attributed Members. Advanced Health wants all of its assigned Members to be covered by PreManage.

The second initiative is connecting contracted physical, behavioral and oral Providers to the Reliance eHealth Collaborative (Reliance), which can create the mechanism for the safe, secure, electronic exchange of health information among authorized providers in the Community. Reliance will complement the Epic EHR initiative and provide connectivity with Providers and CCOs outside Advanced Health's region. Advanced Health has begun conversations to initialize connection
with Reliance. Advanced Health will utilize the HIE Onboarding Program that has been developed by OHA with Reliance. The HIE Onboarding Program will assist with some costs, but if there are more that are not covered, Advanced Health is committed to planning with Providers to minimize costs. Advanced Health is committed to assisting all Providers in its Service Area to connect to Reliance.

Advanced Health’s CIO will actively participate in the HITAG committee to ensure that Advanced Health's project team stays up-to-date on any HIE Onboarding Program Changes.

**C.1.a. How will the Applicant support increased access to HIE for Care Coordination among contracted physical health Providers?** Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

**C.1.b. How will the applicant support increased access to HIE for care coordination among contracted behavioral health Providers?** Please describe your strategy, including any focus on use cases or types of providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

**C.1.c. How will the Applicant support increased access to HIE for care coordination among contracted oral health Providers?** Please describe your strategy, including any focus on use cases or types of providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

Advanced Health does not envision establishing an HIE, but rather, is purposefully working toward a true Community-wide EHR system which will render void the need for a traditional HIE. In the process that resulted in choosing Epic EHR, Advanced Health required that the solution allow access for all Provider types, and prioritized use cases for the following information exchange scenarios: Referral management; sharing of plans of care; exchange of lab results, immunization records, and radiology and imaging information; and secure messaging across and between Providers.

Until the Epic EHR system can be implemented, however, PreManage will serve as the Care Coordination operating system for directed and query based exchange across all Provider types: physical, behavioral, and oral health. Plans of care will be visible within PreManage and accessible on a need-to-know basis, and will serve as the electronic communication method for making, accepting, and confirming Referrals. As Referral parties develop strategies and plans with Members and their Representatives and Family members, these become included elements in an ever-evolving, yet current, care planning and coordination process.
To achieve the goal of full utilization of PreManage across the system, Advanced Health has developed and begun implementing a methodology centered on a collaboration among Advanced Health's IT team, each Provider's IT team, and several "champion" users. Through site visits and in-person meetings, Advanced Health will teach and train local IT teams to perform the weekly and monthly data uploads to take full advantage of PreManage's utility, while the champion users will provide training and support to Providers and Care Coordinators regarding the utilization of PreManage and its benefits. This is another example of Advanced Health's tight, interconnected regional Community lending itself to effective in-person collaboration between all the relevant parties to achieve its goals. Advanced Health is pursuing the advancement of three initiatives to increase health information exchange (HIE) with physical health Providers. Advanced Health will pursue the following implementation activities for each initiative.

These PreManage benefits will be demonstrated through use cases tailored to the needs of each Provider type. For example, Emergency Department (ED) visits can be coupled with chronic disease information such as diabetes for physical health Providers, ED visits or Hospitalization can be associated with depression for Behavioral Health Providers, and ED visits on account of dental related issues such as severe pain can be provided to oral Providers. These combinations and the additional information they provide will inform and assist Care Coordinators at each Provider with providing the necessary outreach and follow up that Members need.

Finally, Advanced Health has begun conversations with Reliance to determine the timelines and costs related to connecting Providers and Provider Organizations (including Hospitals and clinics) to Reliance. Advanced Health plans to take part of the HIE Onboarding Program created by OHA and Reliance. Advanced Health will meet individually with Providers to ensure that connecting to Reliance will be a shared benefit for the Providers and Provider Organizations. Reliance will allow all Providers (physical, behavioral, and oral) and Hospitals to share Member data, with or without being connected to Epic EHR. Advanced Health will work with Reliance to train physical health Providers on best practices when it comes to utilizing Reliance. Reliance will allow all Providers (physical, behavioral, and oral) and Hospitals to share Member data with or without being connected to Epic EHR.

C.1.d. How will the Applicant ensure access to timely Hospital event notifications for contracted physical health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.
C.1.e. How will the Applicant ensure access to timely Hospital event notifications for contracted Behavioral Health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

C.1.f. How will the Applicant ensure access to timely Hospital event notifications for contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

These three questions will be addressed together. Access to timely Hospital event notifications (HENs) for physical health, Behavioral Health and oral health Providers will occur through the following initiatives:

The Community-wide Epic EHR system will include a full suite of HENs. Decisions regarding which HENS to enable will be made by the governing boards established for the EHR system. Because Community Hospitals, physical health Providers, Behavioral Health Provider and oral health Providers will all be represented through the governing boards and committees, decisions regarding alerts and notifications will be developed based on relevant use cases and regional priorities that incorporate and address the needs of types of Providers and the Members for whom they care.

Prior to implementation of the Epic EHR system, and for Providers who decline to participate in the Community-wide Epic EHR, Advanced Health will continue to encourage Providers to take full advantage of the HENs utility of EDie and PreManage. Advanced Health is currently collaborating with the local Hospitals to ensure that EDie notifications are directly tied into their respective EHRs and are properly addressed. Advanced Health is also actively promoting increased deployment of the PreManage tool's HENs utility across its network of Providers. As previously described, Advanced Health has already begun a collaborative team approach to teaching and training Providers' IT teams to fully utilize PreManage's functions, including HENs.

C.1.g. How will the Applicant access and use timely Hospital event notifications within your organization? Please describe your strategy, including any focus areas and methods for use, which HIE tool(s), and any actions you plan.

Currently, Advanced Health's Care Coordinators use the PreManage tool to acquire and analyze information regarding ED visits and inpatient utilization to inform their care plans and in-time Member interventions. PreManage's functionality allows Care Coordinators to generate reports for each user based on the type of care they are focused on is particularly valuable.
When the Community-wide Epic EHR is implemented in the region, Advanced Health's Care Coordinators will be able to react and intervene based on a wider variety of Hospital events. Among them:

- ED utilization coupled with a high-risk or chronic condition, such as diabetes.
- ED utilization coupled with Behavioral Health Member attribution.

Such notifications will be enabled through customized alerts in the EHR platform and use of the platform's reporting tools, which will allow extensive analysis of Member data across the region.

**Table C.1. Table Showing HIE Roadmap and Milestones.**

The activities described in responses to Questions C.1.a. through C.1.g. will occur over the next five years. The specific timeline for those activities, including milestones, is shown in the following table.

*[Table C.1. Begins on next page]*
### TABLE C.1. HIE ROADMAP

<table>
<thead>
<tr>
<th>Year</th>
<th>Utilization of EDie and PreManage</th>
<th>Connectivity to Reliance</th>
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</table>
| 2019 | • Deploy collaborative training on PreManage full utilization.  
      • Work with Primary Care Providers and Subcontractors to amend agreements to express Edie and PreManage expectations.  
      **Milestone:**  
      • Provider and Subcontractor agreements finalized.  
      • 50% of Primary Care Providers are fully utilizing PreManage. |
|      | • Engage fully with Reliance to determine appropriate methods/costs of Provider connection.  
      **Milestone:**  
      • Standard agreement with Reliance.  
      • 10% of Providers live on Reliance. |
| 2020 | • Develop specialty and Provider-type specific use cases for PreManage.  
      • Conduct site visits and training sessions for all Providers that do not use PreManage.  
      • Monitor PreManage use.  
      **Milestone:**  
      • 90% of Primary Care Providers are fully utilizing PreManage.  
      • EDie notifications are populating Hospital EHRs at the time of the visit in the ED. |
|      | • Conduct introduction meetings with Reliance and Providers.  
      **Milestone:** 25% of all Providers are live on Reliance. |
| 2021 | • Continue Provider collaborative training to promote PreManage usage as needed.  
      • Monitor and analyze PreManage to inform promotion activities.  
      **Milestone:** 100% of Primary Care Providers are using PreManage. |
|      | • Begin Reliance interface implementation.  
      • Monitor and track usage of Reliance.  
      **Milestone:** 30% of all Providers are live on Reliance. |
| 2022 | • Sustain PreManage utilization.  
      • Evaluate PreManage utilization at Clinics to verify that PreManage continues to be a beneficial tool. |
|      | • Continue to monitor and track Reliance usage.  
      • Assess benefits of Reliance and promote utilization as necessary.  
      • Share the specifications with the |
<table>
<thead>
<tr>
<th>Year</th>
<th>Utilization of EDie and PreManage</th>
<th>Connectivity to Reliance</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Epic EHR vendor and incorporate the interface development into the implementation plan.</strong></td>
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<td><strong>Milestone:</strong> 40% of all Providers are live on Reliance.</td>
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<tr>
<td>2023</td>
<td>• Sustain PreManage utilization.</td>
<td></td>
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<tr>
<td></td>
<td>• Evaluate PreManage utilization at Clinics to verify that PreManage continues to be a beneficial tool.</td>
<td>• Continue to monitor and track Reliance usage.</td>
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<td></td>
<td></td>
<td>• Assess benefits of Reliance and promote utilization as necessary.</td>
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<tr>
<td></td>
<td></td>
<td>• Enable Reliance interface as Epic EHR goes live.</td>
</tr>
<tr>
<td>2024</td>
<td>• Sustain PreManage utilization.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evaluate PreManage utilization at Clinics to verify that PreManage continues to be a beneficial tool.</td>
<td>• Continue to monitor and track Reliance usage.</td>
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<tr>
<td></td>
<td></td>
<td>• Assess benefits of Reliance and promote utilization as necessary.</td>
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<tr>
<td></td>
<td></td>
<td><strong>Milestone:</strong> 70% of all Providers are live on Reliance.</td>
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</table>

**C.2.a. What assistance you would like from OHA in collecting and reporting on HIE use and setting targets for increased use?**

Advanced Health would like assistance from OHA in the following areas related to HIE use and targets:

- Providing regional and statewide statistics for the use of Reliance, EDie, and PreManage tools.
- Sharing HIE advancement best practices (and known problems) from other CCOs through a newsletter, OHA's website, and symposiums / gatherings.
- Sharing HIE usage targets and metrics from other CCOs to serve as a benchmark and comparison for Advanced Health's efforts, as well to ensure that the Epic EHR is meeting the needs of other Hospitals and Providers across the State.
- Sharing HIE best practices (and known problems) from Providers to serve as a training tool for Advanced Health to use when training its Network Providers.

C.2.b. Please describe your initial plans for collecting data on HIE use and setting targets for increased use by contracted physical health Providers. Include data sources or data collection methods.

As described above, Advanced Health's key HIT initiative, the deployment of a Community-wide Epic EHR, will allow for seamless data sharing among all Providers who choose to implement Epic EHR, through the use of a single platform and Member record. Providers accessing each Member's record will be able to access information across all sites of care, including physical, behavioral and oral health. EHR usage will therefore be used as the basic metric of data sharing. Using OHA's targets as a guideline, Advanced Health and its contracted Providers and Hospitals will track at least the following metrics through data use of the Epic EHR to ensure they are supporting OHA's initiatives:

- Plans of care developed and updated by more than one Provider.
- The number of Members visiting more than one site of care.

Currently, Advanced Health can access the data to produce reports on which Providers are utilizing PreManage, and Advanced Health plans to continue to collect, analyze and use such reports to help it understand trends in PreManage deployment and utilization. This allows Advanced Health to reach out to Primary Care Providers and Provider Organizations that appear to be under-deploying PreManage and provide training or discuss shortfalls or issues the Providers may be having with this tool. Using these reports, Advanced Health will use OHA's set targets for HIE adoption to ensure that Advanced Health and Primary Care Providers are supporting OHA's HIE initiative.

C.2.c. Please describe your initial plans for collecting data on HIE use and setting targets for increased use by contracted Behavioral Health Providers. Include data sources or data collection methods.

Advanced Health will use OHA's set targets for HIE adoption to ensure that Advanced Health and its Behavioral Health Providers are supporting OHA's HIE initiative. Advanced Health plans to collect data on HIE use by Behavioral Health Providers by continuing the in-person, email, and phone meetings with Behavioral Health Providers. This will allow Advanced Health to continue the direct communication with Behavioral Health Providers regarding the use of this tool. Advanced Health can gather data on how Behavioral Health Providers are using Reliance currently and how they might want to use Reliance in the future. Advanced Health will also be able to discuss any issues Behavioral Health...
Providers are having using Reliance. With the data gathered from these meetings, Advanced Health can ensure that more extensive training is provided to confirm that the Behavioral Health Providers are benefiting from the connection with Reliance.

C.2.d. Please describe your initial plans for collecting data on HIE use and setting targets for increased use by contracted oral health Providers. Include data sources or data collection methods.

Advanced Health will use OHA's set targets for HIE adoption to ensure that Advanced Health and the contracted oral health Providers are supporting OHA's HIE initiative. Advanced Health plans to collect data on HIE use by oral health Providers by continuing the in-person, email, and phone meetings with oral health Providers. This will allow Advanced Health to continue the direct communication with oral health Providers. Advanced Health can gather data on how oral health Providers are using Reliance and how they might want to use Reliance in the future. Advanced Health will also be able to discuss any issues oral health Providers are having using Reliance. With the data gathered from these meetings, Advanced Health can ensure that more extensive training is provided to confirm that the oral health Providers are benefiting from the connection with Reliance.

Section D. Health IT for VBP and Population Health Management

**Background:** For the past seven years, Advanced Health has been working with Providers using value-based payment (VBP) arrangements. Indeed, Advanced Health has been a pioneer among CCOs entering into VBP arrangements with Providers. Advanced Health has built deep, trusting relationships with its Providers based on a collaborative framework. A fundamental principle of this collaboration is that Advanced Health's success is intertwined with and dependent upon Providers' success. Sound data, straightforward and transparent reporting, and Advanced Health's personalized Provider support has sustained the success of this relationship.

Advanced Health will continue to build on these successes by deepening its relationships and VBP arrangements with Providers. Its current population health management (PHM) technology supporting VBP arrangements is lean, but Advanced Health has the staff strength to support increasing complexity in VBP arrangements and increasing numbers of those arrangements for its Provider Network.

In addition, Advanced Health is planning to complement its current VBP and PHM technology capabilities through the Epic EHR system. By design, Advanced Health has evaluated solutions offering state of the art PHM and VBP capabilities. Epic EHR, the solution the Key Stakeholders have identified as the most likely system for the Community, offers the *Healthy Planet* module. Healthy Planet will provide...
even more depth for Advanced Health to assist Providers and Provider Organizations to create meaningful VBP arrangements with quality components, and expand Advanced Health’s capabilities, especially in the area of offering real-time interventions, the flexible utilization of risk and attribution models, and the identification of focused gaps in care.

D.1.a. If the Applicant will need technical assistance or guidance from OHA on HIT for VBP, please describe what is needed and when.

Advanced Health would like assistance from OHA in the following areas related to HIT for VBP:

- Sharing best practices (and known problems) from other CCOs and from the Health Care Payment Learning and Action Network for the use of technology to support both population health management (PHM) and VBP.
- Convening scheduled of periodic symposiums where OHA can provide education and build a community network and knowledge base for HIT for VBP.
- Leveraging HITAG to share information detailing the HIT plans of CCOs across the State.
- As VBP arrangements develop, or as VBP metrics are updated, provide recommended data sources to support each developed arrangement or updated component.

D.1.b. What plans do you have for collecting and aggregating data on SDOH&HE that may be self-reported or come from Providers rather than found in claims? Can you match demographic and SDOH&HE-related data with claims data?

Advanced Health recognizes the importance of gathering data on social determinants of health and health equity (SDOH&HE). Advanced Health considers this work foundational and collects and uses SDOH&HE data frequently. For example, Advanced Health stores Member data originating from 834 files, including important Member demographic information. Advanced Health is a primary supporter of its region’s Adverse Childhood Experiences (ACEs) training and education program, South Coast Together. Advanced Health’s analytics team supports South Coast Together by chairing its Metrics Committee and collecting and aggregating relevant data. This includes collecting and aggregating survey data from participants of ACEs trainings and aggregating public and private data related to adverse childhood experiences. Much of the ACEs data relates directly to social determinants of health and health equity. Advanced Health participated in meetings organized by Oregon Pediatric Improvement Partnership (OPIP) and OHA regarding their development of a health complexity risk scoring tool. This tool includes factors for medical and social complexity. Advanced Health has stored the
resulting child-level complexity data and plans to use this data to inform quality, equity, and SDOH efforts. Advanced Health uses the CDPS+Rx tool to calculate medical complexity scores for its Members. Advanced Health also supports the South Coast Regional Early Learning Hub's (SCREL) Metrics Committee. Part of Advanced Health's contribution is the collection and aggregating of education-related data in support of SCREL's objectives. This includes important SDOH data like kindergarten readiness scores.

This and other SDOH&HE data are stored on Advanced Health's servers and in its SQL Enterprise data warehouse. Aggregation and analysis are performed using tools that include SQL Server Management Studio, SAS, R, and Excel. Advanced Health frequently matches demographic and SDOH&HE data to claims data. This is normally performed using one of two methods, depending on data granularity. Much of Advanced Health's demographic, SDOH, and HE data is Advanced Health Member-level with accompanying Medicaid ID. When this is the case, matching SDOH&HE data to claims data is trivial: simply match using Medicaid ID. Often, SDOH&HE data is public data, is pre-aggregated, or it relates to all of Coos and/or Curry Counties rather than Advanced Health Membership alone. When this is the case, the SDOH&HE data can sometimes be compared to aggregated Advanced Health claims data. These analyses always require making careful assumptions and applying appropriate statistical techniques.

Advanced Health will continue collecting and aggregating SDOH&HE data to inform its strategies to improve the health and wellness of its Members. Advanced Health will build upon this work, expanding its SDOH&HE data processing. In 2020, as part of the primary care–based case management workflow, Advanced Health has committed to implementing an annual health risk assessment (HRA) for Members. The HRA will contain questions targeting SDOH&HE parameters. These data points will be able to be associated with the claims data already being collected and aggregated by Advanced Health, providing a rich picture of patient risk level, including SDOH&HE metrics.

D.1.c. What are some key insights for population management that you can currently produce from your data and analysis?

Advanced Health currently uses Milliman PRM Analytics, SQL queries, Crystal reports, and Tableau to produce reporting and visualizations that support several key insights relating to Advanced Health's care management and intervention programs.

As an example, Advanced Health has used the reporting and analysis derived from these tools to gain a deeper understanding of the change in Emergency Department (ED) visit costs. Analysis of the reports generated by these tools showed that per-Member-per-month costs attributable to ED visits were rising steadily over time, a
trend that is not sustainable. Based on this analysis, new 2020 VBP arrangements, including capitation, risk-sharing, and shared savings related to ED visit costs, are being offered to Advanced Health's contracted Hospitals.

In addition, Advanced Health is currently able to produce the following reports that inform (and will continue to inform) VBP arrangements, enabling Advanced Health to optimize its utilization management and care management efforts:

- Total cost of care, on a per-Member-per-month basis.
- Utilization reports, including reports tracking unnecessary ED visits by population, practice, Provider, and Member.
- Member reports by disease type, utilization, Medicaid benefit type, risk, and other relevant priorities.
- Quality reports detailing care gaps by practice, Provider, and Member.
- Medication reports detailing the class, name, and type of medication parsed out by practice, Provider, and Member.
- Care Coordination reports that detail Members by registry, Care Coordination program, and other attributes noted above.

D.2.a. Describe how Applicant will use HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models). Include in your description how Applicant will implement HIT to administer its initial VBP arrangements and how Applicant will ensure that it has the necessary HIT as it scales its VBP arrangements rapidly over the course of 5 years and spreads VBP arrangements to different care settings. Include in your description, plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements over the 5-year contract, including activities, milestones, and timelines.

Advanced Health currently administers VBP arrangements using a suite of lean and flexible HIT tools consisting of Milliman PRM Analytics, SQL Enterprise, Crystal Reports, and Tableau. Advanced Health uses these tools to store, query, and associate data from multiple data sources (e.g., claims and Care Coordination registries). In turn, that data is used to calculate metrics related to VBP arrangements and to inform the activities of Care Coordinators. This solution is scalable and flexible to meet changing needs in the VBP space.

Advanced Health will also leverage OHA's investment in Prometheus Analytics to implement episode-based VBPs. For example, Advanced Health plans to build an episode-based payments system for maternity care, modeled after New York's value based payment system. Information about New York's system can be found here. (https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2018/2018-02-09_maternity.htm)
While Advanced Health is confident in the ability of its current suite of tools to support increasingly complex VBP arrangements, the implementation of the Epic EHR, which, as noted above, will contain a PHM module, will complement and increase Advanced Health's analytical capabilities. Specifically, the PHM tools will be capable of performing near-real time risk stratification based on demographic, clinical, and SDOH&HE information that will be stored in the Epic EHR. The tool will further assist in the identification of gaps in care and the development of care management registries. This increased capability will allow Advanced Health to rapidly respond to changing VBP needs over the next five years.

A timeline for the deployment and implementation detailed in this response is included in Table D1 at the end of this Section.

D.2.b. Describe how Applicant will support contracted Providers with VBP arrangements with actionable data, attribution, and information on performance. Include in your description plans for start of Year 1 as well as plans over the 5 year contract, including activities, milestones, and timelines. Include an explanation of how, by the start of Year 1, Applicant will provide contracted Providers with VBP arrangements with each of the following: (1) Timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers; (2) Accurate and consistent information on patient attribution; and (3) Identification of specific patients who need intervention through the year, so the Providers can take action before the year end.

As a smaller, Rural Community, Advanced Health has deep relationships with its Network Providers and Provider Organizations. Advanced Health already supports its contracted Providers with VBP arrangement by providing actionable data, attribution, and information on performance. Therefore, it is ready for Year 1's requirements. Advanced Health analysts have already developed, and will continue to develop (subject to contractually-required targets, bonuses, and penalties intended to ensure timely performance) custom reports and a quality measures framework that include the following VBP elements:

- Provider performance
- Calculated target
- Progress toward target
- Predicted bonus or penalty based on progress

Advanced Health will meet in-person with contracted Providers quarterly to discuss progress, gaps, and any concerns the Providers may have. Advanced Health will also make the VBP reports available online to Providers for their reference. Advanced Health will work with contracted Providers on timelines based on the risk
of their panels. As an example, if a contracted Provider has slightly riskier population based on assigned Members, Advanced Health will work with the Provider to deliver reports to the contracted Provider more frequently than quarterly.

To promote accuracy, Advanced Health's internal analytics team uses standardized procedures to ensure that collection, aggregation, and analysis of data is accurate. As part of that process, the analytics team performs sanity checks of the underlying data.

At this point, Advanced Health (and its Affiliate, Southwest Oregon IPA, Inc., which previously provided Medicaid services to Medicaid beneficiaries) has amassed more than a decade of experience supporting VBP arrangements and has established a foundation of trust and confidence with its contracted Providers. The Providers, who continue to be more engaged each and every year, appreciate Advanced Health's providing detailed attention to this program and devoting time and resources to in-depth discussions with them. Advanced Health will continue to build on this organizational, regional, and Community strength as VBP arrangements grow in number and complexity.

By the start of Year 1 of the contract, Advanced Health will have provided to Providers its 2020 VBP arrangement information, including baseline financial and quality data and an outline of future performance reports. For example, Advanced Health will provide VBP Hospitals with historical PMPM financial data along with historical performance on ED utilization and readmission rates. The reporting will also clearly delineate financial and quality targets.

Advanced Health will also provide Member attribution and gap reports to Providers when relevant to a given VBP arrangement or quality metric. For example, when Advanced Health implements a LAN Category 4A contract with Advantage Dental by 2021, Advantage Dental will be provided Member-level data and gap information for its performance on OHA/NCQA's Oral Evaluations for Adults with Diabetes measure. Ongoing progress reports will be provided at least quarterly. Whenever possible, on-demand, online data will be provided to Providers.

A timeline for the deployment and implementation detailed in this response is included in Table D1 at the end of this Section.

D.2.c. Describe other ways the Applicant plans to provide actionable data to your Provider Network. Include information on what you currently do, what you plan to do by the start of the contract (Jan. 1, 2020), and what you intend to do in the future. Please include a narrative as well as a Roadmap that includes activities, milestones, and timelines.
Advanced Health (and its Affiliate, Southwest Oregon IPA, Inc., which previously provided Medicaid services to Medicaid beneficiaries) has been implementing VBP arrangements for 10 years, including capitated arrangements with Bay Area Hospital. Providers trust Advanced Health to set up these arrangements and present actionable data that makes effective use of our Provider's time and attention.

Currently, Advanced Health provides actionable data to contracted Providers via in-person meetings, secure email messages, Secure File Transport Protocol (SFTP), and postal mail. This is accomplished in part by utilizing Advanced Health's current suite of VBP tools that were more fully described previously in this Attachment 9. Given the close Community that Advanced Health has fostered, these methods will continue to be the main ways that Advanced Health will provide actionable data to contracted Providers.

On day one of the contract, Advanced Health will be prepared to continue to provide meaningful data that Providers can use to take meaningful actions. This includes insights on financial metrics such as total costs of care and other reporting as detailed in the response to Question D1c. Advanced Health will make this information available using Crystal reports and Tableau, and accessible online, in-person, over email, and through postal mail.

D.2.d. Describe how you will help educate and train Providers on how to use the HIT tools and data that they will receive from the CCOs.

Advanced Health has already developed and implemented a process for Provider HIT education to facilitate HIT tool use, including how to use Milliman PRM Analytics and custom reports. This process is comprised of individualized education sessions, either in-person or over the telephone, which emphasize relevant risk stratification and Member attribution methodologies, as well as elements of VBP arrangements and the logic behind VBP reporting. This personal connection to Providers and the Community it builds is a foundational strength of Advanced Health's operations model. Advanced Health will continue to use its time-tested, high touch training methodology in the coming years, adjusting the education content as the VBP arrangement increase in complexity.

However, as VBP arrangements are increased to 70% of all Provider payments, it will become even more essential that all Providers develop a thorough understanding of the measurements of Provider performance, calculated targets, progress towards targets, and the ability to forecast the bonus or penalty based on progress. As part of the Epic EHR implementation, the EHR vendor will be expected to offer comprehensive and robust training for contracted Providers on the reporting, analytics, and other tools available within the Epic EHR. At that point, Advanced Health may choose to embed its VBP arrangement management
framework (performance, targets, progress, predicted results, etc.) into the PHM tool embedded within the Epic EHR, and provide training accordingly.

Given the depth of Advanced Health's relationships with its contracted Providers, Advanced Health is setting an annual milestone of providing HIT tool education to 100% of contracted Providers. This milestone is included in Table D1 at the end of this Section.

D.2.e. Describe the Applicant's plans for use of HIT for population health management, including supporting Providers with VBP arrangements. Include in the response any plans for start of Year 1, as well as plans over the 5-year contract, including activities, milestones, and timelines. Describe how Applicant will do the following: (1) Use HIT to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services that can inform the focus of interventions to improve outcomes. Please include the tools and data sources that will be used (e.g., claims), and how often the applicant will re-stratify the population.

Currently, Advanced Health uses risk stratification tools available via Milliman PRM Analytics and OHA's tools for risk scoring Medicaid Members. Advanced Health provides quarterly reports that update Providers on the risk scores of the Members in their panel. This has provided Advanced Health with an effective view into ED and inpatient utilization levels, cost of care, and episode costs, as well as clinical risk stratification using Medicaid's registries.

The decisions regarding how to calibrate the risk scores, and which risks to focus on, are determined based on Advanced Health's programmatic priorities.

As an example, Advanced Health's focus on minimizing unnecessary hospitalization means that risk scores will be assigned which will assist in identifying patients likely to seek ED and inpatient care. The data is then shared with Providers and Care Coordinators in the form of reports and registries. Member-centered utilization data is provided to Providers to understand ED utilization trends both over time and by Member population to build proactive individualized plans of care for the Members.

This type of intentionality of HIT tool utilization will continue to be utilized in future risk stratification efforts.

Support for Providers also includes the promotion of the EDie and PreManage tools as described in the responses in this Attachment 9, Section C. These tools provide real-time information regarding patients who are at risk for ED utilization.
As the Epic EHR initiative moves forward, Advanced Health will complement its current risk stratification capabilities by working with Providers to utilize the PHM module embedded in the Epic EHR. Advanced Health will be able to assign risk scores based on regional data across all sites of care while maintaining several risk registries simultaneously. This information will also be provided to Providers through reports and in-person meetings to discuss the data.

**D.2.f. What are your plans to provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in those arrangement(s)?**

Advanced Health currently uses a suite of risk stratification tools to aid in the identification of Members in need of support and strategies for improving quality and cost-containment. Advanced Health uses the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) to risk-stratify Membership by risk of cost. Advanced Health also produces risk scores and values for risk of ED visits, risk of Hospital readmission, and avoidable cost. These tools are used internally and are supplied to Providers in Advanced Health's suite of population health management tools and reports. These tools will be further deployed to support Providers with VBP arrangements. For example, several of Advanced Health's planned 2020 VBPs are linked to Hospital readmission and ED utilization. The staff of Hospitals in these VBP arrangements will be given access to these tools to assist in their internal quality improvement efforts. Some of these tools are and will be available on-demand through an online portal. Others will be provided to Providers at least quarterly. When relevant, Advanced Health will provide risk-stratified Member lists to Providers.

Advanced Health will also support VBP Providers with specific analyses to support quality improvement. For example, Advanced Health's analytics team will study avoidable ED visits using internal claims data and literature review. Advanced Health will supply Hospital VBP Providers with the output of the study and any Member characteristics that may be related to avoidable ED visits. Advanced Health will support all VBPs with studies of this kind.

Upon implementation of the Epic EHR, more risk stratification abilities, enhanced reports and insights will be available to Providers. Advanced Health will be able to assist Provider in developing risk scores based on events recorded in the Epic EHR, such as a completion of a health risk assessment or an annual wellness visit.

**D.2.g. Please describe any other ways that the Applicant will gather information on and measure population health status and outcomes (e.g., claims, clinical metrics). Describe Applicant's HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of year one as well as plans over the 5-year
contract, including activities, milestones, and timelines. Include information about the following items:

D.2.g.(1) Data sources: What data sources do you draw on (for example, if you incorporate clinical quality metrics, what data do you collect and how)? How often do you update the data? How are new data sources added? How do you address data quality?

Advanced Health has robust processes in place to gather information and measure population health status and outcomes for the purposes of supporting VBP arrangements and population health efforts, including gathering, organizing, and matching data from multiple data sources.

Advanced Health’s enterprise data warehouse is updated daily and contains data from multiple sources, including physical health, Behavioral Health, and oral health claims data, transportation data, Member data, and SDOH&HE data. Specific reports or dashboards may be updated less frequently with stored procedures and Tableau extracts if updating daily is unnecessary or inefficient.

When incorporating new data sources, Advanced Health requires performing a thorough review of the new data for quality and consistency. Usually, a conversion or extraction is necessary to match a new data source with the format required to combine with reporting warehouse data. If data quality issues are found, Advanced Health works internally or with the supplying Provider to address and resolve those data quality issues.

Analysis is then performed and produced using the tools described in the following section. Each report goes through a rigorous quality assurance process that includes, at a minimum:

- Collecting requirements for each metric and value-based arrangement
- Identifying relevant data sources and the format and exceptions of the data available
- Developing a SQL query
- Reviewing the data produced using the query
- Cleaning the data and repeating the process as needed

The analytics manager or data scientist reviews every step in this process to ensure the report is based on and contains data that can be both verified and trusted.

D.2.g.(2) Data storage: Where do you store data (e.g., enterprise data warehouse)?
As described above, data is stored in an onsite enterprise data warehouse enabled by Microsoft SQL. This data is backed up locally every 15 minutes and encrypted both during transfer and at rest. Advanced Health is well aware of earthquake and tsunami risk in its Service Area and has made arrangements for secure offsite storage. Data is backed up daily to an offsite state-of-the-art SSAE16 SOC 2 Type 2 certified data center.

D.2.g.(3) Tools: (a) What HIT tool(s) do you use to manage the data and assess performance? (b) What analytics tool(s) do you use? What types of reports do you generate routinely (e.g., daily, weekly, monthly, quarterly)?

Advanced Health has a suite of HIT tools, including Microsoft SQL Server, SAS Institute analytics, Tableau Software analytics, SAP Crystal Reports, and Microsoft Excel, that were chosen based upon their ability to support VBP arrangements, their cost-effectiveness, and their flexibility. These tools are currently used and will continue be used to manage data and assess Advanced Health's and its contracted Providers' performance. They provide support for Advanced Health's current VBP arrangements and PHM while being sufficiently flexible and robust to manage the anticipated increase in VBP complexity.

Examples of reports that Advanced Health routinely generates are incentive gap lists, chronic condition assessment gap lists, access metric performance, and Provider grievance and dismissal reports. All reports are generated monthly, quarterly, or by request.

D.2.g.(4) Workforce: Do you have staff (in-house, contractors, or a combination) who can write and run reports and who can help other staff understand the data? What is your staffing model, including contracted staffing?

Given its track record of managing VBP arrangements, Advanced Health has significant subject matter expertise in-house to address VBP arrangements, reporting construction and execution, and the interpretation and analysis of relevant data. This expertise includes a Director of Financial Planning and Analysis, a Data Scientist, and a Data Analyst. Advanced Health can also rely on its contractor, Milliman, to provide contracted support for additional reporting as needed.

These staffing levels will be maintained and can be scaled up should the need arise. Advanced Health has identified that additional resources may be required to build more reports for contracted Providers as VBP arrangement complexity increases. Advanced Health will stay ahead of this concern and hire the necessary resources required as the need arises.
D.2.g.(5) Dissemination: After reports are run, how do you disseminate analysis to Providers or Care Coordinators in your network? How do you disseminate analysis within your organization?

As mentioned in detail in Questions D.2.b. and D.2.c., Advanced Health currently disseminates analysis to Providers through secure email, online, in-person delivery, SFTP, and mail. These efforts have been very successful and will be maintained as foundational elements as VBP complexity increases.

Advanced Health disseminates analysis within its organization by way of secure email, or in-person meetings. Advanced Health employees also have the ability to run reports instantaneously with the use of a report runner program. Advanced Health's analytics department can tailor a report based on the request, and the analytics team trains employees on how to properly run and analyze the report as well.

D.2.g.(6) Effectiveness: How will you monitor progress on your Roadmap and the effectiveness of the HIT supports implemented or to be implemented?

Advanced Health has developed a Roadmap with milestones and targets for each element of the HIT Roadmap. Those milestones and targets are included in Tables B1, C1, and D1 included in these responses to the Questions in this Attachment 9. Advanced Health will, by August 1, 2019, develop a detailed project plan that will include personnel assignments and the ability to track each task through its completion.

Progress toward milestones and tasks will be monitored on an ongoing basis by Advanced Health's project managers and reported to OHA as required.

D.2.g.(7) Addressing Challenges: What challenges do you anticipate related to HIT to support VBP arrangements with contracted providers, including provider-side challenges? How do you plan to mitigate these challenges? Do you have any planned projects, IT upgrades, or transitions that would affect your ability to have the appropriate HIT for VBP?

Advanced Health is confident in its carefully developed, tested, and tried suite of analytics tools and capable personnel. These core capabilities will be maintained and improved upon, minimizing potential challenges.

To achieve 70% VBP spending by 2024, it will be necessary for Advanced Health to establish VBPs with Providers who do not currently have the ideal suite of technical capabilities to support more complex payment arrangements.
Advanced Health can mitigate this issue by assessing each Provider's technical capabilities and selecting payment models that match those capabilities. For example, a small organization with few finance and analytics staff may not have the necessary technical personnel to evaluate their own performance against a per-Member-per-month payment. They also may not have the capital necessary to assume the risk. In that case, Advanced Health would propose a less complex and less risky model for the Provider. For example, Advanced Health may choose a shared savings and risk model, reducing the administrative and capital risk burden.

Advanced Health can further mitigate this issue by supporting Providers with all necessary reporting and analytics to assess their performance in the VBP. A Provider would only need the staff necessary to validate Advanced Health's reporting. This will reduce the personnel burden and, thus, reduce the barrier to more complex payment models.

Table D.1. Table Showing VBP Roadmap and Milestones.

The activities described in responses to Questions D.2.a through D.2.g will occur over the next five years.

The specific timeline for those activities, including milestones, is shown in the following table.

[Table D.1. Begins on next page]
TABLE D.1.
VBP / HIT ROADMAP

<table>
<thead>
<tr>
<th>Year</th>
<th>HIT to Support VBP Arrangements</th>
</tr>
</thead>
</table>
| 2019 | • Develop standard Provider training on VBP arrangements.  
      • Amend and restate Provider and Subcontractor agreements to reflect developing VBP arrangements over 2020-2024.  
      • **Milestone:**  
      • Provider and Subcontractor agreements finalized. |
| 2020 | • New VBP arrangement will be implemented and managed using current HIT tools.  
      • VBP arrangement Provider education will be delivered.  
      • Synthesized reporting based on the SQL Enterprise Data Warehouse are developed.  
      • **Milestone:**  
      • Advanced Health has VBP Provider training on metrics and supplied HIT tools to 100% of Providers relevant to 2020 VBP arrangements.  
      • 20% of Advanced Health payments will be made under VBP arrangements. These will include VBPs with all service area Hospitals and ADAPT, an SUD Provider. Advanced Health will support these Providers with at least quarterly reporting on Provider performance against any pre-defined financial and quality targets, risk stratification, gap lists, and other data. |
| 2021 | • New VBP arrangements are implemented and managed using current HIT tools.  
      • VBP arrangement Provider education will be delivered.  
      • Synthesized reporting based on the SQL Enterprise Data Warehouse are developed.  
      • **Milestone:**  
      • Advanced Health delivers VBP Provider training on metrics and supplied HIT tools to 100% of Providers relevant to 2020 VBP arrangements.  
      • 35% of Advanced Health payments will be made under VBP arrangements. These will include new VBPs with Advanced Health's dental Subcontractors and others. All will be supported with at least quarterly reporting on Provider performance against any pre-defined financial and quality targets, risk stratification, gap lists, and other data. |
| 2022 | • New VBP arrangements are implemented.  
      • VBP arrangement Provider education will be delivered.  
      • Synthesized reporting based on the SQL Enterprise Data Warehouse are developed. |
<table>
<thead>
<tr>
<th>Year</th>
<th>HIT to Support VBP Arrangements</th>
</tr>
</thead>
</table>
|      | **Milestone:**  
|      |   - Advanced Health has VBP Provider training on metrics and supplied HIT tools to 100% of Providers relevant to 2020 VBP arrangements.  
|      |   - 50% of Advanced Health payments will be made under VBP arrangements. All will be supported with at least quarterly reporting on Provider performance against any pre-defined financial and quality targets, risk stratification, gap lists, and other data.  
| 2023 |   - New VBP arrangements are implemented.  
|      |   - VBP arrangement Provider education is delivered.  
|      |   - Epic PHM education is provided where appropriate.  
|      | **Milestone:**  
|      |   - Advanced Health has VBP Provider training on metrics and supplied HIT tools to 100% of Providers relevant to 2020 VBP arrangements.  
|      |   - 60% of Advanced Health payments will be made under VBP arrangements. All will be supported with at least quarterly reporting on Provider performance against any pre-defined financial and quality targets, risk stratification, gap lists, and other data.  
| 2024 |   - New VBP arrangements are implemented.  
|      |   - VBP arrangement Provider education is delivered.  
|      |   - Epic PHM education is provided where appropriate.  
|      | **Milestone:**  
|      |   - Advanced Health delivers VBP Provider training on metrics and supplied HIT tools to 100% of Providers relevant to 2020 VBP arrangements.  
|      |   - 70% of Advanced Health payments will be made under VBP arrangements. All will be supported with at least quarterly reporting on Provider performance against any pre-defined financial and quality targets, risk stratification, gap lists, and other data.  

WESTERN OREGON ADVANCED HEALTH
CURRY COMMUNITY ADVISORY COUNCIL
COMMUNITY HEALTH IMPROVEMENT PLAN

INTRODUCTION

We are pleased to submit a working draft of our Community Health Improvement Plan (CHIP) for the Curry Western Oregon Advanced Health (WOAH) Community Advisory Council (CAC). We are a brand new CAC, and have been meeting monthly now since February 2015. We have a great, energetic group that has been working hard to develop first our Community Health Assessment (CHA) and CHIP. We understand that the Memorandum of Agreement with Western Oregon Advanced Health requires our new CAC to submit a CHA and CHIP before June of 2015. In order to meet this request, we are submitting this early draft of our CHIP, with the understanding that there are still some other components that will be included in our final draft.

As of the writing of this cover letter, we have had three CAC meetings. We currently have three official members, and have had good attendance and participation from other community partners and citizens. At our last meeting we accepted 4 new membership applications, and have submitted them to the Curry County Board of Commissioners for approval. Their next board meeting is May 6th, 2015, and we anticipate the applications will be approved at that meeting. This will bring our membership to four consumers, and three non-consumer members, keeping our membership ratio of greater than 50% consumers intact.

PROCESS

The original WOAH CAC in Coos Bay developed their CHIP from data collection and work done by the Coos County Public Health Department. At that time there was only one WOAH CAC, serving both Coos and Curry Counties. Now that WOAH has started a Curry County CAC, this group is developing their own CHA and CHIP. We are using the Coos CHIP as our basic document, and adding to it the work we have done in the three times we have been together. We had a terrific brain-storming session at our last meeting, and came up with goals that the entire group agreed represent Curry County’s unique health needs.
OUTCOMES

Basing our plans on the Coos County CHIP, the CHA that the Curry CAC developed, and our latest brain-storming session, we have identified 3 high-level goals for our CAC to work on:

- Linkages and Coordination
- Accessing Care and Services
- Prevention

Medium-level goals are listed under the high-level concepts. Our next step will be to define our smaller-level goals, and then develop work plans to address them.

MOVING FORWARD

Curry County is a small community, with their own distinct strengths and challenges when it comes to improving access to health care, and to promoting healthy lifestyles for its citizens. Some of the challenges include county financial struggles, transportation limitations, and sometimes even the weather! But it is a caring community, with people who support one another and are willing to work for change. Our CAC meetings have been energizing, stimulating, and encouraging. This group is committed to making a positive impact on their community, and come prepared to work together and bring their unique ideas to the table. Although our numbers are small, we are growing! And those attending have been a rich representation of various perspectives and community roles, bringing a healthy diversity to the group. We have appreciated the guidance and support of the WOAH board, and their staff who are working with us; our Innovator Agent from the Transformation Center; our consultant Vanessa Becker; and our partners and consumers who give their time and energy to this process. We could not do this work without each one of them. Our sincere thanks to WOAH for allowing us to work with them in this endeavor. We look forward to our next steps, developing the work plans and making a difference in the health and well-being of our community.

Submitted on behalf of the Curry WOAH Community Advisory Council by Patricia Savage, RN, MSN, CPNP, Chair, May 1, 2015
Applicants must provide a detailed plan for community engagement according to the required components in the RFA Community Engagement Plan Reference Document, including identified gaps and plans to address gaps. **Applicant’s Community Engagement Plan must be no more than 4 pages (according to the RFA spacing and font restrictions), excluding tables. Tables should be completed in the format provided below and submitted with Applicant’s Community Engagement Plan (narrative).**

**Table 1: Stakeholders to be included in the engagement process**

<table>
<thead>
<tr>
<th>All applicants must complete this full table. Applicants may add rows as needed.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1a.</strong> List stakeholder types to be included in the engagement process. Applicants must include, at a minimum, plans to engage the following stakeholder types: OHP consumers, community-based organizations that address disparities and the social determinants of health (“SDOH-HE”), providers, including culturally specific providers as available (includes physical, oral, behavioral, providers of long term services and supports, traditional health workers and health care interpreters), Regional Health Equity Coalitions (if present in the service area), early learning hubs, local public health authorities, local mental health authorities, other local government, and tribes. Add additional rows as needed.</td>
</tr>
<tr>
<td><strong>Part 1b.</strong> List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1.a, with which the applicant will engage. Add additional rows under the stakeholder type as needed.</td>
</tr>
<tr>
<td><strong>Part 1b.</strong> Describe why each listed agency, organization and individual was included.</td>
</tr>
<tr>
<td><strong>Part 1b.</strong> Describe how Applicant plans to develop, maintain or strengthen relationships with each stakeholder and maintain a presence within the community.</td>
</tr>
<tr>
<td>OHP consumers (list in first column below)</td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Advanced Health Board of Director consumer members</td>
</tr>
<tr>
<td>Advanced Health members</td>
</tr>
<tr>
<td>Coos County Community Advisory Council (CAC) consumer members</td>
</tr>
<tr>
<td>Organization</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Coos County Community Health Improvement Plan (CHIP) Subcommittee consumer members</td>
</tr>
<tr>
<td>Curry County Community Advisory (CAC) Council consumer members</td>
</tr>
<tr>
<td>Curry County Community Health Improvement Plan (CHIP) Subcommittee consumer members</td>
</tr>
</tbody>
</table>
to their needs, and seeing them at meetings every month

<table>
<thead>
<tr>
<th>Community-based organizations that address disparities and SDOH-HE (list in first column below)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4-H Club</td>
<td>Margie House</td>
<td>Works for Oregon State University Extension Services in Curry County, responsible for 4-H programs</td>
<td>We plan to strengthen relationship by supporting 4-H activities, involving Margie in CHP initiatives</td>
</tr>
<tr>
<td>Alternative Youth Activities</td>
<td>Scott Cooper</td>
<td>Director</td>
<td>We plan to strengthen relationship by inviting Scott to CAC and CHP activities</td>
</tr>
<tr>
<td>Bandon Community Youth Center</td>
<td>Melinda Torres</td>
<td>Board Chair</td>
<td>We plan to maintain relationship</td>
</tr>
<tr>
<td>Bay Area Senior Center</td>
<td></td>
<td></td>
<td>We plan to develop relationship by inviting to participate in CAC or CHP activities</td>
</tr>
<tr>
<td>Bay Cities Brokerage</td>
<td>Brian Spanine</td>
<td>Director of transportation brokerage for our members</td>
<td>We plan to maintain relationship</td>
</tr>
<tr>
<td>Boy Scouts of America</td>
<td></td>
<td></td>
<td>We plan to develop relationship by inviting to participate in CAC or CHP activities</td>
</tr>
<tr>
<td>Boys and Girls Club of Southwestern Oregon</td>
<td>Denise Gould</td>
<td>Director</td>
<td>We plan to maintain relationship, continue to engage Denise in our community engagement work</td>
</tr>
<tr>
<td>CASA of Coos County</td>
<td>Greg Dalton</td>
<td>Program Director</td>
<td>We plan to maintain relationship, continue to</td>
</tr>
<tr>
<td>Organization</td>
<td>Contact Person</td>
<td>Position/Title</td>
<td>Engagement Plan</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CASA of Curry County</td>
<td>Mona Chandler</td>
<td>Program Director</td>
<td>We plan to maintain relationship, continue to engage Mona in our work</td>
</tr>
<tr>
<td>Childcare Resource &amp; Referral</td>
<td>Danaye Gonzalez</td>
<td>Program Manager, ACE Certified Master Trainer</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Community Living Case Management, Inc.</td>
<td>Mathew Clark</td>
<td></td>
<td>We plan to strengthen our relationship, engage Mathew in improving our referral process &amp; communication</td>
</tr>
<tr>
<td>Coos Bay Farmers’ Market</td>
<td></td>
<td></td>
<td>We plan to continue to work with the Coos Bay Farmers’ Market within our CHP</td>
</tr>
<tr>
<td>Coos Bay North Bend Chamber of Commerce</td>
<td>Clark Walworth</td>
<td>President</td>
<td>We plan to strengthen our relationship and involve the business sector more in our trauma-informed communities work</td>
</tr>
<tr>
<td>Coos &amp; Curry Housing Authority</td>
<td>Marka Turner</td>
<td>Director</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Coos County Area Transit (CCAT)</td>
<td>Sergio Gamino</td>
<td>Executive Director</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Coos County Homeless Coalition</td>
<td></td>
<td></td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Coos Hispanic Leadership Program</td>
<td>Gloria Clark</td>
<td>Member of Coos Hispanic Leadership as well as regular attendee at Advanced Health Coos CAC meetings</td>
<td>We plan to maintain our relationship and continue to work with Gloria to further develop the Equity Coalition</td>
</tr>
</tbody>
</table>

RFA 4690 - Advanced Health

Attachment 10 - Community Engagement Plan Tables 5 of 44
<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Person(s)</th>
<th>Description</th>
<th>Relationship Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curry Community Resource Center</td>
<td>Beth Barker Hidalgo</td>
<td>Advanced Health primary funder for the start-up of integrated community resource center in Curry County</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Curry County Homeless Coalition</td>
<td>Beth Barker Hidalgo</td>
<td>Active group in Curry County</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Curry Public Transit (Coastal Express, Dial-A-Ride)</td>
<td></td>
<td>Only public transit in Curry County</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Every Child Coos County</td>
<td>Melissa Hart</td>
<td>Advanced Health is a financial sponsor of Every Child Coos to recruit foster families</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>For Youth By Youth</td>
<td>Greg Dalton, Cynthia Edwards</td>
<td>Administrative staff</td>
<td>We plan to strengthen our support of this group by supporting the community youth advisory council</td>
</tr>
<tr>
<td>Girl Scouts of America</td>
<td></td>
<td></td>
<td>We plan to develop relationship by inviting to participate in CAC or CHP activities</td>
</tr>
<tr>
<td>Healthy Families Oregon</td>
<td>Michelle Hanna</td>
<td>Supervisor</td>
<td>We plan to strengthen our relationship by increased support to evidenced-based home visiting programs</td>
</tr>
<tr>
<td>Kairos Coastline Services</td>
<td>Carolyn Acker</td>
<td>System of Care Program Manager</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Kids HOPE Center</td>
<td>Ashley Matsui</td>
<td>Program Director</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Organization</td>
<td>Contact Name</td>
<td>Description</td>
<td>Relationship Plan</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Lions Club</td>
<td>Michelle Martin</td>
<td>Lions Club helps our membership with purchasing eye glasses</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>New Community Coalition</td>
<td>Scott Cooper</td>
<td>Executive Director. New Community Coalition sponsors the Poverty Simulation on a regular basis.</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>North Bend Senior Center</td>
<td></td>
<td></td>
<td>We plan to develop relationship by inviting to participate in CAC or CHP activities</td>
</tr>
<tr>
<td>Oregon Coast Community Action</td>
<td>Mike Lehman</td>
<td>Executive Director</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Oregon State University Extension Services</td>
<td>Stephanie Polizzi</td>
<td>Registered Dietician, Chair of our CHP focused on health eating and active living</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Pathways to Positive Parenting</td>
<td>Kathy Barber</td>
<td>Collaborates with us on several projects, serves on our South Coast Together Steering Committee</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Pelican Group</td>
<td></td>
<td>Food pantry for the public</td>
<td>We plan to strengthen our relationship by inviting to our CAC and CHP</td>
</tr>
<tr>
<td>Pregnancy Resource Center</td>
<td></td>
<td>Free resources to public</td>
<td>We plan to strengthen our relationship by inviting to our CAC and CHP</td>
</tr>
<tr>
<td>Salvation Army</td>
<td></td>
<td></td>
<td>We plan to strengthen our relationship by inviting to our CAC and CHP</td>
</tr>
<tr>
<td>South Coast Family Harbor</td>
<td>Tracie Skinner</td>
<td>Therapeutic preschool</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Organization</td>
<td>Contact</td>
<td>Description</td>
<td>Relationship Goals</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Relief Nursery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Coast Head Start</td>
<td>Wendi Baird</td>
<td>High quality Preschool, Early Learning</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>South Coast Hospice and Palliative Care</td>
<td>Linda Furman Grile</td>
<td>Executive Director, Member of our Coos CAC</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>South Coast Oral Health Coalition</td>
<td>Cindy Shirtcliffe</td>
<td>Advantage Dental employee</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>South Coast Regional Early Learning Hub</td>
<td>Heather Baumer</td>
<td>Director of the early learning hub, attends Coos and Curry CAC meetings</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>South Coast Together</td>
<td>Laura Williams</td>
<td>Cross sector, collaborative group created by Advanced Health to promote trauma-informed, self-healing</td>
<td></td>
</tr>
<tr>
<td>The ARK (At Risk Kids) Program</td>
<td>Melinda Johnson</td>
<td>Program Director</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>THE House</td>
<td></td>
<td>Homeless shelter serving adults in need of temporary housing &amp; meals</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>The Nancy Devereux Center</td>
<td>Tara Johnson</td>
<td>Provide meals, clothes, showers, laundry facilities, warming center for homeless</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>United Way of Southwestern Oregon</td>
<td>Jen Shafer, Char Luther</td>
<td>Local nonprofit, community capacity building</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>VA Medical Clinic</td>
<td>Will Wasson</td>
<td>Collaborating on suicide prevention initiative</td>
<td>We plan to strengthen our relationship, invite Will to CAC and CHP meetings</td>
</tr>
<tr>
<td>Wally’s House</td>
<td>Jackalene Antunes</td>
<td>Child sexual abuse services</td>
<td>We plan to strengthen our relationship by providing more support to Wally’s House</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------</td>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Women’s Resource Center</td>
<td></td>
<td></td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Youth Era – Coos Drop</td>
<td>Jay Brown</td>
<td>Peer Support Services for youth in Coos County</td>
<td>We plan to maintain our relationship</td>
</tr>
</tbody>
</table>

**Providers, physical health, including culturally specific providers as available (list in first column below)**

<table>
<thead>
<tr>
<th>Bay Area Hospital</th>
<th>Angie Webster</th>
<th>Director of Community Health Programs</th>
<th>We plan to maintain our relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bay Clinic</td>
<td>Mary Moore, MD</td>
<td>Pediatrician on the Advanced Health Board</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Coast Community Health Center</td>
<td>Linda Maxon, Hollie Strahm</td>
<td>Serves on the Coos and Curry CACs</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Coquille Indian Tribe Community Health Center</td>
<td>Kelle Adamek-Little</td>
<td>Serves on the Coos CHP</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Coquille Valley Hospital</td>
<td>Susie Breuer</td>
<td>Serves on the Coos CHP</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Curry Community Health</td>
<td>Ben Cannon</td>
<td>Member of Curry CAC</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Curry Health Network</td>
<td>Ginny Razo</td>
<td>Serves on Curry CHP</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>North Bend Medical Center</td>
<td>Amarissa Wooden, Lindsey Tyner</td>
<td>Serves on Coos CHP</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Southern Coos Hospital &amp; Health Center</td>
<td>Jodee Tittle</td>
<td>Serves on Coos CHP</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Waterfall Community</td>
<td>Andrea Trenner</td>
<td>Attends Coos CAC, Serves</td>
<td>We plan to maintain our relationship</td>
</tr>
</tbody>
</table>

Attachment 10 - Community Engagement Plan Tables 9 of 44
<table>
<thead>
<tr>
<th>Health Center</th>
<th>on Coos CHP</th>
<th>relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Providers, behavioral health, including culturally specific providers as available (list in first column below)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADAPT</td>
<td>Behavioral Health Specialists</td>
<td>Strengthen</td>
</tr>
<tr>
<td>Bay Clinic</td>
<td>Behavioral Health Specialists</td>
<td>Strengthen</td>
</tr>
<tr>
<td>Coast Community Health Center</td>
<td>Behavioral Health Specialists</td>
<td>Strengthen</td>
</tr>
<tr>
<td>Coos Health and Wellness</td>
<td>David Geels Behavioral Health Director</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Curry Community Health</td>
<td>Erin Porter Behavioral Health Director</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Curry Health Network</td>
<td>Behavioral Health Providers</td>
<td>Strengthen</td>
</tr>
<tr>
<td>Kairos Coastline Services</td>
<td>Carolyn Acker System of Care Program Manager</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>North Bend Medical Center</td>
<td>Behavioral Health Providers</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Waterfall Community Health Center</td>
<td>Behavioral Health Providers</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td><strong>Providers, oral health, including culturally specific providers as available (list in first column below)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advantage Dental</td>
<td>Tom Holt, DDS Member of Coos CHP, Member of Advanced Health Clinical Advisory Panel</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Confederated Tribe Oral Health Center</td>
<td></td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Coquille Indian Tribe Community Health Center</td>
<td></td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Providers, long term services and supports, including culturally specific providers as available (list in first column below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Aging and People with Disabilities</td>
<td>Christy Shipman</td>
<td>Member of Coos CAC</td>
</tr>
<tr>
<td>Community Living Case Management</td>
<td>Mathew Clark</td>
<td></td>
</tr>
</tbody>
</table>

| Providers, traditional health workers, including culturally specific providers as available (list in first column below) |  |
|---|---|---|---|
| Advanced Health | Lela Wells, Jesse Leguee |  | We plan to maintain our relationship |
| Bay Clinic |  |  | Develop |
| Coast Community Health Center |  |  | Develop |
| North Bend Medical Center |  |  | Develop |
| Waterfall Community Health Center |  |  | Develop |

| Providers, health care interpreters (list in first column below) |  |
|---|---|---|---|
| Advanced Health | Selia Colvin | Advanced Health on-site certified healthcare interpreter | We plan to maintain relationship by continuing to involve her in community engagement activities |
| Coos Health and Wellness |  | Coos County Public Health authority | Develop relationship (staff has changed) |
| Curry Community Health |  | Curry County Public Health authority | Develop relationship (staff has changed) |

| Early learning hubs (list in first column below) |  |
|---|---|---|---|
| South Coast Regional Early Learning Hub | Heather Baumer | Director, Attends Coos CAC | Maintain relationship |
**Local public health authorities (list in first column below)**

<table>
<thead>
<tr>
<th>Authority</th>
<th>Contact Person</th>
<th>Related Roles</th>
<th>Relationship Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coos County Public Health</td>
<td>Florence Pourtal Stevens</td>
<td>Member of Coos CAC, Member of CHPs</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Curry Community Health</td>
<td>Ben Cannon</td>
<td>Member of Curry CAC</td>
<td>We plan to maintain our relationship</td>
</tr>
</tbody>
</table>

**Local mental health authorities (list in first column below)**

<table>
<thead>
<tr>
<th>Authority</th>
<th>Contact Person</th>
<th>Related Roles</th>
<th>Relationship Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coos Health and Wellness</td>
<td>David Geels</td>
<td>Member of Coos CAC</td>
<td>We plan to maintain our relationship</td>
</tr>
<tr>
<td>Curry Community Health</td>
<td>Erin Porter</td>
<td>Attends Curry CAC</td>
<td>We plan to maintain our relationship</td>
</tr>
</tbody>
</table>

**Other local government (list in first column below)**

<table>
<thead>
<tr>
<th>Authority</th>
<th>Contact Person</th>
<th>Relationship Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Bandon</td>
<td></td>
<td>Strengthen relationship</td>
</tr>
<tr>
<td>City of Brookings</td>
<td></td>
<td>Strengthen relationship</td>
</tr>
<tr>
<td>City of Coos Bay</td>
<td></td>
<td>Strengthen relationship</td>
</tr>
<tr>
<td>City of Coquille</td>
<td></td>
<td>Strengthen relationship</td>
</tr>
<tr>
<td>City of Gold Beach</td>
<td></td>
<td>Strengthen relationship</td>
</tr>
<tr>
<td>City of Lakeside</td>
<td></td>
<td>Strengthen relationship</td>
</tr>
<tr>
<td>City of Myrtle Point</td>
<td></td>
<td>Strengthen relationship</td>
</tr>
<tr>
<td>City of North Bend</td>
<td>Jessica Engelke, Councilor</td>
<td>Participated in CHA focus groups</td>
</tr>
<tr>
<td>City of Port Orford</td>
<td></td>
<td>Strengthen relationship</td>
</tr>
<tr>
<td>City of Powers</td>
<td></td>
<td>Strengthen relationship</td>
</tr>
<tr>
<td>Coos County</td>
<td>Melissa Cribbins, John Sweet</td>
<td>Coos County Commissioners and Members of our Coos CAC</td>
</tr>
<tr>
<td>Curry County</td>
<td>Court Boice</td>
<td>Curry County Commissioner and attends our Curry County CAC</td>
</tr>
</tbody>
</table>
### Tribes, if present in the service area (list in first column below)

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Contact Person(s)</th>
<th>Relationship Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians</td>
<td>Attends Coos CAC, participates in CHP</td>
<td>Strengthen relationship</td>
</tr>
<tr>
<td>Coquille Indian Tribe</td>
<td>Fauna Larkin, Kelle Little</td>
<td>Past members of Coos CAC, Very involved in Coos CHP</td>
</tr>
<tr>
<td>Tolowa Dee-Ni Nation</td>
<td>Jeri Thompson</td>
<td>Very involved in Curry CHA</td>
</tr>
</tbody>
</table>

### Regional Health Equity Coalitions, if present in the service area (list in first column below)

<table>
<thead>
<tr>
<th>Coalition</th>
<th>Contact Person(s)</th>
<th>Relationship Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Add additional stakeholder types here (list in first column below)

<table>
<thead>
<tr>
<th>Stakeholder Type</th>
<th>Contact Person(s)</th>
<th>Relationship Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bandon School District</td>
<td>Becky Armistead</td>
<td>Ocean Crest Elementary School Principal, interested in ACES work and Kindergarten Preparedness</td>
</tr>
<tr>
<td>Brookings Harbor School District</td>
<td>Angela Crum, Bruce Raleigh</td>
<td>Strengthen relationship by engaging further in CHP activities</td>
</tr>
<tr>
<td>Coos Bay School District</td>
<td>Lisa DeSalvio</td>
<td>Maintain relationship</td>
</tr>
<tr>
<td>Gold Beach School District</td>
<td></td>
<td>Strengthen relationship, further support of Youth Advisory Council</td>
</tr>
<tr>
<td>North Bend School District</td>
<td>Allyson McNeill</td>
<td>Maintain relationship</td>
</tr>
<tr>
<td>South Coast Education School District</td>
<td>Dawn Granger</td>
<td>ACE Certified Master Trainer, collaborator on community initiatives, including equity work</td>
</tr>
<tr>
<td>Southwestern Oregon Community College</td>
<td>Taya Noland</td>
<td>Oversees Early Childhood Programs</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td><strong>Add additional stakeholder types here (list in first column below)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coos History Museum</td>
<td>Amy Pollicino</td>
<td>Education Coordinator</td>
</tr>
<tr>
<td>Curry Public Library</td>
<td>Jeremy Skinner</td>
<td>Library Director, Member of Early Learning Hub Steering Committee</td>
</tr>
<tr>
<td><strong>Add additional stakeholder types here (list in first column below)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coos Bay Police Department</td>
<td>Chief Gary McCullough</td>
<td>Collaborator on Prevention Drug Overdose initiative</td>
</tr>
<tr>
<td>North Bend Police Department</td>
<td>Chief Robert Kappelman</td>
<td>Collaborator on Prevention Drug Overdose initiative</td>
</tr>
<tr>
<td><strong>Add additional stakeholder types here (list in first column below)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curry Juvenile Department</td>
<td>Wendy Lang</td>
<td>Director, ACE Trainer</td>
</tr>
<tr>
<td>South Coast Oral Health Coalition</td>
<td>Margaret Crowley</td>
<td>Liaison</td>
</tr>
</tbody>
</table>
Table 2: Major activities and deliverables for which the CCO will engage the community

<table>
<thead>
<tr>
<th>All applicants must complete this full table.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 2a.</strong> List and describe the five to eight major projects, programs and decisions for which the CCO will engage the community.</td>
</tr>
<tr>
<td><strong>Part 2b.</strong> Identify the level of community engagement for each project, program and decision. Answers must be 1) inform/communicate, 2) consult, 3) involve, 4) collaborate, or 5) shared decision-making. Applicant may include more than one level of engagement for each project, program or decision to account for differences among stakeholder groups.</td>
</tr>
</tbody>
</table>

1. **HEALTH EQUITY**

   **Target Area:** Coos County, Curry County

   In 2018, 55% of Coos County CHA survey respondents and 59% of Curry County CHA survey respondents indicated they did not believe that everyone in their county has an equal opportunity to live a long healthy life if they choose to.

   **Goal:** Improve health equity

   **Outcome Indicators:**
   - Decrease disparities in the health service delivery system
   - Advance equity and inclusion
   - Certified healthcare interpreters are available to all Advanced Health members when needed
   - Oral language translators are available 24 hours a day/7-days a week to Advanced Health members

   **Strategy #1:** Support the Community Equity Coalition’s work with the community to address disparities and

   - **Advanced Health members in Coos and Curry Counties, Historically underserved populations:** Shared decision-making
   - **Advanced Health Community Health Improvement Plan (CHP) member focused on Health Equity initiative:** Shared decision-making
   - **Advanced Health Community Advisory Members in Coos and Curry Counties:** Shared decision-making
   - **Advanced Health Members in Coos and Curry Counties:** Collaborate (with exception of consumer members participating on a CAC, CHP or from a historically underserved population as noted above)
   - **Equity Coalition Member:** Shared decision-making
   - **Healthcare Providers in Coos and Curry Counties:** Collaborate
advancing equity and inclusion in the region by:
- Launching educational campaigns;
- Continue to help plan and support the Annual Diversity Conference (1st Annual Conference held in April 2019);
- Bring Health Literacy and Culturally and Linguistically Appropriate Services (CLAS) Training to our Providers at least annually;
- Adopt and Promote the use of an Equity Impact Analysis Tool
- Work cross-sector to make a collective impact

**Strategy #2:** Improve childhood literacy rates by working with our early learning programs to provide culturally-specific programming

**Strategy #3:** Continue to train and provide Certified Healthcare Interpreters for our members and providers throughout our service area. In addition, continue to provide translation (oral and written) services for our membership.

**Aligns with:**
- Consumer member priorities
- Coos County CHA, 2018; CHP, 2019
- Curry County CHA, 2018; CHP, 2019
- OHA Quality Metric (future)
- Community partner priorities
- Oregon State Health Improvement Plan (SHIP), 2020-2024

| Social Service Agencies in Coos and Curry Counties: Collaborate |
| Special Populations: Consult |
| Community at large: Inform |
## 2. ACCESS TO CARE

**Target Area:** Coos County, Curry County

Coos and Curry Counties are both designated by the Office of Rural Health as Medically Underserved, Health Professional Shortage Areas, Health Professional Shortage Areas for Dental and Mental Health Providers.

**Goal:** All Advanced Health members receive care when they need it

**Outcome Indicators:**
- Consumer Assessment Healthcare Providers and Systems (CAHPS) access survey questions
- Patient-Centered Primary Care Home (PCPCH) Access Standards
- Access to Preventive Care
- Access to Mental Health Care, including System of Care Services (Wrap Around)
- Access to Oral Health Care
- Access to Substance Use Disorder Treatment Services
- Access to Physical Health Care
  - Urgent
  - Routine

**Strategy #1:** Continue to evolve PCPCH Learning Collaborative, led by the Advanced Health CHP, to support current PCPCH recognized clinics in Coos and Curry Counties and to encourage other practices to become recognized

---

**Advanced Health members in Coos and Curry Counties:** Involve

**Community At Large:** Involve

**Local Hospital and Clinic Administrators:** Shared decision-making

**PCPCH Providers:** Shared decision-making

**Physical Health Providers:** Shared decision-making

**Mental Health Providers:** Shared decision-making

**Substance Use Disorder Treatment Providers:** Shared decision-making

**Oral Health Providers:** Shared decision-making

**Southwestern Oregon Community College:** Collaborate

**Oregon Health Science University Rural Campus:** Collaborate
**Strategy #2:** Develop and Implement programs and processes to break down barriers to care
- Expand Traditional Health Worker teams to assess and address barriers to care, including social determinants of health. Use data from past flex funding approvals to inform of common barriers to care.
- Network with social service agencies to establish resource referral processes
- Integrate and align with health-related services as appropriate.

**Strategy #3:** Continue integration of care model between physical, mental, substance use treatment, oral, and social services. Monitor patient access and implement interventions when indicated.

**Strategy #4:** Continue to work with community health service partners to recruit and retain health care professionals in our communities.
- Support Oregon Health Science University (OHSU) Campus of Rural Health Initiatives, when possible

**Aligns with:**
- Consumer member priorities
- Coos County CHA, 2018; CHP, 2019
- Curry County CHA, 2018; CHP, 2019
- Oregon SHIP, 2020-2024
- OHA Quality Metrics
### 3. SUICIDE PREVENTION

**Target Area:** Coos County, Curry County

The 2018 Coos County CHA showed the rate of suicide is on an alarming upward trend and continues to be higher than the state. Self-reported mental health issues and depression also show higher rates in Coos County than statewide for both adults and youth. Nearly one in three adults in Coos County indicate they are struggling with depression. Depression in youth has been steadily increasing for both 8th and 11th graders in Coos County for the last decade and also continues to be higher than the state numbers.

The 2018 Curry County CHA reports that mental health and depression were listed as top concerns by our CHA focus group and survey participants. Youth considering suicide is significantly higher in Curry County than Oregon. 21.1% of 8th graders in 2017 seriously considered attempting suicide, 4.5% actually attempted 6 or more times in the past 12 months, nearly four times that of state percentages (Oregon Healthy Teens Survey 2017). Suicide as a cause of death in all populations in Curry County show an alarming upward trend in number and rate.

**Goals:** Decrease number of suicide attempts and completed suicides

**Outcome Indicators:**

- Number of Completed Suicides

---

**Advanced Health members in Coos and Curry Counties with Mental Health Diagnoses:**

- Collaborate

**Advanced Health Community Health Improvement Plan (CHP) member focused on Health Equity initiative:** Shared decision-making

**Advanced Health Community Advisory Members in Coos and Curry Counties:**

- Shared decision-making

**Advanced Health Members in Coos and Curry Counties:**

- Collaborate

**Health care Providers in Coos and Curry Counties:**

- Collaborate

**Social Service Agencies in Coos and Curry Counties:**

- Collaborate

**Special Populations:**

- Consult

**Community at large:**

- Inform
- Number of Suicide Attempts

**Strategy #1:** Educational Campaigns to increase awareness:
- Out of the Darkness Walk in Coos & Curry Counties
- Town Halls
- Suicide Awareness and Prevention: Finding Hope – colored inserts in 3-county papers
- Social Media campaign

**Strategy #2:** Specific Training to equip people to be able to recognize when someone needs help, and be able to help them develop a plan for safety immediately
- Mental Health First Aid Training in Coos and Curry Counties, every month
- Applied Suicide Intervention Skills Training (ASIST) in multiple locations in Curry County and Coos County. ASIST is a 2-day interactive workshop that teaches participants to recognize when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety.
- Continuing Medical Education (CME) trainings for health care providers across disciplines

**Strategy #3:** Develop Peer Support Groups led by Peer Support Specialist to help families, friends, and those struggling with depression, suicide ideation, and loss.

**Strategy #4:** Integrate and Align Suicide Awareness and Prevention Initiatives with Access to Mental Health
### Care Initiatives and Care Integration Initiatives

- Ensure that everyone who needs mental health care receives mental health care when they need it

#### Strategy #5: Coordinate and integrate with Prescription Drug Overdose Prevention Program for Dual Diagnosis members

**Aligns with:**
- Consumer member priorities
- Coos CHA, 2018; CHP, 2019
- Curry CHA, 2018; CHP, 2019
- Oregon SHIP, 2020-2024

### 4. NUTRITION AS MEDICINE

**Target area:** Coos County, Curry County

The leading causes of death in Coos County are cancer and heart disease (Vital Statistics Oregon Health Authority). The most recent trend data by county (2010 – 2014) shows that Coos County has the second highest rate of cancer deaths in the state, considerable higher that the state and national rates (Vital Statistics Oregon Health Authority). Mortality from Diabetes is increasing in Coos County and also remains higher than the statewide mortality rates (Oregon Vital Statistics Annual Reports 2006-2016). The prevalence and burden of chronic conditions is high in Coos County, higher when compared to the state. More than 60% of adults in Coos County have one or more of the following chronic conditions: angina, arthritis, asthma, cancer, COPD, Advanced Health members in Coos and Curry Counties with Chronic Illness: Collaborate

Advanced Health Community Health Improvement Plan (CHP) member focused on Nutrition initiative: Shared decision-making

Advanced Health Community Advisory Members in Coos and Curry Counties: Shared decision-making

Advanced Health Members in Coos and Curry Counties: Collaborate

Health care Providers in Coos and Curry Counties: Shared decision-making

Social Service Agencies in Coos and Curry County
depression, diabetes, heart attack, or stroke (BRFSS, 2017). Coos County has higher percentages of the population with arthritis, disability and diabetes than the state (BRFSS, 2017).

The leading causes of death in Curry County are also cancer and heart disease (Vital Statistics Oregon Health Authority). Mortality from diabetes is high in Curry County and also remains higher than state rates (Oregon Vital Statistics Annual Reports). The prevalence and burden of chronic conditions is high in Curry County and higher when compared to the state. Nearly 50% of adults in the county have one or more chronic conditions of angina, arthritis, asthma, cancer, COPD, depression, diabetes, hear attack, or stroke (BRFSS, 2017). Curry County has higher percentages of the population with asthma, cancer, COPD, and cardiovascular disease that state percentages (BRFSS, 2017).

**Goal:** Decrease rate of chronic conditions

**Outcome Indicators:**
- Obesity rate (adult, child)
- Cancer rate
- Heart Disease rate
- Cancer rate
- Access to Healthy Food
- Food Insecurity
- Diabetes rate
- Prediabetes rate
- Overall Chronic Conditions rate
- Number of physical activities sites

**Counties:** Shared decision-making

**Special Populations:** Consult

**Community at large:** Inform
**Strategy #1:** Launch Nutrition Continuing Medical Education (CME) Series for health care providers
- Incorporate recipes, cooking demonstrations & classes
- Work with Oregon Health Sciences University Rural Campus to develop student program for nutritional education

**Strategy #2:** Develop food insecurity assessment and referral process and all primary care offices. Establish referral network with social service agencies, local food banks and Farmers’ Markets.

**Strategy #3:** Partner with Schools (school gardens, cooking demonstrations, taste tests, etc.)

**Strategy #4:** Partner with State and Local Cancer Research efforts

**Strategy #5:** Continue to support Diabetes Prevention Program for Advanced Health members (covered benefit for prediabetics)

**Strategy #6:** Launch nutrition and disease prevention and reversal educational campaign for general public that includes community cooking classes and food demonstrations

**Strategy #7:** Pursue the opening of an Indoor pool year-round for Curry County
**Strategy #8:** Support the developing of a Recreation Center for Curry County

**Aligns with:**
- Coos County CHA, 2018; CHP, 2019
- Curry County CHA, 2018; CHP, 2019
- Oregon SHIP, 2020-2024
- Community Partner priorities
- OHA Quality Metrics

**5. EARLY IDENTIFICATION TO SUPPORT KINDERGARTEN READINESS**

**Target area:** Coos County, Curry County

Physical and emotional health have a large impact on school readiness. Early identification of social-emotional, developmental, and other health care needs is important for successful preparation for school. Most often, children’s needs are identified by their healthcare provider, childcare provider, or parent.

The rate of children in Head Start in Coos and Curry County is significantly higher than the statewide average. The south coast generally has only 12 childcare slots per 100 children so there continues to be significant need (Coos CHA, 2018). Childcare availability was listed as a concern in both counties in the 2018 CHA focus groups. High school graduation in both counties is lower than Oregon and is on a downward decline, which represents a significant challenge to health.

**Advanced Health members who are parents in Coos and Curry Counties:** Collaborate

**Advanced Health Community Health Improvement Plan (CHP) member focused on Early Learning initiative:** Shared decision-making

**Advanced Health Community Advisory Members in Coos and Curry Counties:** Shared decision-making

**Advanced Health Members in Coos and Curry Counties:** Collaborate

**Early Learning Providers in Coos and Curry Counties:** Shared decision-making

**Health Care Providers (Pediatricians, Family Physicians, Behavioral Health Providers in Coos and Curry Counties:** Shared decision-making

**Social Service Agencies in Coos and Curry**
Coos and Curry Counties are considered to be infant and toddler childcare “deserts” (Raise Up Oregon: A Statewide Early Learning System Plan, 2019-2023). Our local Childcare Resource and Referral Program was recently selected to be a Baby Promise site and we are excited to support their work establishing licensed infant/toddler childcare in Coos and Curry Counties.

**Goal:** Social-emotional, developmental, and health care needs are identified and addressed early so that children can arrive ready for Kindergarten

**Outcome Indicators:**
- Social-emotional assessments
- Developmental screeners
- Timeliness of well-child exams
- Social determinants of health assessment and referral
- Home visiting program utilization and evaluation
- Access to culturally-responsive services

**Strategy #1:** Monitor utilization of social-emotional assessments, developmental screeners, and well-child exams, and establish referral processes with appropriate providers and community resources

**Strategy #2:** Develop Traditional Health Worker Program with specific focus on assessing children for social determinants of health. Create network of social service providers to address barriers to care.

**Strategy #3:** Develop Baby Store for Advanced Health

**Counties:** Shared decision-making

**Special Populations:** Consult

**Community at large:** Inform
members to provider diapers, baby wipes, formula, clothes, and other infant/toddler supplies to our members in a timely manner as needed.

**Strategy #4:** Work collaboratively with Home Visiting Programs such as Healthy Families Oregon to align efforts and support each other.

**Strategy #5:** Work collaboratively with the community Equity Coalition to ensure that we have culturally-responsive child care services available to meet the needs of our community.

**Aligns with:**
- Coos CHA, 2018; CHP, 2019
- Curry CHA, 2018; CHP, 2019
- Raise Up Oregon: A Statewide Early Learning System Plan, 2019-2023
- South Coast Regional Early Learning Hub priorities

### 6. SOUTH COAST TOGETHER: SELF-HEALING COMMUNITIES INITIATIVE

**Target area:** Coos County, Curry County

In 1998, the first peer-reviewed publication from a landmark study, *Adverse Childhood Experiences (ACES)*, revealed the most powerful determinant of the public’s health (Robert Wood Johnson Foundation, Self-Healing Communities). The study showed that nearly 67% of adults had experienced one or more categories of abuse.

**Advanced Health members who live in Coos and Curry Counties:** Collaborate

**Advanced Health Community Health Improvement Plan (CHP) member focused on ACES and Trauma-informed Care:** Shared decision-making

**Advanced Health Community Advisory Members in Coos and Curry Counties:** Shared decision-making
neglect, and/or dysfunctional family issues before age 18, and 27% had experienced three or more categories (Felitti et al., 1998). Later it was discovered that ACEs are clustered (Dong et al., 2004), compounded by societal responses, and escalate over the life course and across generations. Neuroscientists and epigenetics established the biological and genetic mechanisms that explain why ACEs increase risk for disease, disability, early death (Anda et al., 2006), and intergenerational transmission of ACEs.

The Self-Healing Communities Model is based on 15 years of promoting community capacity and culture change in communities across Washington State, where health outcomes were dramatically improved as a result.

In 2017, Advanced Health initiated the collaborative community effort that is now called, South Coast Together. South Coast Together is focused on training and community capacity building to help the south coast develop a cross-sector common understanding, vocabulary, and approach to preventing adverse childhood experiences (ACEs) which are the most powerful determinant of mental, physical, and behavioral health problems.

Coos and Curry Counties have high rates of ACE-attributed poor health behaviors and outcomes, such as chronic illness, mental illness, substance use, physical and sexual abuse, neglect, children in foster care, homelessness, and smoking. These are all indicators that Coos and Curry Counties have high rates of ACEs.

| **Advanced Health Members in Coos and Curry Counties:** Collaborate |
| **South Coast Together Core Team members:** Shared decision-making |
| **South Coast Together Steering Committee members (multi-sector):** Shared decision-making |
| **South Coast Together Metrics Committee members:** Shared decision-making |
| **South Coast Together Communications Committee members:** Shared decision-making |
| **South Coast Together Training Team (multi-sector):** Shared decision-making |
| **Early Learning Providers in Coos and Curry Counties:** Shared decision-making |
| **Health Care Providers in Coos and Curry Counties:** Shared decision-making |
| **Social Service Agencies in Coos and Curry Counties:** Shared decision-making |
| **Special Populations:** Consult |
| **Community at large:** Inform |
Goal: By 2030, Coos and Curry Counties will have the lowest child trauma indicators in the state of Oregon

Outcome Indicators:
- Trauma-informed Schools
- Trauma-informed health care facilities
- Improved access to behavioral health care
- Number of resilience-building resources in the community
- Decreased rates of abuse and neglect of children
- Increased number of parents participating in Parent/Family Cafes
- Decreased school absences
- Decreased suicide attempts
- Increased number of LGBTQ+ supports available
- Decrease number of families who are food insecure
- Decrease number of families who are homeless
- Increase number of community members trained in ACEs

Strategy #1: Advanced Health will continue to lead and support the Trainers in our service area, including the Coos and Curry County Cohort of ACE Master Trainers, Presenters, Family Café Facilitators

Strategy #2: Implement appropriate assessment for adversity and trauma within the context of the primary care provider office with solid referral and resource network

Strategy #3: Implement a Trauma-informed
Organization Program to require all health care provider hospitals, clinics, and offices to meet trauma-informed care facility standards. Monitor annually.

**Strategy #4:** Create and Implement an ongoing Provider CME program related to the NEAR sciences: Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience.

**Strategy #5:** Continue to move forward the ACE Interface Self-Healing Communities Model implementation

**Aligns with:**
- Consumer Member priorities
- Coos County CHA, 2018; CHP, 2019
- Curry County CHA, 2018, CHP, 2019
- Oregon SHIP, 2020-2024
- Community Partner Priorities

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1. **Inform:** Provide the community with information to assist in their understanding of the issue, opportunities, and solutions. Tools include fact sheets, published reports, media releases, education programs, social media, email, radio, information posted on websites, and informational meetings.

2. **Consult:** Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions.

3. **Involve:** Work directly with the community throughout the process to ensure that community concerns and aspirations are understood and considered. Applicant provides feedback to the community describing how the community input influenced the decision. Tools include meetings with key stakeholders, workshops, subject matter expert and stakeholder roundtables, conferences, and task forces.

4. **Collaborate:** Partner with the community in each aspect of the process, including decision points, the
development of alternatives and the identification of a solution. Tools include advisory committees, consensus building, and participatory decision making.

5. **Shared decision-making:** To place the decision-making in the hands of the community (delegate) or support the actions of community initiated, driven and/or led processes (community driven/led). Tools include delegated decisions to members of the communities impacted through steering committees, policy councils, strategy groups, Community supported processes, advisory bodies, and roles and funding for community organizations.
### Table 3: Engagement with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans

All applicants must complete this full table. Applicants may add rows as needed.

**Part 1.** Applicants with an existing CCO CHA and CHP will submit their most recent CHA and CHP with the community engagement plan.

<table>
<thead>
<tr>
<th>Local public health authorities (list in this column below)</th>
<th>Part 2. List of all local public health authorities, non-profit hospitals, other CCOs that share a portion of the service area, and any federally recognized tribe in the service area that is developing or has a CHA/CHP. Add additional rows as needed.</th>
<th>Part 3. The extent to which each organization was involved in the development of the Applicant's current CHA and CHP. Answers* must be a) competition and cooperation, b) coordination, c) collaboration, or d) not applicable (NA).**</th>
<th>Part 4. For any organization that is a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will list the shared priorities and strategies.***</th>
<th>Part 5. For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the current state of the relationship between the applicant and the organization(s), including gaps.</th>
<th>Part 6. For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the steps the applicant will take to address gaps prior to developing the next CHA and CHP, and the dates by which the applicant will complete key tasks.****</th>
<th>Part 7. Applicants without an existing CHA and CHP or that intend to change their service area will demonstrate that they have reviewed CHAs and CHPs developed by these other organizations. List the health priorities from existing plans.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coos County</td>
<td>Collaboration</td>
<td>Access to Care</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Public Health</td>
<td>Timeliness of Prenatal Care Commercial Tobacco Prevention Suicide Prevention Healthy Eating Active Living</td>
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<tr>
<td>Curry Community Health</td>
<td>Collaboration</td>
<td>Substance Abuse Prevention School-Based Prevention Services Increase Timeliness of Prenatal Care Healthy Food and Lifestyle Increase easy access to information about benefits and services</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Non-profit hospitals (list in this column below)</td>
<td></td>
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</tr>
<tr>
<td>Bay Area Hospital</td>
<td>Collaboration</td>
<td>Healthy Eating Active Living, Decrease Chronic Illnesses</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Coquille Valley Hospital</td>
<td>Collaboration</td>
<td>Healthy Eating Active Living</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td></td>
<td></td>
<td>Collaborated on new CHA and currently collaborating on new CHP</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Southern Coos Hospital &amp; Health Center</th>
<th>Collaboration</th>
<th>Healthy Eating Active Living</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Collaborated on new CHA and currently collaborating on new CHP</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Curry General Hospital</th>
<th>Collaboration</th>
<th>Healthy Eating Active Living</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Collaborated on new CHA and currently collaborating on new CHP</td>
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</tr>
</tbody>
</table>

**Current coordinated care organizations, as of 2019 (list in this column below)**

| Allcare Health | Coordination | N/A | Current | 2018 was the first | N/A |
| Federally recognized tribes that have or are | relationship with Allcare Health staff is positive. We have invited them to participate in our ACEs work, in the Curry CHA, and now in the Curry CHP. Staff from our two CCOs participate on the Steering Committee of the early learning hub, Oral Health Coalition, homeless coalition, housing groups, and several other community committees. |
| year that we conducted the CHA with Allcare staff and we plan to develop the CHP with Allcare staff as well. We will align efforts in the rollout of the CHP. This is something that Allcare and Advanced Health have agreed to do. Advanced Health initiated the collaboration and Allcare accepted. |
## developing a CHA/CHP (list in this column below)

| Coquille Indian Tribe | Collaboration | Access to Care Timeliness of Prenatal Care Commercial Tobacco Prevention Suicide Prevention Healthy Eating Active Living | N/A | N/A | N/A |

*  
  a) Competition and Cooperation: Loose connections and low trust; tacit information sharing; ad hoc communication flows; independent goals; adapting to each other or accommodating others’ actions and goals; power remains with each organization; resources remain with each organization; commitment and accountability only to own organization; relational time frame short; low risk and reward.  
  b) Coordination: Medium connections and work-based trust; structured communication flows and formalized project-based information sharing; joint policies, programs and aligned resources; semi-interdependent goals; power remains with parent organizations; commitment and accountability to parent organization and project; relational time frame medium and based on prior projects; medium risk and reward.  
  c) Collaboration: Dense interdependent connections and high trust; frequent communication; tactical information sharing; systems change; pooled and collective resources; negotiated shared goals; power is shared between organizations; commitment and accountability to network first, community and parent organization; relation time frame long (3 years or more); high risk and reward.  
  d) Not applicable

**If the applicant does not have a current CHA and CHP, the applicant will enter not applicable (NA).**

***Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.***
Table 4: Engagement with social determinants of health and health equity (SDOH-HE) partners for CHA and CHPs

Applicants may add rows as needed.

<table>
<thead>
<tr>
<th>All applicants must complete Part 1.</th>
<th>Applicants with an existing CHA and CHP must complete Parts 2, 3 and 4. Applicants that intend to change their service area must also complete Parts 2, 3, and 4.</th>
<th>Applicants without an existing CHA and CHP or that intend to change their service area must complete Parts 2a and 4a.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1. List of organizations that address the social determinants of health and health equity in the applicant’s service area. Add additional rows as needed.</td>
<td>Part 2. Applicants with an existing CHA and CHP will describe existing partnerships with each identified organization, including whether the organization contributed to the applicant's current CHA and CHP.</td>
<td>Part 2a. Applicants without an existing CHA and CHP will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CC O CHAs and CHPs in the service area. For each organization listed in Part 1, the applicant will document the organization's level of involvement in developing any steps the applicant will take to form relationships and secure participation by each organization prior to developing</td>
</tr>
<tr>
<td>All tribes that are present in the service area (list in this column below). If no tribe is present in the service area, note there are none.</td>
<td>Coquille Indian Tribe</td>
<td>Members of our Coos CAC and leaders in our CHP. Collaborators in our CHA and</td>
</tr>
</tbody>
</table>

---

Note: ** Required for completion.

---

**References:**

- RFA 4690 - Advanced Health
- Attachment 10 - Community Engagement Plan Tables
<table>
<thead>
<tr>
<th>Collaborator in our CHP.</th>
<th>Could strengthen relationship. They have had staff turnover. We need to reach out and engage them in our future work.</th>
<th>Increase communication, continue to invite to CHP develop meetings, invite to Coos CAC meetings, one on one meeting to find out their priorities and how we can align efforts</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians</td>
<td>Attends Coos CAC. Participated in Coos CHA and CHP.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolowa Dee-Ni Nation</td>
<td>Attends our Curry CAC. Participated in our Curry CHA.</td>
<td>Maintain our positive relationship. They are in California but serve Curry County.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All regional health equity coalitions (RHECs) that are present in the service area (list in RFA 4690 - Advanced Health Attachment 10 - Community Engagement Plan Tables)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Collaborations</td>
<td>Notes</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>--------------</td>
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<td>-----</td>
</tr>
<tr>
<td>Coos County Public Health</td>
<td>Member of our Coos CAC, Member of our Coos CHPs, Collaborator in CHA, CHP</td>
<td>Very solid partner</td>
<td>Maintain current engagement</td>
<td>N/A</td>
</tr>
<tr>
<td>Curry Community Health</td>
<td>Member of our Curry CAC, Member of our Curry CHPs, Collaborator in CHA, CHP</td>
<td>Very solid partner</td>
<td>Maintain current engagement</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Organizations that address the four key domains of social determinants of health (list in this column below). If no RHEC is present in the service area, note there are none.
<p>| Oregon Coast Community Action (ORCCA) | Member of our Coos CAC, Attends Curry CAC, Collaborator in Coos &amp; Curry CHAs and CHPs | Long-time partner | Maintain current engagement | N/A | N/A |
| South Coast Head Start | Member of our Coos CAC, Attends Curry CAC, Collaborator in Coos &amp; Curry CHAs and CHPs | Long-time partner | Maintain current engagement | N/A | N/A |
| Coos County Public Health | Member of our Coos CAC, Member of our Coos CHPs, Collaborator in CHA, CHP | Very solid partner | Maintain current engagement | N/A | N/A |
| Curry Community Health | Member of our Curry CAC, Member of our Curry CHPs, Collaborator in CHA, CHP | Very solid partner | Maintain current engagement | N/A | N/A |</p>
<table>
<thead>
<tr>
<th>Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advanced Health</strong></td>
</tr>
<tr>
<td><strong>Coast Community Health Center</strong></td>
</tr>
<tr>
<td><strong>Waterfall Community Health Center</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Culturally specific organizations and organizations that work with underserved or at-risk populations (list in this column below).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other organizations (list in this column below).</td>
</tr>
</tbody>
</table>

*The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health.

**Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.
Table 5: Assessment of existing social determinants of health priorities and process to select Year 1 social determinants of health priorities

All applicants must complete this full table to describe how the applicant will identify social determinants of health (“SDOH-HE”) priorities to meet the CCO SDOH-HE spending requirements. Housing must be included as one of the SDOH-HE spending priorities.

**Part 1.** List of existing SDOH-HE CHP priorities* in applicant’s proposed service area from its own CHP or other existing CCO, local hospital, local public health authority and/or tribal CHPs, if applicable. Add additional rows as needed.

<table>
<thead>
<tr>
<th><strong>Part 1a.</strong> Source for priority (i.e. which CHP it came from).</th>
<th><strong>Part 1b.</strong> Whether priority describes a health outcome goal (i.e. addressing food insecurity to address obesity as a health issue) or priority populations (i.e. addressing early childhood education for children as a priority population) or other.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>Coos CHP, Curry CHP</td>
</tr>
<tr>
<td>Adverse Childhood Experiences/Adverse Life Experiences/Toxic Stress</td>
<td>Coos CHP, Curry CHP</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>Coos CHP, Curry CHP</td>
</tr>
<tr>
<td>Education – Kindergarten Preparedness</td>
<td>Coos CHP, Curry CHP</td>
</tr>
<tr>
<td>Health Equity</td>
<td>Coos CHP, Curry CHP</td>
</tr>
</tbody>
</table>

**Part 2.** Description of process through which the applicant will identify and vet SDOH-HE priorities** in line with CHP priorities for submission to OHA by March 15, 2020. This must include, timelines, milestones, methods for vetting selected priorities with community partners (such as those described in Table B, Part 1) and CAC, and planned actions to clarify and define CCO housing priority in line with statewide priority.
- Process may also include planned actions to identify additional community-based SDOH-HE priorities from CHP priorities.
- If housing has not been identified as a priority in existing CHPs, note that housing must still be selected as an SDOH-HE priority. Consider adding the housing priority in alignment with either a health outcome goal or priority population identified in Part 1b.
Advanced Health’s 2018 Community Health Assessments (CHA) for both Coos and Curry Counties used a broad framework based on social determinants of health. We used the Mobilizing for Action through Planning and Partnership (MAPP) model, a national best practice, as it is a community driven process that results in engagement of new stakeholders, provides a broad understanding of community health issues and helps to identify both strengths and challenges related to health in a community. To identify SDOH-HE priorities, we would go through a facilitated group process of 1) Goal Setting, 2) Review of Primary and Secondary Data, 3) Community Input (focus groups, survey), 4) Decision on Priorities and Strategies, 5) Develop Plan. Logic Model Training would be conducted for all involved and a Logic Model would be completed for each initiative. The CHP and the SDOH-HE initiatives would all be largely based on the CHA, therefore, ensuring alignment.

* Applicants must include description of housing priority if already identified in CHPs. (e.g. housing overall, housing for targeted populations).

** The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health. Refer to the Social Determinants of Health and Health Equity Glossary reference document.
1.1. **Identify stakeholders** (Table 1) to be included in the engagement process. Table 1 is attached.

1.2. **Identify five to eight major projects, programs, or decisions** (Table 2 for which the CCO will engage the community. Table 2 is attached.

1.3. Describe (via narrative) the process for members (both CAC and non-CAC members), health care providers, other service delivery partners, and other stakeholders to provide input that will inform CCO decision-making (for example, how the CAC could ensure a member voice in CCO decision-making). There are several avenues for stakeholders to provide input into the CCO decision-making process. The Community Advisory Council meetings as well as the Advanced Health Board of Directors' meetings are open to the public and have designated time on their agendas for public input. The CAC and Board meetings are advertised publicly and held on regularly schedules. Additionally, Advanced Health has other committees in which providers and service delivery partners participate on, such as the Aggregate Panel of Advisors, Clinical Advisory Panel and Interagency Quality Committee. Furthermore, Advanced Health solicits input from members, providers, and the broader community via surveys, focus groups, and meetings.

1.4 Describe (via narrative) how the Applicant will ensure the member voice is elevated. There are several ways that Advanced Health ensures that our Members' voices are elevated to inform CCO decision-making:

- Two consumer CAC members serve on the Advanced Health Board of Directors and are responsible for relaying information from their respective CAC to the Board;
- Four CAC members serve on the Aggregate Panel of Advisors;
- Advanced Health staff who attend CAC meetings relay member input to the executive team and the Board of Directors;
- Direct phone and email access to our executive team members;
- Through the Grievance System.

1.5. Describe (via narrative) potential barriers to community engagement and how the Applicant will address these barriers. Known barriers to community engagement include transportation and expenses, childcare, accessibility, language and literacy barriers, rural isolation, and information awareness. Coos and Curry Counties are rural areas with very limited public transportation. The Non-Emergent Medical Transportation (NEMT) benefit helps
Advanced Health members with transportation to receive health care services; however, transportation for other purposes is a struggle and a barrier to accessing community services. For those members that own or have access to cars, gas is an expense that is not always affordable. Both counties have a shortage of childcare, especially respite care and infant/toddler care, and it is an expense that not all families can afford. Families who do not speak English as their primary language may face language and literacy barriers. There is an awareness of the need to share community resource information as we have populations that are very isolated.

Advanced Health uses several strategies to address barriers to community engagement:

- Transportation and/or mileage reimbursement is provided to all CAC and CHP consumer members for each meeting that they attend;
- All consumer CAC and CHP members are paid a stipend for a CAC meeting and CHP meeting that they attend each month;
- All consumer CAC and CHP members are paid a childcare stipend for a CAC meeting and CHP meeting that they attend each month;
- Meals are provided at each CAC meeting and all other community engagement meeting held around a meal time;
- Bilingual staff, interpreters, and translated materials are provided for Limited English Proficiency (LEP) individuals;
- Outreach is culturally sensitive as meeting times, places, and formats are chosen by the community group

1.6. Describe (via narrative) the plan to ensure continual quality improvement of the high-level plan throughout the life of the contract, including how quality improvements will be shared back with engaged stakeholders and the larger community. Advanced Health monitors and requires continuous quality improvement of the Community Engagement Plan by:

- On an annual basis, complete a comprehensive evaluation of the Community Engagement Plan in collaboration with the CAC, Stakeholders, and the Board of Directors.
- On an annual basis, update the Community Engagement Plan using the results of the evaluation of the previous year's plan.
- On an annual basis, review and approve the Annual Community Health Improvement Plan Progress Reports;
- On a quarterly basis, review the Community Health Improvement Plans for Coos and Curry Counties and implement changes as necessary to achieve goals and objectives.
- At least every 5 years, conduct a Community Health Assessment, and update the Community Health Improvement Plans for the service area.
The Community Engagement Plan, Community Health Assessment, and Community Health Improvement Plans are all public documents and will be published on Advanced Health’s website and available upon request. Surveys, focus groups and other avenues of soliciting input from members, providers, service providers, and the broader community will be utilized as this input is a critical component of our overall plan and our continuous quality improvement process.

2.1.b. An Applicant with one or more existing CACs will describe its current CAC structure and role(s) and, if applicable, its plans for adapting its CAC structure based on a new or adjusted CCO service area. Advanced Health currently has two Community Advisory Councils (CAC): one in Curry County and one in Coos County. The CACs report directly to the Advanced Health Board of Directors.

Each CAC is comprised of a minimum of 51% Advanced Health Members. To the greatest extent possible, the other membership is made up of a health care provider, social service agency representatives, county public health official, county or city officials, Advanced Health board member, tribal representation, and members of the general community. Each CAC has a Chairperson and Vice-Chairperson who serve one-year terms. The Chairperson helps develop meeting agendas and facilitates each meeting. The Vice-Chairperson facilitates meetings in the absence of the Chairperson. The Chairperson and Vice-Chairperson greet CAC attendees at each meeting. Each CAC nominates and votes one member to represent them on the Advanced Heath Board of Directors. This member acts as a liaison between the CAC and the Board. Advanced Health community engagement staff administratively supports the CACs.

Coos County is located on the Southern Oregon Coast. It is the 16th most populated county in Oregon and it borders Curry and Douglas Counties. The county encompasses 1,629 square miles of rugged mountainous terrain and multiple rural communities and seven incorporated cities: Coquille, Coos Bay, Lakeside, Myrtle Point, Bandon, Powers, and North Bend. The entire county is designated as rural by the Oregon Office of Rural Health. Curry County is the 25th most populated in the state and encompasses 1,648 square miles of rugged mountainous terrain includes hundreds of lakes, rivers and streams stretching from mountains, through the Redwoods and to the Pacific Ocean. There are many isolated rural communities (Agness, Orion, Sixes, Pistol River) and three incorporated cities including Brookings, Gold Beach, and Port Orford. Both counties are designated as rural by the Oregon Office of Rural Health.

In 2018, Advanced Health CACs in Coos and Curry Counties adopted the Oregon Health Authority CAC membership matrix to allow for more efficient tracking of CAC membership demographic data. This has allowed us to be more efficient in our
recruitment strategies and CAC membership diversity monitoring to ensure our CACs represent the diversity of our membership. By mid-2019, Advanced Health will have a new Community Health Improvement Plan (CHP) for Coos and Curry Counties. We plan to use the OHA CAC membership matrix to help us recruit and engage a diverse CHP membership to work on specific CHP initiatives.

2.1.c. All Applicants will describe how they will meaningfully engage tribes and/or tribal advisory committees (if applicable). The Aggregate Panel of Advisors will include CAC and tribal representatives and will be tasked with providing input to the Advanced Health decision-making process. The advisors on the committee will be asked to create tailored outreach strategies that will provide solutions to best meet community needs, provide Advanced Health with feedback on engaging communities, flag potential controversies, help account for a variety of cultural expectations, language, and literacy needs. The advisors will develop effective approaches for outreach and communication to allow for meaningful and effective engagement with the Advanced Health board as well as other stakeholders.

2.1.d. All Applicants will describe strategies for collaborating with CACs from other CCOs that have overlapping service areas. Include strategies to ensure best use of local capacity and resources to avoid overtaxing the community (for example, if the same county, community-based organizations or OHP consumers being asked to participate in more than one CAC or more than one CHA/CHP process). Advanced Health and Allcare Health currently both serve Curry County. Advanced Health invited Allcare Health to join us in conducting a Community Health Assessment in 2018, and we are currently in the process of developing a new Community Health Improvement Plan (CHP) collaboratively. In this process, we have invited Allcare Health CAC members to join us in our work sessions. We have agreed to collaborate on the implementation of shared CHP priorities as to be most efficient with resources and not cause confusion or overburden the local community. We see this as a collective impact approach.

3.5. Describe via narrative how the Applicant's strategy for health-related services (HRS) community benefit initiatives will like with the Applicant's CHP. Advanced Health's board of directors approves the CHP with its included HRS priorities and allocates resources to the CAC for these initiatives. HRS Program committees of the board and CAC select HRS vendors and make sub-allocations.
Coos County
Community Health Assessment 2018
Acknowledgments

Coos Community Health Assessment Committee

Betty Albertson, Department of Human Services
Susie Breuer, Coquille Valley Hospital
Lisa Hendricks, Advanced Health
Heidi Hill, Advantage Dental
Fauna Larkin, Coquille Indian Tribe Community Health Center
Amber Madigan, Coos Health & Wellness
Linda Maxon, Coast Community Health Center
Scott McEachern, Southern Coos Hospital and Health Center
Reneé Menkens, Coos County Friends of Public Health
Ruby Phillips, Advanced Health, Community Advisory Council
Florence Pourtal-Stevens, Coos Health & Wellness
Belle Shepherd, Oregon Health Authority
Cindy Shirtcliff, Advantage Dental
Anna-Marie Slate, Advanced Health Community Advisory Council
JoDee Tittle, Southern Coos Hospital and Health Center
Andrea Trenner, Waterfall Community Health Center and School Based Health Centers
Laura Williams, Advanced Health, South Coast Early Learning Hub
Corey Wampler, South Coast Head Start, Oregon Coast Community Action
Angie Webster, Bay Area Hospital

Consulting & Technical Writing by:
V Consulting & Associates Inc.
The purpose of the Coos County Community Health Assessment (CHA) is to provide a view into the health of the community. The CHA is built on many years of previous community work. The unique and robust collaborative committee included stakeholders working across multiple sectors including: local public health, hospitals, federally qualified health centers, early learning and child focused groups, tribal health services, dental organizations, the local coordinated care organization and many other vital health and human services organizations. The process of engaging community members and organizations to identify strengths and challenges related to health will result in improved planning of services and an improved ability to prioritize resources to improve health outcomes.

The Community Health Assessment process was rooted in values including a desire to present challenges, needs and strengths in the county. The process used a broad framework to view these challenges and strengths based on the social determinants of health. The social determinants of health are the conditions in which people are born, grow, live, work and age. They include many factors that influence health that have not often been connected in a traditional health assessment document. Some of these factors include neighborhood and physical environment, education, social connectivity and economic stability. The 2018 CHA stands apart from past assessments because it identifies challenges and strengths while also recognizing many of the social determinants that influence health in Coos County.

Data used in the Community Health Assessment included primary and secondary data, qualitative and quantitative data. Primary data was collected through focus groups and a community survey. The focus groups and surveys gathered community perceptions on strengths and challenges related to health. Community perceptions and experiences sometimes matched what the secondary data illustrated and other times it did not paint the same picture. Secondary and primary data are intermingled throughout the document, a unique presentation of community health.

The number one strength identified in the primary data collection was appreciation for the physical environment and natural beauty of the county. This was followed by (1) recognition of the people that live in the county; (2) how people support one another through volunteerism; and (3) how people value community.

The CHA document is a comprehensive look at health in Coos County, but it does have limitations. The CHA is not meant to cover every possible factor that influences health nor is it an evaluation of services or the efficacy of the health care system itself. The CHA document is intended to inform continued work on health improvement. Future work will include prioritization of health issues and interventions and exploration of how to build on work that is already being done in the community. The CHA also lists data gaps in the community and areas that need additional study and data collection.
Introduction and Purpose

The 2018 Community Health Assessment (CHA) is a view into the health status of the people that live in Coos County. The assessment process results in an increased understanding of key health issues facing our communities, aids in better planning of services and helps to identify strengths and challenges to address with our health care resources. The development of the assessment also engages community members by listening to their perceptions and experiences about what influences health. The process includes comprehensive data collection and analysis, working across multiple sectors and bringing over a dozen local organizations together. The process of creating the CHA is as important and vital to the community as the document that is produced. The resulting CHA document assists organizations in planning and prioritizing efforts that ultimately improve health outcomes and the health of individuals and our communities. The 2018 Coos CHA was published in April, 2018.

Community Health Assessment Approach & Model

The 2018 CHA is built on several years of previous community work. After the 2013 publication of the Coos Community Health Assessment and subsequent Community Health Improvement Plan (CHIP), several committees organized their efforts to address specific CHIP health priorities. The group expanded to include local hospitals, federally qualified health centers, public health, early learning and child focused groups, the local Coordinated Care Organization (CCO), tribal health services, dental organizations and many other vital health and human service organizations. The desire to pool resources, reduce duplication of effort and meet individual requirements for health assessments drove the group to engage with a consultant to lead and facilitate the 2018 Community Health Assessment in the fall of 2017.

Organization Partners in 2018 Coos Community Health Assessment

| Department of Human Resources | Advantage Dental |
| Oregon Coast Community Action | Coast Community Health Center |
| South Coast Head Start | Coquille Valley Hospital |
| Bay Area Hospital | Waterfall Community Health Center |
| Southern Coos Hospital and Health Center | South Coast Regional Early Learning Hub |
| Coos Health & Wellness | Oregon Health Authority |
| Advanced Health | Coos County Friends of Public Health |
| Coquille Indian Tribe Community Health Center |

The Mobilizing for Action through Planning and Partnerships (MAPP) model was the approach chosen by the committee. The MAPP process is a national best practice. It is a community driven process that results in engagement of new stakeholders, provides a broad understanding of community health issues and helps to identify both strengths and challenges related to health in a community. Due to resources and time required for a robust MAPP process, the committee agreed upon a modified MAPP model with a timeline of October 2017-April 2018.
The work of the CHA was completed by both the consultant and the CHA committee. The CHA committee provided leadership to the process, assisted with primary data collection including focus groups and surveys and were key in engaging community voices. Specific methods used for data collection are outlined in the data section.

**Collaborative Partner Key Requirements**

Many community organizations are required to complete a health assessment. The regulatory bodies that require these assessments vary widely in their frequency, focus and requirements for assessments. They include a broad spectrum of organizations, from the Internal Revenue Service (IRS) to the Oregon Health Authority. Although vastly different, the regulatory requirements for all assessments articulate a need for community organizations to seek to understand strengths and needs in a community to better prioritize health efforts and services.

**Overlapping Key Requirements for Community Health Assessments**

There are many requirements that are shared across all entities that are required to go through a community health assessment process. These include having a balance of types of data, community engagement and input, population based health status data and some level of prioritization of health issues in the community.
**Plans and Processes requiring Community Health Assessments**

**CHNA**
- Required by IRS
- Focus is to identify and assess access and needs of community the hospital is serving.
- Documentation must include written report.
- See Patient Protection and Affordable Care Act requirements for 501(c)3 hospitals. Led by hospital.
- Every 3 years

**CCO**
- Required by Oregon Health Authority
- Purpose is to assess entire community served by CCO, not just Medicaid population. Tied to responsibility of CCO in creating the Triple Aim: Better care, better health and reduced costs.
- Led by CCO, with Community Advisory Council involvement.
- Every 3 years

**Public Health Accreditation**
- Local Health Department participates in/or leads CHA development process.
- Collaborative process resulting in a comprehensive community health assessment.
- Every 5 years

**Other**
- Other includes Federally Qualified Health Centers (FQHCs), Head Start, Early Learning Hubs, Tribal Health Centers.
- Various time lines/frequency/requirements and population focus
Vision & Values of Community Health Assessment Process

One of the first steps in the MAPP process is for the committee to discuss their vision for a healthy community and the values related to assessing and planning for that vision.

- We believe health is very connected to social determinants of health such as education, employment, housing, safety and food
- We believe in addressing poverty and inequity as a root cause of poor health is important
- We believe in a multi-sectoral approach to addressing community health is vital
- We believe we must present a balance of challenges, strengths and assets related to health
- We believe everybody is valuable, when people cease to think they are valuable it affects physical and behavioral health
- We believe the process serves to engage consumers of health services and incorporates the voices of those we serve
- We recognize that the resulting CHA document needs to meet requirements for several organizations and that we can’t cover every possible health issue in one document so we will prioritize what we think is most important to emphasize

Social Determinants of Health & Health Equity Framework

The CHA committee recognizes that multiple factors in a community impact the health of individuals, families and communities. These are often called the Social Determinants of Health. The term Social Determinants of Health is defined by the World Health Organization as “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources.” The social determinants of health influence health inequities. Health inequities are the avoidable, unfair and unjust differences in health status seen within and between individuals and communities.

The traditional way to approach health assessments and health improvement was to focus only on health care services. More recent research and practice has expanded that perspective to recognize that health is more than health care, more than what happens at the health care provider office.
Health care itself influences health, but socioeconomic factors, our physical environment and our individual behaviors also greatly influence our health. Many community health models suggest that up to 40% of the health in a community is related to socioeconomic factors and 30% related to individual health behaviors.

**Types of Data, Data Collection, Data Sources and Limitations**

Data used in the community health assessment included secondary data, primary data, qualitative and quantitative data. Secondary data is data collected by another organization or group. Examples are rates of morbidity and mortality from Oregon Health Authority or demographic data from the US Census. Secondary data at the county level was used most often, but when available and reliable zip code and/or census tract data was used. Newer data was valued over older data, although some sources were older by necessity as the data is no longer being tracked or isn’t available in newer years but still illustrates an important point about health status. Due to small population numbers in some areas of the county, multiple years were sometimes grouped together emphasizing trends over time instead of one year snapshots on some data points, an important consideration for rural community assessments.

Primary data was collected for this assessment through focus groups and surveys. Details of the primary data collection methodology and results can be viewed in the Appendices.

The Community Health Assessment (CHA) has limitations; it is not meant to cover every possible factor that influences health, or every possible health related data point being tracked. It is not meant to be a complete list of all community health needs or health data. It relies heavily on other secondary data assessments and there are notable gaps in readily available local, county, state and national data. The CHA is not a rigorous research study or a process designed to evaluate the efficacy of services or community organizations. It is intended to provide a macro view of community data, help to identify strengths, assets and challenges and engage community in the process of addressing inequities and improving overall community health. Lastly, the CHA document is intended to be added to over the years, complimenting other assessments.
Introduction to Coos County

Coos County is a rural county located on the Southern Oregon Coast. It was recognized as a county in 1853 and named after a local Native American Tribe, the Coos, which some have translated to mean “lake” or “place of pines.” Coos County is the 16th most populated county in Oregon (out of 36 Counties) and it borders Curry and Douglas Counties.

The county has an approximate population of 63,190 people, encompassing 1,629 square miles of land. The rugged mountainous terrain includes hundreds of lakes, rivers and streams stretching from mountains to the Pacific Ocean. There are many unincorporated and isolated rural communities, presenting challenges for transportation and access to services. The seven incorporated cities include Coquille, Coos Bay, Lakeside, Myrtle Point, Bandon, Powers and North Bend. The entire county is designated as rural, by the Oregon Office of Rural Health.
Population Growth

Coos County, like many rural counties in Oregon, has witnessed a slower growth than the state over the last several decades. Negative growth from outmigration was seen 2008-2012 with growth starting again in 2014.

*Focus group and survey participant quotes throughout the document represent perceptions, verbatim, from community members. Sometimes they align with presented secondary data, other times they do not.*

Age, race, ethnicity and language

The median age of residents in Coos County is 48 years old, older than the state median age of 39 years old. Coos County has an older population than the rest of the state. The percentage of those over 60 years of age is steadily increasing and accounts for a larger percentage of the overall population in Coos County. According to census estimates, close to 30% of the county’s population was over 60 years of age in 2010. This percentage is expected to increase to nearly 40% by 2030 and continue to increase, driving changes to health and medical needs in the county.

“Seniors move here expecting to retire and find there are no adequate health care services for them so they leave” —Survey Participant*

Source: PSU Population Research Center Annual Population Report 2017
According to 2015 census estimates, there are 14.4 times more White people in Coos County, than any other race or ethnicity, accounting for 85.8% of the population (approximately 53,860 people). The total percentage of White non-Hispanic people has decreased slightly since the 2013 Community Health Assessment when it was 89.8% of all people in the county. This indicates that race and ethnicity other than White non-Hispanic is growing. The remainder of the population self-identifies as 5.95% Hispanic (3,735), 3.5% Multi-racial (2,191), 2.5% Native American (1,598), 1.2% Asian (765), .6% Black/African American, .3% Other and .1% Islander (datausa.io).

Non-English language speakers account for around 4.8% (approximately 3,074 people) of the total Coos population, considerably lower than the state and national percentages which hover around 21%. Spanish is the most common non-English language spoken. 2.7% of the total population of Coos County are native Spanish speakers (approximately 1,723 people). The next most common non-English language spoken in Coos County is German.

Source: Office of Economic Analysis, Department of Administrative Services, State of Oregon 2013
Coos County has a large population of veterans. Slightly more than 14% (approximately 7,159 from 2011-15 estimates) of the entire population in the county are veterans, higher than the state. 91% of the veterans are male, consistent with other areas. Veterans have higher rates of disability. The majority of veterans in Coos County served in Vietnam, with growth of the population slower than the state over the last several decades.

The county has higher percentages of those with disabilities than state percentages.

Source: US Census Bureau, American Community Survey 2011-15

Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates
**Indicators**
The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percents/percentages.

### Demographic

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Coos County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>Overall growth ↓</td>
</tr>
<tr>
<td><strong>Race &amp; Ethnicity</strong></td>
<td>Hispanic or Latino ↓</td>
</tr>
<tr>
<td></td>
<td>Native American ↑</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>Population 55 and older ↑</td>
</tr>
<tr>
<td></td>
<td>Under 18 years old ↓</td>
</tr>
<tr>
<td></td>
<td>Families with children ↓</td>
</tr>
<tr>
<td><strong>Veterans</strong></td>
<td>Veterans ↑</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>Disability ↑</td>
</tr>
<tr>
<td></td>
<td>Over age 65 with disability ↑</td>
</tr>
</tbody>
</table>

**Key**

↑ = higher (than State)
↓ = lower (than State)
Neighborhood and Physical Environment

Where somebody lives, works and plays influences their health. Indoor and outdoor air quality and exposure to environmental toxins and other hazards affects health outcomes. Opportunities for physical recreation can have a positive affect on health behavior.

**Air quality and recreational opportunities**

Outdoor air quality is a **strength** in Coos County, being consistently better than state and national trends. Recreation opportunities are varied in the county. Physical fitness and recreation facilities (5 establishments listed in 2015) are at a lower rate than the state but open space and outdoor recreational opportunities are many. According to available online data, there are 69 parks in the county, multiple beaches, lakes, forests and streams to recreate (Oregon Hometown Locator 2018) in the county. Trails for hiking, biking and other use are also frequent in the area, providing rich opportunities to recreate outdoors. The weather impacts outdoor recreation while access to built walking and running paths are limited in the county. There are few sidewalks and bike lanes available for recreation along roads.

“In truth, we are a beautiful area with clean air and outdoor resources greater than most places in the world.” —Survey Participant

“People walk less here, we have seasons so nobody wants to walk in the rain.” —Focus Group Participant

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*Recreation and fitness facilities, 2010-2015*

*Coos County and Oregon*

Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2015
Housing availability & quality

Where people live is core to their quality of life. Housing availability and quality is a well-established social determinant of health. Household problems such as overcrowding, incomplete kitchen or plumbing facilities and cost burden are experienced by 37% of the population in Coos County, slightly lower than the state which is at 39% (US Department of Housing and Urban Development 2013). Indoor air quality data is limited, focus groups and surveys elicited several comments about indoor air quality, mold and water damage.

“Lack of stable housing, or unsafe homes, a lot of moldy homes.” “Mold and water damage from roof failure.”—Focus Group Participants

Coos County has higher rates of HUD housing units than the state but the availability and affordability continues to be a problem for many people of the county. The county also has higher percentages of housing devoted to seasonal or vacation housing, reducing availability for local permanent people. Oregon Housing and Community Services (OHCS) surveyed service providers and recipients regarding housing in the fall of 2017. Key themes in the OHCS report that were consistent with the CHA focus groups included significant concerns about affordability of housing and rental housing, lack of supply of housing and the quality of housing in the county. Single family homes were listed as the highest need, followed by multi-family dwellings.

Homelessness

People experiencing homelessness, defined by anyone who lacks a fixed, regular and adequate nighttime residence, was listed as a significant concern in the 2018 CHA primary data focus groups and surveys.

“I’ve been to 14 states and homelessness is quadrupled here, what are we going to do with that, what are we to do?” —Focus Group Participant

The local Devereux Center served more than 1,400 clients in 2017, averaging 200 unduplicated individuals a month. Their warming center averages 40-50 people per night, where they provide warmth, safety, food and a dry place to spend the night for those who live outside (Devereux report, 2017).

“If you live outside you wake up sick”—Focus Group Participant

“Not enough resources for homeless, there are people who give but a lot that need, pay it forward. It could happen to anyone.” —Focus Group Participant
The number of homeless students in the county is trending up. Homelessness in youth can include those without a permanent home but also includes those doubled up or “couch surfing.” In the 2016-2017 school year, 559 children were homeless, 52 of those students were prekindergarten.

Transportation

Transportation and limited public transit remain a challenge in Coos County, particularly for those with limited resources. The people most affected by limited public transit are low-income individuals and families, people with disabilities and older adults. The 2011 Coos County Area Transit Plan lists a wide variety of transportation services but they remain limited in scope and geographic coverage.

“Affordable public transportation is limited to 7am to 5 pm, Monday to Friday. The ability to get to places easily on foot or bike are difficult with the terrain and the spread of the city services here. This can affect ability to get jobs or keep jobs that may have benefits for some. Bike lanes are on some roads and not others. Lack of sidewalks and good lighting in neighborhoods decreases being able to walk safely to and from places and unsafe for kids to be out on street to play.” —Survey Participant

Source: Oregon Department of Education 2017
The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

### Neighborhood and Physical Environment

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Coos County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing Costs</strong></td>
<td>Cost burdened households in rentals &amp; homes with mortgages ↑</td>
</tr>
<tr>
<td></td>
<td>Median value of a house since 2006 ↑</td>
</tr>
<tr>
<td><strong>Housing Quality and Type</strong></td>
<td>Older housing stock ↓</td>
</tr>
<tr>
<td></td>
<td>Severe household problems ↓</td>
</tr>
<tr>
<td><strong>Homelessness</strong></td>
<td>Homeless students ↑</td>
</tr>
<tr>
<td><strong>Air Quality</strong></td>
<td>Ambient air quality ↑</td>
</tr>
<tr>
<td><strong>Recreation and Fitness</strong></td>
<td>Recreational facilities ↓</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td>Use public transit to commute to work ↓</td>
</tr>
<tr>
<td></td>
<td>Walk or bike to work ↓</td>
</tr>
</tbody>
</table>
Economic stability includes factors such as poverty, income, employment and unemployment. Income and income inequality is directly linked to an individual’s health. Income inequality has been shown to have health impacts including increased risk for poor health and increased risk of death.

**Income**

The average and median incomes in Coos County are lower than the state. Poverty levels are higher in the county, compared to state and national percentages.

Within the county, highest incomes are in the Coos Bay census tract, lowest income levels are in the southeastern portions of the county. In 2015, 5,297 individuals were listed as living in extreme poverty, residing mostly on the eastern half of the county. In the county, there are more women than men and more people of color living in poverty.

**Annual family income, 2012-2016 Coos County and Oregon**

<table>
<thead>
<tr>
<th>Average Family Income</th>
<th>Median Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coos County</td>
<td>Oregon</td>
</tr>
<tr>
<td>$67,106</td>
<td>$84,441</td>
</tr>
<tr>
<td>$48,322</td>
<td>$65,479</td>
</tr>
</tbody>
</table>

*Source: US Census Bureau, 2016*

**Average household income by location, 2015 Coos County**

*Source: American Community Survey 5 Year Estimate 2016*
Poverty

In 2015, one in three children in Coos County were living in poverty, much higher than statewide percentages. Coos County has higher levels of poverty overall, ranging from 18-20% of the population living in poverty, depending on source.

**Distribution of various wage buckets, 2015**  
**Regional, Oregon, National**

When compared to state and national wages, the county has more lower-wage jobs.

“Its not just having jobs, but having jobs that have a living wage with insurance for families. I see more families becoming homeless.” —Survey Participant

**Poverty**

In 2015, one in three children in Coos County were living in poverty, much higher than statewide percentages. Coos County has higher levels of poverty overall, ranging from 18-20% of the population living in poverty, depending on source.

**Poverty level by age, 2012-2016**  
**Coos County and Oregon**

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates 2016
Close to 50% of children (4,745 children in 2016) are eligible for free and reduced lunch in Coos County, which is close to averages in the state. The percentage varies within the district, illustrating income inequalities in the county.

“Inform [others] about poverty in community, blame isn’t helpful, but people have so many biases, they don’t want to help others. So many people don’t get it, they think that poverty just goes away without help. We have to accept it’s here and work together to solve it.” -Focus Group Participant

Source: OregonLive 2015

**Students receiving free and reduced-price lunches, 2010–2016**

*Select schools in Coos County*

Source: Oregon Department of Education, 2017
Unemployment rates are higher in Coos County compared to Oregon and peaked in 2009, but has steadily trended downward since 2010. Unemployment in Coos County in 2017 was 6.9%.

Employment and annual census of employees in Coos County have also seen a steady increase as reported by the US Bureau of Labor Statistics. Unemployment decreasing and employment increasing have both been positive indicators of economic growth in the county, a trend beginning in 2014. Growing employment and reducing unemployment since 2014 are considered a strength in the county.

“People who have productive lives with good jobs are just happier people. Get enough of them together and the whole community is happier and healthier.”
—Survey Participant
## Indicators

The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

### Economic Stability

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Coos County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td>Median and average income ↓</td>
</tr>
<tr>
<td></td>
<td>Difference in income by race/ethnicity ↓</td>
</tr>
<tr>
<td><strong>Living in poverty</strong></td>
<td>Living in poverty ↑</td>
</tr>
<tr>
<td></td>
<td>Children live at or below 200% Federal Poverty Level ↑</td>
</tr>
<tr>
<td></td>
<td>Women in poverty ↑</td>
</tr>
<tr>
<td></td>
<td>Poverty by race/ethnicity ↑</td>
</tr>
<tr>
<td><strong>Free and Reduced-price lunches</strong></td>
<td>Students qualifying for free and reduced lunch ↑</td>
</tr>
<tr>
<td><strong>Unemployment</strong></td>
<td>Unemployed ↑</td>
</tr>
</tbody>
</table>
Education

Education is an important social determinant of health, as education increases a person’s overall health also often increases. More education is shown to be linked to longer life and increased income, while lower education attainment can be linked with poor health, higher levels of crime, unemployment and increased stress.

“Key is education. It’s key for everything. Results in knowledge, more health, how to use knowledge and better able to manage every day.” –Focus Group Participant

Early learning

Coos County has a robust early learning system that has benefited positively from many years of community focus. Although the rate of students enrolled in Head Start is significantly higher than the state, the recent needs assessment by the 2016 Oregon Coast Community Action Agency lists that program expansion is still needed to provide supports for families and children in the county. Additionally, the south coast generally has only 12 childcare slots per 100 children and the annual cost of care for a toddler is over 30% of the annual income of a minimum wage worker (ORCCA 2016 Needs Assessment). The early learning system in the county is strong but there continues to be significant needs.

Students in Head Start 2014
(per 10,000 children)

18.51
Coos County

8.84
Oregon

Source: US Department of Health & Human Services, Administration for Children and Families, 2014

Graduation

High school graduation rates have been lower in Coos County than Oregon since 2011 and on a downward decline, representing a significant challenge to health. Latest available data from the Oregon Department of Education shows 58% of ninth graders graduated from high school in their cohort (4 years later) in 2015-16.
“It's a cycle of poverty and lack of education. I've taught for 20 plus years and see generations that are older that didn’t need it and didn’t value it, but it is now. They can’t or don’t see the need for continuing their education. We need to create a different pathway. Perception is that it (education) is not valued and not seen as a way to a different life.” —Focus Group Participant

**Poverty status by educational attainment, 2011-2015**

**Coos County and Oregon**

Source: US Department of Education 2016
**Educational attainment**

Compared to the state average, Coos County has a higher percentage of the population that attended some high school but did not receive a diploma, and fewer people with a bachelor, graduate or professional degree.

“There is still a nucleus of students that don’t value education and stay here. It’s a culture that doesn’t value education.” –Survey Participant

**Educational attainment, 2011-15**

*Coos County and Oregon*

Source: US Census, Fact finder 2018

“Lower education levels lead to the poverty and other issues we have here in our area. Research indicates that educational success—which begins in the elementary schools and goes onward and upward from there—are a huge determinant for future success and life skills. Our schools need to improve to start the chain reaction for improved lifestyles.” —Survey Participant

Southwestern Oregon Community College is the higher education institution in the county, founded in 1961. The college serves approximately 8,306 students annually. 71% of students seeking a certificate or degree received financial aid or scholarships in 2015-2016 (SOCC.edu 2017).
The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percents/percentages.

<table>
<thead>
<tr>
<th>Education</th>
<th>Findings (Coos County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Early Childhood</strong></td>
<td>Students in Head Start</td>
</tr>
<tr>
<td></td>
<td>Early education enrollment (% of 3 and 4 year olds in school)</td>
</tr>
<tr>
<td><strong>Graduation Rates</strong></td>
<td>Graduation rate</td>
</tr>
<tr>
<td><strong>Educational Attainment</strong></td>
<td>Bachelors or advanced degrees</td>
</tr>
</tbody>
</table>
Food

Eating nutritious food and maintaining a healthy diet are important to individual health. Poor nutrition has been shown to increase risk for various chronic health conditions and to increase morbidity and mortality.

A healthy food environment includes access to healthy foods and food security. Access has many facets including the cost, distance and availability of fresh and healthy food options. The USDA defines food insecurity as the lack of access to enough food for all members in a household and limited or uncertain availability of nutritionally adequate foods.

Food insecurity, access and consumption

Access to healthy foods has improved in Coos County and is better than some counties in the state. The USDA gives Coos County a food environment index of 6.9. The food environment index is on a scale of one to ten, with (0) being the worst and (10) being the best. Oregon is listed as having a slightly better food environment index at 7.3 (County Health Rankings 2018). A third of the population in Coos County lives in a food desert, which is also better than the state, but is still identified as a priority. A food desert is defined as a low income census tract where a substantial share of the population has low access to a supermarket or large grocery store.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP) are public programs designed to address food access and insecurity. The rate of stores that accept either WIC or SNAP benefits is more than state averages, indicating a program asset and strength while also revealing that a large number of people qualify for these programs.

“The cost of healthy foods is rather high and unhealthy processed foods are more abundant with a more reasonable cost. We need healthier fresh food to be more reasonably priced. Education for the community showing them how to cook with healthier foods and from scratch in less time. I find that way too many people in our community default to quicker food preparations and quicker to cook products due to school, work, busy schedules, etc... We need to have healthier and quicker food preparation times for meals and less processed and chemically-filled foods.” —Survey Participant
In 2017, 20% of teens in Coos County (in both 8th and 11th grade) answered yes when asked if they ate less than they felt they should because there wasn’t enough money to buy food (Oregon Healthy Teens Survey 2017). This is higher than the state percentage (14%). Additionally, one in four children under 18 experience food insecurity in Coos County.

“[We need] more access to fresh food. Have to travel far to get fresh food, babies want fruit and vegetables but I can’t get fresh ones for them, mostly old or out of cans.”
—Focus Group Participant

Consumption of unhealthy foods, including soda, is higher in Coos County. The percentage of adults who eat five or more servings of fruits and vegetables a day is lower in Coos County than Oregon.

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Consumption of unhealthy foods, including soda, is higher in Coos County. The percentage of adults who eat five or more servings of fruits and vegetables a day is lower in Coos County than Oregon.
The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Coos County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food Insecurity</strong></td>
<td>Adults and children living with food insecurity ↑</td>
</tr>
<tr>
<td><strong>Food Access</strong></td>
<td>Rate of SNAP authorized retailers ↑</td>
</tr>
<tr>
<td></td>
<td>Rate of SNAP (food stamps) recipients ↑</td>
</tr>
<tr>
<td></td>
<td>Rate of WIC authorized stores ↑</td>
</tr>
<tr>
<td><strong>Soda Consumption</strong></td>
<td>Number of adults drinking 7 or more sodas a week ↑</td>
</tr>
<tr>
<td><strong>Fresh Food Consumption</strong></td>
<td>Adults ↓ Youth in 8th grade ↑</td>
</tr>
</tbody>
</table>
Community

Social associations and volunteerism

Social associations are one way to measure social connectivity in a community. Lack of social connectivity and resulting isolation can influence health outcomes of individuals and community.

The rate of social associations in Coos County (County Business Patterns, 2014) is 12.5 per 100,000 population, higher than the Oregon state rate of 10.4 per 10,000, (BRFSS 2014) a strength in the county.

“Volunteering helps with mental health, makes you feel better.” –Focus Group Participant

“Lots of volunteerism, people want to help. There is a woman who goes to the mission every Tuesday for ten years, she has a volunteer spirit.” –Focus Group Participant

Social and emotional support

Participants in the 2018 CHA focus groups and surveys universally chose social support including religious and spiritual values as the second biggest strength in the community. The third biggest strength were the people that live here.

While social associations are strong, many individuals indicate that they still don’t have adequate social and emotional support. Over 20% of youth state that they are neither working or in school, indicating disconnection from community. This is higher than the state.

“A lot of people are isolated, its generational.” –Focus Group Participant

Disconnected youth, 2010-2014
Coos County and Oregon

Source: Measure of America, 2014
Violent crime is lower in Coos County than the state average. Violent crime was trending up until 2011 when it began to decline in the county.

![Violent crime, 2004-2013 Coos County and Oregon](image)

*Source: Federal Bureau of Investigation, FBI Uniform Crime Reports 2015*

The number of convictions for methamphetamine and Heroin are also on a downward trend.

![Convictions for Methamphetamine and Heroin, 2012-2016 Coos County](image)

*Source: Oregon Criminal Justice Commission, 2012-2016*
Intimate partner violence, specifically domestic violence and child abuse, are near state levels (Oregon Annual Uniform Crime Reports, Child Welfare Data Book 2017). However, the percentage of youth that report being intentionally hit or physically hurt by an adult in 2017 is nearly one in four (23.3% Oregon Healthy Teens Survey), consistent with national trends of victims of domestic/intimate partner violence. Child abuse reports are trending up in the county and the state, beginning in 2015 the number of founded reports began increasing from previous years. Coos County is third highest county in the state for children in foster care (Children First Data Book 2017).

In 2016, Coos County had slightly higher rate of law enforcement officers per 1000 people. However, community perceptions illustrate a different perspective and experience. Although violent crime and drug arrests are trending down and law reinforcement officers per capita are higher than the state, 2018 CHA focus group and survey participants identified crime, specifically from drug offenses and violent acts, as being of significant concern.

“Not enough police. Too many panhandlers. I’m always worried for my personal safety and my property being stolen.” —Focus Group Participant
### Indicators

The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

<table>
<thead>
<tr>
<th>Community</th>
<th>Findings (Coos County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Associations and Volunteerism</strong></td>
<td>Social associations/membership organization involvement ↑</td>
</tr>
<tr>
<td><strong>Social and Emotional Support</strong></td>
<td>Individuals without adequate social support ↑</td>
</tr>
<tr>
<td></td>
<td>Disconnected youth ↑</td>
</tr>
<tr>
<td><strong>Crime and Safety</strong></td>
<td>Violent crime ↓</td>
</tr>
<tr>
<td></td>
<td>Domestic violence offenses, arrests ↓</td>
</tr>
<tr>
<td></td>
<td>Law enforcement officers ↑</td>
</tr>
</tbody>
</table>

**Key**

↑ = higher (than State)
↓ = lower (than State)
Health Care System

The health care system provides services to prevent and treat disease. It influences the health of individuals, families and communities. Health disparities, often created by the social determinants of health, affect access to health care services.

Insured and uninsured

Health insurance is one element of access to health care services. Coos County has a high percentage of the population on publicly funded insurance, which includes Medicaid/Oregon Health Plan/OHP, Medicare and Veterans Administration/VA. 2017 estimates from Oregon DMAP and RUPRI, show that 62.6% of the population in the county is on Medicaid, Medicare or both. The age distribution on Medicaid is older in Coos County than in the state as a whole.

The percentage of population with insurance statewide has been increasing since 2011, with a sharp increase in 2015. It was estimated that 96.8% of Oregonians are now covered (2016) by insurance (Oregon Annual Health Insurance Report, 2018).

Access to providers

Access to providers and specific health services is another element of access to health care services. 100% of people in Coos County are considered to be in a health service shortage area. A study by Oregon Health Sciences University in 2016 found multiple barriers to accessing primary care in Coos County. Trouble finding a provider was listed most often followed by transportation and wait time. These findings were supported by comments in the 2018 CHA focus groups and survey comments.

“People should have providers if it’s a healthy community. I know a lot of people don’t have providers. I was on a wait list for 9 months for a Primary Care Physician.”
—Focus Group Participant

“Providers often are not taking new patients, specialists are booked out for months necessitating travel to Eugene and Portland for consultations.” —Survey Participant

“For me personally I would like to see....more health care provider choice. Every time I choose a primary care provider they end up leaving the community and I have to change doctors.” —Focus Group Participant
Access to primary care providers has increased since 2004 but not at the same rate as the state. In 2016 the county had 40,635 FTE/Full Time Equivalent primary care physicians, including family medicine, general practice and internal medicine physicians. Recruitment and retention of providers was consistently listed as a concern in focus groups and survey participant comments.

“Hard to get specialty care here. Hard to keep doctors here. It’s a jumping stone to other communities.” —Survey Participant

“Many specialty services are available here. However, a large number of patients that I see have a very difficult time getting in to see primary care physicians (especially to establish care but also when they have established care but have an urgent issue). Improving access to primary care physicians is essential to improving health care in the area.” —Survey Participant

![Graph showing Access to care providers, 2015-2016 Coos County and Oregon](image)

Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2017

### 2016 Provider Numbers (FTE = Full time equivalent)

- 16.6 FTE Family Medicine Physicians
- 24.035 FTE Internal Medicine Physicians
- 26.528 FTE Nurse Practitioners
- 5.3 FTE Obstetricians/Gynecology
- 5.3 FTE Physician Assistants
- 4.5625 FTE Psychiatrists or Psychiatric Nurse Practitioners
- 20.89 FTE Dentists
- 28.0 FTE LCSW, LMFT, Psychologists
- 42.0 FTE Licensed Counselors

The majority of providers are in Coos Bay, followed by Bandon and Coquille zip codes.

Source: Oregon Office of Rural Health 2018
The Oregon Office of Rural Health has designated Coos County as a Medically Underserved Area (MUA), a Health Professional Shortage Area (HPSA), and a Health Professionals Shortage Area for Dental and Mental Health Providers. The Southern portion of the county has slightly higher scores of unmet need than Coos Bay and the Northern parts of the county.

**Overall scores of unmet health care needs, 2017**

*Source: Oregon Office of Rural Health 2018*
**Oral and dental care accessibility**

Access to **dental care** and oral health services show higher percentages of adults with no dental exam. 41% (approximately 20,953) of adults in the county between 2006-2010 had no dental exam (BRFSS 2010), compared to 29.8% statewide. In 2014, 42.9% of adults stated that it had been more than a year since their last dental exam.

“I need access to preventive care and screening including dental care. I’m on Medicare, but it won’t cover dental. It affects your health.” —Focus Group Participant

“We have very poor dental care here, I have a friend who moved here from California and she asked what’s with the teeth here? Dental seems to be the last thing covered by insurance.” —Focus Group Participant

“We without homes have a big bag of floss here but not enough teeth to use it.” —Focus Group Participant

**Preventive screening**

The percentage of a population that has preventive screenings is an indicator of access to care, specifically quality and timeliness of care. The screenings provided the most often include colorectal cancer screening, mammogram, pap tests, blood sugar tests and cholesterol. Coos County has a lower percentage of the population participating in these screenings than Oregon, with the exception of blood sugar testing.

![Health screenings, adults, 2012-2015](chart)

Coos County and Oregon

Source: Oregon Behavioral Risk Factors Surveillance System 2017
Prenatal care and school-based health centers

Prenatal care is an indicator of maternal and child health services access. Coos County has seen varied percentages of mothers that have had adequate prenatal visits during pregnancy since 2000 and is increasing in percentage, suggesting a positive trend and strength. Inadequate prenatal care is less than five visits prior to delivery or care began in third trimester or after.

“It's hard for single moms and babies.” —Focus Group Participant

Women receiving adequate prenatal care, 2000-2016
Coos County and Oregon

School Based Health Centers provide physical and behavioral health services in elementary, middle and high schools in the county. The majority of services are provided at area high schools followed by fewer centers and services in the middle school. The number of School Based Health centers in elementary schools are limited in the county.

Hospitals

Coos County is served by three hospitals; Bay Area Hospital, Coquille Valley Hospital and Southern Coos Hospital and Health Center. Bay Area Hospital is a regional health district facility. Both Coquille Valley Hospital and Southern Coos Hospital are critical access hospitals, a designation given to certain rural hospitals by the federal Centers for Medicare and Medicaid Services (CMS).
Bay Area Hospital's mission is “We improve the health of our community every day.” Recent additions to Bay Area Hospital include the Joint Replacement Destination Center, which opened in the spring of 2017 and the newly purchased da Vinci® Xi™ Surgical System, which now allows the robotics team to conduct a greater variety of procedures. Other key services include: Interventional cardiology, cancer care, inpatient dialysis, hyperbaric wound care, medical imaging, Obstetrical Care in our Family Birth Center, inpatient and outpatient psychiatric care, pediatrics, orthopedics, bariatric surgery, home health, and a Level 3 trauma center. The hospital also operates the Kids’ Hope Center, caring for the needs of abused children.

Bay Area Hospital has earned the Joint Commission Gold Seal of Approval for quality and patient safety. Individual programs with national accreditations include the Prefontaine Cardiovascular Center, cancer center, medical laboratory, pathology service, Women’s Imaging, Sleep Study Center, home health, and Bay Bariatrics.

Bay Area Hospital is owned by Bay Area Health District and is governed by an elected board of directors. It is Oregon’s only district-owned hospital operating without local tax support. The Bay Area Hospital Community Foundation accepts charitable donations and bequests, with which it supports health care programs as well as a variety of community organizations.

Coquille Valley Hospital’s (CVH) mission is to improve the lives of people in the communities we serve by providing excellent quality, high value, health care services delivered with professional competence and compassion. The primary service area includes the Oregon communities of Coquille, Myrtle Point, Powers, Bridge, Fairview, Dora, Arago and a number of other neighboring communities within the Coquille River Valley, compromising a population of approximately 13,000 people. CVH provides 24-hour emergency, medical and surgical care together with an extensive array of clinical support services.

The mission of the Southern Coos Health District is to “provide quality health care with a personal touch.” The service area is approximately 10,000 people from communities in Coos County and Northern Curry County, including Bandon, Coquille, Port Orford and Langlois. Services include an emergency department, inpatient acute care, swing bed, surgical services, outpatient infusion and wound care, medical imaging services, laboratory services, respiratory therapy and a multi-specialty health center with primary care, internal medicine, surgical, podiatry and behavioral health services.
Focus group and survey participants mentioned frequently that they often had to travel out of the county for health care services. The reasons for traveling out of the county are many, including inpatient hospital services at a different level than available in the county, health care provider shortages and limited specialty services.

The preventive hospitalizations for patients on Medicare with conditions that are ambulatory care sensitive is higher in Coos County than the state. Ambulatory care sensitive conditions include pneumonia, dehydration, asthma, diabetes and other conditions which could have been prevented if adequate primary resources were available and accessed. This indicator illustrates challenges in primary care access.

Focus group and survey participants mentioned frequently that they often had to travel out of the county for health care services. The reasons for traveling out of the county are many, including inpatient hospital services at a different level than available in the county, health care provider shortages and limited specialty services.

**Top 3 Hospitals Medicaid patients, from Coos County, are going to outside of County 2016-2017**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st most visited</td>
<td>Sacred Heart River Bend</td>
</tr>
<tr>
<td>2nd most visited</td>
<td>OHSU</td>
</tr>
<tr>
<td>3rd most visited</td>
<td>Legacy Emanuel Hospital</td>
</tr>
</tbody>
</table>

**Top 3 Reasons Medicaid patients, from Coos County, are going outside of county for inpatient care 2016-2017**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Vaginal delivery live-born infant</td>
</tr>
<tr>
<td>2nd</td>
<td>Cesarean live-born infant</td>
</tr>
<tr>
<td>3rd</td>
<td>Sepsis</td>
</tr>
</tbody>
</table>

*Source: Coordinated Care Organization Enrollee data, 2017*
Local Public Health System

Coos Health & Wellness (CHW) combines the local public health and mental health authority for Coos County. CHW is composed of four divisions including public health, behavioral health, health promotion and administration. CHW Director is appointed by the Board of Commissioners. CHW offers a wide array of public health and mental health services. Some of these include environmental health, WIC, vital records, reproductive and sexual health services, OHP enrollment assistance, home visiting, mental health counseling and treatment for adults and children with mental health issues, and other services. The public health division of CHW has been focusing on ensuring full access to its mandated services to our community. The division is also working on promoting health within the community through various projects such as the CHA, the CHIP, and a breastfeeding promotion campaign.

“I go to Eugene or Portland for all my care due to lack of some basic needs here as well as expense of care here.” —Survey participant
## Indicators

The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

### Health Care System

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Coos County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insured and Uninsured</strong></td>
<td>Public insurance (including Medicaid, Medicare and VA) ↑</td>
</tr>
<tr>
<td><strong>Access to Providers</strong></td>
<td>100% of population living in Health Professional Shortage Area ↑</td>
</tr>
<tr>
<td></td>
<td>Access to primary care physician ↓</td>
</tr>
<tr>
<td></td>
<td>Access to mental health providers ↓</td>
</tr>
<tr>
<td><strong>Oral/Dental Health Accessibility</strong></td>
<td>Adults with no dental exam in last 12 months ↑</td>
</tr>
<tr>
<td><strong>Preventive Screening</strong></td>
<td>Colorectal Cancer Screening ↓</td>
</tr>
<tr>
<td></td>
<td>Mammogram within last 2 years ↓</td>
</tr>
<tr>
<td></td>
<td>Pap Test w/in last three years ↓</td>
</tr>
<tr>
<td></td>
<td>Cholesterol checked in last 5 years ↓</td>
</tr>
<tr>
<td></td>
<td>Blood sugar test within last 3 years ↓</td>
</tr>
<tr>
<td></td>
<td>Screened for HIV ↑</td>
</tr>
<tr>
<td><strong>Prenatal Care Accessibility</strong></td>
<td>Moms getting adequate prenatal care ↓</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td>Preventable hospitalizations ↑</td>
</tr>
</tbody>
</table>
Health Behaviors

Modifiable individual health behaviors such as tobacco use, inadequate physical activity and addictions have significant influence on the health of individuals and communities in Coos County.

**Tobacco**

Tobacco use has remained high in Coos County for many years. Premature death, various cancers, lung and respiratory issues, low birth weight and cardiovascular disease are all linked to tobacco use. The tobacco mortality rate has been high in Coos for over a decade. The percentage of adults in Coos County that are current smokers continues to be one of the highest in the state. More than 50% of adults have smoked at least 100 cigarettes in their life in Coos County, and close to 30% of adults are currently smoking, according to the most recently available BRFSS data 2012-2015.

The financial impact of tobacco in Coos County is also substantial. The latest tobacco fact sheets from the Oregon Health Authority estimates that Coos County experiences 42 million dollars in tobacco related medical costs and 34 million in lost productivity due to premature tobacco-related deaths (Oregon Health Authority Tobacco Fact Sheets 2014).

Smoking among Coos County children and teens is considerably higher than the state as a whole. In 2017, 7% of 8th graders in Coos County had smoked cigarettes in the last 30 days, compared to the state percent of 3%. Coos County 8th graders also had a higher overall tobacco use in 2017 with 11% of 8th graders having used any tobacco, including vaping products, in the past 30 days, compared with 8% in Oregon.

“High rates of smoking and cancer community norms influence our smoking rates. The culture of town affects smoking.” —Focus Group Participant

“Tobacco is a big problem with kids. I walk around the high school and a lot of them are smoking or chewing, they think they are invincible.” —Focus Group Participant

“Cigarette smoking and obesity are big problems in our community that I believe most often continue through family patterns and lack of education regarding healthy choices. Preventive health care in the schools may help.” —Survey participant

**Tobacco-related mortality, 2006-2016**

*Coos County and Oregon*

Source: Oregon Vital Statistics Annual Reports
Excessive heavy alcohol consumption and binge drinking contributes to chronic health issues, including heart disease, cirrhosis of the liver, high blood pressure, stroke and even death. Close to 20% of adults in Coos County report binge drinking in the past month (BRFSS 2012-2015) while over 50% of people in the region (Coos, Curry, Douglas, and Jackson Counties) report using alcohol in the past month (2012-2014). In 2017, the percentage of 8th graders who have never had a first drink in Coos County is slightly less (70%) than statewide (73%) although this indicates that one in three 8th graders have already consumed at least one alcoholic beverage.

“We need inpatient alcohol and drug treatment beds. Sending our community members to Roseburg or further can be detrimental if their entire support system is in Coos Bay. If they have children even more so. I believe this is a barrier to rehab for many, make drug treatment REAL.” —Focus Group Participant

“Until we rid the area of drugs we have no chance of taking back our beautiful area. Drugs and homelessness are big, big problems we must address. I believe even if we build a detox treatment center that would be very helpful.” —Focus Group Participant
Drug use was of high concern in the 2018 CHA focus groups and survey participants. Nearly 1 in 4 participants chose alcohol and/or drug use as the behavior that has the greatest influence on health.

“Drug abuse is prevalent and affects people and their family’s health and kids’ health. Affects minors too.” —Focus Group Participant

**Drug use, 2012-2014 region, state, national***

- Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year among Individuals Aged 12+
- Illicit Drug Dependence or Abuse in the Past Year among Individuals Aged 12+
- Nonmedical Use of Pain Relievers in the Past Year among Individuals Aged 12+
- Cocaine Use in the Past Year among Individuals Aged 12+
- Illicit Drug Use Other Than Marijuana in the Past Month among Individuals Aged 12+
- Illicit Drug Use in the Past Month among Individuals Aged 12+

*data collected prior to legalization of marijuana

Source: National Survey on Drug Use and Health: Annual Averages Based on 2012, 2013, and 2014
“For children, it is parents with substance abuse issues. We have a meth and heroin epidemic in Coos County that is not actively being addressed in relation to the children of users.” —Survey Participant

Youth drug use in Coos County is higher than statewide. 9.2% of 8th graders and 23.3% of 11th graders indicated they had used marijuana in the past 30 days. Also notable is how they consumed marijuana. When asked to choose how they had used it, 96.5% of 11th graders that said they had used marijuana said they had smoked it, 22.4% had eaten it in brownies, cakes, cookies or candy (Oregon Healthy Teen Survey 2017).

The morbidity and mortality associated with inappropriate use of opiate drugs such as codeine, oxycodone, morphine and methadone, have a negative impact on the health of the community. Prescribing patterns for Medicare enrollees in Coos County, during 2013-2014 show higher rates of opioid prescriptions than state and national trends (Center for Medicare and Medicaid Services). This is consistent with prescription patterns in the Medicaid/Oregon Health Plan population, narcotic analgesics (opioids) were the second most prescribed medication in 2016-2017. According to the Oregon Opioid Dashboard in 2018, the fourth quarter of 2017 had Coos County ranked as one of the highest prescribing rate of opioids in the state, at 109.18 per 100,000. Additional data on overdose hospitalizations and deaths due to opioids are found in the health status and outcomes section.

“Pain may lead to substance abuse addiction etc.” —Survey participant

“We have to stop punishing everyone for the sins of others who make bad choices. Like taking effective pain medication away from non-abusing patients who need it to have a better quality of life. Because of “new studies” the opioid crisis has reduced my quality of life even tho I’m very responsible with no abuse issues.” —Survey participant

Coos County has a high burden of hepatitis C virus (HCV). High burden is defined as number of people living with cases, chronic case reports and acute Hepatitis C Virus. Reported risk factors for acute HCV in Oregon include injection drug use, health care exposure, multiple sex partners and other risks, such as street drugs, tattoo, piercing or other blood exposure. Coos County has higher rates of those living with chronic HCV than the state rates. The region (Coos and Curry) has the highest mortality rate of HCV within the Medicaid and CCO population (Oregon Health Division 2017).
Immunizations are an effective tool for preventing communicable disease and death. Coos County has lower rates of vaccinated children and lower rates of flu vaccination for adults over 65 years of age. Although the percent of two year olds that are fully vaccinated is lower than the state, it has been trending up since 2016.
Obesity

Obesity is a modifiable risk factor for several chronic conditions. Obesity is defined as a Body Mass Index (BMI) of 30 or higher. BMI is calculated using both height and weight. Being obese has been associated with increased risk of coronary heart disease, type 2 diabetes, cancer, high blood pressure, stroke, liver and gallbladder disease, among other morbidity and mortality. Nearly one in three people in Coos County are obese, higher than state percentages. The percentage of the population that is considered obese has been on an increase for many decades.

“Obesity is rampant” —Survey participant

“Cigarette smoking and obesity are big problems in our community that I believe most often continue through family patterns and lack of education regarding healthy choices. Preventative health care in the schools may help.” —Focus Group Participant

Regular physical activity and a healthy diet reduce the risk of obesity. Only 14.9% of people in the county meet the Centers for Disease Control (CDC) physical activity recommendations, much lower than the statewide percentage of 24.2%. Adequate physical activity is defined as 2.5 hours a week of moderate intensity or 75 minutes of vigorous-intensity aerobic activity a week. The CDC recommends that children and youth be physically active for at least 60 minutes a day. 28% of 8th and 11th graders in Coos County met those guidelines in 2017 (Oregon Health Teens Survey 2017).

Obesity trend, 2002-2015 Coos County and Oregon

Source: BRFSS 2017
Sexually-transmitted diseases

Sexually-transmitted diseases, including chlamydia and gonorrhea have been generally trending up since 2012. There were 152 cases of chlamydia in Coos County in 2016. Gonorrhea cases increased from one case in 2007 to and 41 cases in the county in 2016 (Oregon Health Division 2017).

Gonorrhea cases by year, Coos County 2007-2016

Source: Oregon Health Division 2017
**Health Behaviors**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Coos County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Smoking ↑</td>
</tr>
<tr>
<td><strong>Alcohol and Other Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Binge drinking ↑</td>
<td></td>
</tr>
<tr>
<td>Heavy drinking ↑</td>
<td></td>
</tr>
<tr>
<td>Youth had first drink ↓</td>
<td></td>
</tr>
<tr>
<td>Opioid prescriptions ↑</td>
<td></td>
</tr>
<tr>
<td>Vaccinations</td>
<td>2-year-old immunization rates (60% vs. 75%) ↓</td>
</tr>
<tr>
<td>Obesity</td>
<td>Obesity* ↑</td>
</tr>
<tr>
<td><em>Fruits, vegetables and soda consumption in food section</em></td>
<td></td>
</tr>
</tbody>
</table>
Mortality (death) has changed in Coos County over the last 80 years, consistent with state and national trends. Advances in science, medical care, living and working conditions have influenced causes of death and disability in the county. The leading causes of death in the county, as well as in the nation, are cancer and chronic disease.

Coos County and Oregon*

Compared to the state of Oregon, Coos County has higher rates of several leading causes of death. The leading causes of death in the county are cancer and heart disease. The most recent trend data by county (2010-2014) shows that Coos County has the second highest rate of cancer death in the state, second to Sherman County and considerably higher than the state and national rates (Vital Statistics Oregon Health Authority). Breast, prostate, lung and colorectal are the most common types of cancer in Coos County.

“We have high rates of cancer here, three people in my family died of cancer from here. So it’s close to home.” —Focus Group Participant

![Leading types of cancer*](chart)

**Leading types of cancer**

2010–2014

Coos County and Oregon

*Source: Oregon State Cancer Registry, 2010-2014

*incidence/new cases
Deaths attributed to tobacco, as already mentioned in the modifiable health behavior section, are also higher in Coos County than Oregon and considerably higher than the Healthy People 2020 national goals.

**Diabetes-related mortality, 2006-2016**  
**Coos County & Oregon**

Source: *Oregon Vital Statistics Annual Reports 2006-2016*

Deaths attributed to tobacco, as already mentioned in the modifiable health behavior section, are also higher in Coos County than Oregon and considerably higher than the Healthy People 2020 national goals.

**Tobacco-linked mortality 2016**  
**Coos County, Oregon, HP 2020**

Source: *Oregon Vital Statistics Annual Reports*

The majority of deaths due to alcohol or drugs are from chronic alcoholic liver disease followed by unintentional injuries (*Oregon Health Authority 2016*). According to the Oregon Opioid Dashboard (2018), the opioid overdose hospitalization rate per 100,000 was 16.59, representing less than five individuals from 2010-2014. The same data source lists a rate of 2.56 per 100,000 for opioid deaths from 2012-2016 in the county. Although small numbers, both hospitalizations and deaths are higher than the statewide rates.
Chronic Conditions

The prevalence and burden of chronic conditions is high in Coos County, higher when compared to the state. More than 60% of adults in Coos County have one or more of the following chronic conditions: angina, arthritis, asthma, cancer, COPD, depression, diabetes, heart attack or stroke. This illustrates a very high burden of chronic disease in the county. Also notable is that Coos County has higher percentages of the population with arthritis, disability and diabetes than the state.

Chronic conditions, 2012-2015
Coos County and Oregon

Source: BRFSS, 2017
Mental health and depression were listed as top concerns by the 2018 CHA focus groups and survey participants. Indicators of mental and behavioral health include suicide rates and percentages of the population experiencing depression. The rate of suicide in Coos County shows an alarming upward trend and continues to be higher than the state.

Suicide, 2000-2016, Coos County and Oregon

“A lot of suicide is related to gambling here, needs more attention.” —Focus Group Participant

Suicide trend, 2000-2016
Coos County and Oregon

Source: Oregon Vital Statistics, Leading Cause of Death and Portland State University, Population Research Center 2017
Self-reported mental health issues and depression also show higher rates in Coos County than statewide, for both adults and youth. Nearly one in three adults in Coos County indicate that they are struggling with depression.

“We need less stigma and taboo. When somebody says you have cancer people are sympathetic. If you have a mental health or substance abuse issue you are taboo.” —Focus Group participant

Depression in youth has been steadily increasing for both 8th and 11th graders in Coos County for the last decade and also continues to be higher than the state numbers.

“I have been out of my depression meds for 2 months. I see my psychiatrist infrequently and my parents can barely pay for rent, let alone my meds.” —Focus Group Participant

Source: Oregon Healthy Teen Survey, 2017
“Mental health issues are extreme”—Survey Participant

“It can take six weeks to get a client into mental health services and often people need weekly [treatment], at least to stabilize, only to get every two weeks or a month for the next appointment. Where is the group therapy, life skills training, wrap-a-round services?” —Survey Participant

“Give voice to those that need it. We’ve come a long way but still have a lot to go. 50 years ago mentally ill people were locked in the basement.” —Focus Group Participant
Oral Health

In Oregon, oral disease is on the rise and Coos County is not an exception. The most recent data shows that adults in Coos County have a higher percentage of poor dental health and youth are less likely to have seen a dentist or dental hygienist for a check-up in the last year. In the 2017 Healthy Teens Survey, only 62.7% of 8th graders in Coos County have seen a dentist or dental hygienist for a check up, exam, teeth cleaning or other dental work in the last 12 months.

**Adults with poor dental health, 2006-2012**

Coos County and Oregon

_19.5%_  
Coos County

_13.6%_  
Oregon

*Source: BRFSS 2006-2012*

“More dental insurance and options. Not straight teeth, people that can’t get teeth pulled, people can’t get braces that need them so they can’t chew.” —Survey Participant

“While pediatric services are easily and rapidly attainable the same services for an adult are painstakingly slow. Both primary health care and dental visits cannot be booked within a reasonable time period. The average for me has been no less than 3-4 months for a primary physician and 6 months for a dental visit. I feel this could be considerably improved.” —Survey Participant
Births

Indicators such as low birth weight have long indicated general maternal and child health in a community. Babies born with low birth weight typically have more long-term disabilities and developmental issues. The rate of low birth weight babies in Coos County has historically been higher than the state until 2009 when it began its downward trend. The Infant Mortality Rate (IMR) in Coos County is now lower than the state, indicating a community strength. Meanwhile, birth rates in Coos County and the state have stayed relatively steady for the last decade. Access to prenatal care is listed as an indicator in the previous Health Services section.

Birth rate, low birth weight and infant mortality, 2005-2015

Coos County and Oregon


*low birth weight defined as weighing less than 5 pounds 8 ounces at birth
Teen pregnancies and births, among young women age 15-19, have been similar to the state rate with an increase over the state rate in 2016. The trend has had a slight dip since 2005. Teen births are an important indicator. Teen parents have unique social, economic and health services support needs. High rates of teen pregnancy can also indicate prevalence of unsafe sex practices.

*Teen births, 2005-2016*
*Coos County and Oregon*

*Source: Oregon Health Authority, Center for Health Statistics, 2017*
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leading causes of death</strong></td>
<td>Cancer, Heart Disease and COPD ↑</td>
</tr>
<tr>
<td></td>
<td>Diabetes-related mortality ↑</td>
</tr>
<tr>
<td></td>
<td>Tobacco-related mortality ↑</td>
</tr>
<tr>
<td><strong>Chronic conditions</strong></td>
<td>Burden of chronic disease ↑</td>
</tr>
<tr>
<td></td>
<td>One or more chronic diseases, arthritis, depression and disability</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>“All cancers” ↑</td>
</tr>
<tr>
<td></td>
<td>Lung cancer ↑</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td>Suicide ↑</td>
</tr>
<tr>
<td></td>
<td>Adults depression ↑</td>
</tr>
<tr>
<td></td>
<td>Youth depression ↑</td>
</tr>
<tr>
<td><strong>Dental/oral health</strong></td>
<td>Poor dental health ↑</td>
</tr>
<tr>
<td><strong>Maternal and pediatric health</strong></td>
<td>Birth rate ↓</td>
</tr>
<tr>
<td></td>
<td>Low birth weight ↑</td>
</tr>
<tr>
<td></td>
<td>Teen birth rate ↑</td>
</tr>
</tbody>
</table>

**Key**

↑ = higher (than State)

↓ = lower (than State)
Data Gaps and Next Steps

The CHA document is a broad snapshot of health in Coos County, and it has limitations. As mentioned in the executive summary, the CHA is not meant to cover every possible factor that influences health nor is it an evaluation of services or the efficacy of the health care system itself. The CHA is also limited by what data is currently being gathered and published and the validity, frequency and level of which the data is presented. The CHA committee identified several data gaps in the process, with the hope that it will drive future data collection and study. The list is not meant to be all inclusive and community members were invited to review and add to the list.

The CHA document is intended to inform and build on current health improvement efforts in the community. It is one step in an ongoing process of community health assessment, planning and improvement. Future work includes prioritization of health issues and interventions and exploration of how to compliment and integrate work that is already being done in the community. The work of improving the health of people in Coos County moving forward will include recognition of strengths, identification of needs and continued collaboration to improve health outcomes of individuals, families and community.

Data Gaps, Possible Future Data Collection and/or Study Topics

| Built environment: specifically sidewalks, running/walking paths, lighting on roads for safety |
| Homelessness & housing availability |
| Dental & oral health utilization and patterns |
| Current resource/services mapping |
| Generational health traits & behaviors |
| Genetic health issues |
| Opioid use & abuse |
| Access to specialty health care and patterns of patients getting care outside of county |
| Transportation |
| Types & characteristics of employment in area |
Primary Data Collection Summary

2018 Coos County Community Health Assessment

Process & Methods

Two primary methods were used to solicit feedback from the community regarding the 2018 Coos County Community Health Assessment. Primary data collection, through focus groups and a community wide survey, provided additional data and context to the secondary data cataloging and analysis. The purpose of the primary data collection was to gather perceptions about health priorities, experiences and gain an understanding of what community members believe influences health the most. Methods included surveys (both paper and online) and targeted focus groups. The primary data collection process was part of a larger community health assessment, following a modified Mobilizing for Action through Planning and Partnerships model (MAPP).

The community survey was written for easy reading and comprehension, resulting in a 99% completion rate. Survey questions mirrored the questions in the targeted focus groups. The survey was available online and in paper/hard copy format, in English and Spanish languages. Additional accommodation for language and/or reading and comprehension was offered. The survey was advertised through many formats: including flyers, social media and via email. 469 people took the survey, eliciting both quantitative health priority ranking data and 371 unique comments.

The 2018 Coos CHA collaborative committee also sponsored ten targeted community focus groups. Eighty-six (86) community members participated in the focus groups. The meetings were held around the county during November and December of 2017. The committee identified and prioritized which groups of individuals they wanted to have targeted feedback from, after lengthy discussion. The committee then chose local champions for each group. The role of the local focus group champion was to lead recruitment, coordination of focus group location, selection of small incentives for participants and introduction of the consultant and facilitator to the participants of the group.

Prioritized Populations for 2018 Coos County Community Health Assessment Focus Groups

- People living with cancer & chronic conditions
- People with disabilities
- Teens/young adults
- Behavioral health, mental health and addictions
- People experiencing homelessness
- Retired & seniors
- Education sector
- Hispanic/Latino and Spanish Speakers
- People working in service industry
- CCO Community Advisory Council and CHA subcommittee
Data was gathered in the focus groups with a combination of instant polling questions utilizing “clickers” that captured instant demographic data and polling on health priorities and perceptions. The second type of tool was open-ended discussion questions. The multiple feedback collection tools ensured 100% participation. Light refreshments and $10 gift cards or equivalent were provided to focus group participants as incentives. The focus groups were complete within two hours and averaged almost nine people per group. 464 unique comments were gathered from focus groups.

### Total primary data collection 2018

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total focus group participants</td>
<td>86</td>
</tr>
<tr>
<td>Total surveys completed</td>
<td>469</td>
</tr>
<tr>
<td>Total individual participants</td>
<td>555</td>
</tr>
<tr>
<td>(both survey and focus group)</td>
<td></td>
</tr>
<tr>
<td>Total qualitative comments</td>
<td>835</td>
</tr>
</tbody>
</table>

There are limitations to focus group and survey data. Neither should stand on its own; the processes are meant to complement and balance the secondary data analysis. The primary data collection methods used in the 2018 Coos County CHA are also not random and instead are considered a convenience sample, not intended to be a complete and random sampling of the community but instead, to provide insight into the health concerns, perceptions and experiences of specific groups within the county. The selection of populations for the focus group and the advertising of the survey were driven by the local CHA committee.
Qualitative and quantitative data were reviewed for themes in both the survey and focus groups. A combined number of 835 unique qualitative comments and several quantitative ranking questions were reviewed for themes. The combined themes and summary data are as follows.

**Primary data themes**

### 3 Biggest strengths in community
- Physical environment (such as air quality and recreational opportunities etc.)
- Social support (including religious/spiritual values, volunteerism etc.)
- The people that live here

### 3 Things that would most improve quality of life here
- Meeting basic needs for everyone (like food, shelter etc.)
- Improved access to affordable housing
- Improving availability of jobs

### 3 Behaviors with the most influence on health
- Alcohol and/or drug abuse
- Eating habits and nutrition
- Tobacco use

### 3 Community Conditions you see the most
- Poverty or ability to meet financial responsibilities
- Homelessness/availability of housing
- Availability of jobs with a living wage (lack of)

### Health Equity

55% of participants don’t believe that everyone in Coos County has an equal opportunity to live a long healthy life if they choose to.
Purpose of Local Public Health System Assessment

The primary purpose of the NPHPS Local Public Health System Assessment Report is to promote continuous improvement that will result in positive outcomes for system performance. Local health departments and their public health system partners can use the Assessment Report as a working tool to:

- **Better understand current system functioning and performance**
- **Identify and prioritize areas of strengths, weaknesses, and opportunities for improvement**
- **Articulate the value that quality improvement initiatives will bring to the public health system**
- **Develop an initial work plan with specific quality improvement strategies to achieve goals**
- **Begin taking action for achieving performance and quality improvement in one or more targeted areas**
- **Re-assess the progress of improvement efforts at regular intervals**

This summary report is designed to facilitate communication and sharing among and within programs, partners, and organizations, based on a common understanding of how a high performing and effective public health system can operate. This shared frame of reference will help build commitment and focus for setting priorities and improving public health system performance. Outcomes for performance include delivery of all ten essential public health services at optimal levels.

Acknowledgments

The National Public Health Performance Standards (NPHPS) was developed collaboratively by the program’s national partner organizations. The NPHPS partner organizations include: Centers for Disease Control and Prevention (CDC); American Public Health Association (APHA); Association of State and Territorial Health Officials (ASTHO); National Association of County and City Health Officials (NACCHO); National Association of Local Boards of Health (NALBOH); National Network of Public Health Institutes (NNPHI); and then Public Health Foundation (PHF). We thank the staff of these organizations for their time and expertise in the support of the NPHPS.

Background

The NPHPS is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPS assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. Through these assessments, responding sites can consider the activities of all public health system partners, thus addressing the activities of all public, private and voluntary entities that contribute to public health within the community.
The NPHPS assessments are intended to help users answer questions such as “What are the components, activities, competencies, and capacities of our public health system?” and “How well are the ten Essential Public Health Services being provided in our system?” The dialogue that occurs in the process of answering the questions in the assessment instrument can help to identify strengths and weaknesses, determine opportunities for immediate improvements, and establish priorities for long term investments for improving the public health system.

Three assessment instruments have been designed to assist state and local partners in assessing and improving their public health systems or boards of health. These instruments are the:

- **State Public Health System Performance Assessment Instrument,**
- **Local Public Health System Performance Assessment Instrument,** and
- **Public Health Governing Entity Performance Assessment Instrument**

The information obtained from assessments may then be used to improve and better coordinate public health activities at state and local levels. In addition, the results gathered provide an understanding of how state and local public health systems and governing entities are performing. This information helps local, state and national partners make better and more effective policy and resource decisions to improve the nation’s public health as a whole.

**Introduction**

The NPHPS Local Public Health System Assessment Report is designed to help health departments and public health system partners create a snapshot of where they are relative to the National Public Health Performance Standards and to progressively move toward refining and improving outcomes for performance across the public health system.

The NPHPS state, local, and governance instruments also offer opportunity and robust data to link to health departments, public health system partners and/or community-wide strategic planning processes, as well as to Public Health Accreditation Board (PHAB) standards. For example, assessment of the environment external to the public health organization is a key component of all strategic planning, and the NPHPS assessment readily provides a structured process and an evidence-base upon which key organizational decisions may be made and priorities established. The assessment may also be used as a component of community health improvement planning processes, such as Mobilizing for Action through Planning and Partnerships (MAPP) or other community-wide strategic planning efforts, including state health improvement planning and community health improvement planning. The NPHPS process also drives assessment and improvement activities that may be used to support a Health Department in meeting PHAB standards. Regardless of whether using MAPP or another health improvement process, partners should use the NPHPS results to support quality improvement.

The self-assessment is structured around the Model Standards for each of the ten Essential Public Health Services, (EPHS), hereafter referred to as the Essential Services, which were developed through a comprehensive, collaborative process involving input from national, state and local experts in public health. Altogether, for the local assessment, 30 Model Standards serve as quality indicators that are organized into the ten essential public health service areas in the instrument and address the three core functions of public health.
About the Report

The NPHPS assessment instruments are constructed using the ten Essential Services as a framework. Within the Local Instrument, each Essential Service includes between 2–4 Model Standards that describe the key aspects of an optimally performing public health system. Each Model Standard is followed by assessment questions that serve as measures of performance. Responses to these questions indicate how well the Model Standard—which portrays the highest level of performance or gold standard—is being met.

The table below characterizes levels of activity for Essential Services and Model Standards. Using the responses to all of the assessment questions, a scoring process generates score for each Model Standard, Essential Service, and one overall assessment score.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal Activity (76-100%)</td>
<td>Greater than 75% of the activity described within the question is met</td>
</tr>
<tr>
<td>Significant Activity (51-75%)</td>
<td>Greater than 50%, but no more than 75% of the activity described within the question is met</td>
</tr>
<tr>
<td>Moderate Activity (26-50%)</td>
<td>Greater than 25%, but no more than 50% of the activity described within the question is met</td>
</tr>
<tr>
<td>Minimal Activity (1-25%)</td>
<td>Greater than zero, but no more than 25% of the activity described within the question is met</td>
</tr>
<tr>
<td>No Activity (0%)</td>
<td>0% or absolutely no activity</td>
</tr>
</tbody>
</table>

Summary of Local Public Health Assessment Response Options

Understanding Data Limitations

There are a number of limitations to the NPHPS assessment data due to self-report, wide variations in the breadth and knowledge of participants, the variety of assessment methods used, and differences in interpretation of assessment questions. Data and resultant information should not be interpreted to reflect the capacity or performance of any single agency or organization within the public health system or used for comparisons between jurisdictions or organizations. Use of NPHPS generated data and associated recommendations are limited to guiding an overall public health infrastructure and performance improvement process for the public health system as determined by organizations involved in the assessment.
All performance scores are an average; Model Standard scores are an average of the question scores within that Model Standard, Essential Service scores are an average of the Model Standard scores within that Essential Service and the overall assessment score is the average of the Essential Service scores. The responses to the questions within the assessment are based upon processes that utilize input from diverse system participants with different experiences and perspectives. The gathering of these inputs and the development of a response for each question incorporates an element of subjectivity, which may be minimized through the use of particular assessment methods. Additionally, while certain assessment methods are recommended, processes differ among sites. The assessment methods are not fully standardized and these differences in administration of the self-assessment may introduce an element of measurement error. In addition, there are differences in knowledge about the public health system among assessment participants. This may lead to some interpretation differences and issues for some questions, potentially introducing a degree of random non-sampling error.

**Action Planning**

In any systems improvement and planning process, it is important to involve all public health system partners in determining ways to improve the quality of essential public health services provided by the system. Participation in the improvement and planning activities included in your action plan is the responsibility of all partners within the public health system.
Overall Performance, Priority and Contribution Scores by Essential Public Health Service and Corresponding Model Standard

Overall Scores for Each Essential Public Health Service for Coos County
Performance Scores by Essential Public Health Service for Each Model Standard

The following table displays the average performance score for each of the Model Standards within each Essential Service. This level of analysis enables you to identify specific activities that contributed to high or low performance within each Essential Service.

Table 2. Overall performance, priority, and contribution scores by essential public health service and corresponding model standard

<table>
<thead>
<tr>
<th>Model Standards by Essential Services</th>
<th>Performance Scores</th>
</tr>
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<tbody>
<tr>
<td>ES 1: Monitor Health Status</td>
<td></td>
</tr>
<tr>
<td>1.1 Community Health Assessment</td>
<td>61.1</td>
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<tr>
<td>1.2 Current Technology</td>
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<td>1.3 Registries</td>
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<td>ES 2: Diagnose and Investigate</td>
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<td>2.1 Identification/Surveillance</td>
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<td>2.2 Emergency Response</td>
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<td>2.3 Laboratories</td>
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<td>ES 3: Educate/Empower</td>
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<tr>
<td>3.1 Health Education/Promotion</td>
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<td>6.3 Enforce Laws</td>
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<td>7.2 Assure Linkage</td>
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<td>8.2 Workforce Standards</td>
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<td>8.4 Leadership Development</td>
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<td>9.1 Evaluation of Population Health</td>
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<td>Median Score</td>
<td>55.6</td>
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## Helpful acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BAH</strong></td>
<td>Bay Area Hospital</td>
</tr>
<tr>
<td><strong>BMI</strong></td>
<td>Body mass index</td>
</tr>
<tr>
<td><strong>BRFSS</strong></td>
<td>Behavioral Risk Factor Surveillance System</td>
</tr>
<tr>
<td><strong>CCO</strong></td>
<td>Coordinated Care Organization</td>
</tr>
<tr>
<td><strong>CHA</strong></td>
<td>Community Health Assessment</td>
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<tr>
<td><strong>CHNA</strong></td>
<td>Community Health Needs Assessment</td>
</tr>
<tr>
<td><strong>CMS</strong></td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td><strong>CT</strong></td>
<td>Computerized Tomography</td>
</tr>
<tr>
<td><strong>FTE</strong></td>
<td>Full Time Equivalent</td>
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<tr>
<td><strong>HCV</strong></td>
<td>Hepatitis C Virus</td>
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<tr>
<td><strong>IMRT</strong></td>
<td>Intensity-modulated radiation therapy</td>
</tr>
<tr>
<td><strong>LPHD</strong></td>
<td>Local Public Health Department</td>
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<tr>
<td><strong>MAPP</strong></td>
<td>Mobilizing for Action through Planning and Partnerships</td>
</tr>
<tr>
<td><strong>MRI</strong></td>
<td>Magnetic Resonance Imaging</td>
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<tr>
<td><strong>OHA</strong></td>
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<td><strong>ORCCA</strong></td>
<td>Oregon Coast Community Action</td>
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<tr>
<td><strong>PET</strong></td>
<td>Polyethylene Terephthalate</td>
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<tr>
<td><strong>SNAP</strong></td>
<td>Supplemental Nutrition Assistance Program</td>
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<tr>
<td><strong>WIC</strong></td>
<td>Special Supplemental Nutrition Program for Women, Infants and Children</td>
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<td><strong>1.1.2.1 d</strong> Factors that contribute to specific populations’ health challenges</td>
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<td>31-39</td>
</tr>
<tr>
<td><strong>1.1.2.2</strong> Community review and contribution to CHA (survey and presentations of document)</td>
<td>see documentation</td>
</tr>
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<td><strong>7.1.3.2a</strong> Assessment of capacity and distribution of health care providers</td>
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<td>IRS Form 990, Schedule H (2017)</td>
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<tr>
<td><strong>Part V Section B Line 3a</strong></td>
<td>A definition of the community served by the hospital facility</td>
</tr>
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<td><strong>Part V Section B Line 3b</strong></td>
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<td><strong>Part V Section B Line 3c</strong></td>
<td>Existing health care facilities and resources in the community that are available to respond to the health needs of the community</td>
</tr>
<tr>
<td><strong>Part V section B Line 3d</strong></td>
<td>How data was obtained</td>
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<td><strong>Part V Section B Line 3e</strong></td>
<td>Significant health needs of the community</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3f</strong></td>
<td>Primary and chronic disease needs and other health issues of uninsured persons, low-income persons and minority groups</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3g</strong></td>
<td>Process for identifying and prioritizing community health needs and services to meet the community health needs</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3h</strong></td>
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<td><strong>Part V Section B Line 3i</strong></td>
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Acknowledgments

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Cameron McVay, AllCare Health
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Kari Swoboda, AllCare Health
Jeri Lynn Thompson, Tolowa Dee-Ni Nation
Laura Williams, Advanced Health, South Coast Regional Early Learning Hub
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Introduction and Purpose

The 2018 Community Health Assessment (CHA) is a view into the health status of the people that live in Curry County. The assessment process results in an increased understanding of key health issues facing the community, aids in better planning of services and helps to identify strengths and challenges to address with health care resources. The development of the assessment also engages community members by listening to their perceptions and experiences about what influences health. The process includes comprehensive data collection and analysis, working across multiple sectors and bringing many local organizations together.

2018 marks the first time all of the partners collaborated on a single health assessment, with a desire to reduce duplication and share resources. The process of the CHA is as important and vital to the community as the document that is produced. The resulting CHA document assists organizations in planning and prioritizing efforts that ultimately improve health outcomes, the health of individuals and communities.

Community Health Assessment Approach & Model

The 2018 Community Health Assessment committee began meeting in 2017 to build a collaborative including the local hospital, the local federally qualified health center, public health, early learning and child focused groups, the local Coordinated Care Organizations (CCO), tribal representation, dental organizations and many other vital health and human service organizations. The desire to pool resources, reduce duplication of effort and meet individual requirements for health assessments drove the group to engage with a consultant to lead and facilitate the 2018 Community Health Assessment in the fall of 2017.

Organization Partners in 2018 Curry Community Health Assessment

| Curry General Hospital                        | Advantage Dental                      |
| Oregon Coast Community Action (ORCCA)        | Coast Community Health Center         |
| Curry Health Network                         | Curry Community Health                |
| Advanced Health (formerly WOAH)              | Tolowa Dee-Ni Nation                  |
| AllCare Health                               | Oregon Health Authority               |
| South Coast Regional Early Learning Hub      |                                        |

The Mobilizing for Action through Planning and Partnerships (MAPP) model was the approach chosen by the committee. The MAPP process is a national best practice. It is a community driven process that results in engagement of new stakeholders, provides a broad understanding of community health issues and helps to identify both strengths and challenges related to health in a community. Due to resources and time required for a robust MAPP process, the committee agreed upon a modified MAPP model with a time line of November 2017-April 2018.
The work of the CHA was completed by both the consultant and the CHA committee. The CHA committee provided leadership to the process, assisted with primary data collection including focus groups and surveys and were key in engaging community voice and input. Specific methods of data collection are outlined in the data section.

**Collaborative Partner Key Requirements**

Many community organizations are required to complete a health assessment. The regulatory bodies that require these assessments vary widely in their frequency, focus and requirements for assessments. They include a broad spectrum of organizations, from the IRS to the Oregon Health Authority. Although vastly different, the regulatory requirements for assessments all articulate a need for community organizations to seek to understand strengths and needs in a community to better prioritize health efforts and services.

There are many requirements that are shared across all entities that are required to go through a community health assessment process. These include having a balance of types of data, community engagement and input, population based health status data and some level of prioritization of health issues in the community.

**Overlapping Key Requirements for Community Health Assessments**

- Population Based-Health Status Data
- Primary & Secondary Data
- Community Engagement & Input
- Prioritization of Health Issues
**Plans and Processes Requiring Community Health Assessments**

**CHNA**
- Required by IRS
- Focus is to identify and assess access and needs of community the hospital is serving.
- Documentation must include written report.
- See Patient Protection and Affordable Care Act requirements for 501(c)3 hospitals.
- Led by hospital
- Every 3 years

**CCO**
- Required by Oregon Health Authority
- Purpose is to assess entire community served by CCO, not just Medicaid population. Tied to responsibility of CCO in creating the Triple Aim: Better care, better health and reduced costs.
- Led by CCO, with CAC involvement.
- Proposed to be every 3 years

**Public Health Accreditation**
- Collaborative process resulting in a comprehensive community health assessment.
- Led by County Public Health with collaborative partners
- Every 5 years

**Other**
- Other includes Federally Qualified Health Centers (FQHCs), Head Start, Early Learning Hubs, Tribal Health Centers
- Various time lines/frequency/requirements and population focus
Vision & Values of Community Health Assessment Process

One of the first processes in the MAPP process is to have the committee discuss their vision for a healthy community and the values related to assessing and planning for that vision.

- We believe health is very connected to the social determinants of health such as education, employment, housing and food
- We believe in building on our strengths, not only looking at barriers and needs in our assessment process
- We believe it is important to focus on health equity and address inequities data when we are able to while also remembering our rural county has inequities to urban counties in the state
- We believe there is value in building on previous assessment work while not duplicating effort
- We recognize that this assessment cannot focus on all things related to health but it does identify areas we can impact
- We believe that the process we go through engages consumers of health services and incorporates the voices of those we serve
- We believe addressing poverty as a root cause of poor health is important
- We believe reducing child abuse and chronic stress in families improves health

Social Determinants of Health & Health Equity Framework

The CHA committee recognizes that multiple factors in a community impact the health of individuals, families and communities. These are often called the Social Determinants of Health. The term Social Determinants of Health is defined by the World Health Organization as “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources.” The social determinants of health influence health inequities. Health inequities are the avoidable, unfair and unjust differences in health status seen within and between individuals and communities.

The traditional way to approach health assessments and health improvement was to focus on status, outcomes and health care services. More recent research and practice has expanded that perspective, to recognize that health is more than health care, more than just what happens at the doctor's office.
Health care itself is an important influence on health, but socioeconomic factors, our physical environment and our individual behaviors also greatly influence our health.

Many community health models suggest that up to 40% of the health in the community is related to socioeconomic factors.

**Types of Data, Data Collection, Data Sources and Limitations**

Data used in the community health assessment included primary and secondary data, qualitative and quantitative data. Secondary data is data collected by another organization or group. Examples are rates of morbidity and mortality from Oregon Health Authority or demographic data from the US Census. Secondary data at the county level was used most often, but when available and reliable zip code and/or census tract data was available it was highlighted. Newer data was valued over older data, although some sources were older by necessity as the data is no longer being tracked or isn’t available in newer years and illustrates an important point about health status. Due to small population numbers in some areas of the county, multiple years were sometimes grouped together emphasizing trends over time instead of one-year snapshots on some data points, an important consideration for rural community assessments.

Primary data collection was collected by focus groups and surveys. Details of the primary data collection methodology and results can be viewed in the Appendix.

The Community Health Assessment has limitations, it is not meant to cover every possible factor that influences health, or every possible health related data point being tracked. It is not meant to be a complete list of all community health needs or health data. It relies heavily on other secondary data assessments and there are notable gaps in readily available local, county and national data. The CHA is not a rigorous research study or a process designed to evaluate the efficacy of services or community organizations. It is intended to provide a macro view of community data, help to identify strengths, assets and challenges and engage community in the process of addressing inequities and improving overall community health. Lastly, the CHA document is intended to be built on and added to over the years, complimenting other assessments and not standing alone.
Demographics

Introduction to Curry County

Curry County is a rural county located along the Pacific Coast in the Southwest corner of Oregon. Its boundaries include the Pacific Ocean on the West, California on the South, Coos County to the North and Josephine County on the West. The County was recognized as a county in 1855 and is the 25th most populated county (out of 36) in the state.

The county has an approximate population of 22,600 residents, encompassing 1648 square miles of land. The rugged mountainous terrain includes hundreds of lakes, rivers and streams stretching from mountains, through the Redwoods and to the Pacific Ocean. There are many unincorporated and isolated rural communities, presenting challenges for transportation and access to services. The three incorporated cities include Brookings, Gold Beach and Port Orford. The entire county is designated as rural, by the Oregon Office of Rural Health.
Curry County, like many other rural counties, has witnessed a slower population growth than the state over the last several decades. Curry County did see a significant influx of residents in 2008-2010 but then the rate of change dipped and slowed beginning in 2010.

**Rate of population change, 2002-2016, Curry County**

The median age of residents in Curry County is 55 years old, much older than the state median age of 39 years old. Curry County has an older population than the rest of the state, with the percentage of those over 60 years of age steadily increasing and accounting for a larger percentage of overall population. According to census estimates, 30% of the county population was over 65 years of age in 2015. The percentage of those over 60 years old is expected to increase to close to 40% by 2030. Also notable is that only 16% of the population is less than 17 years old compared to 21% in Oregon.

**Age distribution, 2011-2015 Curry County and Oregon**

*Source: US Census Bureau, American Community Survey 2011-2015*
“We have retirees that need lots of assorted medical care, several types of which are not available locally.” —Survey Participant

According to 2015 census estimates, there are more White residents in Curry County, than any other race or ethnicity, accounting for 87.5% of the population. The remainder of the population self-identifies as 6.29% Hispanic, 3.31% Multi-racial, 1.91% Native American, .55% Asian.

Non-English language speakers average around 4.55% of the total Curry population, considerably lower than the State and National averages which hover around 21%. Spanish is the most common non-English language spoken, 2.83% of the total population of Curry County are native Spanish speakers.

**Veterans, 2011-2015 Curry County and Oregon**

![Veterans chart]

*Source: US Census Bureau, American Community Survey 2011-15*

Curry County has a large population of veterans, close to double the state average. The veterans in Curry County are also older. The majority of Veterans in Curry county served in Vietnam, 3.13 times greater than any other conflict (Data USA 2018).

**Veteran community by age, 2011-15**

*Curry County and Oregon*

![Veteran community by age chart]

*Source: US Census Bureau, American Community Survey 2011-15*
Curry County also has a higher percentage of people with disabilities than the state average. Many of those with disabilities are 65 or older in the county.

"Curry County has more disabled people than we realize, including veterans with PTSD and hyper-vigilance." —Focus Group Participant

Disabilities, 2011-2015
Curry County and Oregon

Disability by age, 2011-2015
Curry County and Oregon

Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates
**Indicators**

The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

**Demographic**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Curry County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>Overall growth ↓</td>
</tr>
<tr>
<td><strong>Race &amp; Ethnicity</strong></td>
<td>Percent Hispanic or Latino ↓</td>
</tr>
<tr>
<td></td>
<td>Percent Native American ↓</td>
</tr>
<tr>
<td><strong>Spanish Speakers</strong></td>
<td>Decreasing percent of Spanish speakers ↓</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>Percent population 55 and older ↑</td>
</tr>
<tr>
<td></td>
<td>Percent under 18 years old ↓</td>
</tr>
<tr>
<td></td>
<td>Percent families with children ↓</td>
</tr>
<tr>
<td><strong>Veterans</strong></td>
<td>Percent veterans, mostly men ↑</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>Percent disability ↑</td>
</tr>
<tr>
<td></td>
<td>Percent over age 65 with disability ↑</td>
</tr>
</tbody>
</table>
Neighborhood and Physical Environment

Physical environment is one important social determinant of health. Where somebody lives and how they move around from place to place to access basic services such as grocery stores, health care and work greatly influences health. Physical environment such as indoor and outdoor air quality also affects health outcomes. Exposure to environmental toxins and other hazards such as lead influence health conditions. Opportunities for physical recreation, either built or natural, affects health behavior.

Outdoor air quality is a strength in Curry County, consistently better than state and national air quality. The wildfire season in 2017 was particularly damaging and affected the air quality, but up until then, the particulate matter in the air was significantly lower than National Ambient Air Quality standards. Physical environment, including air quality and recreational opportunities, was overwhelming chosen as the biggest strength of the county, by participants in the 2018 CHA surveys and focus groups.

“Quality of air we breath, most especially during the fire season and how many of us in the community suffered and still are from the damaging effects of the poor air quality we breathed in during two months from the now historic Chetco Bar Fire in 2017.” —Survey Participant

“Having just moved here, I would say air quality, location, general environment is a strength, meaning it isn’t like Los Angeles.” —Focus Group Participant

Indoor air quality data is difficult to gather in the county, but many focus group and survey participants mentioned it as being poor in the county.

“Quite a few houses have mold issues and are in general need of repair.” —Focus Group Participant

Natural outdoor recreation opportunities are many in the county. According to available online data, there are 40 parks in the county. There are also multiple trails for hiking, biking and recreation and dozens of beaches, lakes, forests and streams (Oregon Hometown locator). The weather can impact outdoor recreation while access to built walking and running paths are
There are limited built environment recreation opportunities, including limited walking and bike lanes, sidewalks and established gym facilities. The rate of establishments is higher than the state average but the number of establishments is still low at four total facilities in the entire county.

“We don’t have much indoor walking during rainy season or indoor swimming pool, we need both I think.” —Survey Participant
**Housing**

Where people live is core to quality of life. Housing availability and quality is a well-established social determinant of health. Household quality problems such as overcrowding, incomplete kitchen or plumbing facilities and cost burden are experienced by 39% of the population in Curry County, higher than the State average (US Census Bureau, American Community Survey 2011-2015).

Household costs are related to availability. 35% of households in Curry County (estimated 3,971 households) are cost burdened, meaning their rent or mortgage exceed 30% of their household income, this is higher than state levels. According to the recent Brookings Housing Needs Assessment (October 2017), the majority of the households (in Brookings) that are cost burdened have an annual income between $20,000-35,000, making a strong case for more affordable housing options and rentals. Availability of housing was second only to poverty in the biggest concern for focus group and survey participants of the 2018 CHA process.

“**HUGE lack of affordable housing for the working class just adds to our problems. Even making above minimum wage a person/family has to pay a large percentage of their income just to have a roof over their head, that is often sub-par and leaves them with little to meet other requirements of living in our society. In this community one is LUCKY to find something that is under 50% of your income, this is outrageous and sets our community up for failure in the long run.**” —Survey Participant

“**Too much planning efforts for expensive housing and not enough in affordable, family housing.**” —Survey Participant

“**We can’t attract people to fill positions because there is no housing, we need more affordable housing inventory.**” —Focus Group Participant

The median value of homes has decreased in the county since 2006. Curry County also has higher percentages of housing dedicated to seasonal or recreational use, close to 50% of vacant housing is used for seasonal, recreational or occasional use. The 2017 Brookings Housing Needs Assessment also listed that in Brookings, 49.8% of vacant housing is seasonal or recreational use in 2010, climbing to an estimated 61.1% in 2017 and projected to be 70% in Brookings alone by 2025, showing an increasing trend.

“**Housing is limited. Some of its from vacation housing, making rent too high or not even available. Its why we have so many mobile homes here.**” —Focus Group Participant
Housing affordability and availability was consistently listed as a concern related to recruitment of professionals to the area, specifically in the health care and education industries.

"I’ve come here from California, I can get a nice house way cheaper here but I can’t find a place to rent while I shop. Affects doctors and teachers, I had a week to find a house when I moved here for a job and settled for something I’m not happy in." —Focus Group Participant
Homelessness

People experiencing homelessness, defined by anyone who lacks a fixed, regular and adequate nighttime residence, was listed as a significant concern in the 2018 CHA primary data focus groups and surveys. The number of homeless adults is increasing according to the annual point in time count.

The number of homeless students is also increasing and trending up county wide and in most districts. Homelessness in youth can include those without a permanent home but also includes those doubled up or “couch surfing.”

“We see more grandparents living with their kids and their kids’ kids or single parents going to live with other families. It affects large swaths of youth that don’t have a bed or a regular room of their own.” —Focus Group Participant

Homeless count, 2011-2016
Curry County

Source: Oregon Housing and Community Services 2011-2017
“Homelessness has increased, we have couch surfers that don’t learn the skills they used to in school.” —Focus Group Participant

**Transportation**

Limited public transit and the geographical distance and terrain affects transportation to work, school and health care, particularly for those with limited resources. According to US Census estimates, 85.5% of workers drive to work (2015), 0% used public transit, slightly over 8% walked in Curry County. Transportation, particularly to medical appointments was a consistent issue brought up in both focus groups and by survey participants.

“Transportation is a problem, some people don’t have a car or reliable car or they can’t afford gas.” —Focus Group Participant

“Transportation is limited, most transportation here is special support from friends, if you don’t have friends you don’t get transportation.” —Focus Group Participant
The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Curry County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing Availability</strong></td>
<td>Vacant housing dedicated to recreational/vacation or occasional use 🙂</td>
</tr>
<tr>
<td><strong>Housing Costs</strong></td>
<td>Cost burdened households in rentals &amp; homes with mortgages 🙄</td>
</tr>
<tr>
<td></td>
<td>Median value of a house since 2006 ⬇</td>
</tr>
<tr>
<td><strong>Housing Quality and Type</strong></td>
<td>Severe household problems 🙆</td>
</tr>
<tr>
<td><strong>Homelessness</strong></td>
<td>Homeless students by district trending up 🙆</td>
</tr>
<tr>
<td></td>
<td>Homeless adults trending up 🙆</td>
</tr>
<tr>
<td><strong>Air Quality</strong></td>
<td>Outdoor air quality 🙆</td>
</tr>
<tr>
<td><strong>Recreation and Fitness</strong></td>
<td>Recreational facilities 🙆</td>
</tr>
</tbody>
</table>
Economic Stability

Income

Economic stability is a social determinant of health and it includes issues such as poverty, income, employment and unemployment. Income and income inequality is directly linked to an individual’s health. Income inequality has been shown to have health impacts including increased risk for poor health and increased risk of death. The average and median incomes in Curry County are lower than state levels. Poverty levels are increased in the County, compared to state and national percentages.

Annual family income, 2012-2016 Curry County and Oregon

When compared to state and national wages, the county has more of its jobs in the lower wage categories, most in the under $40,000 annual salary.

Source: US Census Bureau
Poverty

The percentage of the population living in poverty in the county ranges 17-18% depending on source.

Poverty in Oregon

Source: American Community Survey PUMS 1-Year Estimate
Poverty affects those in older age categories disproportionately in Curry County, compared to state averages. Those over 64 years of age are over twice as likely to be living in poverty than people of the same ages statewide. Furthermore, women are more likely than men to be living in poverty in Curry County. 48.5% of children under 18 live below 200% of the federal poverty level in the county, according to 2011-2015 census estimates.

![Poverty level by age](image_url)

*Source: U.S. Census Bureau*
Another indicator of poverty includes children who are eligible for free or reduced lunches at school. In Curry County, 60% of children are eligible, more than the state average (51%) and higher than neighboring Coos county.

**Students receiving free and reduced lunch select schools in Curry County, 2010-2016**

![Bar chart showing percentage of students receiving free and reduced lunch in select schools in Curry County, 2010-2016](source: Oregon Department of Education)

**Employment and unemployment**

Employment and annual census of employees has been trending up in Curry County since 2014, a trend consistent across the region.

**Annual census of employees, 2007-2016**

![Line chart showing annual census of employees in Curry County, 2007-2016](source: US Bureau of Labor Statistics)
Unemployment remains higher than the state average but has been trending down since 2009, a positive trend. Unemployment in Curry County in 2017 was 6.9%.

**Unemployment, 2006-2017**

**Curry County and Oregon**

```
0 5% 10% 15%
```


**Indicators**

The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percentage/percentages.

### Economic Stability

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Curry County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td>Income ↓</td>
</tr>
<tr>
<td></td>
<td>Individuals with lower wage jobs ↑</td>
</tr>
<tr>
<td><strong>Living in poverty</strong></td>
<td>Living in poverty ↑</td>
</tr>
<tr>
<td></td>
<td>Living in poverty over 65 years of age ↑</td>
</tr>
<tr>
<td></td>
<td>Children live at or below 200% Federal Poverty Level ↑</td>
</tr>
<tr>
<td><strong>Free and Reduced-price lunches</strong></td>
<td>Students qualifying for free and reduced lunch ↑</td>
</tr>
<tr>
<td><strong>Unemployment</strong></td>
<td>Percentage unemployed ↑</td>
</tr>
</tbody>
</table>
Education

Education is an important social determinant of health, as education increases a person’s overall health also often increases. More education has been shown to be linked to longer life and increased income, while lower education attainment can be linked with poor health, higher levels of crime, unemployment and increased stress.

Children and Early Learning

Children in Curry County have benefited from early learning programs like Head Start. The rate of students enrolled in Head Start is significantly higher than state averages, a clear strength of the community.

Students in Head Start 2014
(per 10,000 children)

<table>
<thead>
<tr>
<th></th>
<th>Curry County</th>
<th>Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35.25</td>
<td>8.84</td>
</tr>
</tbody>
</table>

Kindergarten assessment scores are close to state averages, with Hispanic children scoring slightly better than state scores in Curry County.

“Healthy communities have support and recognition and focus on children. They are our future.”—Survey Participant

Childcare availability was listed as a concern in the 2018 CHA focus groups. Data from the National Data System for Child Care showed 20 providers registered in Curry County, but only 15 choosing to be listed. All of the providers listed are in Brookings with the exception of one in Langlois and one in Gold Beach.

“We need more accessible, safe child care and activities, safe bike paths, being able to not stress about where my kids are and if they are safe while you are at work.” -Focus Group Participant
"We have a childcare issue limiting families from being able to find jobs and stick with them, leading to decreased basic needs for the families." - Survey Participant

**Kindergarten assessment scores, 2016-2017**
**Curry County and Oregon**

![Graph showing assessment scores for different demographics in Curry County vs. Oregon.](chart)

**Absenteeism, Graduation & Education Attainment**

Absenteeism in school is an indicator related to education. Curry County has higher percentages of absenteeism in 8th and 11th graders, with physical reasons being listed as the highest reason for absenteeism. One in four 8th graders missed between 3-10 days of school in 2017.

**Absenteeism in 8th graders, 2017**
**Curry County and Oregon**

![Graph showing absenteeism rates in 8th graders in Curry County vs. Oregon.](chart)
“We have a low graduate rate, knowledge deficit and hopeless abound.” —Focus Group Participant

High school graduation has been slightly lower in Curry County than Oregon since 2011 similar to neighboring Coos County. Latest available data shows 72.6% of ninth graders graduated from high school in their cohort (4 years later) in 2015-16.

4 year cohort graduation rates, 2008-2016
Curry County and Oregon

“We have a low emphasis on education.” —Focus Group Participant

When compared to the state, Curry has fewer people with bachelors, graduate or professional degrees than state averages.

“With loss of logging and fishing industry its been hard. We used to have 400 kids in high school, now there are only about 100.” —Survey Participant
People in Curry County with less educational attainment are more likely to be living in poverty.
The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percentage/percentages.

<table>
<thead>
<tr>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
</tr>
<tr>
<td>Early Childhood</td>
</tr>
<tr>
<td>Graduation Rates</td>
</tr>
<tr>
<td>Educational Attainment</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Food

Eating nutritious food and maintaining a healthy diet are important to individual health. Poor nutrition has been shown to increase risk for various chronic health conditions and to increase morbidity and mortality. A healthy food environment includes access to healthy foods and food security.

Access to food has many facets including the cost, distance and availability of fresh and healthy food options. The USDA defines food insecurity as lack of access to enough food for all members in a household and limited or uncertain availability of nutritionally adequate foods. 1 in 4 children (24.5%), aged 18 and younger in the county remain food insecure, higher than the state average. Overall, residents of Curry County experience more food insecurity than in the state as whole.

Adults and children with food insecurity, 2015
Oregon and Curry County

Twenty percent of 8th graders in Curry County answered yes when asked if they ate less than they felt they should because there wasn’t enough money to buy food. This is higher than the 14% state average (Oregon Healthy Teens Survey 2017).

Access to healthy foods has improved since the 2013 Community Health Assessment and is better than some counties in the state. The food environment index for Curry County is 6.9, the same as neighboring Coos County. The food environment index is based a scale of one to ten, with (0) being the worst and (10) being the best. 5% of the county has limited access to healthy foods, according to the USDA Food Security Survey, Feeding America 2014 survey.
“We don’t have fresh enough food. You know what they say...small communities get the least fresh food and it’s true here in Gold Beach.” —Survey Participant

33.3% of the population in Curry County lives in a food desert, which is slightly better than state averages but still identifies a need. A food desert is defined as a low-income census tract where a substantial share of residents have low access to a supermarket or large grocery store.

“As to food, I notice a distinct lack of freshness of everything food wise. Buy fresh and it’s bad two days later. Everything comes “fresh” to Gold Beach is already at the end of its freshness.”—Focus Group Participant

Women, Infants and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP) benefits are public programs designed to address food access and insecurity. The rate of stores that accept either WIC or SNAP benefits is more than state averages, indicating a program asset and strength while also indicating a large number of residents qualifying for benefits.

“SNAP and WIC have increased availability.”—Survey Participant

**SNAP (2016) and WIC (2011) authorized stores**

<table>
<thead>
<tr>
<th></th>
<th>WIC</th>
<th>SNAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curry County</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rate per 100,000

Source: US Department of Agriculture, Economic Research Service 2011

Youth drinking water four times a day or more

<table>
<thead>
<tr>
<th></th>
<th>Grade 8</th>
<th>Grade 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>33.0%</td>
<td>50.2%</td>
</tr>
<tr>
<td>Curry County</td>
<td>50.4%</td>
<td>49.4%</td>
</tr>
</tbody>
</table>

Source: Oregon Healthy Teen Survey, 2017
Eating five or more servings of fruits and vegetables a day is lower, for adults, in Curry than Oregon. 48% of 8th graders have consumed soda 1-3 times in the past 7 days, while water consumption in 8th graders is lower than state averages, according to 2017 Healthy Teens Survey.

**Adults consuming at least 5 servings of fruits and vegetables a day, 2012-2015**

*Curry County and Oregon*

“**When parents are either not working and depressed or are working multiple wage jobs, they don’t and can’t prepare healthy food. We need a low-cost walk-in fresh food store, combined with education on quick, low cost, healthy food preparation.**” —Focus Group Participant

**Source:** Oregon BRFSS County Combined Dataset 2012-15

**What 8th graders drink 2017**

*Curry County and Oregon*

**Source:** Oregon Healthy Teen Survey, 2017
## Indicators

The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

### Key

- **↑** = higher (than State)
- **↓** = lower (than State)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Curry County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food Insecurity</strong></td>
<td>Adults and children living with food insecurity  <strong>↑</strong></td>
</tr>
</tbody>
</table>
| **Food Access**         | SNAP authorized retailers  **↑**  
|                         | WIC authorized stores  **↑** |
| **Soda Consumption**    | 8th graders drinking sodas  **↑**  
|                         | Adult soda consumption  **↑** |
| **Fresh Food Consumption** | Adults consuming fruits and vegetables  **↓** |
Indicators related to community include social connections and crime. Social associations are one way to measure social connectivity and social cohesion in a community. Lack of social connectivity and resulting isolation can influence health outcomes of individuals and community.

The number of membership organizations such as service organizations like Rotary or Zonta, sports groups, political organizations, clubs and professional organizations indicate volunteerism and connectivity. The rate of such associations in Curry County (2014) is 11.5 per 100,000 population, higher than Oregon’s average of 10.4 per 100,000, a strength in the county.

“The library and book clubs have saved my life because they are a supportive environment.” —Focus Group Participant

Participants in the 2018 CHA focus groups and surveys universally chose social support including religious and spiritual values as the second biggest strength in the community. The third biggest strength were the people that live here, similar to neighboring rural counties.

While social associations are strong, many individuals indicate that they still don’t have adequate social and emotional support. 23% of individuals in the county say they don’t have adequate social and emotional support. Nearly one in three (27%) youth state that they are neither working or in school, indicating disconnection from community. This is higher than state averages.
“Need to address people who isolate themselves, pockets of isolation here. We could improve a lot of things by spending more time together, building relationships, solving problems more together. Sometimes it only takes one person to reach out and reduce isolation.” Focus Group Participant

Bullying in schools is also an indicator of social cohesion. 29.3% of 8th grade youth in Curry County experienced bullying in 2017, near the state average (Oregon Healthy Teens Survey 2017). The top reason for bullying was appearance (weight, clothes, acne or other physical characteristics), followed by gender (someone thought you were gay, lesbian or bisexual). The trend/percent of youth experiencing bullying is decreasing.

Bullying in schools is also an indicator of social cohesion. 29.3% of 8th grade youth in Curry County experienced bullying in 2017, near the state average (Oregon Healthy Teens Survey 2017). The top reason for bullying was appearance (weight, clothes, acne or other physical characteristics), followed by gender (someone thought you were gay, lesbian or bisexual). The trend/percent of youth experiencing bullying is decreasing.

Source: Measure of America, using American Community Survey Data

Youth experiencing bullying, 2005-2017
Curry County and Oregon

Source: Oregon Healthy Teens Survey
Violent crime is lower than state averages. Violent crime was trending up until 2009 until it began to decline again in Curry County.

**Violent crime, 2004-2013**

*Curry County and Oregon*

[Graph showing violent crime trends from 2004 to 2013 for Curry County and Oregon.]

*Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports*

The number of convictions for methamphetamine and heroin in the county are also on a downward trend.

**Convictions for Methamphetamine and Heroin, 2012-2016**

*Curry County*

[Graph showing convictions for methamphetamine and heroin from 2012 to 2016 for Curry County.]

*Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports*
The institutionalized population or jail incarceration rate is higher than the state and has been on an upward trend since 1980.

\[\text{Jail incarceration, 1980-2014} \]
\[\text{Curry County and Oregon} \]

*Source: Vera Project, Bureau of Justice Statistics (BJS) Annual Survey of Jails (ASJ) and Census of Jails (COJ). 1980-2014*

The percentage of youth that report being intentionally hit or physically hurt by an adult in 2017 is nearly one in three (26.8%), higher than neighboring Coos County and state averages (Oregon Healthy Teens Survey 2017). However, the number of founded child abuse cases in the county is trending down. The victimization rate in Curry County is considerably lower at 8.2 per 1,000 children than state rates which hover close to 14 per 1,000 (DHS Child Welfare Data Book 2016). The number of children in foster care in the county in 2017 was 43. Foster care placement stability, which is the number of children in foster care with two or fewer placements, as a percentage of total number of children in foster care, is one of the worst in the state, ranking 32nd out of 36 counties in Oregon at 48.5% (Children’s First Child Data Book, 2017).
“There is a lot of dysfunction and violence in mixed households/mixed houses and families that are mixed. You lose control of your family unit when mixed. Just because you have a warm bed you can’t rationalize the other horrors and violence because it’s better than living in a car, sometimes it’s not.” —Focus Group Participant

Child abuse reports*
2010-2016
Curry County

*founded child abuse reports

Source: Child Welfare Data Book. 2010-16

Curry County had approximately fifty two law enforcement officers across all agencies (Oregon Annual Uniform Crime Reports, 2016) in 2016.

“There isn’t any law enforcement here. We can’t even recruit them, no money for them and too few of them. No regular policing, only if there is a severe drug issue. Really no policing in the mountains, it’s scary.” —Focus Group Participant
The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Curry County vs. Oregon)</th>
</tr>
</thead>
</table>
| **Social Associations and Volunteerism**      | Social associations/membership organization involvement  
|                                                |                                                     |
| **Social and Emotional Support**              | Individuals without adequate social support  
|                                                | Disconnected youth  
| **Crime and Safety**                          | Violent crime  
|                                                | Child abuse and neglect  
|                                                | Foster care stability  

**Key**

↑ = higher (than State)
↓ = lower (than State)
Health Care System

The health care system provides services to prevent and treat disease. It influences the health of individuals, families and communities. Health disparities, often created by the social determinants of health, affect access to health care services.

Insured and uninsured

Health insurance influences access to health care services. Curry County has a higher percentage of the population on publicly funded insurance, which includes Medicaid/Oregon Health Plan/OHP, Coordinated Care Organizations, Medicare and The Veterans Administration/VA. Estimates from Oregon DMAP and RUPRI, indicate that 65.8% of the population in the county was on either Medicaid, Medicare or both in 2017, this is higher than previous year estimates. The percentage of people on public insurance within the county is highest in Port Orford, followed by Brookings and then Gold Beach. 47.4% of those on Medicaid in Curry County, from 2011-2015, were 18-64 years old, 31.8% were under 18 year old and 20.8% were 65 years or older (US Census 5 year estimates).

Public insurance coverage by zip code, 2011-2015

![Graph showing public insurance coverage by zip code, 2011-2015.]

Port Orford 97465: Medicare coverage 39.1%, Medicaid/means-tested public coverage 34.6%, Any public coverage 67.7%, VA Health Care 8.2%, Medicaid/means-tested public coverage 16.6%, Medicare coverage 6.5%. Gold Beach 97444: Medicare coverage 41.4%, Medicaid/means-tested public coverage 27.7%, Any public coverage 69.1%, VA Health Care 11.6%, Medicaid/means-tested public coverage 16.6%, Medicare coverage 6.5%. Brookings 97415: Medicare coverage 49.6%, Medicaid/means-tested public coverage 35.7%, Any public coverage 85.3%, VA Health Care 7.7%, Medicaid/means-tested public coverage 17.7%, Medicare coverage 6.5%. Curry County: Medicare coverage 49.7%, Medicaid/means-tested public coverage 34.3%, Any public coverage 84.0%, VA Health Care 19.1%, Medicaid/means-tested public coverage 7.6%.

Source: U.S. Census, American Community Survey 2011-2015

The percentage of people with health insurance has been increasing statewide since 2011, with a sharp increase in 2015. It is estimated that 96.8% of Oregonians were covered by insurance in 2016 (Oregon Annual Health Insurance Report, 2018).
Access to providers

Access to providers and specific health services is another element of access to health care services. Access to primary care providers has increased since 2008, although the area continues to be experiencing a health care provider shortage. The Oregon Office of Rural Health designates Curry County a Medically Under-served Area (MUA), a Health Professional Shortage Area (HPSA), and a Health Professionals Shortage Area for Dental and Mental Health Providers. These designations show Port Orford as the highest unmet need in the county, followed by Gold Beach and then Brookings (Oregon Office of Rural Health 2017).

In 2016 the county had 18.0 FTE/Full Time Equivalent Primary Care providers, including Internal Medicine Physicians, Family Medicine Physicians and General Practice Physicians. (Oregon Office of Rural Health 2018). The majority of providers are in Brookings followed by Gold Beach.

![Access to primary care, 2004-2014](source)

**Source:** US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File
“Access to doctors is a huge problem. Just one example—I have been trying to get an appointment for my daughter for a prescription refill for over six months and can’t get anyone to even call me back.”—Focus Group Participant
### 2016 Provider Numbers (FTE=Full Time Equivalent)

- **8.5 FTE Family Medicine Physicians**
- **1.0 FTE General Practice**
- **8.8 FTE Internal Medicine Physicians**
- **1.5 FTE Obstetricians/Gynecology**
- **1.4 FTE Pediatricians**
- **9.6 FTE Nurse Practitioners**
- **5.2 FTE Physician Assistants**
- **7.1 FTE Dentists**
- **1.9 FTE Psychiatrist/Psychologist**
- **3.0 FTE Licensed Social Workers**
- **3.0 FTE Licensed Counselors, LMFT, Psychologists**

Source: Oregon Office of Rural Health 2018

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**Health Facilities**

While Curry General Hospital in Gold Beach, Oregon has been in existence for more than 66 years, Curry Health District dba Curry Health Network was only established in October 1983. Located in America’s Wild Rivers Coast, the District is bounded in the north by Elk River (north of Port Orford), south by Pistol River (south of Gold Beach) and includes Agness (a 35-mile drive west along the Rogue River).

The District is a municipal corporation, a form of local government as an Oregon Special District (Health District) and derives a portion of its operating revenue from a tax base. It has been granted 501(c)(3) status by the Internal Revenue Service, and as such, has the exemptions and rights that such status affords. A board of five elected directors governs the District.

Curry General Hospital is certified as a Critical Access Hospital and is the sole hospital serving Curry County, located in the county seat of Gold Beach, Oregon. The aged hospital was replaced in 2017 with a 62,900 square foot state-of-the-art facility. The Network owns and operates Curry Medical Center in Brookings, Curry Medical Practice and Curry Medical West in Gold Beach, and Curry Family Medical in Port Orford.

Curry Health Network offers emergency medical services; inpatient and outpatient services; primary and specialty care including non-interventional cardiology, general surgery, urology, gynecology, orthopedics and pain management; cardiopulmonary services including rehabilitation; physical, occupational and speech therapy; laboratory and imaging services; and an inpatient pharmacy.
The mission of Curry Health Network is healthy communities with efficient, quality health care; our vision is to be the region’s premier rural healthcare system. We share the values of integrity, compassion, accountability, stewardship, teamwork and excellence.

Recruitment and retention of providers was listed consistently as a concern in focus groups and survey participant comments.

“We have a problem with the availability of good doctors that stay so you can keep on seeing them. It’s an inconvenience to drive 100 plus miles to see a good doctor or specialist.”—Survey Participant

“Access to health care providers who stay in the area for more than a year and provide quality care, we don’t have that here.”—Survey Participant

“Providers, it’s hard to get them here and to stay. They can’t get their kids into good schools or have housing problems and so they move.”—Focus Group Participant

**Access to Specific Services**

Access to **dentists** in Curry County is more difficult than statewide. The rate of dentists has been lower in the county for the last several years. The percentage of adults who have had no dental exam in the past year is also higher at 33.9% (BRFSS 2006-2010). Youth are also less likely to have accessed dental care in the county than in the state. 71.3% of 8th graders and 59.8% of 11th graders in the county accessed dental care in 2017 (Oregon Healthy Teens Survey 2017).

![Rate of dentists per 100,000 Curry County and Oregon](chart)

**Rate of dentists per 100,000 Curry County and Oregon**

![Chart showing the rate of dentists per 100,000 in Curry County and Oregon from 2010 to 2015.](chart)

Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2015
The percentage of a population that has preventive screenings is an indicator of access to care, specifically the quality and availability of care and timeliness of access. The screenings provided the most often include cholesterol testing, blood sugar testing, colon cancer screening by sigmoidoscopy or colonoscopy and mammogram. Curry County performs fewer screenings than the state overall. Mammograms are particularly lower for Curry County women age 50-74. Blood sugar testing is the only screening that exceeds state percentages.

“We don’t have access to affordable and quality preventative health care. A lot of people have health issues, or they let it go too long and can’t get preventative care.” —Survey Participant

Preventive Screenings 2012-2015 Curry County and Oregon

*Applicable populations:
Percent cholesterol checked within last 5 years; Percent blood sugar test in past 3 years; Percent current on colorectal cancer screening, 50-75 years old; Percent of mammogram within past 2 years 50-74 years old.
*pap test numbers too small in Curry County to be statistically reliable

Source: BRFSS 2012-2015
Prenatal care is an indicator of maternal and child health services access. Curry County has higher percentages of women receiving inadequate prenatal care than the state. Inadequate prenatal care is less than 5 visits prior to delivery or care began in third trimester or after.

The percentage of women who are receiving adequate prenatal care is lower than state percentages. In 2016, 90% of women in the county received adequate prenatal care, compared to state percentages of 94% (Oregon Vital Statistics 2016). Inadequate prenatal care, defined as less than 5 visits prior to delivery or if care begins in third trimester or after. 10% of women in the county received inadequate prenatal care in the 2016 (Office of Rural Health 2017).

“Our rural community is lacking basic health care needs and services such as OB services, putting a strain on young growing families.” -Survey participant

School-Based Health Centers provide physical and behavioral health services in elementary, middle and high schools in the county. Curry Community Health currently has a family nurse practitioner in Brookings Harbor High School two days a week, offering primary cares services. Of the three school districts in the county, there are 1.2 FTE therapists assigned to the schools.

Hospitals
The preventive hospitalizations for patients on Medicare with conditions that are ambulatory care sensitive is higher in Curry County. Ambulatory care sensitive conditions include pneumonia, dehydration, asthma, diabetes and other conditions which could have been prevented if adequate primary resources were available and accessed. This indicator illustrates challenges in primary care access.

Preventable Hospitalizations for Medicare Enrollees, 2014
Curry County and Oregon

Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care
Curry County patients have to travel out of the county for inpatient hospital services. The reasons for traveling out of the county are many including rural geography, health care provider shortage and limited specialty services.

“I have to travel all the way to Los Angeles for specialists and I am disabled.” —Survey Participant

“Many of our people travel a long and dangerous road to Medford for care. We now have this new hospital, let's try to keep some of those dollars here.” —Survey Participant

<table>
<thead>
<tr>
<th>Top 3 Hospitals Medicaid Patients, from Curry County, are going to outside of Curry County 2016-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st most visited</td>
</tr>
<tr>
<td>2nd most visited</td>
</tr>
<tr>
<td>3rd most visited</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top 3 Reasons Medicaid Patients, from Curry County, are going outside of county for inpatient care, 2016-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
</tr>
<tr>
<td>2nd</td>
</tr>
<tr>
<td>3rd</td>
</tr>
</tbody>
</table>

Source: Coordinated Care Organization Enrollee data, 2016-2017
The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

### Health Care System

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Curry County vs. Oregon)</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insured and Uninsured</strong></td>
<td>Population on public insurance coverage (Medicaid, Medicare and VA) ↑</td>
<td></td>
</tr>
<tr>
<td><strong>Access to Providers</strong></td>
<td>Access to primary care physician ↓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access to mental health providers ↓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access to dental providers ↓</td>
<td></td>
</tr>
<tr>
<td><strong>Oral/Dental Health Accessibility</strong></td>
<td>Adults with no dental exam ↓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Youth with no dental exam ↓</td>
<td></td>
</tr>
<tr>
<td><strong>Preventative Screening</strong></td>
<td>Colorectal Cancer Screening ↓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mammogram within last 2 years ↓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cholesterol checked in last 5 years ↓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood sugar test within last 3 years ↑</td>
<td></td>
</tr>
<tr>
<td><strong>Prenatal Care Accessibility</strong></td>
<td>Moms getting adequate prenatal care ↓</td>
<td></td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td>Preventable hospitalizations ↑</td>
<td></td>
</tr>
</tbody>
</table>
**Health Behaviors**

Individual health behaviors such as tobacco use, inadequate physical activity and addictions, have significant influence on the health of individuals and communities in Curry County.

*Tobacco* use is a modifiable health behavior that has significant health consequences. Premature death, various cancers, lung and respiratory issues, low birth weight and cardiovascular disease are all linked to tobacco use. The tobacco mortality rate has been higher in Curry than the state rate for over a decade.

The percentage of adults in Curry County that are current smokers continues to be one of the highest in the state. More than 60% of adults have ever smoked in Curry County, more than one in four adults (25.6%) are currently smoking cigarettes (BRFSS 2015). 7.4% of 11th graders in the county smoked cigarettes in the last 30 days.Nearly 5% of 11th graders in the county have used e-cigarettes or other vaping products in the last 30 days (Oregon Healthy Teens Survey 2017).

![Tobacco-linked mortality](source.png)

*Source: Oregon Vital Statistics Annual Reports*
The financial impact of tobacco in the county is also substantial. The latest tobacco fact sheets from the Oregon Health Authority estimates that Curry County experiences 16.3 million dollars in tobacco related medical costs and 13.1 million in lost productivity due to premature tobacco-related deaths. 1,598 people are estimated to have a serious illness caused by tobacco in Curry County (Oregon Health Authority Tobacco Fact Sheets 2014).

**Alcohol and other drugs**

Excessive heavy alcohol consumption and binge drinking contribute to chronic health issues, including heart disease, cirrhosis of the liver, high blood pressure, stroke and even death. More than 20% of adults in the county report binge drinking in the past month while over 50% of residents twelve and older, in the region of Coos, Douglas, Jackson and Curry Counties report using alcohol in the past month. Binge drinking is increasing in the county, exceeding percentages at the State level.

“Not enough activities for kids so they drink and drive and party. There are a lot of accidents from that on Hwy 101 in our county, at night during the summer especially.” —Focus Group Participant

```
Adults binge drinking, 2012-2015
Curry County and Oregon
```

![Graph showing adults binge drinking, 2012-2015 for Curry County and Oregon.]

*Source: National Survey on Drug Use and Health, Annual Averages Based on 2012, 2013, and 2014*

“I’m not a doctor so don’t know the answer, but my observation on most people is they tend to drink a lot of alcohol.” —Survey Participant

75.8% of 8th graders stated they had never had a drink of alcohol, indicating nearly one in four 8th graders had already drank more than a few sips of alcohol (Oregon Healthy Teens Survey 2017).
Regional data on illicit drug use show that 12.5% of people in the region (Coos, Curry, Douglas, Jackson, Josephine and Klamath) had used an illicit drug in the past month, higher than national percentages.

“We all know drugs are a problem, but people that use drugs are still just people, jails aren’t the answer. They should be seen as people first, to help the problem in our community.” —Focus Group Participant

Marijuana use by youth (1 or more days in the past 30 days) was reported by 6.7% of 8th graders and 20.9% of 11th graders in Curry County in 2017 (Oregon Healthy Teens Survey 2017). How they consumed marijuana was not available as the numbers were too small to be statistically reliable. Reliable numbers for marijuana use by adults, since legalization, are not available but comments about using marijuana for pain were brought up several times in the 2018 CHA focus group and surveys.

“I chose medical marijuana, so I can choose to control my meds and be off of prescriptions.” —Focus Group Participant

“I smoke it every day, helps with harm reduction, helps me forget about my pain.” —Focus Group Participant

“We don’t stigmatize people with heart disease for eating red meat, we must educate and treat addicts like people. I didn’t wake up and say I want to be an addict, I didn’t want to lose my family.” -Focus Group Participant

### Drug use, 2012-2014
Region, State and National

<table>
<thead>
<tr>
<th>Percentage</th>
<th>US</th>
<th>Oregon</th>
<th>Region 4 - Coos, Curry, Douglas, Jackson, Josephine, Klamath</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any illicit drug use in the past month</td>
<td>15%</td>
<td>12%</td>
<td>20%</td>
</tr>
<tr>
<td>Illicit drug use other than marijuana* in the past month</td>
<td>10%</td>
<td>8%</td>
<td>15%</td>
</tr>
<tr>
<td>Cocaine use in the past year</td>
<td>5%</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Nonmedical use of pain relievers in the past year</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Illicit drug dependence or abuse in the past year</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Needing but not receiving treatment for illicit drug use in the past year</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

*data collected prior to legalization


2018 Curry County Community Health Assessment - 49
Opioid and other drug use

The morbidity and mortality associated with inappropriate use of opiate drugs such as codeine, oxycodone, morphine and methadone, have a negative impact on the health of the community. Prescribing patterns for Curry residents on Medicare for 2013-2014 show higher rates of opioid prescriptions than state and national trends. Curry County had a 8.17% prescribing rate for Opioids in 2013 and 8.86% rate in 2014. This is consistent with prescription patterns in the Medicaid/Oregon Health Plan population, narcotic analgesics (opioids) were the second most prescribed medication in 2016-2017 within the Medicaid population of the county. According to the Oregon Opioid Dashboard Curry county has the highest rate in the state of individuals receiving opioids per 1,000. Among the youth, 25.5% of 11th graders in Curry County say that it would be either easy or very easy to get prescription drugs not prescribed to them in 2017 (Healthy Teens Survey 2017).

“I understand that its expensive and people get addicted, but we need more options for managing chronic pain without strict numbers, if something works for somebody, we should be able to adapt and be case by case, individualize for needs.” —Focus Group Participant

Curry County has a high burden of the hepatitis C virus (Oregon Health Division 2017). High burden is defined as the number of people living with cases, chronic case reports and acute hepatitis C virus (HCV). Risk factors for HCV include injection drug use, health care exposure, multiple sex partners and other risk factors such as street drug use, tattoo, piercing or other blood exposure. Curry County has higher rates of those living with HCV and acute reports than the state. The region (Coos and Curry counties) has the highest mortality rate, in the state, from chronic hepatitis within the Medicaid/CCO population (Oregon Health Division 2017).
Vaccinations are a modifiable health behavior. Immunizations are an effective tool for preventing disease and death and Curry County has lower rates of vaccinating 2 year old children than in the state. The percentage of vaccinated 2-year olds in Curry County is 47% compared to 64% in Oregon as a whole (Oregon Immunization Program, 2008-2015).

**Adults 65+ who received vaccination within past year, 2010-2013**

**Curry County and Oregon**

<table>
<thead>
<tr>
<th>Type of Vaccination</th>
<th>Oregon</th>
<th>Curry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>74.6%</td>
<td>72.2%</td>
</tr>
<tr>
<td>Seasonal Flu</td>
<td>56.2%</td>
<td>59.3%</td>
</tr>
</tbody>
</table>

*Source: BRFSS 2010-2013*

**Two-year old immunization rates, 2014-2017**

**Curry County and Oregon**

*Source: Oregon Immunization Program, 2008-15*
**Obesity** is a modifiable risk factor for several chronic conditions. Obesity is defined as a Body Mass Index (BMI) of 30 or higher. BMI is calculated using both height and weight. Being obese has been associated with increased risk of coronary heart disease, type 2 diabetes, cancer, high blood pressure, stroke, liver and gallbladder disease, among other morbidity and mortality. 38% of people in the county are obese, higher than the state average of 27.1% (BRFSS 2015). Only 65.8% of youth are considered a healthy weight in the county.

**“We must combine eating ‘habits,’ access to healthy foods and exercise as one behavior.” —Survey Participant**

**Youth Weight 2017**
*Curry County and Oregon*

<table>
<thead>
<tr>
<th></th>
<th>Oregon</th>
<th>Curry County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight</td>
<td>14.3%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Obese</td>
<td>11.4%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Healthy Weight</td>
<td>74.3%</td>
<td>65.8%</td>
</tr>
</tbody>
</table>

Source: Oregon Healthy Teens Survey 2017

**“We all have to take personal responsibility, make better decisions, be more disciplined. People spend tons of money at DQ, McDonalds, KFC and Taco Bell, they then sit in their car and pig out at the port. Health begins in the mindset.” —Survey Participant**

The percentage of the population that is considered obese has been on an increase for decades in the county and statewide.

**Obesity trend 2002-2015**
*Curry County and Oregon*

Source: BRFSS 2010-2013
### Health Behaviors

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Curry County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Population smoking $\uparrow$</td>
</tr>
</tbody>
</table>
| Alcohol and Other Drugs | Higher rates of binge drinking $\uparrow$  
|                     | Opioid prescribing rates $\uparrow$   
|                     | Illicit drug use $\uparrow$          |
| Vaccinations       | 2-year old immunization rates $\downarrow$ |
|                     | Adult vaccinations $\downarrow$       |
| Obesity            | Rates of obesity $\uparrow$           |
Health Status and Outcomes

**Mortality**

Causes of death (mortality) has changed in the county over the last 80 years, consistent with state and national trends. Advances in science, medical care, living and working conditions have influenced causes of death and disability in the county.

Curry County has higher rates of several **leading causes of death**. The leading cause of death in the county is cancer followed by heart disease. Breast, lung and prostate cancer are the most common types of cancer in Curry County.

**Leading causes of death, 2011-2015**

*Select cities in Curry County and Oregon*

Sources: Vital Statistics Annual Report, Oregon Health Authority

*crude death rates by cause*
“The air quality is not good with factories spewing chemical pollution into the air and wood burning fireplaces emitting large air particulates which causes asthma and lung cancer.” —Survey Participant

### Leading Types of Cancer*

**2010-2014, Curry County and Oregon**

![Graph showing leading types of cancer](image)

*new cases  

Source: Oregon State Cancer Registry, 2010-2014

Mortality from diabetes is high in Curry County and also remains higher than state rates. Deaths attributed to tobacco, as already mentioned in the modifiable health behavior section, are also higher in Curry County than Oregon and considerably higher than the Healthy People 2020 national goals.

### Diabetes-related mortality, 2006-2016

**Curry County and Oregon**

![Graph showing diabetes-related mortality](image)

Source: Oregon Vital Statistics Annual Reports

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Attachment 10 - Community Health Assessment - Curry County
Tobacco-related mortality, 2016
Curry County, Oregon, Healthy People 2020

Source: Oregon Vital Statistics Annual Reports
The prevalence and burden of chronic conditions is high in Curry County and higher when compared to the state. Nearly 50% of adults in the county have one or more conditions of angina, arthritis, asthma, cancer, COPD, depression, diabetes, heart attack or stroke. This illustrates a very high burden of chronic disease in the county. Also notable is that Curry County has higher percentages of the population with asthma, cancer, COPD and cardiovascular disease than state percentages.

“Smoking and alcoholism are choices that also lead to other chronic conditions.”—Survey Participant

**Chronic conditions among adults, 2012-2015**

*Curry County and Oregon*
The majority of deaths due to alcohol or drugs are from chronic alcoholic liver disease followed by unintentional injuries. There have been zero deaths marked as from opioids since 2012 in Curry County.

**Deaths due to alcohol or drugs, 2016**

**Curry County**

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic alcoholic liver disease</td>
<td>4</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>2</td>
</tr>
<tr>
<td>Other alcohol induced</td>
<td>1</td>
</tr>
<tr>
<td>Other drug induced</td>
<td>1</td>
</tr>
<tr>
<td>Suicides</td>
<td>0</td>
</tr>
<tr>
<td>Opioid</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Oregon State Vital Statistics

**Mental Health & Suicide**

Mental health and **depression** were listed as top concerns by the 2018 CHA focus groups and survey participants. Indicators of mental and behavioral health include suicide rates and percentages of the population experiencing depression.

**Youth depression, 2017**

**Curry County and Oregon**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Curry County</th>
<th>Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td>8th</td>
<td>29.3%</td>
<td>30.1%</td>
</tr>
<tr>
<td>11th</td>
<td>30.5%</td>
<td>32.2%</td>
</tr>
</tbody>
</table>

Source: Oregon Healthy Teens

Self reported mental health and depression remain a problem in Curry County youth. A third of 8th graders and 11th graders indicate they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities (Oregon Healthy Teens Survey 2017). Youth considering suicide is significantly higher in Curry County than Oregon. 21.1% of 8th graders in the county in 2017 seriously considered attempting suicide, 4.5% actually attempted 6 or more times in the past 12 months, nearly four times that of state percentages.
“Suicide here is huge because of lack of sun, lack of mental health services and isolated communities.” —Focus Group Participant

Suicide as a cause of death in all populations in the county show an alarming upward trend in number and rate.

![Suicide Trend Graph](source:image)

*Source: Oregon Vital Statistics*
20.3% of adults reported depression in Curry County while 34.1% of adults on Medicaid in the county listed either a mild to serious mental health condition in 2015.

### Mental health conditions, Medicaid population, 2015 Curry County

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults (26 and older) with serious MH condition</td>
<td>11.0%</td>
</tr>
<tr>
<td>Adults (26 and older) with mild to moderate MH condition</td>
<td>23.1%</td>
</tr>
<tr>
<td>Young adults (18 to 25) with serious MH condition</td>
<td>5.5%</td>
</tr>
<tr>
<td>Young adults (18 to 25) with mild to moderate MH condition</td>
<td>22.2%</td>
</tr>
<tr>
<td>Youth (12 to 17) with MH condition</td>
<td>33.5%</td>
</tr>
<tr>
<td>Children under 12 with MH condition</td>
<td>24.7%</td>
</tr>
</tbody>
</table>

*MH is Mental Health

### Oral Health

A third of the population of adults in the county indicate poor dental health, twice that of the state percentage. Youth in the county are less likely to have seen a dentist or dental hygienist for a check-up in the last year than youth statewide. In 2017, only 59.8% of 11th graders in the county had seen a dentist or dental hygienist for a check-up, exam, teeth cleaning or other dental work in the last 12 months (Oregon Healthy Teens Survey 2017). Additional data on access to dental care is in the previous health services section.

### Percent of adults with poor dental health, 2006-2012

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curry County</td>
<td>30.7%</td>
</tr>
<tr>
<td>Oregon</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

*Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES*
Births

Low birth weight is an indicator of general maternal and child health in a community. Babies born with low birth weight typically have more long-term disabilities and developmental issues. The rates of low birth weight and infant mortality in the county have bounced up and down since 2005, typical of a rural County with lower overall population numbers. The Infant Mortality Rate (IMR) in the county has varied from 0-11.7 since 2005. An IMR of higher than 9.9 usually indicates an at risk population for federal programs such as Healthy Start.

Birth rate, low birth weight and infant mortality rate, 2005-2016
Curry County and Oregon

Teen births, defined as births happening to young women age 15-19, is higher than the state average and trending up while the state trend is going down. Teen births are an important indicator as often teen parents have unique social, economic and health services support needs. High rates of teen pregnancy can also indicate prevalence of unsafe sex practices.

Teen births, 2011-2016
Curry County and Oregon


Source: Oregon Health Authority, Center for Health Statistics
Health Status and Outcome Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings (Curry County vs. Oregon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leading causes of death</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetes mortality</td>
<td>↑</td>
</tr>
<tr>
<td>Tobacco mortality</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Chronic conditions</strong></td>
<td></td>
</tr>
<tr>
<td>Asthma, cancer, COPD, cardiovascular disease and heart attack</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
</tr>
<tr>
<td>Breast and lung cancer</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Suicide</strong></td>
<td></td>
</tr>
<tr>
<td>Suicide adults</td>
<td>↑</td>
</tr>
<tr>
<td>Suicide attempts youth</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Dental / oral health</strong></td>
<td></td>
</tr>
<tr>
<td>Dental health poor</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Maternal and pediatric health</strong></td>
<td></td>
</tr>
<tr>
<td>Teen births</td>
<td>↑</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>↑</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>↑</td>
</tr>
<tr>
<td>Birth rate</td>
<td>↓</td>
</tr>
</tbody>
</table>

**Key**

↑ = higher (than State)
↓ = lower (than State)
The CHA document is a snapshot of health in Curry County. The CHA has limitations, it is not meant to cover every possible factor that influences health nor is it an evaluation of services or efficacy of the health care system itself. The CHA is limited by what data is currently being gathered and published while also being limited by the validity, frequency and level of data that other entities gather and report. The CHA committee identified several data gaps in the CHA process, with the hope that the list will drive future data collection and study.

### Data Gaps, Possible Future Data Collection and/or Study Topics

<table>
<thead>
<tr>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness &amp; housing availability</td>
</tr>
<tr>
<td>Dental &amp; oral health</td>
</tr>
<tr>
<td>Opioid use &amp; abuse</td>
</tr>
<tr>
<td>Access to specialty health care</td>
</tr>
<tr>
<td>Provider retention efforts</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
</tbody>
</table>

The CHA is intended to inform and build on current health efforts in the community. The CHA is one step in an ongoing process of community health assessment, planning and improvement. Future work includes prioritization of health issues and interventions and exploration of how to compliment and integrate work that is already being done in the community.
Primary Data Collection Summary

2018 Curry Community Health Assessment

Process & Methods
Two primary methods were used to solicit feedback from the community regarding the 2018 Curry Community Health Assessment. Primary data collection, through focus groups and a community wide survey, provides additional data and context to the secondary data cataloging and analysis. The purpose of the primary data collection was to gather perceptions about health priorities, experiences and gain an understanding of what community members believe influences health the most. Methods included surveys (both paper and online) and targeted focus groups. The primary data collection process is part of a larger community health assessment, following a modified Mobilizing for Action through Planning and Partnerships model (MAPP).

The community survey was written for easy reading and comprehension, resulting in a 98% completion rate. Survey questions mirrored the questions in the targeted focus groups. The survey was available online and in paper/hard copy format, in English and in Spanish language. Additional accommodation for language and/or reading and comprehension was offered. The survey was advertised in many formats, including flyers, social media and via email. 310 people took the survey, eliciting both quantitative health priority ranking data and 298 unique comments.

The 2018 Curry CHA collaborative committee also sponsored ten targeted community focus groups. Forty-six (46) community members participated in the focus groups. The meetings were held around the county during January 2018. The committee identified and prioritized which groups of individuals they wanted to have targeted feedback from, after lengthy discussion. The committee then chose local champions for each group. The role of the local focus group champion was to lead recruitment, coordination of focus group location, selection of small incentives for participants and introduction of the consultant and facilitator to the participants of the group.

Prioritized Populations for 2018 Curry Community Health Assessment Focus Groups

• Health Care Providers
• Tribal Community
• Education
• Seniors and retirees
• Behavioral Health & Addictions
• Chronic pain
Data was gathered in the focus groups with a combination of instant polling questions utilizing “clickers” that captured instant demographic data and polling on health priorities and perceptions. The second type of tool were open-ended discussion questions. The multiple feedback collection tools ensured 100% of focus group participants. Light refreshments and $10 gift cards or equivalent were provided to focus group participants as incentives. The focus groups were complete within two hours and averaged almost nine people per group. 268 unique comments were gathered from focus groups.

<table>
<thead>
<tr>
<th>Total primary data collection 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total focus group participants</td>
</tr>
<tr>
<td>Total surveys completed</td>
</tr>
<tr>
<td>Total individual participants (both survey and focus group)</td>
</tr>
<tr>
<td>Total qualitative comments</td>
</tr>
</tbody>
</table>
Primary data themes

3 Biggest strengths in community
- Physical Environment (such as air quality and recreational opportunities etc.)
- The people that live here
- Social Support (including religious/spiritual values, volunteerism etc.)

3 Things that would most improve quality of life here
- Improved Access to affordable housing
- Access to affordable health care
- Improving availability of jobs

3 Behaviors with the most influence on health
- Alcohol and/or drug abuse
- Eating habits and nutrition
- Not getting health care when you need it

3 Community Conditions you see the most
- Poverty or ability to meet financial responsibilities
- Homelessness/availability of housing
- Lack of health care facilities and services

3 Health issues you see the most
- Mental health problems
- Substance abuse
- Cancer

Health Equity
59% of participants don’t believe that everyone in Curry County has an equal opportunity to live a long healthy life if they choose to.

There are limitations to focus group and survey data. Neither should stand on its own, the processes are meant to compliment and balance the secondary data analysis. The primary data collection methods used in the 2018 Curry CHA are also not random and instead are considered a convenience sample, not intended to be a complete and random sampling of the community but instead, to provide insight into the health concerns, perceptions and experiences of specific groups within the county. The selection of populations for the focus group and the advertising of the survey were driven by the local CHA committee.
## Helpful acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>BRFSS</td>
<td>Behavioral Risk Factor Surveillance System</td>
</tr>
<tr>
<td>CCO</td>
<td>Coordinated Care Organization</td>
</tr>
<tr>
<td>CHA</td>
<td>Community Health Assessment</td>
</tr>
<tr>
<td>CHNA</td>
<td>Community Health Needs Assessment</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CT</td>
<td>Computerized Tomography</td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C Virus</td>
</tr>
<tr>
<td>IMRT</td>
<td>Intensity-modulated radiation therapy</td>
</tr>
<tr>
<td>MAPP</td>
<td>Mobilizing for Action through Planning and Partnerships</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>OHA</td>
<td>Oregon Health Authority</td>
</tr>
<tr>
<td>ORCCA</td>
<td>Oregon Coast Community Action</td>
</tr>
<tr>
<td>PET</td>
<td>Polyethylene Terephthalate</td>
</tr>
<tr>
<td>PHAB</td>
<td>Public Health Accreditation Board</td>
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<tr>
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COOS COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN
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Steering Committee Members and Plan Development Participants

**Current Members**

- **Betty Albertson**, District Manager, Department of Human Services
- **Barbara Bassett**, Health Education Director, Coos County Health and Human Services
- **Terri Camp**, RN, MHL, Chief Quality Officer, Bay Area Hospital
- **Shannon Durkee**, Tobacco Prevention Program Coordinator, Coos County Health and Human Services
- **Cynthia Edwards**, Health Education Coordinator, Coos County Health and Human Services
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- **Bailey Richards**, CHIP Volunteer, AmeriCorp VISTA at Coos County Health and Human Services
- **Skaidra Scholey**, Program Development, North Bend Medical Center
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- **Ginger Swan**, Director, Coos County Health and Human Services
- **John Sweet**, County Commissioner, Coos County
- **Angie Webster**, Director of Clinical & Professional Development, Bay Area Hospital
- **Laura Williams**, Customer Service and Provider Relations Director, WOAH

**Past Members**

- **Chris Beebe**, Senior Account Executive, KCBY Television
- **Alison Booth**, Teen Parent Program Director, Coos Bay School District
- **Stephen Brown**, ND, MPH, Coos County Public Health Department
- **Lynda Buford**, RN, Public Health Nurse and Accreditation Assistant, Coos County Public Health Department
- **Kathy Cooley**, RN, Home Visiting Manager, Coos County Public Health
- **Melissa Cribbins**, County Commissioner, Coos County
- **Sonja Flowers**, Account Executive, KCBY Television
- **Linda Furman Grile**, South Coast Hospice
- **David Geels**, LPC, Director, Coos County Mental Health Department
- **Tom Holt**, DDS, Coos Bay Dentist
- **Melody Gillard-Juarez**, ED, Grants Manager, Southern Coos Health District; Executive Director, Southern Coos Health Foundation
- **Divneet Kaur**, Medical Student, Bandon Community Health Center
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- **Kelle Little**, RD, CDE, Health and Human Services Administrator, Coquille Indian Tribe
- **James Martin**, MD, Psychiatrist, Bay Area Hospital
- **Linda Maxon**, Executive Director, Bandon Community Health Center
• **Lindi Quinn**, Citizen, *Coos County Friends of Public Health and Women’s Health Coalition*
• **Gregory Saunders**, MD, MPH, *Community Representative*
• **Kathy Saunders**, MS, MPH, RD, LD
• **Lonnie Scarborough**, RN, BA, *Western Oregon Advanced Health*
• **Marilyn Schmidt**, Volunteer, *Maslow Project*
• **Dane Smith**, DDS, *Cavity Free Kids*
• **Frances Smith**, Past Administrator, *Coos County Public Health Department*
• **Jennifer Stephens**, Health Programs Coordinator, *Coquille Indian Tribe*
• **Emily Thornton**, Reporter, *The World Newspaper*
• **Kathleen Walsh**, RN, Community Crossroads Café & Retired SWOCC Nursing Faculty
• **Sannie Warbis**, RNC, BS, Interim Director of Quality, *Bay Area Hospital*
• **Kathy Wright**, RN, Certified Addictions
• **Kevin Urban**, Parks and Recreation, *City of Coquille*
• **Herb Yussim**, Broker/Owner, *Oregon Bay Properties*
• **Nikki Zogg**, PhD, MPH, Past Administrator, *Coos County Public Health Department*
• **WOAH Oregon Health Plan Members – Survey Participants**
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Timeline

The following timeline outlines the development of the Community Health Improvement Plan, including the Community Health Assessment process:

**October 2012:** At the Western Oregon Advanced Health (WOAH) Community Advisory Council Subcommittee on Assessment meeting, the requirements for a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) were reviewed. The group began drafting a plan for a collaborative community health improvement process.

**January 2013:** Recruiting for CHA subcommittee members began.

**March-May 2013:** Data collection for the CHA was conducted, including monthly meetings to collect input from committee members on resources and needs. At the conclusion of data collection, the group discussed the CHA findings and identified eight priority areas for the CHIP to address. The group performed a Strength, Weakness, Opportunity, and Threat (SWOT) analysis for the eight priority areas (see Appendix A).

**June-August 2013:** The CHA document was written by the Coos County Public Health Administrator. In July, the Subcommittee on Assessment began working on the CHIP based on the eight identified priority areas.

**September 2013:** The CHA was finalized.

**October 2013:** The CHIP was presented to the WOAH Community Advisory Council and accepted.

**November 2013:** The CHIP was referred to the WOAH Board and approved.

**January 2014:** Recruitment for the CHIP Steering Committee began.

**February-June 2014:** The first CHIP Steering Committee meeting was held in February. Over the next four months, the Steering Committee identified several issues with the original CHIP document. These included the CHIP being too expansive, the objectives being too broad, and partnering agencies lacking adequate accountability measures for their assigned objectives.

**July 2014:** Eight subcommittees of the CHIP Steering Committee were formed based on the eight priority areas. Subcommittee actions and the development of the updated CHIP document are outlined in more detail below.

**August 2014 – March 2015:** Implementation of some activities from the previous CHIP was undertaken. A CHIP revision was planned and written by the Steering Committee. The new edition reduced the number of priority areas to four using a dot prioritization exercise.
CHIP Review and Update Process

The CHIP Steering Committee began the review and update process in July of 2014. The initial goals were to prioritize remaining objectives, edit objectives to incorporate SMART (specific, measurable, attainable, relevant and time based) criteria, and identify work that was either completed or in progress by partner agencies. Eight sub-committees were formed corresponding to the original eight priority areas: access to healthcare, chronic illness management, chronic illness prevention, dental health, fall prevention, maternal and child health, mental health, and socioeconomic disparities.

Each sub-committee met twice. The first meetings occurred in July 2014, where committees used a prioritization matrix to evaluate all objectives on their feasibility, impact, morbidity, and existing resources. Committees held second meetings in August and September 2014 to evaluate objectives based on SMART criteria and clarify which organization/representative will be the main contact for data collection for each objective. Several concerns arose during these meetings:

1. Are the existing objectives an appropriate focus for the CHIP?
2. Who is responsible for working on the established objectives? There are multiple players and providers noted in the original plan but lack of ownership.
3. The original plan is not manageable. There are too many priority areas, goals and objectives. Most plans have no more than 3 to 4 priority areas.
4. Objectives are not measureable and read more like activities.

Due to the concerns expressed, Coos Health & Wellness convened a CHIP Action Team comprised of Florence Pourtal-Stevens, Public Health Administrator, Barbara Bassett, Health Education Director, Cynthia Edwards, Health Education Coordinator, and Bailey Richards, CHIP VISTA Volunteer. The goals of the CHIP Action Team were to:

1. Streamline the number of priority areas, goals and objectives
2. Create a framework to support SMART criteria within the plan
3. Publish a draft revision of the plan

First, the CHIP Action Team reviewed data collected in the 2013 Coos County Community Health Assessment and identified areas that had countywide data and baselines. These areas created a framework for measurable objectives to be drafted into, which were then grouped under the already-existing priority areas and goals. Next, all goals and objectives were reviewed against the following criteria:

1. Feasibility Yes/No
2. Measurable Yes/No
3. Baseline Yes/No
The goals and objectives that remained were reworded to ensure that they were SMART and aligned with national benchmarks such as Healthy People 2020.

The CHIP document was regularly reviewed and discussed throughout this process by the CHIP steering committee. After the CHIP Action Team identified SMART goals and objectives, the steering committee then went through a prioritization exercise and selected five overall goals for the 2015 edition of the Coos County CHIP. These goals are grouped under four of the eight original priority areas: Access to Healthcare, Chronic Disease Prevention/Healthy Lifestyles, Mental Health, and Maternal and Child Health. This structure preserves the work done on the CHA and previous CHIP, including subcommittee work, illustrates how the new CHIP is connected to those documents, and narrows the plan’s scope so that future work is realistic and attainable.

Moving forward, the committee plans to divide into five subcommittees (one for each goal) to develop and implement strategies and actions. These strategies will be developed with the aid of two strategic frameworks (see page 11) and will comprise the CHIP Implementation Plan.
Strategic Frameworks

The 2013 CHA and CHIP were created using a simplified Mobilizing for Action through Planning and Partnerships (MAPP) model, with integral support from the CHIP steering committee in community partnership development. For the 2015 edition of the CHIP, we plan to develop subcommittees for each goal that will use the SWOT analysis laid out in the CHA (see Appendix A), the social-ecological prevention framework (see Appendix B), and the Community Health Improvement Matrix (see Appendix C) as the foundation for their strategy-building.

2013 CHIP Framework: MAPP

MAPP is a community-driven strategic planning tool for improving community health. The process is facilitated by public health leaders and is intended to help communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.

The modified aspects of MAPP implemented in the Coos County Health Assessment project were in the area of assessment. Committee meetings were used in lieu of conducting the...
Community Themes and Strengths Assessment and the Forces of Change Assessment. The CHIP describes the Strategic Issues and Goals/Strategies steps of the MAPP model as they pertain to improving health in Coos County.

2015 CHIP Framework 1: Social-Ecological Model

The social-ecological model looks at planning using a connected approach. The model suggests strategizing under the following five areas (see Appendix B for visual model):

- Individual – Enhancing skills, knowledge, attitudes and motivation
- Interpersonal – Increasing support from friends, family and peers
- Organizational – Changing policies and practices of an organization
- Community – Collaborating and creating partnership to effect change in the community and increase the efficiency and effectiveness of care
- Public Policy – Developing, influencing and enforcing local, state and national laws which promote health and create safe and healthy environments

The social-ecological model recognizes there are small and large units for planning. Small steps of forward progress contribute to large steps, and the large in turn contribute to the small. There is ecological synergy in how we address health issues that promote a more holistic, coordinated, and population-based planning structure.

Figure 2: Social-Ecological Model

2015 CHIP Framework 2: Community Health Improvement Matrix

The Community Health Improvement Matrix is “a bivariate map that includes the level of prevention on the vertical axis and the level of intervention on the horizontal axis, to conceptualize all community health improvement/implementation activities. The matrix’s prevention levels include the three traditional public health categories: primary (reduce susceptibility or exposure to health threats), secondary (detect and treat disease in early stages), and tertiary (alleviate the effects of disease and injury).” NACCHO also added a fourth category: “contextual (preventing the emergence of predisposing social and environmental conditions that can lead to causation of disease).”

![Community Health Improvement Matrix](image)

Figure 3: Community Health Improvement Matrix
CHIP Priority Areas

Access to Healthcare

According to Healthy People 2020, access to health services means “the timely use of personal health services to achieve the best health outcomes.” Access to healthcare impacts:

- Overall physical, social, and mental health status
- Prevention of disease and disability
- Detection and treatment of health conditions
- Quality of life
- Preventable death
- Life expectancy

Having access to Primary Care Providers (PCPs) is especially important, as PCPs are a consistent source of health services for patients. PCPs can develop personal and long-term relationships with patients, provide integrated services, and practice with family and community context in mind.

The national benchmark ratio of primary care providers to population, as listed in the 2015 County Health Rankings, is 1:1,045. The state ratio in Oregon is 1:1,105, while Coos County has a ratio of 1:1,117. According to the Health Resources and Services Administration, Coos County is classified as a Medically Underserved Area/Population for low-income people and a Primary Care Health Care Professional Shortage Area for low-income and homeless people. Additionally, based on research completed by the Oregon Office of Rural Health, Powers has a 0% capacity to provide medical care, while Coquille and Myrtle Point have a 57.1% capacity for primary care appointments.

The CHIP steering committee selected access to healthcare as a priority area because our provider-to-patient ratio falls short of state and national standards. Additionally, the communities of Coquille, Myrtle Point, and Powers are consistently ranked among the top ten worst rural Oregon communities in healthcare access. Having inadequate access to health services leads to unmet health needs, delays in receiving appropriate care, inability to get preventive services, and hospitalizations that could have been prevented, and we plan to reduce loss of life and cost to the county by addressing this issue.

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. (Healthy People 2020)
Chronic Disease Prevention/Healthy Lifestyles

According to the 2015 Robert Wood Johnson County Health Rankings, Coos County ranks 32nd (with 34th being the worst) for overall health factors in Oregon.\(^{xi}\) Much of this ranking is based on preventable or behavioral health risk factors in Coos County, such as smoking and obesity.

Prevalence of tobacco use poses a significant challenge to the health of Coos County residents. 26% of Coos County adults smoke, including 23.4% of pregnant mothers.\(^{xii}\) In the 2012 Student Wellness Survey, 11.4% of eleventh graders reported smoking within the last thirty days, and 14.1% reported using other tobacco products within the same period.\(^{xiii}\) \(^{xiv}\) Overall rates for the state of Oregon show lower numbers in all but one of these areas: 16.1% of adults, 12.2% of pregnant mothers, and 11.9% of 11th graders smoke, and 9.7% of 11th graders use other tobacco products.

Of preventable causes of death in Coos County, 27% were caused by tobacco use.\(^{xv}\) Cancer related to smoking and tobacco use is the leading cause of death in Coos County, particularly lung and bronchus cancer.\(^{xvi}\) Of all the counties in Oregon, Coos has the third highest rate of esophagus cancer, second highest rate of lung cancer, and the highest rate of oral and pharyngeal cancer. In 2011, 1,250 years of life were lost due to cancer in Coos County.\(^{xvii}\)

Due to these factors, the economic cost of tobacco in the county is immense. In 2013, the county spent an estimated $39.1 million on tobacco-related medical care. The county also lost $34.2 million from indirect costs due to tobacco-related deaths.

Obesity is also a serious risk factor for chronic disease in Coos County. The CDC defines obesity in adults having a Body Mass Index (BMI) of 30 or higher, and in children as having a BMI at or above the 95th percentile. 30% of adults in the county are obese, compared to 27% statewide and 25% for national top performers.\(^{xviii}\) Child obesity rates are relatively on par with state rates, although there is still much room for improvement: 10.8% of 8th graders and 10.9% of 11th graders in Coos County are obese.\(^{xix}\) The county is less physically active than the state average, as 22% of residents are categorized as “physically inactive,” compared with Oregon’s 20%.\(^{xx}\)

Poor nutrition and weight status have been linked with multiple poor health outcomes. These include being overweight or obese, malnutrition, iron-deficiency anemia, heart disease, high blood pressure, dyslipidemia (poor lipid profiles), type 2 diabetes, osteoporosis, oral disease, constipation, diverticular disease, and some cancers.\(^{xxi}\)

The Centers for Disease Control and Prevention (CDC) cites prevention as one of the most important determinants of health and wellness outcomes.\(^{xxii}\) Poor nutrition and weight have been shown to be highly preventable by using strategies such as
building public knowledge, social support, food and agriculture programs, and food assistance policies. The CHIP steering committee has decided to focus on decreasing tobacco use and obesity to address chronic disease, not only because of the devastating health impacts they are having on Coos County, but also because they are considered “winnable battles” of public health. By taking a preventive approach to tobacco and obesity, we plan to help Coos County residents begin healthy cycles of behavior.
Mental Health

Healthy People 2020 states that mental disorders are the most common causes of disability in the United States, and that the disease burden of mental illness is among the highest of all diseases. Mental illness accounts for 25% of all years of life lost to disability and premature mortality.\textsuperscript{xxv}

According to the Centers for Disease Control and Prevention, in 2011 over 39,500 people killed themselves, and suicide and self-inflicted injuries resulted in an estimated $41.2 billion in combined medical and work loss costs. Suicide was the second leading cause of death among persons aged 15-35, fourth among persons aged 36-54 years, eighth among persons aged 55-64, and tenth overall.\textsuperscript{xxvi}

Suicide is a concerning problem in Coos County. From 2008 to 2010, 7% of adults in Coos County self-reported having at least one major depressive episode in the last year,\textsuperscript{xxvii} and from 2009 to 2011, there were 142 suicide-related hospitalizations in the county. From 2003 to 2010, 149 individuals committed suicide, the majority of which were committed by individuals 45 to 64 years of age.\textsuperscript{xxviii} Coos County’s suicide rates per 100,000 people are also considerably higher than the state’s in every age group, and are over double the state rate for people ages 18-24.\textsuperscript{xxix}

Of additional concern is Coos County’s high use of residential-based psychiatric treatment for children. Coos County averages approximately 6.5 children in residential care on a daily basis, a figure that is three times the state average.\textsuperscript{x} However, there are no psychiatric residential facilities within the county or region, which means that children and their families must travel to Eugene or Portland to access care. This often results in inadequate use of family therapy, parent training, and other evidence-based modalities. Coos County exceeds the state in rates of youth who exhibit psychological distress: 12% of eighth graders and 11.4% of eleventh graders, versus 8.4% of eighth graders and 8.3% of eleventh graders at the state level.\textsuperscript{xxxii}

Suicide is a leading cause of death in the United States. Over 483,586 people with self-inflicted injuries were treated in U.S. emergency departments since 2012. (Centers for Disease Control and Prevention)

The CHIP steering committee selected this priority area because of the high suicide rate in Coos County, as well as mental health’s close intersection with various other health areas. According to Healthy People 2020, “mental illnesses, such as depression and anxiety, affect people’s ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person’s ability to participate in treatment and recovery.”\textsuperscript{xxxii} We plan to address health and wellness holistically, and improving mental health and suicide rates in Coos County is a critical piece of this.
Maternal and Child Health

Healthy People 2020 states that maternal and child well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system.\textsuperscript{xxxiii}

Improving the well-being of mothers and children is an important public health goal for Coos County and the nation. Helping pregnant mothers access early and timely prenatal care will increase their chances of identifying existing health risks and preventing future problems for mother and child. These issues can include hypertension and heart disease, diabetes, depression, genetic conditions, sexually transmitted diseases, tobacco and alcohol use, inadequate nutrition, and unhealthy weight.\textsuperscript{xxxiv}

In Coos County, 74\% of expectant mothers receive prenatal care in their first trimester. While this is a better rate than some surrounding counties, Coos County falls short of meeting the state average of 78\% or the national average of 84\%.\textsuperscript{xxxv}

Additionally, only 34.4\% of Oregon mothers report that after their baby was born, a healthcare worker talked with them about how to prevent their baby from getting tooth decay. In Coos County, 81\% of eighth graders saw a dentist in the past 24 months, while 87.7\% of 11\textsuperscript{th} graders did.\textsuperscript{xxvi}

Likewise, poor oral health has been shown to increase risk factors for dental caries (tooth decay), periodontal (gum) diseases, cleft lip and palate, oral and facial pain, and oral and pharyngeal cancers. This impacts a person’s ability to speak, smile, smell, touch, taste, chew, swallow, and make facial expressions to show feelings and emotions.\textsuperscript{xxvii}

The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality care. (Healthy People 2020)\textsuperscript{xxviii}

Certain conditions contribute to people’s likelihood of receiving early prenatal and dental care. Age, cultural differences, health literacy, work status, comorbid diagnoses, and socioeconomic status can all have an impact on a woman’s ability to access first trimester care. Additionally, health system factors like cost, scheduling systems, or location may also be preventive.\textsuperscript{xxviii}

The CHIP steering committee selected Maternal and Child Health as a priority because health risk factors can begin forming for a human being as early as preconception. We aim to improve health outcomes for mothers, children, and future generations through early prevention and intervention.
Community Health Improvement Plan

The Community Health Improvement Plan (CHIP) identifies the top health priority areas from Community Health Assessment data, outlines strategies for action, and provides baselines and targets to measure progress. This document is not intended to describe every possible area for health improvement in the community – rather, it identifies the areas of highest concern and potential for change, and combines the efforts of many organizations in the community so that they are cooperatively working towards common health improvement goals.

This section outlines the broad plan for addressing community health priority areas by breaking them down into goals and objectives. The goals and objectives describe more specifically what the group wishes to achieve within each priority area, and parallel national priorities when possible by using Healthy People 2020 targets.

Priority Area: Access to Healthcare

Goal 1: Increase access to care providers

Objective 1: To be determined by subcommittee

Priority Area: Chronic Disease Prevention/Healthy Lifestyles

Goal 1: Decrease tobacco initiation and use

Objective 1: By 2020, develop a strategic plan that takes a comprehensive approach to addressing tobacco initiation in Coos County.

Objective 2: By 2020, increase the percentage of adult non-smokers from 71.9% to 88% (Healthy People 2020).

Objective 3: By 2020, increase the percentage of youth non-smokers from 85.8% (11th grade) to 100%.

Objective 4: By 2020, increase the percentage of women who do not smoke during pregnancy from 76.7% to 98.6% (Healthy People 2020).

Goal 2: Obesity reduction and prevention

Objective 1: By 2020, decrease the percentage of people (adults and youth) in Coos County who are obese from 30% to 25% (Robert Wood Johnson County Health Rankings).
Objective 2: To be determined by subcommittee – will incorporate nutrition programs

**Priority Area: Mental Health**

**Goal 1:** Prevent suicides

Objective 1: By 2020, decrease the number of suicides from 29.7 suicide deaths per 100,000 people to 10.2 deaths per 100,000 people (Healthy People 2020).

**Priority Area: Maternal and Child Health**

**Goal 1:** Increase the timeliness of prenatal care

Objective 1: By 2020, increase the percent of women who receive prenatal care in the first trimester from 75.3% to 77.9% (Healthy People 2020).

Objective 2: By 2020, expand the First Tooth Training to all service agencies and family practice pediatric offices in Coos County (Strategic Plan for Oral Health in Oregon: 2014-2020).

Objective 3: By 2020, promote oral exams and treatment for pregnant women in all OBGYN practices in Coos County (Strategic Plan for Oral Health in Oregon: 2014-2020).
## Appendix A: SWOT Analysis

Table 63: Coos County Priority Areas and Gap Analysis Results

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Strength</th>
<th>Weakness</th>
<th>Opportunity</th>
<th>Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to healthcare</td>
<td>- Radiation Center, Oncology Clinic, and Cardiac Unit</td>
<td>- Lack urgent care</td>
<td>- Telehealth</td>
<td>- Provider shortage</td>
</tr>
<tr>
<td></td>
<td>- Fewer uninsured people</td>
<td>- Low pay for providers</td>
<td>- Recruiting new providers</td>
<td>- Costly recruitment</td>
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<tr>
<td></td>
<td>- Area FQHC, CHCs and SBHCs</td>
<td>- Rural location</td>
<td>- J1 waiver: foreign-trained providers</td>
<td>- Larger communities competing for and more attractive to providers, and have historically held the market</td>
</tr>
<tr>
<td></td>
<td>- Critical Access Hospitals</td>
<td>- National Health Services Corp shortage</td>
<td>- Care management</td>
<td>- Lower income for providers</td>
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<tr>
<td></td>
<td>- Nursing homes</td>
<td>- Timely access</td>
<td></td>
<td>- Lack of specialty care</td>
</tr>
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<td></td>
<td>- Care management</td>
<td>- Individual compartmentalization</td>
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<td>- Socioeconomic status</td>
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<td></td>
<td>- Memory care</td>
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<td>- Public transportation</td>
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<tr>
<td></td>
<td>- SWOCC – educating future healthcare industry workers</td>
<td></td>
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<td>- High liability costs to provide transportation for clients</td>
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<td>Priority Area</td>
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<td>Weakness</td>
<td>Opportunity</td>
<td>Threat</td>
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<tr>
<td>Chronic illness management</td>
<td>• Home health agencies</td>
<td>• Individual weakness to manage health issues (self-care)</td>
<td>• Living Well with Chronic Conditions program and similar programs</td>
<td>• Non-compliant patients</td>
</tr>
<tr>
<td></td>
<td>• Dialysis/wound management</td>
<td>• Rates of chronic conditions in Coos/Curry County</td>
<td>• Streamline chronic illness management programs</td>
<td>• Schools nursing capacity on decline</td>
</tr>
<tr>
<td></td>
<td>• Care management</td>
<td>• Burden on physicians</td>
<td>• Identify common goals for organizations that want to collaborate</td>
<td>• Multi-generational families with chronic conditions</td>
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<td></td>
<td>• Diabetic education through Bay Area Hospital</td>
<td>• Lack continuous flow of communication, which allows people to fall</td>
<td>• Diabetic education through Southern Coos Hospital</td>
<td>• Changing federal &amp; state rules that create problems for end-of-life</td>
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<td></td>
<td>• Collaborative effort to decrease hospital readmissions</td>
<td>through the cracks resulting in ED visits/readmits</td>
<td>• Cancer treatment navigator</td>
<td>care</td>
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<td></td>
<td></td>
<td>• Dementia patients with no affordable place to go for long-term care</td>
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<tr>
<td>Chronic illness prevention</td>
<td>• Funding for tobacco initiation and use prevention</td>
<td>• Clear vision/ plan</td>
<td>• New funding streams</td>
<td>• Local culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Funding for policy development; physical activity/nutrition and built</td>
<td>• Untapped expertise</td>
<td>• Built environment</td>
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<td></td>
<td></td>
<td>environment; sustainable quality programs</td>
<td>• Eliminate food deserts</td>
<td>• Funding doesn’t support prevention</td>
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<td></td>
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<td>• Sustainability</td>
<td>• Peer support</td>
<td>• Lack of support for healthy foods in schools</td>
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<td>• Link education to schools</td>
<td>• Health in all policies</td>
<td>• State stops promoting healthy choices</td>
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<td>• Grocery store displays/ marketing strategies</td>
<td>• Worksite wellness programs</td>
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<td>• Lack of nutrition expertise</td>
<td>• SNAP &amp; EBT @ Farmers Markets</td>
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<td></td>
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<td>• SWOCC – community would benefit from a new workforce trained/educated in</td>
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<td></td>
<td>community healthcare</td>
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<tr>
<td>Dental health</td>
<td>• Private funding (Ready to Smile)</td>
<td>• Need exceeds service availability</td>
<td>• OHP expansion</td>
<td>• Medicare does not cover dental</td>
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<td></td>
<td>• Cavity Free Kids</td>
<td>• Diet and nutrition</td>
<td>• Expand models</td>
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<td></td>
<td>• Advantage Dental</td>
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<td>• WIC-Dental linkage</td>
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<td></td>
<td></td>
<td></td>
<td>• Personal dental hygiene</td>
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### Coos County Community Health Improvement Plan

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Strength</th>
<th>Weakness</th>
<th>Opportunity</th>
<th>Threat</th>
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<tbody>
<tr>
<td>Fall prevention</td>
<td>• Fall prevention programs at acute &amp; long-term care settings</td>
<td>• Lack collaborative effort by community</td>
<td>• Community-based fall prevention programs</td>
<td>• Increased proportion of older adults in Coos County</td>
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<tr>
<td></td>
<td>• Personal alert systems (for when falls occur)</td>
<td></td>
<td>• Personal knowledge of how to use assisting devices</td>
<td>• Limited resources</td>
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<td></td>
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<td>• Increased proportion of older adults in Coos County</td>
<td>• Home bound</td>
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<td></td>
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<td></td>
<td>• Lack of family support</td>
<td>• Lack of family support</td>
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<tr>
<td>Maternal and child health</td>
<td>• Head Start</td>
<td>• High percent of tobacco use among pregnant women</td>
<td>• Preventing unintended pregnancies</td>
<td>• Family support</td>
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<tr>
<td></td>
<td>• Title X</td>
<td>• Low birth weight</td>
<td>• Access to prenatal care (1st trimester)</td>
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<td></td>
<td>• Midwives</td>
<td>• Births to women &lt; 19 years of age</td>
<td>• Preventing preterm labor</td>
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<td></td>
<td>• Home visiting programs</td>
<td>• Births to unwed mothers</td>
<td>• Food insecurity/nutrition</td>
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<td></td>
<td>• MOMS</td>
<td>• High rates of fetal mortality</td>
<td>• Promotion of services for programs</td>
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<td></td>
<td>• Breastfeeding programs</td>
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<td>• Healthy Start</td>
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<td></td>
<td>• No-cost pregnancy testing</td>
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<td></td>
<td>• BCHC &amp; FQHC</td>
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<td></td>
<td>• WIC</td>
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<td></td>
<td>• Children’s Relief Nursery</td>
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<tr>
<td>Mental health</td>
<td>• Well-coordinated services between Coos County Mental Health and other service providers</td>
<td>• Provider shortage</td>
<td>• Peer support</td>
<td>• Lack social/parental support</td>
</tr>
<tr>
<td></td>
<td>• CaCoon home visiting program</td>
<td>• Recruiting</td>
<td>• Integrate child psychologist into clinics</td>
<td>• Access to providers for people not on OHP</td>
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<tr>
<td></td>
<td>• Nancy Deveraux Center</td>
<td>• Need exceeds capacity</td>
<td>• Better treatment options (medications and evidence-based program)</td>
<td>• Stigma</td>
</tr>
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<td></td>
<td>• Children’s Advocacy Center</td>
<td>• Serving outlying rural areas (e.g., Myrtle Point, Powers)</td>
<td>• Integrate care for children</td>
<td>• Higher levels of care becoming less available statewide for children and adults</td>
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<td></td>
<td></td>
<td>• Housing</td>
<td></td>
<td>• Intergenerational poverty</td>
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<td></td>
<td></td>
<td>• Local care for children who require higher levels of care</td>
<td></td>
<td>• Rates of domestic violence, child abuse, and substance abuse</td>
</tr>
<tr>
<td>Socioeconomic disparities</td>
<td>• OHP</td>
<td>• Programs focus on symptoms not root cause</td>
<td>• Linking services (e.g., WIC and SNAP)</td>
<td>• Economic environment</td>
</tr>
<tr>
<td></td>
<td>• Local food cupboards</td>
<td>• Getting new businesses here</td>
<td>• Tying education to local industry needs</td>
<td>• Lack of affordable housing</td>
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<tr>
<td></td>
<td>• Safety net clinics</td>
<td>• Helping students be successful (e.g., graduate)</td>
<td>• Chamber of Commerce working on jobs</td>
<td>• Multigenerational poverty</td>
</tr>
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<td></td>
<td>• Churches with fresh food</td>
<td></td>
<td>• City Managers and Parks &amp; Recreation working on developing safe places to live and recreate (e.g., parks, bike-ways, walking paths)</td>
<td>• Low education attainment</td>
</tr>
<tr>
<td></td>
<td>• THE &amp; Bay Area Mission (homeless housing)</td>
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<td>• ORRCA</td>
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<td></td>
<td>• SWOCC and their partnerships with other education institutions</td>
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Appendix B: Social-Ecological Model of Prevention

Appendix C: Community Health Improvement Matrix

Using the Community Health Improvement Matrix

Prevention Levels: Prevention aims to minimize the occurrence of disease or its consequences. Levels include:
- Contextual: Prevent the emergence of predisposing social and environmental conditions that can lead to causation of disease
- Primary: Reduce susceptibility or exposure to health threats
- Secondary: Detect and treat disease in early stages
- Tertiary: Alleviate the effects of disease and injury

Intervention Levels: Intervention levels are built on a socioecological model that recognizes different factors affecting health.
- Individual: Characteristics of the individual such as knowledge, attitudes, behavior, self-concept, skills, etc. Includes the individual's developmental history
- Interpersonal: Formal and informal social network and social support systems, including family, work group, and friendship networks
- Organizational: Social institutions with organizational characteristics, and formal (and informal) rules and regulations for operation
- Community: Relationships among organizations, institutions, and informal networks within defined boundaries
- Public Policy: Local, state, and national laws and policies
References

3. NACCHO Research Brief, November 2014
4. NACCHO Research Brief, November 2014
5. www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
6. www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
13. 2013 CHA, p. 28
15. 2013 CHA, p. 11
16. 2013 CHA, p. 11-12
17. 2013 CHA, p. 11-12
19. 2013 CHA, p. 16
27. 2013 CHA, p. 19
28. 2013 CHA, p. 14
29. 2013 CHA, p. 14
30. 2013 CHA, p. 19
31. 2013 CHA, p. 18
36. 2013 CHA, p. 46
Linkages and Coordination

Communication About Benefits
Increase easy to access information to consumers about benefits and services

School Based Health Services
Support activities to expand school based health services outside of Brookings

Accessing Care and Services

Transportation
Support non-emergent medical transportation to increase access and coordination

Mental Health and Addictions
Identify opportunities for CAC to improve coordination of mental health and substance abuse services and treatment

Prevention

Substance Abuse Prevention
Support peer-to-peer prevention efforts to prevent ATOD (alcohol, tobacco and other drugs) abuse

Healthy Food and Lifestyle
Support programs that expand access to healthy food and physical activity

Purpose of the CHIP
The purpose of the CHIP is to outline activities that the CCO and CAC will focus on to improve the health of individuals on the Oregon Health Plan. The Curry County CHIP compliments the Coos County CHIP submitted by WOAH in 2014.
A Community Health Improvement plan or CHIP is a process and a document that outlines WOAH plans to support improved health of consumers on the Oregon Health Plan. This CHIP outlines high-level priorities that the newly formed (February 2015) Curry CAC established for their focus. This CHIP is complimentary to the 2014 WOAH CHIP and 2013 Curry County Community Health Needs Assessment. The CHIP does not encompass all projects the CCO is working on but instead communicates activities that CAC members will engage with CCO staff to accomplish over the next 12 months.

CAC CHIP Process

The Curry CAC for WOAH is newly formed with the first meeting in February 2015. The memorandum of Agreement with WOAH and the Oregon Health Authority requires that the new Curry CAC submit a CHA and CHIP before June of 2015. In order to meet the request the Curry CAC started by reviewing both the Curry Health Needs Assessment published by Curry Public Health in 2013, then reviewed the WOAH CHIP, submitted in 2014.

The CAC met again in March 2015 (second CAC meeting) to discuss, prioritize and establish their three CHIP focus areas. Those areas are: A) Linkages and Coordination; B) Accessing Care and Services; C) Prevention. Two of the focus areas are similar to the WOAH CHIP submitted in 2014. Strategies within each focus area are outlined in the High Level Strategies Map. Detailed activities, CAC champions, timeline and measurements will be established over the summer of 2015, after submission of the CHIP High Level Strategies Map. This document serves to outline high-level priorities and strategies and is complimentary to the 2014 WOAH CHIP.

Next Steps

Developing a detailed work plan, expanding CAC membership and engaging CAC members to work with CCO staff on activities in the work plan will begin after submission of the CHIP in June 2015. Gathering additional community input for future CHIP work while also considering additional community issues such as health equity, maternal and child health and other OHA CHIP priorities will be considered in future CHIPs.
Policy Statement

Consistent with relevant Oregon Administrative Rules (OARs) and Oregon Revised Statutes (ORS) it is the absolute policy of the governing board of directors for Advanced Health, that all Members who need, or could benefit from, language access services and auxiliary aids shall be provided with those services and high-quality aids at no cost to the Member. Further, all services provided to Members, without exception, whether by employees, providers, contractors, or the staff members of providers and contractors, shall be culturally and linguistically appropriate.

Definitions

Limited English Proficiency (LEP) means potential enrollees and enrollees who do not speak English as their primary language and who have limited ability to read, write, speak, or understand English.

Prevalent means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient. In Coos and Curry Counties, the only prevalent language is Spanish.

Procedures

1) Related to Access

a) Members shall have reasonable access to Spanish language interpreter services made available through directly employed Certified Health Care Language Interpreters, and staff members of providers and contractors who are also Certified Health Care Language Interpreters. Further, Members shall have 24-hour per day access to a telephonic Medical Language
Interpretation line, and the costs shall be borne exclusively by Advanced Health.

b) Members who need American Sign Language, or alternate visual formats, shall be provided with those services upon reasonable advanced notice.

c) Members who need, upon their request, shall be provided with copies of the Member Handbook in large print or audio-recorded formats.

2) Related to Practice
   a) Advanced Health shall make oral interpretation available in all languages and written translation available in each prevalent non-English language. All written materials for potential enrollees, including large print (>18-point), must explain the availability of written translations or oral interpretation to understand the information provided and the toll-free TTY/TTY number.

   b) Advanced Health shall make its written materials that are crucial to obtaining services, including at a minimum, provider directories, Member Handbook, appeal and grievance notices, and denial and termination notices, available in Spanish and English. These written materials must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost.

   c) Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost. These include TTY/TTY toll-free numbers, American Sign Language, ASL video directory, and the temporary lending of amplification devices at open meetings of the board of directors or any meeting of the CACs.

   d) Advanced Health shall not discriminate in its practices, communications, access, or delivery of services to any individual on the basis of race, color, national origin, disability, age, gender, gender preference, or gender identity.

   e) Advanced Health shall make its written materials that are crucial to obtaining services, including at a minimum, provider directories, Member Handbook, appeal and grievance notices, and denial and termination notices, available in print format at the sixth-grade reading level as defined by the Center for Medicaid and Medicare Services (CMS), Toolkit for Making Written Material Clear and Effective, Part 7, SMOG (Simple Measure of Gobbledygook) methodology that takes into account grade-level, syllable counts, syntax, and readability formulae.

3) Related to Quality
   a) By 31 December 2019, every employee of Advanced Health, every provider and employee of provider, and every contractor and employee of contractor, shall satisfactorily complete recognized courses of study in cultural and linguistic competency, health literacy, and trauma-informed practices, and shall provide proof of completion for credentialing and personnel files. Thereafter, within thirty (30) days of employment, or at the time of initial
credentialing, all personnel referenced above shall complete and document these three training requirements.

4) Related to Evaluation and Monitoring
Advanced Health's score on relevant quality and access variables, as measured by the CAHPS survey, among respondents of minority groups or persons with disabilities, shall be equal to, or better than, the composite scores for those variables attained by general survey respondents, and shall steadily improve over time.
Background: Western Oregon Advanced Health, LLC (abn *Advanced Health*) was initially certified by the Oregon Health Authority (OHA) as a Coordinated Care Organization (CCO) in the first wave of CCO applicants in 2012. For the past seven years, Advanced Health has been meeting the health care needs of 18,477 Medicaid beneficiaries in Coos County and 2,230 Members in Curry County, for a combined total of 20,707 Members, in the southwestern-most corner of Oregon. Advanced Health shares Curry County with AllCare, Inc. and primarily serves residents in the more northern portions of Curry County (e.g., Port Orford and Gold Beach), while All Care serves approximately 3,000 residents, drawn largely from the more populous southern community of Brookings.

Coos and Curry Counties are federally classified as *rural*, while the communities of Powers and Agness carry federal designations as *rural-remote* or *frontier*. To that end, Advanced Health's community-based service delivery system is unlike that of metropolitan or urban CCOs, in that it seeks to engage all healthcare Providers throughout a 3,227 square-mile area. Collectively Coos and Curry Counties support a population base of 85,790 persons, or 26.5 persons per square mile. Over one-half of the land mass is federally characterized as *sparsely populated*.

A.1.a. Did Applicant obtain Community involvement in the development of the Application? Extensive community involvement was solicited in the development of Advanced Health's application. Beginning in early 2018, Advanced Health raptly followed the Health Policy Board's processes and thinking as they began to shape *CCO 2.0*, and broadly disseminated this information, as it became available, to its Board of Directors, network partners, Community Advisory Councils (CACs), Clinical Advisory Panel (CAP), social service agencies, and Community stakeholders. When the Oregon Health Policy Board conducted its CCO 2.0 listening sessions, Advanced Health assured that the local event was well attended, with diverse representation from Members, advocates, Community stakeholders, Subcontractors, Providers, and members of its Board of Directors. It was amid this backdrop that both Community Advisory Councils began their work in crafting an entirely new Community Health Assessment. The resultant Community Health Improvement Plan is in draft form, scheduled for completion in May 2019, and significantly informed both the development of this Application and the attached Community Engagement Plan.

Throughout 2018, Advanced Health's Board of Directors, which includes Providers, Subcontractors, Community stakeholders, and consumers, monitored the evolution
of CCO 2.0. Beginning in October, 2018, when the final version of the Oregon Health Policy Board's recommendations became available, and continuing through February, 2019, the Board of Directors was presented with multiple options for addressing the changes reflected in CCO 2.0, and at its March 2019 meeting, adopted the framework for the situate application.

A.1.b. Applicant will submit a plan via the RFA Community Engagement Plan for engaging key stakeholders, including OHP consumers, Community-based organizations that address disparities and the social determinants of health, providers, local public health authorities, Tribes, and others, in its work. The Plan will include strategies for engaging its Community Advisory Council and developing shared Community Health Assessments and Community Health Improvement Plan priorities and strategies. Advanced Health's Community Engagement Plan is attached.

A.2. Requested Documents: Completed RFA Community Engagement Plan, including all required elements as described in RFA Community Engagement Plan Requirement Components and attaching required Tables in RFA Community Engagement Plan Required Tables (page limit: 4 pages, excluding tables). Advanced Health's Community Engagement Plan is attached.

B.1.a. Informational Question: Does Applicant currently hold any agreements or MOUs with entities that meet the definition of SDOH-HE partners, including housing partners? Yes. If yes, please describe the agreement. Advanced Health has entered into its fifth, one-year, formal grant agreement with the Devereux Center, a community-based non-profit entity, for the provision of support services, Emergency Department diversions, and the operation of a warming center for persons experiencing housing instability.

Advanced Health has entered into a one-year, formal grant agreement with Every Child, a local chapter of a statewide non-profit entity, for the provision of supports to children in the foster care system and the identification and recruitment of additional foster parents.

Advanced Health has entered into a two-year, formal grant agreement with the Curry Homeless Coalition, a Community-based non-profit entity, for the establishment and operation of a one-stop community integrated services system in Gold Beach.

In 2018, Advanced Health entered into a formal grant agreement with the Curry Homeless Coalition to fund a housing needs assessment study. The project was successfully completed, and the grant period has concluded.
Advanced Health has entered into a formal, one-year grant agreement with the United Way of Southwestern Oregon to develop the capacity of that organization to better meet the needs of Community-based non-profit entities that address SDOH-HE, with an emphasis on families with children aged 0 to 5.

The United Way of Southwestern Oregon serves as the fiscal agent for Coos Housing Action Team (HAT), an exciting and emerging partnership that has attracted key Community leaders and is forging ahead to address the Community's housing crisis and extensive affordable housing needs. In 2018, Advanced Health entered into a grant agreement with the United Way, on behalf of the HAT, to fund a housing needs assessment study. In 2019, Advanced Health entered into a formal grant agreement with the United Way, on behalf of the HAT, to fund a housing strategic plan.

In aggregate, in 2017 and 2018, Advanced Health invested $300,000 in an Adverse Childhood Experiences (ACEs) education and training project in which Advanced Health served as the backbone organization. Advanced Health is willing to contribute $100,000 per annum in Health-Related Services funding to this continuing effort, but is asking that the community identify an alternate, community-based, non-profit entity to serve as the backbone organization. A formal grant agreement will be developed once the new backbone organization is identified.

B.1.b Informational Question: Does Applicant currently have performance milestones and/or metrics in place related to SDOH-HE? These milestones/metrics may be at the plan level or provider level. If yes, please describe. Advanced Health has established milestone and/or specific metrics in its grant agreements with the Devereux Center (numbers of persons assisted in accessing health services other than through Emergency Departments, numbers of persons assisted in accessing preventative health services,) Every Child (numbers of new foster parents recruited), Curry Homeless Coalition (numbers of persons assisted in establishing eligibility for the Oregon Health Plan, numbers of individuals assisted in accessing primary and preventative health care, number of Hospital diversions, number of persons assisted in securing and retaining supported employment), and United Way of Southwestern Oregon (measurable increases in fund-development activities that benefit non-profit entities who address SDOH-HE).

The ACEs leadership team has seated an internal metrics committee which is working on measuring the impacts of this program. To date, the metrics identified are process measures; no outcome or impact objectives have been identified.

B.1.c. Informational Question: Does Applicant have a current policy in place defining the role of the CAC in tracking, reviewing, and determining
how SDOH-HE spending occurs? No. If yes, please attach current policy. If no, describe how Applicant intends to define the role of the CAC in directing, tracking, and reviewing SDOH-HE spending. Advanced Health's current policies and procedures governing the CACs do not specifically address the CAC's role in tracking, reviewing, and determining how SDOH-HE investments will occur. New policies will be promulgated and available by the time of the readiness review. Extended responses to Question B.1.d. detail the role of the CAC and other partners in directing, tracking, and reviewing SDOH-HE investments.

B.1.d. Informational Question: Please describe how the Applicant intends to award funding for SDOH-HE projects.

Step 1: Advanced Health's Board of Directors will seat a five-member Governance SDOH-HE Program Committee, comprised of at least two Board members and two SDOH-HE experts from the Community who are not affiliated with any entity that is likely to be an applicant for Advanced Health's SDOH-HE initiatives. At least one Community member of the Governance SDOH-HE Program Committee must hold expertise in health equity. Governance SDOH-HE Program Committee members must be willing to make a substantial initial time commitment.

Step 2: Each of Advanced Health's two CACs will also seat a five-member CAC SDOH-HE Program Committee, comprised of at least three consumer-members, one of whom must be representative of a Tribe or ethnic minority. No person appointed to the CAC SDOH-HE Program Committee may be an employee or board member of a Community-based organization or public health entity that is likely to be an applicant for Advanced Health’s SDOH-HE initiatives. CAC SDOH-HE Program Committee members must be willing to make a substantial initial time commitment. Consumer-members of the CAC Program Committee will be provided with stipends, transportation, and child care to facilitate their participation.

Step 3: Over the course of multiple sessions, the Governance and CAC SDOH-HE Program Committees will meet for a robust program of in-service training on program development. All meetings will be announced and open to the public. The combined Committees will be exposed to data-based needs assessment and strategies that address needs while targeting narrowly-defined populations. Inherent in these strategies are the concepts of models that work, Evidence-Based models and Evidence-Based best practices. Representatives from charitable foundations will share their experiences in grant-making, including both their successes and failures. Specifically, trainers from charitable foundations will speak to the importance of building sustainment into each funded initiative from its outset. The combined Committees will study the ten-year effort of the Northwest Area Foundation that expended $100 million in ten discrete northwest communities over the course of one decade to address the root causes of poverty, and the failure of that effort to produce results. Comparisons will be made between the root causes of
poverty and social determinants of health to examine similarities and differences, and to chart Evidence-Based courses that are more likely to produce desired outcomes. The combined Committees will learn the tenets behind logic models, and the differences among process objectives, outcome objectives (distal and proximal outcomes) and impact objectives. The combined Committees will learn to differentiate from among capacity-building strategies, program strategies, and capital strategies. Finally, the combined Committees will be introduced to program evaluation methodologies, and will learn how to select, from a range of evaluation methods available, those that are the most rigorous, yet cost-effective.

**Step 4:** It is a given that one of the three SDOH-HE initiatives that will be addressed by Advanced Health will be supported housing. In addition, each CAC SDOH-HE Program Committee will submit to the Governance SDOH-HE Program Committee three or four strategic priorities for SDOH-HE consideration. The method of submission shall be in the form of logic models. The submitted SDOH-HE initiatives must be priorities that are included in the CAC's Community Health Improvement Plan or in the State's Health Improvement Plan. The Governance SDOH-HE Program Committee, in consultation with the full Board of Directors for Advanced Health, will make the final selection from among the CAC SDOH-HE Program Committee's nominations (logic models) as to the two non-housing focus areas for SDOH-HE initiatives. The Board meeting at which this decision is made shall be announced and open to the public. Advanced Health's Board of Directors will make this determination based on need, likelihood of sustainment, strength of logic models, and ability to articulate ambitious yet attainable outcome measures.

**Step 5:** From among the funds available, the CAC SDOH-HE Program Committee will determine the amount of resources to be invested in each of the two selected SDOE-HE initiatives. The CAC SDOH-HE Program Committee at which this decision is made shall be widely announced and open to the public.

**Step 6:** Subject to the approval of the OHA, the Governance SDOH-HE Program Committee will draft a solicitation for each of the two non-housing SDOE-HE initiatives and shall require that respondents to the solicitation provide sustainment strategies, logic models, ambitious yet attainable outcome objectives, a rich program narrative, and a detailed line-item budget with justifications. A firm due date will be required. Applicants will be delimited to: non-clinical, private, Community-based, non-profit, tax-exempt organizations that are headquartered in Coos and Curry Counties; and local public health entities.

**Step 7:** The CAC SDOH-HE Program Committee will review and comment on the Governance Program Committee's solicitation, and reasonable revisions from the CAC SDOH-HE Program Committee will be accommodated.
Step 8: Advanced Health will issue and widely disseminate, using print, newsprint, and broadcast media, the solicitation and convene a bidder's conference. Members of the CAC SDOH-HE Program Committee will participate on the panel at the bidder's conference. The bidder's conference will be broadly announced.

Step 9: Acting together, the Governance SDOH-HE Program Committee and the CAC SDOH-HE Program Committee will review and score SDOH-HE applications and make single- or multiple-year grant award decisions, subject to funds available and the approval of the OHA and Advanced Health's Board of Directors.

Step 10: Advanced Health will conduct readiness reviews and enter into contractual agreements with the successful bidders. The nature of the contractual agreement shall be that of a cooperative agreement through which Advanced Health and the CACs may become substantially involved. Cooperative agreements shall set forth programmatic and financial reporting requirements, and the metrics that must be attained for contract renewal. Process objectives will be accepted for the first year; all subsequent years will require time-framed and measurable outcome objectives.

Step 11: Together, the Governance SDOH-HE Program Committee and CAC SDOH-HE Program Committee will identify and retain the services of an independent, neutral, and well-qualified individual or firm to provide program evaluation services for the SDOH-HE initiatives. Both SDOH-HE Program Committees will continue to meet for the purposes of periodic, and at least quarterly, program evaluation and oversight functions. An Annual Summary of Findings shall be prepared and widely disseminated to Members, SDOE-HE partners, and community stakeholders.

B.1.d.(1) How will Applicant guard against potential conflicts of interest? Please refer to Steps 1 and 2, above.

B.1.d.(2) How will Applicant ensure a transparent and equitable process? Please refer to Steps 3, 4, and 5, above.

B.1.d.(3) How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the community. Please refer to Step 11, above.

B.2.a. Please describe the criteria Applicant will apply when selecting SDOH-HE partners. When selecting SDOH-HE partners, the CAC Program Committee and the Governance Program Committee will apply the following criteria:

- The degree to which the proposed project is a local CHIP priority;
- The degree to which the proposed project is a SHIP priority;
• The degree to which a documented need for the project exists in the Community;
• The degree to which the proposed project addresses the identified need, and defines the targeted population to benefit from the program;
• The degree to which the proposed project incorporates the use of Evidence-Based models and practices;
• The capacity of the applicant organization to carry out the project;
• The technological capacity of the applicant to track and report outcomes;
• The quality of the logic modeling submitted by the applicant;
• The degree to which the applicant can articulate realistic, ambitious, time-framed, and measurable outcomes;
• The degree to which the project budget is reasonable, allowable, and allocable;
• The degree to which the project budget includes leveraged resources; and,
• The degree to which the project budget establishes a clear glide path to long-term project sustainment and self-sufficiency.

Coos and Curry Counties are home to many small, but vital, Community-based, non-profit, social service agencies who, in truth, may not possess adequate capacity to meet the selection criteria stated above. To this end, Advanced Health has entered into a three-year grant agreement with the United Way of Southwestern Oregon, through which the United Way will make capacity-building grants available to local social service agencies, with operating budgets of less than $1 million, who address SDOH-HE issues, with an emphasis on those serving families with children aged 0 to 5. It would be difficult for a small non-profit agency to approach Advanced Health and request technical assistance for capacity-building, if Advanced Health might later look unfavorably on that agency for its lack of capacity. For this reason, all capacity-building grants will be made through an application process with the United Way. By capacity-building, Advanced Health does not mean programmatic expansion. Rather, it intends to help, through the United Way, for such purposes as board development, technology infrastructure, fund development, strategic planning, technical assistance and training, and program planning. Advanced Health is committing $440,000 in Community benefit resources to this effort over a three-year period, beginning in 2019. Advanced Health hopes to build the capacity of all social service agencies, such that they can be competitive in their quest for SDOH-HE resources.

For decades, those entities traditionally charged with developing housing in Coos and Curry Counties (local housing authorities; the local community action agency; CMHPs with special resources made available to them) have failed to develop any housing stock that is owned or operated by a local entity. During years in which HUD funding generously flowed, no HUD grants were sought. All state grants that targeted persons with SPMI were turned over to a Jackson-County-based non-profit entity. For this reason, it was refreshing when a new coalition was formed in 2017,
known as the Housing Advisory Team (HAT). This group has attracted county commissioners, city managers, city councilors, housing developers, community leaders, and traditional housing partners. Advanced Health provided the HAT with funding to undertake a comprehensive housing needs assessment study (2018) and a follow-up housing strategic plan (2019) with plans to develop Oregon's first Community-owned housing trust fund. With the consent of OHA, Advanced Health would prefer to directly engage the HAT in a SDOH-HE negotiated contract for supported housing, rather than to splinter this group and its momentum by making supported housing investments with any other entity. Further, because the need is so acute, Advanced Health would request OHA's consent to allocate 50 percent of its SDOH-HE investments in housing, and the remaining 50 percent in the other two, yet-to-be-identified SDOH-HE initiatives. Regardless of OHA's mechanism for calculating SDOH-HE spending, Advanced Health is committed to investing at least $500,000 per annum in allowable housing initiatives.

B.2.b. Please describe how Applicant will broadly communicate the following information to the public and through its network of partners:

- **Its SDOH-HE spending priorities**: Please refer to Step 4 of B.1.d.
- **The availability of funding for projects**: Please refer to Steps 5 and 8 of B.1.d.
- **How interested parties can apply for consideration**: Refer to Step 8 of B.1.d.
- **The project selection process**: Please refer to Steps 9 and 10 of B.1.d.

B.2.c. Please describe how Applicant will track and report SDOE-HE expenses and outcomes, including technological capacity and process for sharing and collecting data, financial systems, and methods for data collection. In the negotiated process, leading to the execution of a cooperative agreement, Advanced Health will articulate its expectations for data collection and financial reporting. Investments made through the United Way's capacity-building grants in prior years will have assisted SDOH-HE applicants to develop adequate technology systems to track and report the required data. Depending on the nature of the SDOH-HE projects funded, data sets will be electronically submitted to Advanced Health on quarterly or semi-annual bases. Data will be used to measure productivity, penetration, processes and outcomes.

Financial expenditures reports will be required annually. For cooperative agreements of less than $100,000, no additional financial information will be required. For cooperative agreements that range from $100,001 to $499,999, limited financial reviews will be required. For cooperative agreements exceeding $500,000, independent timely financial audit reports will be required.

B.2.d. Applicant will submit a plan for selecting community SDOH-HE spending priorities in line with existing CHP priorities and the statewide
priority on Housing-Related Services and Supports via the RFA Community Engagement Plan, as referenced in Section A. Advanced Health's Plan for selecting SDOH-HE investment priorities is captured in B.1.d, Steps 1 through 10, in B.2.a (related to housing), and in the RFA Community Engagement Plan that is attached.

C.1.a. Informational Question: Please describe how HRS Community benefit investment decisions will be made, including the types of entities eligible for funding, how entities may apply, the process for how funding will be awarded, the role of the CAC (and Tribes/tribal advisory committee if applicable) in determining how investment decisions are made, and how HRS spending will align with CHP priorities. Advanced Health has historically made significant HRS investments, spending in excess of $1 million in this category in 2018. However, Advanced Health's processes for so-doing have not been formalized. HRS investments were made for projects advanced by the CACs, Clinical Advisory Panel, executive staff, individual Board members, or direct inquiries from Community-based organizations.

In responding to Question B.1.d, Advanced Health provided the step-by-step approach that it will use when making SDOH-HE investment decisions. Advanced Health will mirror the exact same step-by-step process when making HRS investment decisions, except that Advanced Health will allocate the value of sums available, and CACs will not be restricted to nominating only three or four programs. HRS Program Committees will be seated at the governance and CAC levels, with the caveat that no person may serve on both the SDOH-HE Program Committee and the HRS Program Committee.

D.1. Informational Question: Please identify the data source(s) Applicant proposes to use when defining the demographic composition of Medicaid Members in the Applicant's Service Area. For demographic data that is not provided by OHA, Advanced Health will rely on extrapolation from updated data sets maintained by Portland State University's Center for Population Studies. Technical assistance may be sought from the Transformation Center's Office of Equity and Inclusion.

D.2. Evaluation Question: Applicant will submit a plan via the RFA Community Engagement Plan, as referenced in Section A, for engaging CAC representatives that align with the CHP priorities and membership demographics, how it will meaningfully engage OHP consumer(s) on the CCO board and describe how it will meaningfully engage Tribes and/or tribal advisory committee (if applicable). Applicant may refer to guidance document CAC Member Assessment Recruitment Matrix. Advanced Health's RFA Community Engagement Plan is attached.
E.1.a. Informational Question: Please briefly describe the Applicant's current organizational capacity to develop, administer, and monitor completion of training material to organizational staff and contractors, including whether the Applicant currently requires its Providers or Sub-contractors to complete training topics on health and Health Equity. By December 31, 2019, all employees, Providers, employees of providers, contractors, and employees of contractors are required to complete acceptable training in cultural and linguistic competency, health literacy, and trauma-informed practices. Certificates of completion must be submitted to credentialing and personnel files. Advanced Health has adequate controls in place to ensure that training is completed and documented.

E.1.b. Informational Question: Please describe Applicant's capacity to collect and analyze REAL+D data. Advanced Health's capacity to collect REAL+D data, unless provided by OHA, is limited, but can be improved through building responsive technology infrastructure and reliable data collection mechanisms. Advanced Health enjoys the services of three data analysts/data scientists who have tremendous acumen in analyzing any data sets, including REAL+D.

E.2.a. Evaluation Question: Please provide a general description of the Applicant's organizational practices, related to the provision of culturally and linguistically appropriate services. Include description of data collection procedures and how data informs the provision of such services, if applicable. Coos and Curry Counties are characterized by a paucity of ethnic diversity at 10.7 percent and 9.6 percent, respectively. Only 35 Member households are Spanish-speaking and local public schools have eliminated their migrant education and ESL programs. CAHPS scores for persons of minority status were found to be no different than those from the dominant Anglo population. In consultation with the Office of Equity and Inclusion, the greatest disparities were identified for persons with disabilities, and particularly persons with mobility disabilities. Advanced Health requires all personnel, Providers, and contractors to complete cultural and linguistically competence and health literacy training and has brought expert trainers and speakers to the Community. Advanced Health is committed to providing culturally and linguistically appropriate services through the retention of translators and interpreters, print material available in Spanish, and the inclusion of Native American and Hispanic providers within its network.

E.2.b. Evaluation Question: Please describe the strategies to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the service area. Of Advanced Health's and SWOIPA's personnel, five of one hundred employees are of Hispanic or Native American heritage. Two hold administrative-level positions and one directs the human services department. Advanced Health is excited about the
opportunities to expand its cadre of Traditional Health Workers by 100-to-120 persons and will recruit heavily for these positions from among current Members and minority populations.

E.2.c. Please describe how Applicant will ensure the provision of linguistically appropriate services to Members, including the use of bilingual personnel, qualified and certified interpreter services, translation of notices in languages other than English, including the use of alternative formats. Applicant should describe how services can be accessed by the Member, staff, and Provider, and how Applicant intends to measure and or evaluate the quality of language services. Advanced Health's abbreviated policies and procedures addressing this inquiry are attached.

E.2.d. Please describe how Applicant will ensure Members with disabilities will have access to auxiliary aids and services at no cost as required in 42 CFR 438.10, 42 CFR Part 92, and Section 1557 of the Affordable Care Act. Response should include how Applicant plans to monitor access for Members with disabilities with all contracted providers. Advanced Health's abbreviated policies and procedures addressing auxiliary aids for Members with disabilities are attached.

E.3. Required Documents: Policies and Procedures describing language access services, practices, evaluation, and monitoring for appropriateness and quality. Policies and Procedures related to the provision of culturally and linguistically appropriate services. These documents are attached, and are counted within the 14-page limit, as the instructions did not state that they fell outside of the page limitations – hence their abbreviated versions.

F.1.a. Informational Question: Does Applicant currently utilize THWs in any capacity? Yes. If yes, please describe how they are utilized, how performance is measured and evaluated, and identify the number of THWs (by type) in the Applicant's workforce. Throughout the network, approximately 40 Community Health Workers are employed as members of teams to provide care management functions and to aid Members during transitions. Individual performance is measured by supervisors.

F.1.b. Informational Question: If Applicant currently utilizes THWs, please describe the payment methodology used to reimburse for THW services, including any alternative payment structures. THWs are paid on an hourly basis, and not on the basis of encounter data or alternative payment structures.

F.2.a. Evaluation Question: Please submit the THW Integration and Utilization Plan. Advanced health's THW Integration and Utilization Plan is attached.
G.1. Applicant will submit a proposal via the RFA Community Engagement Plan, referenced in Section A. Advanced Health’s RFA Community Engagement Plan is attached.
ADVANCED HEALTH
TRADITIONAL HEALTH WORKER INTEGRATION AND UTILIZATION PLAN
Attachment 10

I. Background and Significance

Substantial clinical research has evaluated the efficacy of Traditional Health Workers (THWs) and concluded that their integration and utilization within the health care system holds the promises of: reducing costs associated with care; addressing the social determinants of health; ameliorating health disparities in culturally-appropriate ways; and, supporting whole person care. Effective Traditional Health Workers are those who are selected from the community being served, are representative of the population served, and reflect shared life experiences with members of the target population.

Because an accredited Traditional Health Worker education program was absent from the community, Advanced Health supported its first four Traditional Health Workers in accessing education at Rogue Community College in Jackson County. Advanced Health provided financial development assistance to Southwestern Oregon Community College (SOCC) to establish an accredited Traditional Health Worker education program that graduated its initial cohort of Traditional Health Workers in 2017 (N = 24). A second cohort (N = 24) completed their education in 2018. Participants in these two cohorts were chosen from among persons who were currently employed throughout Advanced Health's network, persons volunteering in those setting, or individuals already known to Advanced Health and its network as needing employment and being highly representative of the target population (e.g., members of the Community Advisory Council). As of this writing, SOCC holds accreditation for educating Community Health Workers, but not for providing training for Peer Wellness Specialists, Personal Health Navigators, Peer Support Specialists, or Doulas. When Peer Support Specialists have been required for Advanced Health's Children's System of Care (SOC) program, that training has been procured by sending trainees to the tri-county metropolitan area.

Advanced Health has completely restructured its primary-care case management program, Intensive Care Coordination (ICC) program, and Exceptional Needs Care Coordination (ENCC) program. Traditional Health Workers will be used extensively within these case management and care coordination programs, and Advanced Health estimates that it will require the services of 100 to 120 additional Traditional Health Workers by the close of 2020. Moreover, there is a growing demand for adding Youth and Family Peer Support Specialists for the System of Care program. Finally, Advanced Health desires to cross-train each of its customer service representatives as Personal Health Navigators. To achieve these ends, as it has done in the past, Advanced Health will underwrite the costs of Traditional Health Worker education at SOCC and will provide fiscal development resources to
SOCC to add accredited programs for Navigators and Peers. Advanced Health hopes to launch one course in September 2019, a second in November 2019, and two additional courses during the first six months of 2020.

II. Plan for Integrating Traditional Health Workers in Service Delivery Communication with Members about Traditional Health Workers, and Increasing Traditional Health Worker Utilization

Integrating Traditional Health Workers in Service Delivery: In the past, Advanced Health, through its contracted provider of integrated physical and behavioral health services, Southwestern Oregon Independent Practice (SWOIPA) has only contracted with individual providers. Nonetheless, most primary care providers are organized in practice groups (i.e., Bay Clinic; Coast Community Health Center; Curry Health Network; North Bend Medical Center; Waterfall Community Health Center). SWOIPA will change its contracting processes, and will now contract with practice groups, in addition to individual providers. In specific, SWOIPA will contract with practice groups and Primary-Care Patient Centered Medical Homes (PCPCHs) for the provision of primary-care case management services. Practice groups will be responsible for configuring primary-care case management teams and allocating teams to primary care teams within their practice group. SWOIPA will offset the full cost of embedding primary-care case management services at every primary care practice location, using a pmpm methodology. Primary-care case management teams will be comprised of registered nurses, as the team leader and supervisor, and Community Health Workers, Navigators, and in some cases, Peers. Primary-care case management teams will conduct initial and annual screening activities for Members (i.e., health-risk factors; social and emotional well-being; adverse childhood experiences; and social determinants of health), and will develop and manage written plans of care for those Members who screen positive, or who are members of priority or special population groups. Through this strategy, Traditional Health Workers will be integrated in every primary health care setting and will have direct and meaningful contact with every Member.

Advanced Health is undertaking a series of strategies to significantly increase the number of Assertive Community Treatment (ACT) Teams who will work, with small patient ratios, with Members who are diagnosed with severe and persistent mental illness (SPMI). Through the ACT Team model, treatment and ICC/ENCC care coordination will be provided by a single team. Each team will be comprised of a full-time licensed mental health professional (as the lead team member and supervisor), two ICC/ENCC care coordinators, and fractional skill trainers/supported employment developers, registered nurses, and prescribers. Carefully chosen Community Health Workers, Navigators, and Peers will be selected to serve as members of ACT Teams in the capacity of well-supervised care coordinators.
Communicating with Members about the Benefits and Availability of Traditional Health Worker Services: Because the concept of perceiving a Traditional Health Worker as a valued member of the health care team may be new for some Members, care will be taken to communicate with Members about the benefits and availability of Traditional Health Worker services through such vehicles as the Member Handbook, Advanced Health's website, print materials on primary-care case management, and community educational forums. Many Members' first contact at Advanced Health is through the customer service division. As customer service personnel become cross-trained as Navigators, they will answer the phone differently, and identify themselves as a Navigator – a form of Traditional Health Worker – who is available to address Members' inquiries and needs. When Members first present at their primary care providers' offices, they will meet the members of their primary-care team, including Traditional Health Workers, and will receive information about each person's role in patient-centered and team-based care.

Increasing Health Worker Utilization: Through the two salient strategies identified above (primary-care case management, and ACT Team ICC/ENCC care coordination), Advanced Health will significantly increase its utilization of Traditional Health Workers, growing this workforce by 100-120 new workers. In turn, Advanced Health's Members will increase their utilization of Traditional Health Workers as those individuals play ever-increasing roles in customer service, case management, and care coordination.

III. Implementation of Best Practices

Advanced Health is aware of best practice recommendations tendered by the Traditional Health Worker Commission with respect to training and education programs and requirements, systems integration, payment models, scope of practice and supervision, and retention. Training and education requirements fall within the scope of the local community college and the accrediting board. Nonetheless, and because Advanced Health will be rapidly adding so many new Traditional Health Workers, who will be reporting to primary care practices where the requirement for primary-care case management services may also be new, immediately upon completion of the formal curricula at SOCC, Advanced Health will invite all new graduates to participate in an additional 35 hours of on-site training at Advanced Health. It is through this process that Advanced Health will instruct in the use of screening tools, discuss standards for plans of care, orient to health information technology that will be used, provide contact information for the Traditional Health Worker Liaison, and build a sense of team. In-service training will continue on a regular monthly basis under the guidance of the Traditional Health Worker Liaison.
Within Advanced Health's system, Traditional Health Workers will be integrated in two primary ways: (1) as a valued member of a primary-care case management team that integrates and coordinates between the Member, the primary care provider, and any clinical or non-clinical service that may be needed to meet the objectives of the Member's individualized plan of care; or, (2) as a fully integrated member of an ACT-Team that integrates and coordinates between the Member, the Member's primary therapist, the Member's family or caregivers, all relevant levels and transitions in care, and all clinical or non-clinical long- or short-term services and supports.

Traditional Health Workers will be paid by group medical practices that are under contract to SWOIPA. Traditional Health Workers will be required to submit encounter data for all encounterable contacts with Members but encounter data will not form the basis of their compensation. Instead, Traditional Health Workers will be compensated at an hourly rate that may not be less than $15 per hour with reasonable additional benefits. [In southern Oregon, the living wage for two working adults with children ranges from $13.59 to $16.73.] Advanced Health does foresee, and enthusiastically supports, the circumstance under which current Members will become Traditional Health Workers and use readily-available employment opportunities to advance on the socio-economic scale.

Traditional Health Workers will be placed in settings in which their assigned tasks fall clearly within their scope of practice. Community Health Workers will be members of primary-health case management teams in which they provide care coordination, assist with referrals, contribute to team-based plans of care, and assist with transitions, under the direct supervision of registered nurses. Community Health Workers and Peer Wellness Specialists will also be members of ICC/ENCC teams in which they provide care coordination, assist with referrals, contribute to plans of care, and provide support during transitions, under the supervision of licensed mental health professional. Personal Health Navigators will be employed by SWOIPA, under the supervision of both registered nurses and licensed mental health professionals, to provide care coordination. Peer Support Specialists will work in behavioral health settings as members of ACT and SOC teams, providing direct care, care coordination, and health promotion under the supervision of licensed mental health professionals.

In a concerted effort to contribute to job satisfaction and retain Traditional Health Workers, Advanced Health will assure that these Workers connect with others doing similar work through models of team-based care and meaningful monthly meetings of all Traditional Health Workers. Advanced Health will provide multiple opportunities for training and professional development and will identify a Traditional Health Worker Liaison to support Workers' needs and efforts.
Measurements of Baseline Utilization and Performance Over Time: Advanced Health will require that all services provided by Traditional Health Workers that can be encounterable be submitted on a regular weekly basis in the form of claim and encounter data. Once at scale, encounter data gathered during the first six months will form the baseline measurement, and the goal will be to for encounters to steadily increase in numbers over time as evidence that Traditional Health Worker services are being adequately utilized. Encounter data will also be analyzed to determine productivity levels for teams, types of Traditional Health Workers, and individual Traditional Health Workers. More productive teams may be asked to provide in-service training to teams with lower productivity levels.

Utilization of the Traditional Health Worker Liaison Position: Advanced Health is excited to retain the full-time services of a Traditional Health Worker Liaison. Initially, this individual will expend tremendous time and effort interfacing with SOCC to add new Traditional Health Worker specialty modules and recruiting prospective students to participate in the educational program and matriculate to employment within Advanced Health's network. Concurrently, the Traditional Health Worker Liaison will be interfacing with practice settings to prepare them to receive, assimilate, and support Traditional Health Workers, and preparing Advanced Health's post-graduation and in-service training programs. It is intended that the post-graduation/pre-placement training will be robust and will familiarize new graduates with Advanced Health's models of practice, documentation, and standards. On an ongoing basis, the Traditional Health Worker Liaison will co-supervise Traditional Health Workers in concert with registered nurses or licensed mental health professionals who serve as the leaders of the THW's teams.

The Traditional Health Worker Liaison is further charged with the responsibilities of developing educational information for Members regarding the purpose and benefits of connecting with Traditional Health Workers and advocating for Traditional Health Workers throughout Advanced Health's network and with community stakeholders.
Background: Western Oregon Advanced Health, LLC (dba Advanced Health) was initially certified by the Oregon Health Authority (OHA) as a Coordinated Care Organization (CCO) in the first wave of CCO applicants in 2012. For the past seven years, Advanced Health has been meeting the healthcare needs of 18,477 Medicaid beneficiaries in Coos County and 2,230 Members in Curry County, for a combined total of 20,707 Members, in the southwestern-most corner of Oregon. Advanced Health shares Curry County with AllCare and primarily serves residents in the more northern portions of Curry County (e.g., Port Orford and Gold Beach), while AllCare serves approximately 3,000 residents, drawn largely from the more populous southern community of Brookings.

Coos and Curry Counties are federally classified as rural, while the communities of Powers and Agness carry federal designations as rural-remote or frontier. To that end, Advanced Health's Community-based service delivery system is unlike that of metropolitan or urban CCOs, in that it seeks to engage all health Providers throughout a 3,227 square-mile area. Collectively Coos and Curry Counties support a population base of 85,790 persons, or 26.5 persons per square mile. Over one-half of the land mass is federally characterized as sparsely populated.

Under CCO 1.0, Advanced Health delegated all physical health and Substance Use Disorder (SUD) services to Southwest Oregon IPA, Inc. (SWOIPA). In turn, SWOIPA delegated SUD services to ADAPT, Inc. ADAPT has been certified by OHA for the provision of in-patient, residential (adult and adolescent), intensive out-patient, out-patient, detoxification, and medication-assisted treatment (MAT) services. With the onset of CCO 2.0, Advanced Health will enter into a Privileged Provider contract with SWOIPA for the full integration of physical and Behavioral Health services under a global budget. Privileged Provider contracts differ from delegation contracts in that there are certain privileges that may or may not be awarded to a contractor, depending on the contractor's capabilities and prior performance. Privileges include, but are not limited to, credentialing; sub-contracting; and utilization management.

Through SWOIPA, Advanced Health contractually secures the services of 105 physicians who practice at 23 discrete addresses in practice configurations that range from solo private practice to fifty-physician multi-specialty group practices. The area is served by a single DRG hospital (Bay Area Hospital) and three Rural Critical Access Hospitals in Gold Beach, Bandon, and Coquille.
Similarly, under CCO 1.0, Advanced Health delegate all dental and oral health services to Advantage Dental, with caveats that Advanced Health held the right to empanel additional oral health Providers if Advantage Dental was unable to meet the full array of Members' needs. Under CCO 2.0, Advanced Health will no longer use a delegation model, and instead will enter into Privileged Provider agreements, or cooperative agreements in which Advanced Health retains significant involvement.

In both counties, the boards of county commissioners retain status as the Local Mental Health Authority (LMHA). In Coos County, Coos Health and Wellness (CHW), a division of county government, is certified by OHA as the Community Mental Health Program (CMHP), while in Curry County that designation is held by Curry Community Health, which is independent from county government and organized as an Oregon not-for-profit corporation that enjoys tax-exempt status pursuant to IRS 501(c)(3). Under CCO 1.0, Medicaid-supported mental health benefits were delegated by Advanced Health to the two CMHPs. Under CCO 2.0, Advanced Health will no longer use a delegation model.

A.1. How does Applicant plan to ensure that Behavioral Health, oral health and physical health services are seamlessly integrated so that Members are unaware of any differences in how the benefits are managed? Advanced Health has long been a champion of the Patient-Centered Primary Care Home (PCPCH) model. Today, 87 percent of Advanced Health's Members are served through OHA-recognized PCPCHs. PCPCHs are primary healthcare clinics that are recognized by the OHA for their commitment to providing high-quality, patient-centered care. At its heart, the PCPCH model of care fosters strong relationships with patients and their families to better care for the whole person. Primary care homes reduce costs and improve care through the early identification of problems, focusing on prevention, wellness, and managing chronic conditions.

Incumbent in the PCPCH model is the practice of team-based care. Each member is assigned, not only to a Primary Care Provider, but to a healthcare team in which the Primary Care Provider serves as the leader, and the Member serves as the most important team member or partner. Team-based care is a strategic redistribution of work among members of a practice team. In this model, all members of the Primary Care Provider-led team play an integral role in providing patient care. All five of Advanced Health's largest PCPCHs (Bay Clinic; Coast Community Health Center; Curry Health Network; North Bend Medical Center; Waterfall Community Health Center) currently include licensed Behavioral Health specialists as members of the healthcare team. By January 1, 2020, licensed Behavioral Health specialists will be embedded at all primary care practices within Advanced Health's network.

When Members first visit their PCPCH, they are introduced to all team members who will participate in their care, including their Primary Care Provider, nurse,
case manager, medical assistant, and Behavioral Health specialist. Members are likely to see more than one of their team members at the occasion of any visit. Behavioral Health specialists enter and exit each medical appointment in the same manner as do nurses and medical assistants. For Members, there is no perceptible difference as to how various component pieces of the Medicaid benefit are managed or delivered.

Members are assisted to understand that not all healthcare conditions are best treated in the primary care setting, and willingly accept referrals when those are made by the Primary Care Provider. If a Member requires a referral to specialized Behavioral Health services (e.g., detoxification, Applied Behavioral Analysis, Assertive Community Treatment (ACT), MAT), these referrals are made in precisely the same way as are referrals to neurologists, urologists, orthopedic surgeons, or other medical specialties or sub-specialties.

All Primary Care Providers perform oral health assessments whenever conducting child or adult wellness, preventative, or comprehensive physical examinations. Only Advanced Health's two federally qualified health centers (Coast Community Health Center and Waterfall Community Health Center) include oral hygienists as members of the healthcare team. Advanced Health's Clinical Advisory Panel will promulgate oral health integration requirements for all PCPCHs by August 1, 2019.

As of this writing, and to complete an entirely new (2019) Community Health Improvement Plan (CHIP), the Community Advisory Councils (CACs) in both Coos and Curry Counties are completing a scholarly and facilitated assessment of care integration. For the purposes of this study, care integration was defined to mean the purposeful presence or coordination of services that maximally support a person or family at each opportunity for interaction with social and health systems. The Coos County CAC found that, within Advanced Health's current service delivery system, the best examples of care integration were: integration created through the opioid coalition; Behavioral Health services in primary care offices; preventative dental fluoride treatment in elementary school settings; Behavioral Health in school-based health centers; dental care within public health and Behavioral Health programs; and, nurse-driven Care Coordination in hospitals and clinics. The greatest opportunities to improve Care Coordination in Coos County were found to be in: vision care; oral health in the primary healthcare setting; SUD treatment in the primary care setting; health literacy; patient navigation; assistance to parents for kindergarten readiness; resilience information and intervention for adverse childhood experiences; capacity-building in every social service sector; housing; and healthcare for persons who are unstably housed.

In Curry County, the CAC found that, within Advanced Health's current service delivery system, the best examples of care integration were: school-based health centers; the newly-forming Curry Social Services Integration program; CCO-driven
case management and Care Coordination; the local child abuse intervention center (Wally's House); the Early Learning Hub; Non-Emergency Medical Transportation (NEMT); and public health programs. The greatest opportunities to improve Care Coordination in Curry County were found to be in: Curry Community Health; inclusion of SDOH screening at primary care practices; early childhood education; food insecurity; employment skills training; (SUD) treatment beyond that which currently exists; oral health services at primary care settings; peer support services deployment of a housing resource navigator; and, workforce housing.

A.2. How will Applicant manage the Global Budget (as defined in ORS 414-025) in a fully integrated manner meaning that Applicant will not identify a pre-determined cap on Behavioral Health spending, nor separate funding for Behavioral Health and physical health care by delegating the benefit coverage to separate entities that do not coordinate or integrate? With a few exceptions, discussed in the following paragraphs, Advanced Health will contract all behavioral and physical health services to Southwest Oregon Independent Practice Association (SWOIPA) through a single contract instrument that requires the coordination and integration of all non-dental health services. The contract instrument will stipulate a per-member-per-month (pmpm) basis for payment for all covered health benefits, be they physical or behavioral. The contract instrument will further specify that SWOIPA may not place any pre-determined ceiling on Behavioral Health spending, nor separate funding for behavioral and physical healthcare nor may SWOIPA enter into any value-based payment (VBP) agreement in which Behavioral Health spending is tracked separately from physical health services. To accomplish these ends, most outpatient mental health services, and the early phases of SUD out-patient services, will be provided by the licensed Behavioral Health specialists who work as team members at SWOIPA's contracted PCPCHs. In specific, the type of contract that Advanced Health will employ with SWOIPA will be that of a "Privileged Provider." As a "Privileged Provider," SWOIPA will have the authority to enter into sub-contracts with physical and Behavioral Health Providers, to oversee and implement the credentialing function for physical and Behavioral Health Providers, and to undertake first-tier utilization management. By first-tier utilization management, we mean that SWOIPA may approve all prior authorization requests. However, any prior authorization request that SWOIPA contemplates denying must be referred to Advanced Health for second-tier utilization management. Advanced Health, and Advanced Health alone, holds the singular authority to deny a prior approval request.

SWOIPA will enter into standard contracts with PCPCHs for integrated primary Behavioral Health services. SWOIPA will enter into Privileged Provider agreements with CMHPs for existing ACT teams. Finally, SWOIPA will enter into a Privileged Provider contract with ADAPT for detoxification, medication-assisted treatment, and out-patient SUD services.
Certain Behavioral Health services will not fall under the privileged contractor arrangement with SWOIPA. The enabling legislation that created CCOs (HB 3650) and supporting statutes (ORS 414.153) require CCOs to recognize the responsibilities of counties (pursuant to ORS 430.620) to operate CMHPs in the following areas: (a) persons at risk of entering or transitioning from the state Hospital or residential care; (b) Care Coordination for residential services and supports; (c) the mental health crisis system; (d) specialized services, such as System of Care (SOC) and ACT; and, (e) specialized services to reduce criminal justice recidivism (such as a local mental health court) (Although CCOs are required to contract with CMHPs for this set of services, the contracts are not required to be exclusive.). To this end, Advanced Health will enter into a Privileged Provider contract with the two CMHPs for the provision of crisis response, supported employment, residential, and corrections services, and with ADAPT for the provision of SUD residential services.

On or about May 1, 2019, Advanced Health and SWOIPA will issue simplified solicitations for: peer-delivered services; adult and child out-patient mental health specialty services; specialty services designed to meet the needs of children with serious emotional disturbances (SED); Applied Behavioral Analysis (ABA); Wraparound and Children's System of Care (SOC); ACT expansion teams; and, Curry-County-based SUD out-patient treatment. Under the solicitation process, CMHPs will be offered non-exclusive contracts if qualifying proposals are received.

A.3. How will Applicant fund Behavioral Health for its Service Area in compliance with the Mental Health Parity and Addiction Equity Act of 2008? Advanced Health has filed with the OHA a detailed, seventy-plus-page document that details its full compliance with the Mental Health Parity and Addiction Equity Act. In determining the contractual relationships for the provision of integrated Behavioral Health services, Advanced Health exercised great caution in aligning contracts with contractors according to issues of parity. For example, except as required under ORS 414.153, all service elements for which parity in service delivery is reasonably identified (e.g., out-patient services; in-patient services; specialty services) are bundled into a single integrated Privileged Provider contractual mechanism with SWOIPA. In other words, SWOIPA will hold the obligation to treat all out-patient, in-patient, and specialty services for physical and Behavioral Health with absolute parity, in terms of access, quality, and cost. In those circumstances in which parity in service delivery is less easily equated between physical health and Behavioral Health systems (e.g., twenty-four-hour mobile crisis response, residential treatment, Psychiatric Security Review Board cases, supported employment, corrections services), Advanced Health will retain for itself all contracting authority in order to assure compliance with federal parity regulations with respect to access, quality, and cost.
A.4. How will Applicant monitor the need for Behavioral Health services and fund Behavioral Health to address prevalence rather than historical regional spend? How will Applicant monitor cost and utilization of the Behavioral Health benefit? Under its primary care case management program, Advanced Health will issue new practice guidelines that will require Primary Care Providers to screen all new Members within thirty (30) days of Enrollment, and annually thereafter, for health risks, Behavioral Health conditions, adverse childhood experiences (ACEs) and social determinants of health (SDOH). Data from initial and annual assessments will be concurrently entered into an electronic database such that, at any point in time, Advanced Health can analyze the proportion of Members assigned to any Primary Care Provider or PCPCH who screen positive for these health, Behavioral Health, and social determinant of health factors. If any single, or multiple, Primary Care Provider or PCPCH is found to have a disproportionately high number of assigned Members who present with Behavioral Health conditions, increased pmpm funding will be made available to that practice for the services of licensed Behavioral Health specialists. The inverse is also true if there are found to be Primary Care Provider or PCPCH practices that identify low numbers of Members with Behavioral Health needs. In other words, social capital and financial resources will be shifted based on the needs of Members.

For Behavioral Health programs that are provided outside of the Primary Care Provider or PCPCH setting, contracts will include a statement of work, and that statement of work will establish each program’s capacity. For example, a contract for an ACT Team may state that the ACT Team’s capacity is for thirty (30) Members, or a contract for MAT may state that the MAT program's capacity is fixed at one hundred (100) Members. Capacity will be monitored on a quarterly basis using reporting templates that are built into contracts, or by monitoring encounter data (with the caveat encounter data must be submitted for no- and low-cost claims). As programs near contractually established capacities, resources will be allocated to either expand an existing program’s capacity or to establish an additional program in an area with the greatest geographic need. Contrariwise, if it is found that a program continues to operate over time at less than capacity, contracts and resources assigned to those contracts, will be shifted to programs for which higher utilization needs are in demand by the Member population. Once again, resources follow Members and are allocated based on Member needs and not according to an arithmetic formula.

A.5. How will Applicant contract for Behavioral Health services in primary care service delivery locations, contract for physical health services in Behavioral Health care service delivery locations, reimburse for the complete Behavioral Health Benefit Package, and ensure providers integrate Behavioral Health services and physical health services? Advanced Health, through SWOIPA (as previously set forth in A.1 and A.2), will contract with all Primary Care Providers and PCPCHs, including School-Based
Health Centers (SBHCs) for fully integrated physical and Behavioral Health services. There is currently only one Behavioral Health Care Home in Coos County, and this entity will receive an identical contract for fully integrated physical and Behavioral Health services (Advanced Health supports the Behavioral Health Care Home (BHCH) model and will encourage the development of additional Behavioral Health Care Homes within its service delivery area. As additional Behavioral Health Care Homes are added to Advanced Health's network, they will enjoy the same level of support as existing Behavioral Health Care Homes and PCPCHs.). Primary Care Providers, PCPCHs, SBHCs, and BHCHs receive capitation payments for a milieu of services, including panel management, case management, and integrated Behavioral Health services. Primary Care Providers, PCPCHs, SBHCs, and BHCHs are blind as to any price differential among these three elements.

Primary Care Providers, PCPCHs, SBHCs, and BHCHs are required to submit encounter data for every encounter, even if a Behavioral Health encounter falls on the same day as a physical health encounter, or if the encounter results in no- or low-payment. It is through this mechanism that Advanced Health and SWOIPA can track the actual utilization trends among Primary Care Providers, PCPCHs, SBHCs, and BHCHs to determine if full integration is occurring in the practice setting. For example, if a given monthly period a PCPCH submits one encounter data for 300 physical health encounters and only three (3) Behavioral Health encounters, Advanced Health would seriously doubt whether full integration is occurring in that practice. This assumption could be further clarified by reviewing the number of Members assigned to that practice who had screened positive for a Behavioral Health concern during the annual case management assessment or re-assessment.

For those elements of the complete Behavioral Health benefit package that are not provided by Primary Care Providers, or in the PCPCH, SBHC, or BHCH setting (e.g., residential treatment, Behavioral Health specialty services, MAT, ACT, ABA), separate contractual mechanisms exist for the purchase of those services. There will be at least one contracted Provider for every required service element within the Behavioral Health benefit package, and in most cases, multiple contractors. Primary Care Providers may refer to these services and contractors without prior authorization (In most cases, prior authorization for continuing Behavioral Health specialty services is also not required. When prior authorization is required, it is for the purpose of assuring that the Member has need of, and is eligible for, the service. For example, a Member with no history of diagnosis along the autism spectrum would not be deemed to need, or eligible for, Applied Behavioral Analysis (ABA)).

A.6. How will Applicant ensure the full Behavioral Health benefit is available to all Members in Applicant's Service Area? The first-line in ensuring that all Members have access to the full Behavioral Health benefit occurs
at the Primary Care Provider level. Every Member assigned to Advanced Health by
the OHA is then assigned by Advanced Health to a Primary Care Provider. There
are no "open cards" or unassigned Members within Advanced Health's internal
system or network. Within thirty days of assignment by Advanced Health to a
Primary Care Provider, the Primary Care Provider is contractually obligated to
conduct an initial screening assessment to identify health risks, Behavioral Health
concerns, adverse childhood experiences, and issues related to social determinants
of health. Those Members who screen positive for any of these variables will be
promptly appointed with the Primary Care Provider and/or PCPCH team for
consultative and follow-up purposes. Depending on need and diagnosis, Members
may receive out-patient mental health benefits within the PCPCH practice or
receive referrals for SUD or Behavioral Health specialty services as a result of the
consultation. Primary Care Providers and PCPCHs are located throughout
Advanced Health's service delivery area. For isolated Members who reside in the
remote and frontier community of Powers (Coos County), the transit distance to
Myrtle Point is 21 miles (32 minutes). For isolated Members who reside in the
remote and frontier community of Agness (Curry County), the transit distance to
Gold Beach is 35 miles. Non-Emergency Medical Transportation (NEMT) services
are made available (Multiple prior efforts to establish on-site health services in
Agness and Powers have failed. Supported by a local tax base and the prospective
payment system (PPS), the Powers Rural Health District operated a Rural Health
Clinic until 2012. Waterfall Community Health Center established a combined
school-based and community health clinic in 2013 but withdrew its services in 2017.
In both cases, economies-of-scale resulted in the closure of both clinics.

The second-line in ensuring that all Members have access to the full Behavioral
Health benefit is an open-door policy that permits any Member to self-refer to all
Behavioral Health services. As a matter of policy, Primary Care Provider or other
official referrals are not required to initially access Behavioral Health services from
any Behavioral Health contractor within the network. The Member Handbook
includes a complete listing of all service elements within the Behavioral Health
benefit and informs Members how to access those services. Navigators (previously
referred to as customer service representatives) are available during regular
business hours to assist Members in accessing services.

The third-line in ensuring that all Members have access to the full Behavioral
Health benefit is to assure that Advanced Health has identified, and entered into at
least one contract agreement, for every element included in the complete Behavioral
Health benefit package. Advanced Health maintains a continually updated
Delivery System Network roster of contracted Providers, and through regular
monitoring of this roster by the Medical Director, can identify any lapses in
contractually available services.

Attachment 11 - Behavioral Health Questionnaire
If a Behavioral Health treatment or recovery option is not available within the service delivery area, or no timely capacity exists within the service delivery area, Advanced Health assumes full responsibility for Members' Behavioral Health benefit and assists the Member in receiving services out-of-area.

A.7. How will Applicant ensure timely access to all Behavioral Health services for all Members? For routine Behavioral Health needs, Primary Care Providers are required to offer appointing for Medicaid beneficiaries that is consistent with the Community norm, with no lengthier of a wait time than that accorded to any other Community member, howsoever insured.

For urgent Behavioral Health needs, PCPCHs are required to offer non-traditional hours of operation, thereby assuring evening and weekend accessibility. In addition, PCPCHs are required to offer same-day appointing upon reasonable Member request. Contracts are in place for walk-in or urgent care in Coos Bay, North Bend, and Coquille. The two CMHPs reserve unscheduled time each day for walk-in services.

For emergent Behavioral Health needs, Advanced Health provides twenty-four-hour-per-day, seven-day-per-week (24/7) mobile crisis services throughout its entire service delivery area.

Advanced Health is cognizant of the OHA's accessibility standards and time-frames, as articulated in OAR 410-141-3220, and particularly for priority or special populations, in part comprised of: pregnant women; Members who are IV drug or opioid users; veterans and members of their families; women parenting children aged 0 to 5; all children aged 0 to 5; Members diagnosed with I/DD; Members receiving long-term care (LTC) or long-term services and supports (LTSS); Members who are diagnosed with a Serious Emotional Disturbance (SED) or Serious and Persistent Mental Illness (SPMI); Members with special healthcare needs; Members involved in the juvenile or adult criminal justice system; and Members, family members, caregivers and guardians of children who are involved in the child welfare system. All health service contracts issued by Advanced Health or SWOIPA make direct reference to OAR 410-141-3220 and reiterate timeliness and accessibility standards. New policies are being developed that will require all Providers to enter into the clinical record the date on which Members make requests for appointments, thereby permitting Advanced Health to monitor the wait times between the date of the request and the date of the actual appointment. These provisions are further enforced through vigilant contract monitoring performed by directly-employed compliance personnel.

A.8. How will Applicant ensure that Members can receive Behavioral Health services out of the Service Area, due to lack of access within the Service Area, and that Applicant will remain responsible for arranging
and paying for such out-of-service-area care? Immediately upon learning that a Member requires a Behavioral Health service that is not available within Advanced Health's service area, the matter is simultaneously referred to Advanced Health's directly-employed Senior Care Coordination Executive. This individual is empowered to identify an out-of-area resource, negotiate a payment rate, authorize the service on behalf of the Member, and arrange for expeditious transportation for the Member, and if appropriate, concerned family member(s). In most such cases, Advanced Health asks the Referral program to provide a copy of its standard contract for endorsement and signature by Advanced Health. Advanced Health accepts financial responsibility for out-of-area services authorized by the Senior Care Coordination Executive or his or her designee. If Advanced Health establishes a pattern of relying on an out-of-area Behavioral Health Provider over the course of time, every effort is made to identify or create a local, in-area resource to meet current and future needs.

A.9. How will Applicant ensure Applicant's physical, oral and Behavioral Health providers are completing comprehensive screening of physical and Behavioral Health care using evidence-based screening tools? Advanced Health' Clinical Advisory Panel is in the process of identifying one or more evidence-based, normed, and standardized screening tools for use in all settings. Advanced Health expects that the identified tools will empirically assess health risks, adverse childhood experiences, Behavioral Health needs, and social determinants of health. Prior to adopting these instruments, Advanced Health will seek the OHA's approval of the tools to not set into action a comprehensive screening protocol that fails to meet the OHA's standards or expectations. Advanced Health is reviewing multiple number assessment instruments, with a tendency toward a tool set that has been adopted by California's Medicaid program, but wants to assure that any adopted tool can be converted to electronic format with yields from the tool's variables entered into system-wide case management software.

The primary responsibility for the initial screening and annual re-assessment resides with Primary Care Providers, PCPCHs, and BHCHs as a function of the primary care case management program. Because a universal tool will be employed, with all data fields entered system-wide software (Pre-manage/Community EHR), compliance personnel will be able to determine the degree to which each Primary Care Provider, PCPCH, and BHCH is timely performing its mandatory comprehensive screening contractual obligations. Primary Care Provider, PCPCH, and BHCH entities that lag or fall short of meeting screening standards will be placed on corrective action which may result in sanctions.

Because it is possible that a handful of Members will have appointments with behavioral or oral health Providers prior to receiving comprehensive screening at
their assigned Primary Care Provider's office, oral and Behavioral Health Providers will be cross-trained in the administration of the screening tool and required to perform that function at the time of initial contact with the Member.

A.10. How will Applicant ensure access to Mobile Crisis Services for all Members to promote stabilization in a community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute Care Psychiatric Hospital, in accordance with OAR 309-019-0105, 309-019-0150, 309-019,0242, and 309-019-0300 to 309-019-0320? For the past three years, Advanced Health has contracted with Coos Health and Wellness to provide 24/7 Community-based mobile crisis response services for adolescents experiencing a Behavioral Health crisis. The program, called My CRU (Crisis Response Unit), has enjoyed widespread Community support, and is often called upon by law enforcement, educators, parents, and young persons through peer- or self-referral. My CRU has demonstrated success in stabilizing adolescents in their home and family setting, diverting youth or parents to respite services, and has resulted in a decrease in adolescent visits to the emergency department for reasons of psychiatric symptoms or complaints and a corresponding reduction in adolescent acute care psychiatric hospitalization. Despite its many successes, My CRU has been expensive to operate and has relied, in part, on special allocations from Advanced Health and external grant funding.

Advanced Health understands and appreciates the costs associated with providing 24/7 mobile crisis response services for all Members, regardless of age, and accept the financial and programmatic responsibility for so-doing. Advanced Health will enter into Privileged Provider agreements with both CMHPs for the provision of mobile crisis response services and will fully fund the costs of these programs. Curry Community Health is the recipient of special grant funds to establish its program, and Advanced Health will provide full resources for ongoing operating costs. If it is found that neither CMHP can cost-effectively afford to cover the vast and sparsely-populated regions with Coos and Curry Counties, Advanced Health is exploring the provision of mobile crisis response services in frontier regions through contracts with local Emergency Medical Services (EMS) and Rural Fire Services personnel who have received advanced training in Behavioral Health crisis response.

A.11. Describe how Applicant will utilize Peers in the Behavioral Health system. Peer Wellness Specialists focus on recovery from substance use, mental health, and/or physical conditions. Peer Support Specialists focus on recovery from substance use and/or mental health conditions. Within this latter category, Peer Support Specialists are further defined as either Family Support Specialists or Youth Support Specialists. Family Support Specialists and Youth Support Specialists are primarily used in Advanced Health's formalized Wraparound and System of Care (SOC) programs.
ADAPT, as the SUD treatment Provider, makes extensive use of Certified Drug and Alcohol Counselors – I (CADC-I), as well as other certified and licensed professionals. The overwhelming majority of CADC-I counselors are individuals who have personally experienced chemical dependency issues and can verify two years of sobriety, along with completion of 150 hours of formal education, 1,000 hours of supervised practice, and passing scores on the National Certification Exam. Although ADAPT's SUD programs do not currently use the services of Peer Wellness Specialists, per se, Members in SUD treatment are very likely to encounter peers among the cadre of CADC-I counselors employed by the organization. Additional peer services are available in Community-based settings through peer self-help programs, such as Alcoholics Anonymous. A Community-based program, Bay Area First Steps, is a recovery community model. All services are provided by Peer Wellness Specialists who operate without clinical supervision, and thus this program is ineligible for admission to Advanced Health's Provider Network.

As of this writing, Peer Wellness Specialists are deployed in both CMHPs. The peer program at Coos Health and Wellness is widely acclaimed by Members and offers an array of support, wellness, socialization, and recreational activities that are designed and directed by CHAOS, which is the peer-driven leadership group that advises and oversees peer programs at Coos Health and Wellness.

Curry Community Health provides peer services at two settings: in Brookings and Gold Beach. One program operates in a permissively-zoned, county-owned, single family dwelling, and the other program is "homeless" and operates at the offices of Coos Health and Wellness. The program that is "homeless" is the source of frequent criticism by Members who believe the program receives an excessive amount of clinical supervision and is not permitted any degree of self-governance or self-determination. This issue has been the source of considerable attention by the Curry County Community Advisory Committee (CAC), and that entity has formed a Peer Advisory sub-committee to attempt to address the issue. Advanced Health provided mini-grant support, through its quality improvement incubator program, to the Peer Advisory sub-committee, but that effort, along with other interventions, failed to produce results that met with the satisfaction of the Curry County CAC. To this end, on or about May 1, 2019, Advanced Health will issue a solicitation for peer-delivered Behavioral Health support services in Curry County. The CAC's Peer Advisory sub-committee will assist in the review, selection, and ongoing evaluation of the successful bidder, a new peer delivery system will be established, and an appropriate contract will be executed.

A.12. How will Applicant ensure access to a diversity of integrated community supports that mitigate SDOH-HE, increase individuals' integration into the community, and ensure all Members access to peer...
services and networks? Adult individuals who are diagnosed with Severe and Persistent Mental Illness receive Intensive Care Coordination (ICC) or Exceptional Needs Care Coordination (ENCC) services, that include a written Care Plan. Using health-related spending, Advanced Health will authorize any reasonable social, recreational, educational, occupational, or peer-delivered services and supports that may be reasonably expected to increase an individual's integration into the Community or mitigate SDOH-HE issues or concerns.

Similarly, children and youth who are diagnosed with Serious Emotional Disorders (SED) receive ICC/ENCC services in concert with Wraparound and System of Care (SOC) services. Within these two program elements, all participants are offered the services of Family and Youth Support Specialists, and resources are allocated for health-related spending to permit ICC/ENCC care coordinators to authorize a wide array of programs and activities, including extracurricular activities in the school setting, tutoring, mentoring, Community-based athletic programs, summer camp, music and dance lessons, membership in youth development organizations – literally any reasonable effort or activity that will mitigate adverse childhood experiences, foster resiliency, create normalizing peer relationships, offset social determinants of health, improve health equity, or increase the child's or youth's successful integration into the Community.

As discussed in Attachment 10, related to the Social Determinants of Health, Advanced Health's CACs have been diligent in their preparation of a new CHIP (2019). That Plan will include the CAP's recommendations for health-related services, including those services that target individual Members (flexible services) and those that are available to the general population (Community benefit activities). The CAP is empowered to identify responsive programming, engage in ongoing program evaluation, and exercise authority over dedicated health-related services funds. Through these mechanisms, Advanced Health’s consumers have the greatest voice in identifying and evaluating integrated Community supports that mitigate SDOH and equity bias, and that are the most attracted to Members in improving Community integration.

B.1. Please describe Applicant’s process to provide Warm Handoffs, any potential barriers to ensuring Warm Handoffs occur and are documented, and how Applicant plans to address them. Licensed Behavioral Health specialists will be embedded in every Primary Care Provider and PCPCH practice. It is anticipated that Warm Handoffs will occur on a frequent and consistent basis. Primary Care Provider and PCPCH practices will be required to submit accurate and timely encounter data for all warm handoffs (and continuing Behavioral Health encounters). Encounter data for warm handoffs and ongoing Behavioral Health services provided in Primary Care Provider and PCPCH practices will be summarized and analyzed on a regular quarterly basis. As stated in A.4, if any single, or multiple, Primary Care Provider or PCPCH practice is found to have a
disproportionately high number of Behavioral Health encounters, increased pmpm funding will be made available to that practice for the services of licensed Behavioral Health specialists. The inverse is also true: if there are found to be Primary Care Provider or PCPCH practices that provide low numbers of Behavioral Health encounters, after counseling with those practices to understand and overcome barriers, pmpm payment rates will be adjusted downward. In other words, social capital and financial resources will be shifted based on the needs of Members and actual utilization patterns. Advanced Health's largest PCPCH practices (Bay Clinic, Coast Community Health Center, Curry Health Network, North Bend Medical Center, and Waterfall Community Health Center) have been using team-based care, complete with embedded Behavioral Health specialists and warm handoffs, and are experienced in this model. No barriers to implementation or documentation are predicted, but should such barriers emerge, Advanced Health will take timely, appropriate, and well-documented corrective action.

B.2. How does Applicant plan to assess for need and utilization of in-home care services (Behavioral Health services delivered in the Member's home) for Members? All Members who need in-home Behavioral Health services will be assigned to an ACT team or to the Children's System of Care (SOC). Each ACT or SOC team will be staffed by a licensed mental health professional, two ICC/ENCC care coordinators, and the fractional (part-time) services of a registered nurse, supported employment and/or skills trainer, and a prescriber. The ICC/ENCC care coordinators are tasked with the responsibility for assessing needs and developing written plans of care, in consultation with each Member, and family members of Member. It is recognized that plans of care may call for the delivery of in-home Behavioral Health services. It is the intent of the ACT and SOC programs to provide services in home- and Community-based settings (rather than in formalized office settings). To this end, ACT and SOC teams will safely provide in-home Behavioral Health services consistent with each Member's written plan of care. ACT teams are available to Members twenty-four-hours-per day, seven days per week.

B.3. Please describe Applicant's process for discharge planning, noting that discharge planning begins at the beginning of the Episode of Care and must be included in the care plan. Discharge planning involves the transition of a patient's care from one level of care to the next or Episode of Care. Treatment team and the patient and/or the patient's representative participate in discharge planning activities. In Advanced Health's model, it is anticipated that most Members who may experience a transition-in-care have already been identified and are participating with an ACT or SOC team. Under these circumstances, the ACT or SOC team will have been involved with the Member, and the Member's representative, at the earliest onset of the transition-in-care. Hopefully, most transitions-in-care will have been thoughtfully contemplated and be consistent with the Member's written care plan.
The Member, and Member's representative, will be assisted by the ACT or SOC team through each step of the transition-in-care, including discharge planning. Discharge planning will commence concurrent with the onset of the transition-in-care, will be Member- and family-focused, and will result in planful, ego syntonic, and trauma-informed transitions that are purposed at meeting each individual Member's unique needs.

Under isolated circumstances, a Member who is not served by an ACT or SOC team may experience conditions that result in emergent episodes of care or transitions-in-care (e.g., unanticipated early onset of psychosis). These Members, and their families or representatives, will receive immediate assistance from Advanced Health's Senior Care Management Executive until their ICC/ENCC coordination needs can be transferred to an ACT or SOC team. Such members will be prioritized for access to an ACT or SOC team.

For Members who are entering or exiting in-patient or residential services, and particularly for those Members who have been placed in facilities that are outside of the service delivery area, ICC/ENCC care coordinators shall have contact with the Member at least two times per month prior to discharge, and two times during the week prior to discharge. Every effort will be made to assure that these contacts occur on a face-to-face basis. If appropriate, the ICC/ENCC care coordinator will arrange a warm handoff for Members if they will be transferred to another relevant care Provider during the transition-in-care. For Members in acute care, ICC/ENCC coordinators shall have contact with the Member, preferably on a face-to-face basis, within one business day of admission, and two times per week until discharge. Per ICC/ENCC standards, Members will be timely reassessed in the event of triggering criteria.

B.4. Please describe Applicant's plan to coordinate Behavioral Health care for fully dual eligible Members with Medicare providers and Medicare plans, including ensuring proper billing for Medicare covered services and addressing barriers to Fully Dual Eligibles accessing OHP Covered Services. Advanced Health's Provider Network captures fully 98 percent of all Providers represented in Coos and Curry Counties. To this end, the same Providers who are Medicaid Providers are also Medicare Providers. This means that the coordination of Behavioral Health services for dual eligible Members can be accomplished by one-in-the-same Provider. Advanced Health offers the full range of covered Behavioral Health benefits to all Members, regardless of status as Medicaid-only or dual-eligible.

SWOIPA, Advanced Health's bundled physical and Behavioral Health contractor, holds a contract with Pacific Source, a Medicare Advantage Plan, for coordinating the Medicaid and Medicare benefits for fully dually eligible beneficiaries. North Bend Medical Center (NBMC) is in the process of establishing a Medicare
Accountable Care Organization (ACO). When CMS issues an approval of NBMC's ACO application, Advanced Health will enter a Memorandum of Understanding with NBMC for the coordination of benefits for shared beneficiaries, with a focus on addressing and resolving any access or billing barriers that may exist.

Claim processing services are contracted by Advanced Health to DOCS Management Company, pursuant to an administrative services agreement. Claims processing personnel employed by DOCS are familiar with the problematic issues that can arise in receiving and processing claims for dual-eligible Members. Rather than to deny improperly submitted claims out-of-hand, claims personnel reach out to Providers and members of their billing departments, and provide technical assistance in claim re-submission.

C.1. Describe how Applicant plans to develop a comprehensive Behavioral Health plan for Applicant's Service Area. Please include dates, milestone, and Community partners.

C.2. Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the CHP. Please include dates and milestones.

C.3. Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the local plan. Please include dates and milestones.

The responses to these three questions will be aggregated and taken as a whole. Advanced Health has undertaken three Community Health Assessments (CACs) (2012, 2014, and 2018) and three CHIPs (2013, 2015, and 2019) and is familiar with the processes and requirements for those documents. In the development of the CHA and CHIP, the processes were primarily driven by the CACs, with technical assistance provided by an independent consultant, a facilitator, and Advanced Health's staff. Advanced Health will follow a similar pattern for the development of a Community Behavioral Health Assessment and a Community Behavioral Health Improvement Plan, with the main differentiating factor that the Assessment and the Plan will be a joint effort of the Local Mental Health Authorities (LMHAs) and Advanced Health. The following enumerated narrative sets forth the steps for so-doing, subject to the approval of the OHA.

1. Advanced Health will enter a Memorandum of Understanding, separately, with the LMHAs for each of Coos and Curry Counties. If other CCOs are serving either county, the additional other CCOs will be asked to enjoin the Memorandum of Understanding. All efforts identified in the Memorandum of Understanding, leading to the development of the Community Behavioral Health Assessments (CBHA) and Community Behavioral Health Improvement Plans (CBHIP), will be mutually agreeable among the parties.
2. The Memoranda of Understanding will call for the appointment of a Blue-Ribbon Behavioral Health Task Force (BRBHTF). In each county the BRBHTF will be comprised of:
   - A county commissioner to represent the LMHA;
   - An executive or clinician from each CMHP operating in the county;
   - An executive from each CCO operating in the county;
   - A member of the governing Board of each CCO operating in the county;
   - An executive or clinician representing the SUD treatment program;
   - One individual representing the Local Alcohol and Drug Planning Committee (LADPC);
   - Two members of the Community Advisory Council;
   - One individual representing the Early Learning Hub;
   - One individual representing Tribe(s) present in the Community;
   - One member representing the educational Community;
   - One physician representing the medical Community;
   - One stakeholder representing the social services Community; and,
   - One judge, corrections officer, or alternate justice representative.

3. Collectively, the parties to the MOU and the BRBHTF will engage the services of a neutral and independent consultant who will gather quantitative and qualitative data related to Behavioral Health needs and gaps in each county that will form the basis for the Community Behavioral Health Assessment (CBHA).

4. In developing the CBHA, it is expected that the assessment will: be based on research; include population-based and Member-based quantitative data, including Behavioral Health disparities and inequities; evaluate the adequacy of existing Behavioral Health programs; identify under-utilization, over-utilization, and gaps in service; account for Behavioral Health needs across the life cycle; include qualitative data collected from Members through focus group activities and/or surveys; and analyze historical and current Behavioral Health services spending.

5. The CBHA will be serially approved by each LMHA, Local Alcohol and Drug Planning Committee (LADPC), each CAC, any other CCOs operating in the service delivery area, and Advanced Health’s Board of Directors.

6. Based on the adopted CBHA, an independent consultant and facilitator will be engaged by Advanced Health and the LMHAs to develop recommendations to the BRBHTF for the Community Behavioral Health Improvement Plans (CBHIP).

7. The BRBHTF will accept, reject, or modify the consultant's recommendations, leading to the development of a CBHIP. At this time, any resource-allocation
or billing issues, and post-2021 residential services planning, whether introduced by the consultant, will be addressed.

8. The CBHIP will be serially adopted by each LMHA, Local Alcohol and Drug Planning Committee (LADPC), each CAC, any other CCOs operating in the service delivery area, and Advanced Health’s Board of Directors. This work must be completed by September 30, 2020, such that: recommendations contained in the CBHIP can be solidified through a second Memoranda of Understanding with the LMHA in each county (subject to the approval of the OHA); and any contractual changes required for the implementation of the CBHIP can be negotiated with Behavioral Health Providers prior to the start of the next annual budget period on January 1, 2021.

9. A time-delimited reconciliation committee will be seated and comprised of representatives of the BRBHTF and the CACs for the singular purpose of consolidating and prioritizing the existing CHIP and the CBHIP into a single guidance document.

### Table 1
COMMUNITY BEHAVIORAL HEALTH IMPROVEMENT PLAN: DATES, MILESTONES AND DELIVERABLES

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Deliverable</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter MOUs with Coos and Curry LMHAs, per Step 1</td>
<td>Signed copies of MOUs</td>
<td>08-01-19</td>
</tr>
<tr>
<td>Seat and orient members of the Blue-Ribbon Behavioral Health Task Force (BRBHTF), per Step 2</td>
<td>Minutes of initial meeting</td>
<td>09-30-19</td>
</tr>
<tr>
<td>CCOs, LMHA, and BRBHTF competitively identify an independent consultant to undertake the Community Behavioral Health Assessment (CBHA), per Step 3</td>
<td>Executed contract with independent consultant</td>
<td>12-31-19</td>
</tr>
<tr>
<td>Consultant completes CBHA per Step 4</td>
<td>Hard copy CBHA</td>
<td>03-31-20</td>
</tr>
<tr>
<td>CCOs, LMHA, and BRBHTF competitively identify an independent consultant to undertake the Community Behavioral Health Improvement Planning (CBHIP) process and plan development, per Step 6</td>
<td>Executed contract with independent consultant</td>
<td>04-01-20</td>
</tr>
<tr>
<td>LMHAs, LADPCs, CACs, and CCOs serially approve CBHA per Step 5</td>
<td>Minutes of meetings at which approvals were granted</td>
<td>04-30-20</td>
</tr>
<tr>
<td>CBHIO consultant submits recommendations to BRBHTF</td>
<td>Consultant's draft recommendations</td>
<td>06-15-20</td>
</tr>
<tr>
<td>BRBHTF considers and weighs recommendations, and with assistance from Consultant, develops finalized CBHIP, per Step 7</td>
<td>Hard copy CBHIP (one for each county)</td>
<td>08-15-20</td>
</tr>
<tr>
<td>LMHAs, LADPCs, CACs, and CCOs serially approve CBHIP per Step 8</td>
<td>Minutes of meetings at which approvals were granted</td>
<td>09-15-20</td>
</tr>
<tr>
<td>Advanced Health requests the consent of the OHA in implementing recommendations of the CBHIP</td>
<td></td>
<td>09-15-20</td>
</tr>
</tbody>
</table>
C.4. Does Applicant expect any challenges or barriers to executing the written plan or MOU extension with the Local Mental Health Authority? If yes, please describe. Initial consultations have already occurred between Advanced Health and the two LMHAs. The parties agree that a new MOU or MOU extension is appropriate and are agreed as to the scope of work. No challenges or barriers are anticipated.

D.1. Please provide a report on the Behavioral Health needs in Applicant's Service Area. Table 2 provides a summary overview of diagnoses entered for Advanced Health's Members.

Table 2
BEHAVIORAL HEALTH DIAGNOSTIC PREVALENCE SUMMARY FOR ADVANCED HEALTH'S MEMBERS

<table>
<thead>
<tr>
<th>SPMI Diagnoses</th>
<th>Number</th>
<th>SUD</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Disorder</td>
<td>600</td>
<td>Nicotine Disorders</td>
<td>3,698</td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>459</td>
<td>Alcohol Disorders</td>
<td>1,139</td>
</tr>
<tr>
<td>Persistent Depressive Disorders</td>
<td>441</td>
<td>Cannabis Disorders</td>
<td>1,106</td>
</tr>
<tr>
<td>Borderline/Other Personality Dis</td>
<td>274</td>
<td>Stimulant Disorders</td>
<td>749</td>
</tr>
<tr>
<td>Dementia</td>
<td>162</td>
<td>Opioid Disorders</td>
<td>441</td>
</tr>
<tr>
<td>Total SPMI*</td>
<td>1,936</td>
<td>Other Substance Disorders</td>
<td>383</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total SUD*</td>
<td>7,516</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Childhood SED Diagnoses</th>
<th>Number</th>
<th>Intellectual Disabilities</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorder Starting in Childhood</td>
<td>1,135</td>
<td>I/DD Diagnoses (Unduplicated)</td>
<td>115</td>
</tr>
<tr>
<td>Pervasive Development Disorder</td>
<td>738</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total SED*</td>
<td>1,873</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Totals represent the total amount of times the diagnosis has been assigned over the past two years and is not an unduplicated count of Members receiving the diagnosis as Members may carry multiple diagnoses.

If Advanced Health applies the specification that is used for incentive metrics (i.e., at least two diagnoses of illness on the SPMI schedule within a three-year period for diagnoses entered after the Member was over the age of 18), the number of Members with SPMI is estimated at 3,053. In addition to these data, 5,068 Members received psychiatric diagnoses for non-SPMI conditions (i.e., generalized anxiety; dysthymia; sleep disorders; transient situational disturbances).
D.2. Please provide an analysis of Applicant's workforce to provide needed services that will lead to better health, based on existing Behavioral Health needs of the population in Applicant's Service Area. Table 3 sets forth the number of Enrollees and mental health service Providers, by zip codes, and establishes the mental health Provider-to-Enrollee ratio for each zip code, as of mid-2018.

**Table 3**  
MENTAL HEALTH PROVIDER-TO-ENROLLEE RATIOS BY ZIP CODE

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Community</th>
<th>Enrollees</th>
<th>Mental Health Providers</th>
<th>Mental Health Provider to Enrollee Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>97449</td>
<td>Lakeside (Community Shared with Trillium)</td>
<td>380</td>
<td></td>
<td>0:380</td>
</tr>
<tr>
<td>97459</td>
<td>North Bend (Served Exclusively by WOAH)</td>
<td>3,723</td>
<td>51</td>
<td>1:73</td>
</tr>
<tr>
<td>97420</td>
<td>Coos Bay (Served Exclusively by WOAH)</td>
<td>8,374</td>
<td>15</td>
<td>1:558</td>
</tr>
<tr>
<td>97423</td>
<td>Coquille (Served Exclusively by WOAH)</td>
<td>1,765</td>
<td></td>
<td>0:1765</td>
</tr>
<tr>
<td>97411</td>
<td>Bandon (Served Exclusively by WOAH)</td>
<td>1,838</td>
<td>3</td>
<td>1:613</td>
</tr>
<tr>
<td>97458</td>
<td>Myrtle Point (Served Exclusively by WOAH)</td>
<td>1,284</td>
<td></td>
<td>0:1284</td>
</tr>
<tr>
<td>97466</td>
<td>Powers (Served Exclusively by WOAH)</td>
<td>265</td>
<td></td>
<td>0:265</td>
</tr>
<tr>
<td>97450</td>
<td>Langlois (Community Shared with AllCare)</td>
<td>147</td>
<td></td>
<td>0:147</td>
</tr>
<tr>
<td>97476</td>
<td>Sixes (Community Shared with AllCare)</td>
<td>67</td>
<td></td>
<td>0:67</td>
</tr>
<tr>
<td>97465</td>
<td>Port Orford (Community Shared with AllCare)</td>
<td>471</td>
<td></td>
<td>0:471</td>
</tr>
<tr>
<td>97406</td>
<td>Agness (Community Shared with AllCare)</td>
<td>13</td>
<td></td>
<td>0:13</td>
</tr>
<tr>
<td>97444</td>
<td>Gold Beach (Community Shared with AllCare)</td>
<td>658</td>
<td>9</td>
<td>1:73</td>
</tr>
<tr>
<td>97415</td>
<td>Brookings (Community Shared with AllCare)</td>
<td>850</td>
<td>8</td>
<td>1:106</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,835</strong></td>
<td><strong>86</strong></td>
<td></td>
<td><strong>1:231</strong></td>
</tr>
</tbody>
</table>

Again, at first glance, it appears that some communities are overserved while other communities are woefully underserved. To this end, additional analyses are required.

- Residents of Lakeside may travel 13 miles via Highway 101 to access mental health services in North Bend. If transportation is a barrier, NEMT is available at no cost.

- Although the Delivery System Network Excel document identifies each Provider with a "home address" at their headquarter offices, both Coos Health and Wellness and Curry Community Health out-station mental Providers in distant communities. Fully 20 percent of the 51 mental health workers who are employed by Coos Health and Wellness in North Bend (N = 10) are permanently assigned to a satellite clinic in the county seat of Coquille, and from that location serve residents of Coquille and Myrtle Point. Similarly, Curry Community Health maintains permanent offices in Gold
Beach and Brookings where 17 mental health professionals are employed. Of those professionals, two are out-stationed on a permanent basis in Port Orford to serve the communities of Langlois, Sixes, Port Orford, and Agness. If transportation is a barrier, NEMT is available at no cost.

- In the remote Community of Powers, Waterfall Community Health Center provides mental health services via telemedicine. If Enrollees prefer face-to-face encounters, NEMT is available at no cost.

Of the 86 mental health professionals serving Coos and Curry Counties: 28 are Licensed Professional Counselors; 14 are (Licensed) Clinical Social Workers; 4 are Psychiatric Nurse Practitioners; 3 are Licensed Marriage and Family Therapists; 1 is a Licensed Clinical Psychologist; 1 is a Psychiatrist; and the remaining 35 are unlicensed individuals who work in Community mental health settings and who are classified as qualified mental health professionals or qualified mental health associates. When HRSA works to identify specific Community needs, it does not include licensed professional counselors, qualified mental health professionals, or qualified mental health associates. If federal standards were applied, Coos and Curry Counties would be characterized by a total of 23 federally recognized mental health professionals, resulting in a mental health professional to Enrollee ratio of 1:862, which exceeds federal minimum recommendations of 1:1000.

Nonetheless, HRSA's Catchment Area 14, which includes both Coos and Curry Counties, holds a federal Mental Health Professional Shortage Area designation (Designation 7419994114). The designation applies to the entire geographic population, irrespective of income or insurance status. The primary reason for the designation is not so much a shortage of recognized mental health professionals, but a weighted shortage of prescribers. With four psychiatric nurse practitioners and a single psychiatrist, the ratio of psychiatric prescribers to Enrollees is 1:3967. To improve this ratio, and to provide Enrollees with access to second opinions: NEMT is made available to patients to consult with non-participating psychiatric prescribers in Eugene and Medford; prior authorization requests for out-of-panel or out-of-area consultations are rarely, if ever, denied; and, telemedicine is frequently used, particularly in Curry County, for ongoing psychiatric medication management.

In 2016, on behalf of the Health Systems Division at OHA, Health Insight conducted a survey of adults and the parents/guardians of children who had accessed mental health services between July and December of 2015 using Oregon Health Plan (OHP) benefits. For the survey variable, location of services was convenient, 70 (86 percent) respondents Enrolled with Advanced Health replied agree or strongly agree, while 11 (14 percent) replied disagree or strongly disagree. For the survey variable, services were available at convenient times, 74 (92.5
percent) respondents with Advanced Health replied agree or strongly agree, while 6 (7.5 percent) replied disagree or strongly disagree.

Substance Use Disorder Services: Table 4 sets forth the number of Enrollees and substance abuse treatment Providers, by zip codes, and establishes the substance abuse treatment Provider-to-Enrollee ratio for each zip code, as of mid-2018.

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Community</th>
<th>Enrollees</th>
<th>SUD Providers</th>
<th>SUD Provider to Enrollee Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>97449</td>
<td>Lakeside (Community Shared with Trillium)</td>
<td>380</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97459</td>
<td>North Bend (Served Exclusively by WOAH)</td>
<td>3,723</td>
<td>13</td>
<td>1:286</td>
</tr>
<tr>
<td>97420</td>
<td>Coos Bay (Served Exclusively by WOAH)</td>
<td>8,374</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97423</td>
<td>Coquille (Served Exclusively by WOAH)</td>
<td>1,765</td>
<td></td>
<td>1:1765</td>
</tr>
<tr>
<td>97411</td>
<td>Bandon (Served Exclusively by WOAH)</td>
<td>1,838</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97458</td>
<td>Myrtle Point (Served Exclusively by WOAH)</td>
<td>1,284</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97466</td>
<td>Powers (Served Exclusively by WOAH)</td>
<td>265</td>
<td></td>
<td>1:265</td>
</tr>
<tr>
<td>97450</td>
<td>Langlois (Community Shared with AllCare)</td>
<td>147</td>
<td></td>
<td>1:147</td>
</tr>
<tr>
<td>97476</td>
<td>Sixes (Community Shared with AllCare)</td>
<td>67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97465</td>
<td>Port Orford (Community Shared with AllCare)</td>
<td>471</td>
<td></td>
<td>1:471</td>
</tr>
<tr>
<td>97406</td>
<td>Agness (Community Shared with AllCare)</td>
<td>13</td>
<td></td>
<td>1:13</td>
</tr>
<tr>
<td>97444</td>
<td>Gold Beach (Community Shared with AllCare)</td>
<td>658</td>
<td>3</td>
<td>1:228</td>
</tr>
<tr>
<td>97415</td>
<td>Brookings (Community Shared with AllCare)</td>
<td>850</td>
<td>2</td>
<td>1:425</td>
</tr>
<tr>
<td>Total</td>
<td>19,835</td>
<td>18</td>
<td></td>
<td>1:1102</td>
</tr>
</tbody>
</table>

In the entire state of Oregon, there are only twelve fully professional addiction treatment Providers (i.e., clinical psychologists, physicians, or psychiatrists who devote the preponderance of their practice to the treatment of SUDs) (HIPAASpace, www.hipaaspace.com). Two of those individuals, both clinical psychologists, are in southern Oregon: Rita Sullivan, PhD, who practices in Jackson County; and Gregory Brigham, PhD, who serves as the chief executive officer for ADAPT, the entity to whom SWOIPA has delegated authority for its addiction treatment programs.

To a significant extent, addiction treatment services in Oregon are provided by Certified Alcohol and Drug Counselors (CADCs) The CADC-I requires no formal degree and is issued after 150 hours of addiction counseling education and 1,000 hours of clinical supervision. The CADC-I credential is primarily intended for those individuals who are in recovery, who can verify at least two years of sobriety and abstinence, and who will largely serve as peer facilitators or recovery counselors. While the CADC-II credential requires 300 hours of counseling education and a
bachelor's degree, an associate degree is often accepted under waivers. The CADC-III credential requires a master's degree. ADAPT retains the services of 2.0 FTE licensed counselors/therapists and 16 CADCs, the majority of whom are certified at the CADC-I level. These individuals provide the preponderance of out-patient substance abuse treatment services. ADAPT has recently opened an intensive day treatment program (with housing supports) in Coos County that will operate under the supervision of a Licensed Clinical Social Worker. Also, under the supervision of Licensed Clinical Social Workers are adolescent and adult residential treatment programs located in neighboring Douglas County, in Roseburg. Finally, ADAPT operates a locally based Medication Assisted Treatment (MAT) program that accesses ongoing prescribing from a primary care physician via telemedicine. Advanced Health's Enrollees have access to these service elements.

**Behavioral Health Workforce Shortage, and Development and Quality Improvement Needs:** There is a moderate, yet growing, need for licensed and qualified mental health professionals in Curry County. Curry Community Health has suffered significant issues related to workforce stability and has been unable to retain enough Behavioral Health workers and nurses to retain an acceptable fidelity score for its ACT program.

Nonetheless, Advanced Health is committed to deploying eight-to-ten additional ACT teams throughout its geography to meet the needs of Members who are diagnosed with SPMI. Incumbent in this model will be the embedding of two ICC/ENCC care coordinators per team, thereby permitting Members to receive treatment and care coordination through a single high-intensity team. To undertake this ambitious goal, Advanced Health will require the services of 54 additional traditional health workers, who will serve as team extenders.

Finally, to improve the quality of Behavioral Health services, Advanced Health seeks to use the five-year-term of CCO 2.0 to phase-out the use of CADC-Is, qualified mental health professionals, and qualified mental health associates throughout its network, and to operate instead with fully licensed professionals who are assisted by traditional health workers.

**D.3. How does Applicant plan to work with Applicant's local communities and local and state educational resources to develop an action plan to ensure the workforce is prepared to provide Behavioral Health services to Applicant's Members?** Advanced Health is currently involved with Southwestern Oregon Workforce Development, and the Board of Directors for this entity has identified the healthcare workforce as a major priority. One such effort, in cooperation with Southwestern Oregon Community College, has been the development of an off-site master's training program in clinical social work, offered by Portland State University through distance learning, but convened on the campus of Southwestern Oregon Community College (A separate effort, discussed
elsewhere, has been to bring a certification program to the Community for medical assistants.). To increase the rate of enrollment in the clinical social worker training program, and to improve the quality of Behavioral Health services offered to Members, in 2020 and 2021, Advanced Health will offer financial assistance, in the amount of $5,000 per person, for a maximum of five candidates per annum, for those individuals who are currently working as qualified mental health professionals, or qualified mental health associates, within Advanced Health's network, and who are desirous of matriculating through a degree program that leads to clinical licensure. Beginning in 2022, the same levels of financial assistance will be offered to any candidate who meets the entrance requirements to the clinical social worker training program, and who agree to remain in the Community post-graduation.

Similarly, Advanced Health will offer financial assistance, in the amount of $2,500 per person, for a maximum of five candidates per annum, for those individuals who are currently working as at the CADC-I level within the Advanced Health's network, with the goal of assisting these individuals to become certified at the CADC-II level, or beyond.

Southwest Oregon Community College evidenced multiple barriers to the development of a traditional health worker training program. The first cohorts in Coos and Curry Counties to be certified as Community health workers were trained, at Advanced Health's expense, at Rogue Community College in neighboring Jackson County. In 2017, Advanced Health provided the financial support needed by Southwestern Oregon Community College for the training of a faculty member who, in turn, could obtain the appropriate level of education required to permit Southwestern Oregon Community College's traditional health worker program to become accredited. In both 2017 and 2018, Southwestern Oregon Community College enrolled 24 individuals in its Community health worker training program. The first cohort of 24 students was comprised of individuals currently employed throughout Advanced Health's network, and Advanced Health sponsored the full cost of the educational program for these employees. In 2018, Advanced Health subsidized all but $500 of tuition expenses for an additional cadre of 24 students, many of whom were drawn from the Community.

In order to develop the 54 additional traditional health workers that are needed to meet the Behavioral Health needs of Members, Advanced Health will provide financial assistance to Southwestern Oregon Community College to develop an accredited training program for personal health navigators. In addition, Advanced Health will sponsor at least two traditional health worker training programs at Southwestern Oregon Community College. If timely arrangements can be made, the first course will be offered in the fall of 2019, and the second course in 2020. Because employment vacancies will exist for all graduates of the program, employers will interview and pre-approve persons for participation. Upon
graduation, the graduate will be employed by the pre-approving employers. Because Advanced Health Members have needs that

D.4. What is Applicant's strategy to ensure workforce capacity meets the needs of Applicant's Members and Potential Members? In addition to the strategies cited under D.3, Advanced Health is keenly aware that its Members are requesting a more diverse and expanded program of peer-delivered services. To this end, Advanced Health will provide financial assistance to Southwestern Oregon Community College to develop an accredited training program for peer wellness specialists. It is envisioned that accreditation will be received during 2020. Until local accreditation is obtained, Advanced Health will provide qualified peer wellness candidates with options for out-of-area training.

Advanced Health's most pressing Behavioral Health workforce development need is for psychiatric evaluators and prescribers. Southern Oregon State University (Ashland) offers an advanced degree for mental health/psychiatric advanced practice nurse practitioners. Advanced Health has a standing offer to provide up to $50,000 in financial assistance to any registered nurse who holds a bachelor's of science degree in nursing, who can meet the entrance requirements to the mental health/psychiatric nurse practitioner training program at Southern Oregon University, and who will make a commitment to practice in Coos or Curry County upon graduation from the program.

D.5. What strategies does Applicant plan to use to support the workforce pipeline in Applicant's area? The U.S. Department of Education provides federal TRIO grants to academic institutions (and other entities) purposed at identifying and providing educational services to individuals from disadvantaged backgrounds. The program originally included three distinct federal grant programs (hence the name, TRIO) but was expanded under the Obama administration to include eight programs, the most familiar of which are Educational Opportunity Centers, Student Support Services, Talent Search, and Upward Bound. Southwestern Oregon Community College is a recipient of an Upward Bound grant ($263,938 per annum) with 52 participants, and a Talent Search grant ($306,024 per annum) with 622 participants. Both the Talent Search and Upward Bound program identifies youth from disadvantaged backgrounds during high school, provides career counseling and tutoring, and, assist participants in completing high school and meeting college entrance requirements. Advanced Health will lend social capital to these two programs purposed at emphasizing healthcare careers, and especially local opportunities for careers in the Behavioral Health field. Advanced Health can envision a program in which first-year college students who hold an interest in a health career, and who are enrolled in Talent Search or Upward Bound, complete training as Community health workers, peer wellness specialists, or navigators. This would create a circumstance in which students would have access to family-wage employment while completing the
balance of their academic goals, thereby alleviating the financial stressors that accompany higher education – particularly for those from disadvantaged backgrounds. At the same time, employment as a traditional health worker will provide student-employees with meaningful first-hand experience in the healthcare industry.

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Workforce, offers a wide array of grant programs purposed at the development of health professionals, only three of which target Behavioral Health, and of those, two target training to address the opioid crisis. Nonetheless, the Bureau of Health Workforce has developed a series of well-researched grants that are effective in developing the nursing workforce and other allied health professionals (e.g., Nursing Workforce Diversity grants; Allied Health Professional grants; and Nurse Education, Practice, Quality, and Retention grants). Each of these evidence-based programs share structures that are similar to the U.S. Department of Education’s TRIO grants: identify students at the high school level; stimulate an interest in a health career (including those careers that require a formal college degree and those for which only certificates are required); provide academic advisement, tutoring, and mentoring; and assist with college entry requirements and applications. In some of these programs, students at the high school level earn stipends for participation in program activities (advisement; job shadowing; tutoring; mentoring; campus tours), and these stipends are deposited into a scholarship account on the students’ behalves.

The Health Resources and Services Administration (HRSA) has developed an evidence-based and innovative program entitled Kids Into Health Careers, which is particularly purposed at introducing middle and high school students (and their parents) to the vast array of careers that exist in the healthcare industry. The program has been extensively field-tested in rural communities. In most rural communities, Kids Into Health Careers has been a programmatic offering of Area Health Education Centers. The program is assembled in a kit and includes: guidance materials to use when working with local school systems; an operating instruction booklet; parent information; and presentation materials for students stratified by age. Parent education materials include thirty (30) sources of financial aid and a list of federally funded health facility contacts for additional information.

HOSA is an international student organization recognized by the U.S. Department of Education, and its two-fold mission is to promote career opportunities in the healthcare industry and to enhance the delivery of quality healthcare to all people. HOSA’s goal is to encourage all health science instructors and students to join and be actively involved in HOSA. HOSA is not a club to which a few students join. Rather, HOSA is a powerful instructional tool that works best when it is integrated into health sciences education at the high school level.
There are potentially multiple solutions purposed at developing a workforce pipeline in Advanced Health’s service area, but only one, the federal TRIO program, is in operation and its focus is not delimited to health careers or professions. Nonetheless, programs such as Bureau of Health Workforce initiatives, Kids Into Health Careers, and HOSA, represent evidence-based potential solutions for Coos and Curry Counties. Armed with knowledge about models that work, Advanced Health will convene a summit during 2020, in partnership with the state and local educational and workforce development communities, to identify the best solution, or combination of solutions, to build a health workforce pipeline, beginning at least by the high school years. With its educational and workforce development partners, Advanced Health will commit social and financial resources to launch and sustain a defined workforce development pipeline.

D.6. How will Applicant utilize the data required to be collected and reported about Members with SPMI to improve the quality of services and outcomes for this population? What other data and processes will Applicant collect and utilize for this purpose? Clinical data pertinent to Members with SPMI (as well as assessment data for Members with SUD, using ASAM assessment protocols) will be reported in MOTS. Regular reviews of MOTS summary data will assist Advanced Health in planning for the treatment, care coordination, and support needs for these individuals, thereby improving the quality of services for this population. Prior planning for access, timeliness, and special programming needs will improve the quality of care, which in turn will result in improved clinical and functional outcomes.

Advanced Health will quarterly report on the number and percentage of Members who receive each of the following Behavioral Health services, categorized by mental health and SUDs, and the numbers of Members that may have been placed on waitlists, or referred to out-of-area services due to a lack of local specialized programs or capacity: ACT; supported employment; peer-delivered services; non-secure residential; acute care; emergency department; State Hospital; and for children with SED, Wraparound and system of care. Data regarding wait times for services will also be gathered and analyzed. These data will inform two separate types of analyses. The first analysis will determine if under- or over-utilization is occurring; while the second will determine specific information about gaps-in-service, if any. If under-utilization is found, Advanced Health will conduct a root cause analysis to determine if specific services are not needed at the volume at which they are staffed, or if Members are dissatisfied with the service, or service Provider, and thus avoiding the receipt of that service (along with an analysis of grievance data). If over-utilization is found, again a root cause analysis will be conducted, and if needed, professional and financial resources will be shifted, expanded, or newly created to address identified needs. If it is found that Members are wait-listed for local services, or too frequently referred to out-of-area service Providers, again, professional and financial resources will be deployed to expand or create those services that are in greater need than anticipated.
D.7. What outreach and/or collaboration has Applicant conducted with Tribes and/or other Indian Health Care Providers in Applicant's Service Area to establish plans for coordination of care, coordination of access to services (including crisis services) and coordination of patient release?

Two recognized Tribes exist in Advanced Health's service area: The Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (located in Coos, Curry, Lincoln, Douglas, and Lane Counties); and the Coquille Indian Tribe (with 538 Tribal members dispersed across Coos, Curry, Douglas, Jackson, and Lane Counties, 350 of whom reside in Coos County). Advanced Health was the first CCO to enter a formal, OHA-approved, contractual mechanism wherein members of the Coquille Tribe may elect to receive their Medicaid benefits either through the CCO or through their federally recognized Coquille Indian Tribe Community Health Center. Advanced Health recognizes Coquille Indian Tribe Community Health Center as a Primary Care Provider within its network, and the Primary Care Providers affiliated with the Tribal Health Center are free to make referrals throughout Advanced Health's network for the full complement of services, including Behavioral Health services. In some cases, Tribal members elect to maintain their enrollment with the Tribal Clinic, but then when the need exists for services beyond the scope or capability of the Tribal Clinic, transfer their Medicaid Enrollment to Advanced Health. Advanced Health is entirely comfortable with this arrangement, even though it results in some adverse selection at the greatest moment of need (and cost). Responsibility for care, and care coordination is managed either at the Tribal Clinic (for Tribal members who elect to Enroll with the Clinic), or by Advanced Health for those Tribal members who elect to Enroll with the CCO.

In Coos County, Advanced Health has reached a similar agreement with the Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians. This confederated Tribe does not enjoy the benefit of a Native American Health Center, and Tribal members are provided with the option of maintaining their existing Medicaid benefits (largely through open cards) or Enrolling in the CCO. Tribal leaders encourage Enrollment in Advanced Health's CCO, although no pressure is applied to Tribal members to make any Enrollment decision.

There are two Rancherias (Elk Valley and Resighini) and two Tribes present in Del Norte County in northern California, at the southern border of Curry County: Tolowa Dee-ni Nation; and Yurok Tribe of California. Of these, the Yurok is the largest, and many of its Tribal members reside in the Brookings-Harbor area of Curry County. This Tribe operates a Native American Health Center in Crescent City, California. Advanced Health has engaged in outreach efforts to the Yurok Tribe, and while no formal agreement has been reached, there is interest on both sides.
E.1. How will Applicant support efforts to address opioid use disorder and dependency? This includes: E.1.a. How will Applicant provide, in a culturally responsive and linguistically appropriate manner, SUD services to Members, including outpatient, intensive outpatient, residential, detoxification and MAT services? Effective 31 December 2019, all Providers and contractors must submit evidence of completed meaningful training in Cultural and Linguistic Competency in order to remain included on Advanced Health's network. By all Providers and all contractors, Advanced Health means every Provider, employee of Provider, contractor, employee of contractor, sub-contractor, and employee of sub-contractor, regardless of status as a professional, para-professional, peer, or administrative support personnel, who has direct contact with Advanced Health's Members. As Advanced Health adds traditional health workers and CADC-IIs to its network, care will be exercised in identifying and retaining personnel who are representative of the target population. Advanced Health will directly contract with ADAPT, an OHA-approved Provider of SUD services, for adult and adolescent residential treatment services. Advanced Health will directly contract with Southwest Oregon Independent Practice Association (SWOIPA) for fully integrated physical and Behavioral Health services within the global budget. In turn, SWOIPA will contract with ADAPT for outpatient, intensive outpatient, detoxification, and medication-assisted treatment (MAT) services. ADAPT will provide each of these service elements in both Coos and Curry Counties, except for outpatient SUD services. SWOIPA will issue a solicitation to identify an experienced and appropriately certified or licensed Provider of SUD outpatient services in Curry County; ADAPT may or may not elect to respond to this solicitation. The successful bidder will be identified in time to initiate service delivery in Curry County by 31 December 2019. Regardless of the contractual mechanism, Advanced Health will reserve for itself the sole and exclusive right to deny all SUD-related prior authorization requests. In 2018, SWOIPA provided $100,000 to ADAPT to offset up-front costs for the development of a local MAT program. Similarly, in 2016, SWOIPA provided $432,000 to ADAPT in matching funds to secure a facility for housing-supported intensive outpatient treatment for SUD, thereby assuring that this service element was available in the local Community. Because the housing facility is only authorized for adults, in 2019, SWOIPA will provide up to $500,000 to secure a second facility for parents-with-children, in order that parents may participate in intensive outpatient treatment services for SUD while enjoying the benefits of family permanency or rapid reunification.

E.1.b. How will Applicant provide culturally responsive and linguistically appropriate alcohol, tobacco, and other drug abuse prevention and education services that reduce SUD risk to Members? Prevention and education services are provided through multiple arrangements and in multiple settings and locations. In partnership with Advanced Health, Coos Health and Wellness contractually provides alcohol and tobacco prevention education in the
schools, as well as tobacco cessation education for adults. Advanced Health directly provides tobacco cessation services in Curry County, and local school districts in Curry County include alcohol and tobacco prevention and education as a component of the academic curriculum. Students in both counties who are served by school-based health centers have immediate access to alcohol and tobacco prevention and education programs, and those schools that are un-served by a school-based health center are assigned school counselors through CMHPs or FQHCs. Advanced Health directly operates a highly visible opioid risk awareness program that includes multi-media messaging. Finally, in partnership with Advanced Health, Bay Area Hospital's Community education program features periodic Community-wide education programs related to alcohol, tobacco, opioid, and other drug abuse prevention, early identification, and entry-to-treatment. Some Community educational sessions are available in the Spanish language, or with the assistance of American Sign Language interpreters.

E.1.c. How will Applicant inform Members, in a culturally responsive and linguistically appropriate manner, of SUD services, which will include outpatient, intensive outpatient, residential, detoxification and MAT services? Information regarding Advanced Health's SUD services, of all required types, is provided in the Member Handbook and posted to Advanced Health's website. The Member Handbook is available in the Spanish language, and in recorded format for persons with visual or reading difficulties. Advanced Health maintains a cadre of in-house Navigators who assist Members in identifying Providers and services throughout the network. One of these navigators is also a certified Spanish language health interpreter. As Advanced Health adds additional traditional health workers to its network, care will be exercised in identifying and retaining personnel who are reflective of the target population of Members.

E.1.d. In collaboration with local providers and CMHPs, how will Applicant ensure that adequate workforce, Provider capacity, and recovery support services exist in Applicant's Service Area for individuals and families in need of opioid use disorder treatment and recovery services? This includes: sufficient up-to-date-training of contracted providers on the PDMP, prescribing guidelines, buprenorphine waiver eligibility, overdose reversal, and accurate data reporting on utilization and capacity. As early as 2011, Advanced Health engaged the consulting services of Jim Shames, MD, who was the original founder of the Opioid Prescribers' Group (OPG) in Jackson County. Dr. Shames' work was ultimately morphed to become the Oregon Pain Guidance (also, OPG). With input from Dr. Shames, Advanced Health's medical director began to make rounds with all prescribers within Advanced Health's network to discuss appropriate opioid prescribing and to identify local solutions for patients who had become addicted to prescribed opioid medications. This effort was followed by medical chart reviews and further consultations with prescribers, and with Advanced Health's Director of Clinical
Pharmacy. Collectively, these efforts resulted in the early local adoption by pharmacies of the Prescription Drug Monitoring Program (PDMP). Today, policies and procedures regarding the PDM, prescribing guidelines, and resources available to prescribers and their patients, are summarized in the Provider Handbook. (Instructions for accurately reporting utilization, wait-lists, and capacity are also included in the Provider Handbook.)

In order to increase capacity within Advanced Health's network, physicians have been made aware of the processes for obtaining waivers for prescribing buprenorphine. While the presence of a MAT program in Coos County has eased demands, unmet needs continue to exist in Curry County. Currently, Advanced Health, ADAPT, and SWOIPA are in dialogue about several possible solutions, including: establishing a satellite MAT program in Curry County; transporting Curry County Member to the MAT program in Coos County; and increasing the number of buprenorphine-waived prescribers in Curry County.

Advanced Health has been operating a highly visible and intensive opioid program in Coos and Curry Counties, and through this effort has convened annual Opioid Summits that have drawn 100s of participants, including prescribers, SUD prevention and treatment personnel, law enforcement, public health officials, educators, Members, and concerned family members of Members. This program initially trained law enforcement and first responders in the use of naloxone and has since offered at least six Community training sessions that are well-advertised and open to the general Community at no cost. Upon completion of a training session, naloxone is provided at no cost to program participants. Attendance has been remarkable, and the training sessions are scheduled to continue at quarterly intervals well into 2020.

Information regarding workforce adequacy and Provider capacity has been previously set forth in D.2, D.3, and D.4. In its treatment programs, ADAPT employs the evidence-based Community Reinforcement Approach (CRA) for adults, and Adolescent Community Reinforcement Approach (A-CRA) for adolescents. According to this model, to reinforce gains made during treatment, persons in recovery can benefit from recovery support services, which include continuing care (aftercare), mutual help groups (AA), and peer recovery support offered in a Community setting where fellow recovering persons can share their experiences, provide mutual support, and lend assistance to a substance-free lifestyle. Aftercare plans are developed for all persons as they near completion of formalized treatment, and include office-based follow-up at monthly, and then quarterly, intervals. AA and NA groups for persons in recovery and their families are readily available throughout the Community, and the services of both paid and volunteer peer wellness specialists continue to be made available for as long as the Member, or family member of Member, desires.
E.1.e. How will Applicant coordinate with providers to have as many eligible providers as possible be DATA-waived so they can prescribe MAT drugs? Advanced Health's medical director makes regular rounds with Providers and leads specialty-specific, Hospital-based committee meetings. Each of these provide an opportunity to encourage Providers to become DATA-waived for the prescribing of MAT drugs. At present, a full-court-press is being undertaken in Curry County to increase the number of DATA-waived Providers and Advanced Health has already decided to bring DATA-waived training to the local Community for physicians and mid-level practitioners, scheduled for the next 90 days. There are currently three DATA-waived prescribers in Curry County (Lori Johns, NP, William McDougall, DO, and Mark Silver, MD) and two in Coos County (Julian Ospina, MD, and Charles Reagan, MD). Coos County Members also have access to six DATA-waived prescribers, through an affiliation with ADAPT, who practice in neighboring Douglas County, and who provide some services via telemedicine.

E.1.f. How will Applicant coordinate care with local Hospitals, Emergency Departments, law enforcement, EMS, DCOs, certified peers, housing coordinators, and other local partners to facilitate the continuum of care (prevention, treatment, recovery) for individuals and families struggling with opioid use disorder in Applicant's community? All Members who are diagnosed with opioid use disorder are considered by Advanced Health to be priority special populations, and as such, are eligible for intensive and exceptional needs care coordination (ICC/ENCC). These Members will be offered an assignment to an ICC/ENCC care coordinator who will work with each Member, and family members of Member, to establish a mutually-agreeable and holistic plan of care for each appropriate phase: prevention; treatment; relapse; recovery. ICC/ENCC care coordinators become the Members' tool for coordinating care for the full spectrum of needs (medical, social, educational, vocational, housing, nutrition, recreation, socialization) and resolving issues that may emerge from negative contacts with child protective services, law enforcement or the criminal justice system. (Additional detail regarding Advanced Health's ICC/ENCC program follows in Section E.3.)

E.1.g. How will Applicant provide additional efforts to address opioid use disorder and dependency, including (i) comprehensive treatment and prevention; (ii) care coordination and transitions between levels of care (especially from high levels of care such as hospitalization, withdrawal and residential); (iii) adherence to treatment plans; (iv) increase rates of identification, initiation, and engagement; and, (v) reduction in overdoses and overdose-related deaths? Advanced Health has recently added local housing-assisted intensive day treatment services (2017) and a MAT program that is currently serving 100 Members (2018). Plans are underway to increase the capacity of the MAT program to serve as many as 200 unduplicated Members. Opioid prevention efforts are embedded in Advanced Health's Opioid Program,
previously discussed, and include widespread, well-received, and Community-based Naloxone training and dispensing. This effort has already contributed to a reduction in overdose-related deaths in Coos and Curry Counties. Additional detail regarding Advanced Health’s care coordinator program is provided in Section E.3, that follows. To the extent that it is permissible, SWOIPA will include value-based payment methodologies when contracting for SUD services. These methodologies are not envisioned to be punitive, but rather, to create incentives for variables related to identification, initiation of treatment, and engagement in treatment. Any proposal to incorporate value-based payments for SUD Providers will be submitted to the OHA for approval prior to implementation.

E.2. Applicant will prioritize access for pregnant women, and children aged birth through five years, to health services, developmental services, Early Intervention, targeted supportive services, and Behavioral Health treatment. (and)

E.2.a. How will Applicant ensure that periodic social-emotional screening for all children aged birth through five years is conducted in the primary care setting? What will take place if the screening reveals concerns? The American Academy of Pediatricians promulgates practice guidelines that recommends social, emotional, and developmental screening at nine, eighteen, and thirty months of age, and autism-specific screening at eighteen and twenty-four months of age, in addition to social, emotional, and developmental surveillance at each visit. The local Early Learning Hub has been an advocate of the Ages and Stages Questionnaire, which is particularly adept at identifying social and emotional issues, as well as the early identification of learning disabilities. These questionnaires are administered at twenty-four and sixty-months of age, ideally prior to Enrollment in kindergarten. In addition, Advanced Health requires that every pediatric patient be screened within thirty (30) days of enrollment in the CCO, and at least annually thereafter. If a pediatric Member initiates care at the time of birth pediatric Members can expect the following protocol:

- CCO-required screening for health risks and social determinants of health within thirty (30) days of birth;
- APA-approved physical, social, emotional, and developmental screening at age nine months;
- CCO-required re-assessment for health risks, adverse childhood experiences, and social determinants of health at age twelve months;
- APA-approved physical, social, emotional, and developmental screening at age eighteen months;
- CCO-required re-assessment for health risks, adverse childhood experiences, and social determinants of health at age twenty-four months;
- Ages and Stages Questionnaire for social and emotional development at age twenty-four months;
• CCO-required re-assessment for health risks, adverse childhood experiences, and social determinants of health at age thirty-six months;
• APA-approved physical, social, emotional, and developmental screening at age thirty months;
• CCO-required re-assessment for health risks, adverse childhood experiences, and social determinants of health at age forty-eight months;
• *Ages and Stages Questionnaire* for social and emotional development at age sixty months; and,
• CCO-required re-assessment for health risks, adverse childhood experiences, and social determinants of health at age sixty months.

Advanced Health ensures that required screenings are conducted in the primary health setting by promulgating standards within its *Provider Handbook*, monitoring electronic databases, and when indicated and under the direction of the chief medical officer, conducting quality improvement clinical chart reviews with follow-up Provider counseling. When the results of screening activities produce concerns, within-clinic referrals are made to either primary-care case management personnel or in-house licensed Behavioral Health specialists. In turn, case managers and Behavioral Health specialists may make referrals for Intensive Care Coordination (ICC) or Exceptional Needs Care Coordination (ENCC).

**E.2.b. What screening tool(s) to assess for adverse childhood experiences (ACEs) and trauma will be used. How will Applicant assess for resiliency? How will Applicant evaluate the use of these screenings and their application to developing service and support plans?** Advanced Health's Clinical Advisory Panel is in the process of identifying the tool that will be universally applied throughout Advanced Health's network for screening for ACEs and trauma. Currently under consideration are:

- *Adverse Childhood Experience Questionnaire*, https://www.goodtherapy.org;
- *Adverse Childhood Experiences Questionnaire*, http://traumadissociation.com/ace;
- *ACEs Questionnaire*, https://www.ncjfcj.org/sites/default/files/Finding%20Living%20with%20Trauma%20Survey%20Tool,
  http://traumadissociation.com/questionnaires

Similarly, no specific instrument has yet to be identified by Advanced Health's Clinical Advisory Panel for the assessment of resiliency. The instrument that is the most favored by The Resilience Project of the American Academy of Pediatricians is the *Resilience Questionnaire*, however this instrument provides mostly an assessment of parental resiliency and support systems. While potentially valuable, it cannot be substituted as an assessment of the patient's resilience. Most likely,
the Clinical Advisory Panel will adopt the Brief Resilience Checklist, http://resiliencyinc.com/assessment, as it is primarily a screening tool that has been designed to document the presence of all risk and protective factors within a given child or family. It has been tested on a large high-risk cohort with children but may not be the most appropriate choice for adolescents. Other instruments that have been considered include the Resiliency Scales for Children and Adolescents (RSCA), Child and Youth Resilience Measure (CYRM), Assessing Developmental Strengths Questionnaire (ADS), Resilience and Youth Development Model of the California Healthy Kids Survey, Adolescent Resilience Questionnaire (ARQ), and Resilience Scale (RS). Multiple of these tools are more akin to formal psychometric diagnostic instruments than screening devices. Advanced Health will consult with the OHA and seek its approval for any ACEs, trauma, or resiliency instrument prior to its adoption for universal application within Advanced Health's network. OHA's approval will be sought prior to the time of the readiness review.

After the selected screening tools have been in use for at least six months, but not more than twelve months, Advanced Health's Clinical Advisory Panel will convene focus groups of health practitioners to determine how useful, or not, the tools have been in informing case management service and support plans. If the tools are found to have value, their use will continue. If the tools are found to have little value in informing on-the-ground service and support plans, or meaningful interventions, new tools will be sought.

From federally-funded research conducted by the Center for the Study of Social Policy's Strengthening Families initiative, that there are five specific strategies, each with multiple variables and delivery mechanisms that are known to promote the development of protective factors (resilience) among children and most adults who have been negatively impacted by adverse experiences or trauma. Those factors are: parenting resilience (for adults); social connections (for children and adults); knowledge of child development (for adults); concrete support in times of need (for children and adults); and social and emotional competence (for children and adults). To this end, the plans of care for all children who have been negatively impacted by adverse experiences or trauma, and who screen positive for low levels of resilience, will include attention to each of these domains. Advanced Health will work with the Parenting Project at Southwestern Oregon Community College (SOCC) and will provide health-related services funding to that entity, to provide specialized parenting assistance, inclusive of child developmental expectations, for parents of children who have a history of trauma and who are of low resiliency. The purpose of the parenting assistance is to help parents to manage stress, develop self-confidence, call forth inner strength to proactively meet personal and family challenges, seek help when it is needed, and hold stressors sufficiently at bay to continue the provision of nurturing attention to one's child or children. This parenting assistance may include work in small groups but is more likely to deliver services through ego-bolstering activities, coaching, and mentoring.
Plans of care will specifically identify concrete supports and services that parents can access on behalf of their children during times of need (e.g., healthy food, a safe environment, health and health-related services, social and emotional supports, legal services, financial services), and will augment those services with on-demand navigation assistance. In addition, plans of care will address social and emotional competence through family-identified activities that promote positive parenting, fostering a strong and secure parent-child relationship in which children feel safe in expressing their emotions, limit-setting, separating emotions from actions, and, encouraging self-regulation behavior. Finally, plans of care will address each identified family's needs for social connections, including building trusting relationships, feeling respected and appreciated, having familial and social support systems who can provide emotional support and buffer parents from stressors, while providing a sense of connectedness that enables families to feel secure, confident, and empowered to "give back" to others.

E.2.c. How will Applicant support Providers in screening all (universal screening) pregnant women for Behavioral Health needs, at least once during pregnancy and post-partum? Advanced Health will support primary care and obstetrical Providers in their patient screening processes by embedding both Behavioral Health specialists and primary-care case managers in every practice. The Primary Care Providers and obstetricians who attend pregnant and post-partum women may decide whom within their practice group will perform screening functions (e.g., the Provider, proper; the Behavioral Health specialists; or the case manager). Regardless of who performs the formal Behavioral Health screening, it is ill-conceived to conclude that screening once during the prenatal period is adequate. It is not! Pregnant women should be screened throughout the gestational period for Behavioral Health needs, and particularly for depression. Rather than producing a formalized screening tool at the occasion of every prenatal visit (Beck Depression Inventory) or at the time of the post-natal visit (Edinburgh Postnatal Depression Scale), caring and astute clinicians will more informally and conversationally inquire about changes in appetite, sleep patterns, libido, and engagement in pleasurable activities. So-doing builds rapport between the Provider and patient, establishes trust, and is more patient-centric than handing the patient yet another form, questionnaire, tablet, or survey to complete. That said, Advanced Health will require the use of the PHQ-9, according to the administration frequency protocols established for that instrument, for all pregnant and post-partum women.

Advanced Health ensures that required Behavioral Health screenings occur during the pre- and post-natal periods by promulgating standards within its Provider Handbook, monitoring electronic databases, and when indicated and under the direction of the chief medical officer, conducting quality improvement clinical chart reviews with follow-up Provider counseling.
E.2.d. How will Applicant ensure that clinical staff members providing post-partum care are prepared to refer patients to appropriate Behavioral Health resources when indicated and that systems are in place to ensure follow-up for diagnosis and treatment? Advanced Health embeds Behavioral Health specialists in every primary and obstetrical care setting. If a patient screens positive for a Behavioral Health concern during either the pre-natal or post-partum period, no formal referral is needed. A warm handoff can be undertaken between the clinician and the Behavioral Health specialist at the precise moment that the concern is identified. The Behavioral Health specialist will assure the patient's (and infant's) safety and may make an immediate intervention, arrange for medication if indicated, schedule a return visit, schedule the patient for a consult with a higher-level licensed mental health professional, bring to bear the resources of the primary care case management team for social supports and Community-level interventions, or any combination of these. The primary-care case management team develops a written plan of care and enters it into Pre-manage/Community EHR – an electronic system that permits Advanced Health's supervising personnel to assure that appropriate follow-up and treatment have been initiated. Pregnant and post-partum women with Behavioral Health needs are considered priority populations for inclusion in Advanced Health's ICC/ENCC care coordination program.

E.2.e. How will evidence-based Dyadic Treatment, and treatment allowing children to remain living with their primary parent or guardian, be defined and made available to families who need these treatments? (and)

E.2.h. How will Applicant ensure children referred to the highest levels of care (day treatment, subacute or PRTS) are able to continue Dyadic Treatment with their parents or primary caregivers whenever possible? Three or four licensed mental health professionals at Coos Health and Wellness have been trained to fidelity in Parent-Child Interactive Therapy (PCIT). PCIT is an evidence-based didactic treatment that involves parents together with their children. PCIT is conducted through "coaching" sessions, during which the parent and child are in a play room, while the therapist is in an observation room, observing the parent-child interaction, and providing in-the-moment coaching to the parent on skills purposed at warmly handling the child's behavior. When Coos Health and Wellness constructed its new facility (2018), care was taken to include three-to-four purpose-based therapy offices for PCIT, assuring that the physical facility supports play rooms, observation rooms, and time-out options.

PCIT is made available to all parent-child dyads who need, and can benefit from, the therapeutic model. Under some circumstances, preference may be given to the population of parent-child dyads who are involved in the child welfare system, or for whom early disruptive behavior has come to the attention of juvenile justice officials. Whether or not children receiving PCIT are permitted to live with their primary parent or guardian is not a matter for Advanced Health to determine, but
rather which falls within the purview of child protective services and the courts. However, when child protective services or the courts do permit supervised visitation by parents for children who are in out-of-home protective placements, Advanced Health has worked with child protective services to arrange for PCIT sessions to run concurrent with supervised visitation sessions. Even children who are placed in the highest levels of care (day treatment, subacute, PRTS) may participate, or continue to participate, in PCIT, provided that the level-of-care in which the child is placed is within the boundaries of the local Community. Advanced Health can transport children locally from day treatment to PCIT, using NEMT services, but cannot transport children who are residing in an up-state residential facility to PCIT treatment. Instead, Advanced Health would seek to identify a Provider of didactic therapy services in the Community in which the child's residential program is based and use NEMT services to transport the parent from the local Community to the Community in which the child is residing.

Advanced Health has concerns for those families in which a parent must undergo residential treatment for SUD, because this requirement may result in a disruption in the parent-child bonding process or result in a traumatic out-of-home placement for the child. The nearest source of residential parent-with-child SUD treatment is in Roseburg, and children, aged five years and younger, unless there is a court order to the contrary, can accompany their parents to treatment. When this occurs, the SUD Provider makes every effort to accelerate residential treatment, and to return the parent and child(ren) to the local Community as early as clinically reasonable. Once returned to the local Community, the parent may participate in intensive day treatment, and PCIT services will be initiated or continued (if interrupted during the residential treatment stay).

Advanced Health will be establishing a reunification group home for parents who are returning to the Community following residential treatment and who need transitional drug-free housing. The reunification group home will foster the reunification of both parents (if present, and only one parent needed residential treatment) and parents with children over the age of five (who may have been placed in short-term foster care or relative foster care). PCIT will be made available to all out-patient residents of the reunification group home, with dual focuses on rapid reunification of children with parents and permanency for the child.

E.2.f. How will Applicant ensure that Providers conduct in-home Assessments for adequacy of Family Supports, and offer supportive services (for example, housing adequacy, nutrition and food, diaper needs, transportation needs, safety needs and home visiting)? If a child or adolescent is participating in Wraparound/System of Care (SOC) it is expected that, with parental consent, an initial in-home assessment will be made by the SOC Team. Similarly, if a parenting adult is enrolled in the ACT program, and with appropriate consents, the ACT Team is expected to make an initial in-home
assessment for the safety and welfare of the adult who is diagnosed with SPMI and any children who may reside in the home. If continuing in-home assessments or visits are warranted, the SOC and ACT Teams may continue the provision of those services or may refer families with young children to the local public health agency, for example, for lactation support.

The local public health agencies provide home visiting services under the Babies First!, Parents as Teachers, CaCoon, and Oregon Mother's Care programs. Regardless of how titled, these programs support maternity case management through home visiting and other supports that target eligible pregnant women, and targeted case management that provides home visiting and other supports that target eligible infants, toddlers, and adolescents with special healthcare needs (Neither Coos or Curry County public health entities operate a Nurse-Family Partnership program.). Advanced Health will enter into a Memorandum of Understanding with the local public health agencies for the delivery of home visiting services, and will offset the costs of these visits, regardless of whether the Member qualifies for targeted case management or maternity case management. Any Primary Care Provider, pediatrician, obstetrician, or licensed Behavioral Health professional may make referrals to the public health departments' home visiting programs. If home visiting services conclude that a Member needs foodstuff, other nutritional needs (infant formula), diaper needs, safety needs, or the like, the costs for these can be authorized as flexible services or health-related services and supports.

E.2.g. Describe how Applicant will meet the additional Complex Care Management and evidenced-based Behavioral Health intervention needs of children 0 to 5, and their caregivers, with indications of ACEs and high complexity. Four distinct vehicles exist to meet the needs of children aged 0 to 5, and their caregivers, with indications of ACEs or high-levels of psycho-social-behavioral complexity. (1) These children and caregivers will first be identified in the primary care practice through periodic pediatric screening (Reference E.2.a). If the child or caregiver screens positive for high health risks, ACEs, or SDOH, the child will be immediately enrolled in the primary-care case management program. (2) The child and caregiver will also have immediate access to the Behavioral Health specialist who is embedded in the primary care practice. (3) If the needs of the child or caregiver cannot be met solely by the primary-care case management team, the child will be referred for Intensive Care Coordination/Exceptional Needs Care Coordination (ICC/ENCC). The ICC/ENCC care coordinator will become responsible for meeting the child's combined and unique needs through a system of coordinated referrals to specialists and supports, with appropriate follow-up. (4) These referrals and supports may include: therapeutic pre-school; PCIT; or participation in Wraparound/System of Care (SOC).
As was previously set-forth in E.2.b, from federally-funded research conducted by the Center for the Study of Social Policy's Strengthening Families initiative, that there are five specific strategies, each with multiple variables and delivery mechanisms, that are known to promote the development of protective factors (resilience) among children and most adults who have been negatively impacted by adverse experiences or trauma. Those factors are: parenting resilience (for adults); social connections (for children, adults, and caregivers); knowledge of child development (for adults and caregivers); concrete support in times of need (for children, adults, and caregivers); and social and emotional competence (for children, adults, and caregivers). To this end, the plans of care for all children who have been negatively impacted by adverse experiences or trauma, and who screen positive for low levels of resilience, will include attention to each of these domains.

E.2.f. Describe Applicant's annual training plan for Applicant's staff and Providers that address ACEs, trauma-informed approaches and practices, tools and interventions that promote healing from trauma, and the creation/support of resilience for families. By 31 December 2019, all members of Advanced Health's staff and every Provider included in Advanced Health's delivery system network Excel spreadsheets, will be required to complete training in Culturally and Linguistically Appropriate Services (CLAS), unconscious/implicit bias, health literacy and plain language, civil rights regulations, and trauma-informed practices. Documentation of completed training will be entered into staff members' personnel records and Providers' credentialing files. Training in HIPAA regulations is an additional requirement for employed staff. Thereafter, as new employees are retained, they will be required to complete and document CLAS, unconscious/implicit bias, health literacy and plain language, trauma-informed practices, HIPAA, and civil rights regulations training within thirty (30) days of the date of hire. New Providers will be required to submit verification of training in CLAS, unconscious/implicit bias, health literacy and plain language, civil rights regulations, and trauma-informed practices during the initial credentialing and biennial re-credentialing process. Advanced Health will impose identical requirements from the foregoing for all clinical contractors and their clinical subcontractors.

For the past two years, Advanced Health has invested $250,000 in a local ACEs project and is contributing an additional $100,000 in 2019. Advanced Health will turn to Community-based ACEs leaders to help inform future and ongoing training needs with respect to trauma-informed practices, tools and interventions that promote healing from trauma, and the creation/support of resilience for families. As the local ACEs project rolls-out its Family Cafes, it is envisioned that the ACEs leaders will learn more about aggregate family needs and will be best situated to recommend additional training topics.
Advanced Health’s directly-employed and contracted case managers and care coordinators will be the individuals with the greatest volume and intensity of interactions with persons who have been negatively impacted by trauma. These individuals will be assembled for continuous and on-going in-service training at quarterly intervals throughout the five-year CCO contract term. If it is found that in-service training is insufficient in accomplishing the transfer of knowledge, individual development plans may be required for all persons performing navigator, case management, peer support, and care coordination services.

Applicant is required to ensure a care coordinator is identified for individuals with severe and persistent mental illness (SPMI), children with serious emotional disorders (SED), individuals in medication assisted treatment (MAT) for substance use disorder (SUD), and Members of Prioritized Populations. Applicant must develop standards for Care Coordination that reflect principles that are trauma-informed, linguistically appropriate, and Culturally Responsive. Applicant must ensure Care Coordination is provided for all children in Child Welfare and state custody and for other prioritized populations (e.g., intellectual / developmental disabilities (I/DD)). Applicant must establish outcome measure tools for Care Coordination.

In advance of answering specific evaluation questions related to care coordination, Advanced Health sets forth this overview of its care coordination model, in the belief that so-doing will enhance the readers' understanding and provide helpful insights as to why the model has been developed in a unique and innovative way. All case management services will exist at the primary care level, including the management of mental health diagnoses that are less severe than SPMI (for adults) or SED (for children). Accordingly, Primary Care Providers and PCPCHs inherit the responsibility for implementing case management services consistent with policies and procedures promulgated by Southwest Oregon Independent Practice Association (SWOIPA). Primary-care case management services (PCCM) are separate and qualitatively different from care coordination services. SWOIPA will pay a per-member-per-month (pmpm) fee to Primary Care Providers and/or PCPCHs to provide both case management and integrated Behavioral Health services.

No specific model of case management has been identified. There are multiple case management models available (strengths-based case management; clinical case management; acute care case management; disease-focused case management; supportive case management; nursing model case management; self-determination case management). Advanced Health’s Medical Director, or the Clinical Advisory Panel, will determine whether a uniform model of case management will be utilized throughout all Primary Care Provider practices, or whether Primary Care Providers will be permitted to select an evidence-based model from among the many models
that are available. Consideration must be given to selecting a model that can be supported by Advanced Health's HIT system, as Advanced Health must engage in the consistent and constant monitoring of all case management functions.

At its most simple elements, Primary Care Provider practices will screen all assigned members, both within 30 days of the date of assignment, and annually thereafter, using approved tools, for issues related to physical health risks, mental and emotional health, appropriate development, adverse childhood experiences, history of trauma, oral health needs, SUDs, social determinants of health, and health equity. Members who screen positive will be enrolled in PCCM. Those who do not screen positive will not be enrolled, unless new needs are identified upon reassessment or there is a triggering event. Members who are determined to be among priority populations, or at high risk, SPMI or SED, criminally involved, experiencing a triggering event, or having special healthcare needs, will be referred for Intensive Care Coordination (ICC) or Exceptional Needs Care Coordination (ENCC) (collectively, ICC/ENCC).

Members whose physical, social, emotional, behavioral, housing, and financial needs cannot be addressed through PCCM will be served through Intensive Care Coordination (ICC) or Exceptional Needs Care Coordination (ENCC) (The terms are used interchangeably and mean the same thing, hence the abbreviation, ICC/ENCC.) Certain populations are required to be enrolled in ICC/ENCC, unless the patient refuses ICC/ENCC services. Those populations are: pregnant and parenting women with SUD or mental health disorders; IV drug users; persons with opioid use disorders; veterans with SUD; all SED and SPMI; parents at risk of losing children to state custody; children aged 0 to 5 with ACEs and (defined) exacerbating events; members on waitlist for Oregon State Hospital; MAT participants; individuals at risk of first-episode psychosis (included in SED population); persons with intellectual and developmental disabilities (I/DD); juveniles involved in the justice system (likely included in SED); adult corrections population; children identified with clinically low levels of resilience, and, persons who are unstably housed.

By regulation, ICC/ENCC is the responsibility of the CCO. Advanced Health accepts this responsibility and will retain the services of a full-time, masters-level, licensed mental health professional, who is directly responsible for overseeing all ICC/ENCC services, howsoever delivered. This individual will be a direct employee of the CCO, and the functions assigned to this position will not be delegated or subcontracted. Because of the extensive administrative requirements placed on this position, the position will be further assisted by the full-time services of a registered nurse, thereby placing both behavioral and healthcare experts at the head of the ICC/ENCC program. Administrative rules describe a range of functions that are attributed to this position, and they are extensive, including direct responsibility for holding all other care coordinators responsible, and exercising full oversight and
supervision to assigned care coordinators. Under Advanced Health's Care Coordination Plan, care coordination responsibilities will follow most patients to their treatment settings, as follows:

- ADAPT will provide ICC/ENCC services to special populations assigned to that entity for treatment (pregnant and parenting women with SUD; IV drug users; opioid use disorders; veterans with SUD; parents at risk of losing child custody or otherwise involved in the child welfare system with SUD; MAT participants; persons who are unstably housed with SUD);
- ACT Teams (bolstered by two ICC/ENCC Care Coordinators per team) will provide ICC/ENCC services to SPMI and corrections-involved populations, including veterans with SPMI; SPMI in residential and in-patient care; pregnant and parenting women with mental health issues; parents involved in the child welfare system with mental health diagnoses; adult corrections population; SPMI who are unstably housed; (over time, ACT Teams may become specialized, with each ACT Team serving a concentrated group, i.e., veterans and family members of veterans who are diagnosed with post-traumatic stress disorder (PTSD); persons diagnosed with SPMI who are chronically unstably housed; Members who are involved in the local mental health court or other corrections programs and who are diagnosed with SPMI); and,
- The contracted Provider for System of Care (SOC) and/or Wraparound Services will provide ICC/ENCC services to the Seriously Emotionally Disturbed (SED) pediatric population, including: individuals at risk of first-episode psychosis; children aged 0 to 5 with ACEs, children involved in the child welfare system, youth involved in the juvenile justice system who are diagnosed with SED; children with clinically low levels of resilience or an absence of protective factors; and children evidencing other exacerbating factors. SOC Teams will be developed, similar to ACT Teams. In addition to other required staffing elements, each SOC Team will be staffed by two ICC/ENCC care coordinators, providing each SOC Team with the capacity to serve thirty (30) Members.

Remaining Members needing ICC/ENCC services will receive those services from through care coordinators who are directly employed by the CCO. Populations to be served by directly-employed personnel include: persons with intellectual or developmental disabilities; persons with exceptional needs other than Behavioral Health that cannot be managed in the primary care setting (i.e., persons with communication disabilities; persons who are blind; children with significant physical or learning disabilities); pregnant or parenting women who are homeless; pregnant and parenting women for whom SPMI and SUD have been obviated; and, Members receiving long-term care (LTC) or long-term services and supports (LTSS) from Aging and Persons with Disabilities, either who cannot be managed by the Primary Care Provider, or during transitions in care.
E.3.a.(1) Describe Applicant's screening and stratification process for Care Coordination, specifically; (1) How will Applicant determine which enrollees receive Care Coordination services? All Members are screened for numerous (previously itemized) risk factors within the primary care setting by primary care case managers within thirty (30) days of Enrollment, or upon the occasion of triggering events, and annually thereafter. Any Member who screens positive for ICC/ENCC services is promptly referred to Advanced Health's Senior ICC/ENCC Executive, who, in consultation with Member, the Member's family (if relevant) Primary Care Providers, Behavioral Health specialists, and the chief medical officer, will determine if the Member is eligible for, and can benefit from, ICC/ENCC services.

E.3.a.(2). How will Applicant ensure that enrollees who need Care Coordination are able to access these services? At this time, and for the foreseeable future, Advanced Health will not stratify Members for ICC/ENCC services, or develop wait-lists, but rather will seek to meet the needs of all Members who need, or could benefit from, ICC/ENCC Care Coordination. As the number of Members needing ICC/ENCC services increases, Advanced Health envisions issuing additional contracts for ICC/ENCC services, and particularly for those ICC/ENCC services made available through ACT and SOC teams. Care will be taken to locate ACT and SOC teams throughout the geography of Coos and Curry Counties, and not to place teams only in the more populated communities of Coos Bay and North Bend, thereby promoting geographic access to ICC/ENCC services.

E.3.a.(3). How will Applicant identify enrollees who have had no utilization within the first six months of Enrollment, and what strategies will Applicant use to contact and assess these enrollees. Advanced Health requires all Primary Care Providers to contact and assess, every Member within thirty (30) days of Enrollment and annually thereafter. Primary care practices are required to document at least three credible attempts to establish contact with the Member, through at least two different means (telephone; mail; outreach). Advanced Health expects that efforts to contact and assess Enrollees will continue beyond the three contractually established contacts and beyond the ninety-day period if prior efforts have proven unsuccessful. Nonetheless, Advanced Health must respect the decisions of Members to decline participation in assessments, responding to written letters of request, or accepting telephone contacts.

E.3.b. How does Applicant plan to complete the initial screening and assessment for ICC/ENCC within the designated timeline? Advanced Health requires primary care practices to screen all new members within thirty (30) days of assignment. This contract provision is enforced through monitoring of encounter submission data, screening entries made to Pre-manage/Community EHR, and clinical chart reviews. Upon completion of the screening, all Members who screen
positive (i.e., either presenting with exceptional healthcare needs, or being a member of a priority population) and as potentially eligible for ICC/ENCC are referred on that same day to the Senior ICC/ENCC Executive, who is charged with the responsibility for assuring timely assignment to ICC/ENCC services. Referrals to the Senior ICC/ENCC Executive are not limited to those that arise through the initial and annual screening processes. Any medical or behavioral Provider within Advanced Health’s network may make referrals for ICC/ENCC, as may select Community partners (i.e., juvenile justice; child welfare; I/DD support Providers; APD). Triggering events and annual re-assessments may also prompt immediate referrals to the Senior ICC/ENCC Executive and ICC/ENCC services.

E.3.c. Please describe Applicant’s proposed process for developing, monitoring the implementation of, and for updating intensive Care Coordination plans. All ICC/ENCC Care Coordination plans must be uploaded to Advanced Health’s electronic Pre-manage/Community EHR system within five days of their development and completion. Care plans must be updated at least monthly. The Senior ICC/ENCC Executive will review at least 75 percent of all care plans each month, analyzing both timeliness and clinical quality. Through this monitoring process, the Senior ICC/ENCC Executive will identify those Care Coordinators who are delinquent in the timely development or updating of care plans, or those whose care plans are incomplete or sub-standard. When issues related to untimely, incomplete, or sub-standard care plans are identified, the relevant Care Coordinators will be subject to progressive discipline, beginning with counseling and training, followed by formal corrective action, up to and including termination.

E.3.d. How does Applicant plan to provide cost-effective integrated Care Coordination (including all health and social support systems)? Advanced Health’s pre-eminent model for providing ICC/ENCC services is through embedding ICC/ENCC Care Coordinators in an expanded number of ACT and ACT-like teams, and the use of System-of-Care (SOC) or SOC-Teams, that mirror ACT teams, but are configured with different team members (i.e., skills trainers, peer support specialists, family support specialists). Regardless of how titled, each ACT and SOC team will be staffed by a licensed Behavioral Health clinician, a part-time registered nurse, and two ICC/ENCC Care Coordinators (along with other allied health professionals and traditional healthcare workers). At its most basic element, ACT offers customized, Community-based services for people living with mental illness. Under Advanced Health’s model, ACT will offer customized, Community-based services for people living with mental illness, or SUDs, or other special healthcare needs, or who are members of a priority population. ACT originated because researchers concluded that Hospital training programs to prepare psychiatric patients for Community living after discharge were ineffective, and that providing treatment, training, and support within the Community setting after discharge was far superior. With the locus of control in the Community, ACT uses
assertive outreach to engage patients who are reluctant to keep appointments in traditional office settings. ACT is successful because it combines essential ingredients:

- Assertive outreach;
- Shifting delivery to Community (rather than clinical office) settings;
- Holistic approach (that includes illness management, medication management, housing, finances, practical problem-solving, immediate needs, and anything else critical to an individual's health, safety, and satisfaction);
- Use of multidisciplinary teams;
- Service integration (that has multiple advantages over brokered models);
- Direct service delivery model (in which the clinical professionals assigned to the ACT team provide services directly, rather than making referrals to other Providers);
- Continuous coverage (24-hours per day/7 days per week);
- Low patient-staff ratios; and,
- Long-term and continuous care.

It is precisely because ACT offers these essential ingredients that it has become Advanced Health preferred model for delivering ICC/ENCC services – even for those Members who are not diagnosed with SPMI, SED, or SUD. The very model integrates all treatment, Care Coordination, and all health and support systems within the ACT team. While it is acknowledged that using the ACT model to deliver ICC/ENCC services may not be cost-effective in its earliest implementation, it is believed that the model will prove its cost-efficacy over time.

E.3.e. What is Applicant's policy for ensuring Applicant is operating in a way guided by person-centered, Culturally Responsive, and trauma-informed principles? Advanced Health's policies require that all services be provided in ways that are person-centric, culturally responsive, and trauma-informed. Advanced Health ensures compliance with these policies by: promulgating policies in the Provider Handbook; requiring initial and ongoing training and in-service education; inviting ACEs-trained specialists to review practices and make recommendations to the Chief Medical Officer and Board of Directors; inviting experts from the OHA's Office of Equity and Inclusion to study operations and tender recommendations; and, submitting all action items that come before Advanced Health's Board of Directors for review and comment by the Aggregate Panel of Advisors that is comprised of Members, equity advisors, Tribal advisors, clinical advisors, quality advisors, and compliance advisors.

E.3.f. Does Applicant plan to delegate Care Coordination outside of Applicant's organization? How does Applicant plan to enforce the Contract requirements if Care Coordination delegation is chosen? Because the OHA has directed that Advanced Health must manage the Global Budget in a
fully integrated manner, Advanced Health will engage with Southwestern Oregon Independent Practice Association (SWOIPA) for all physical health and Behavioral Health services, including ICC/ENCC services for Members who are diagnosed with SPMI, SUD, and SED. The precise nature of this engagement is not in the form of a contract or delegation model, but instead, is a cooperative agreement in which Advanced Health will retain substantial administrative and clinical involvement. So-doing assures that Members will receive Care Coordination services in the same integrated setting as they receive treatment services, without the need to bounce between two systems of care: one for treatment and one for Care Coordination.

At the advice of legal counsel, and in a concerted effort to avoid any conflict-of-interest, Advanced Health's Board of Directors will retain the contracted services of a neutral, independent, and experienced consultant who will become responsible for monitoring SWOIPA's performance and compliance under its contract with Advanced Health. The Board of Directors, in consultation with the contractor, will determine contract elements that are to be continuously monitored, as well as special quarterly studies. Performance of the ICC/ENCC care coordination program will be one area that is identified for continuous monitoring. Compliance reports will be generated at least quarterly and submitted directly to Advanced Health's Board of Directors, thereby bypassing any concurrent employees of Advanced Health and SWOIPA. The independent contract monitor will have contractually established direct access to Advanced Health's Board of Directors, in much the same way as the chief compliance officer is accorded such access.

E.3.g. For Fully Dual Eligibles, describe any specific Care Coordination partnerships with your Affiliated Medicare Advantage Plan for Behavioral Health issues. Advanced Health does not operate a (affiliated) Medicare Advantage Plan. Advanced Health has entered a contractual mechanism with Pacific Source for the coordination of benefits for Pacific Source's members who are fully dually eligible. North Bend Medical Center, a fifty-plus-member physician group practice and significant contributor to Advanced Health's Provider Network, is in the process of seeking certification from CMS for a Medicare Accountable Care Organization (ACO). After certification has been secured, Advanced Health will enter into a memorandum of understanding (MOU) with the newly formed ACO for the coordinated provision of Care Coordination services. Advanced Health is willing to take the lead with Medicare Plans in providing Care Coordination for fully dually eligible Members.

E.3.h. What is Applicant's strategy for engaging specialized ICC populations? What is Applicant's plan for addressing engagement barriers with ICC populations? Because ACT has been found to be an evidence-based best practice model for engaging special populations (specifically persons who are diagnosed with SPMI), Advanced Health will use ACT Teams as the backbone for the provision of all ICC/ENCC services – including specialized populations that are
not necessarily diagnosed with SPMI. ACT has the benefit of being mobile and Community-based. Members are not required to keep weekly appointments that are convened in a clinical office setting, but rather, services are provided on-demand in least-restrictive, in-home, Community, and natural environmental settings. Because the most important member of every ACT Team is the Enrollee (Member), the Member will be encouraged to give voice to the manner and setting in which (s)he prefers to receive services. Advanced Health believes that the basic underpinnings of the ACT program, in which ICC/ENCC services are embedded, will provide Members with a refreshing, inviting, and barrier-free approach to engaging treatment and Care Coordination on their terms.

E.3.i. Please describe Applicant's process of notifying a Member if they are discharged from Care Coordination and/or ICC services. Please include additional processes in place for Members who are being discharged due to lack of engagement. ICC/ENCC services will be embedded in ACT Teams, as previously described. One of the tenets of the ACT model is that services are continuous, long-term, and in many cases, life-long. Unfortunately, persons who are diagnosed with SPMI are unlikely to make full and complete recoveries (The "P" in "SPMI" stands for "persistent."). Individuals involved in medication-assisted treatment for opioids may continue in treatment for the balance of their lives. Nomadic individuals who are unstably housed by choice, may remain unstably housed until their health condition no longer permits outdoor living. Individuals who are involved in ICC/ENCC for reasons of concurrent involvement in the Behavioral Health and criminal justice system may be facing long-term periods of parole, and any parole violation may extend the length of that parole.

The fidelity matrix for the ACT program includes measurements related to retention in, and long-term participation, in the program. Discharges from ACT programs result in a loss of "fidelity points." Herein lies the rub: Advanced Health anticipates that the preponderance of Members participating in ACT will continue to participate in ACT over the long-term. Accordingly, Advanced Health recognizes and accepts the need to continuously develop and support new ACT Teams to serve additional Members as time and circumstances evolve. Members may only be discharged from ACT under the following circumstances: the Member indicates that (s)he no longer wishes to participate in ACT; the Member no longer needs ACT services as mutually identified by the Member and his or her ACT Team; the Member is no longer benefitting from the services of the ACT Team, as assessed by the Senior ICC/ENCC Executive; or the Member is no longer available to participate in ACT for reasons of re-location, Disenrollment from the CCO, or death.

One of the most salient hallmarks of the ACT program is the commitment to engage those Members who have been difficult to engage in other settings and service delivery systems. When it comes to matters of engagement, skilled ACT professionals don't give up. They persist! If any individual ACT Team evidences a
disproportionate number of failures-to-engage, Advanced Health will interpret that as a failure of the ACT Team and not the Member. Such an ACT Team may need to be re-configured, placed under new clinical leadership, be re-supplied with personnel who are well-skilled in fostering a therapeutic alliance, provided with additional training, or placed under corrective action.

On the infrequent occasion when Members are discharged from ACT, they will receive a written notification from the Senior ICC/ENCC Executive, written at the sixth-grade reading level, and mailed to the Member's last known address. If a family member, caregiver, or guardian has been involved in the Member's ACT participation, that individual will also receive a copy of the letter of discharge. The discharge letter will specify the reason that ICC/ENCC services are being withdrawn through the ACT program; alternative assistances that are available to the Member; the Member's right to appeal the discharge decision; and the rights accorded to the Member to return to ACT and ICC/ENCC services at any time, or to be assigned to a different ACT Team.

E.3.j. Describe Applicant's plans to ensure continuity of care for Members while in different levels of care and/or episodes of care, including those outside of Applicant's Service Area. How will Applicant coordinate with Providers across levels of care? Continuity of care, artfully managing planful transitions in care, providing direct services and supports during transitions in care, and coordinating with all Providers involved in a Member's care, whether locally situated in the service area or far-flung, is the precise work of ICC/ENCC care coordination. Therefore, Advanced Health plans to address these circumstances by providing Care Coordination that is embedded in ACT, using highly skilled personnel, who are committed to providing appropriate clinical and social supports to a small number of Members. This is not just a matter of meeting administrative rules: it is a matter of caring. It is a matter of identifying those healthcare workers who are willing to commit their professional practice to fifteen persons who evidence high needs and a paucity of resources.

Immediately upon learning that a Member requires services that are not available within Advanced Health's service area, the matter is simultaneously referred to Advanced Health's directly-employed Senior Care Coordination Executive. This individual is empowered to identify an out-of-area resource, negotiate a payment rate, authorize the service on behalf of the Member, and arrange for expeditious transportation for the Member, and if appropriate, concerned family member(s). In most such cases, Advanced Health asks the referral program to provide a copy of its standard contract for endorsement and signature by Advanced Health. Advanced Health accepts financial responsibility for out-of-area services authorized by the Senior Care Coordination Executive or his or her designee. The assigned ACT Team is held accountable for continuity of care, coordinating the efforts of local and out-of-area Providers, discharge planning, and contacting Members who are being service
outside of the service area on a twice-weekly basis, and more frequently if indicated. When circumstances permit, it is desired that at least one weekly contact be on a face-to-face basis. If Advanced Health establishes a pattern of relying on an out-of-area Behavioral Health Provider over the course of time, every effort is made to identify or create a local, in-area resource to meet current and future needs.

In Advanced Health's model, it is anticipated that most Members who may experience a transition-in-care have already been identified and are participating with an ACT or SOC team. Under these circumstances, the ACT or SOC team will have been involved with the Member, and the Member's representative, at the earliest onset of the transition-in-care. Hopefully, most transitions-in-care will have been thoughtfully contemplated and be consistent with the Member's written care plan. The Member, and Member's representative, will be assisted by the ACT or SOC team through each step of the transition-in-care.

Under isolated circumstances, a Member who is not served by an ACT or SOC team may experience conditions that result in emergent episodes of care or transitions-in-care (e.g., unanticipated early onset of psychosis). These Members, and their families or representatives, will receive immediate assistance from Advanced Health's Senior Care Management Executive until their ICC/ENCC coordination needs can be transferred to an ACT or SOC team. Such members will be prioritized for access to an ACT or SOC team.

For Members who are entering or exiting in-patient or residential services, and particularly for those Members who have been placed in facilities that are outside of the service delivery area, ICC/ENCC Care Coordinators shall have contact with the Member at least two times per month prior to discharge, and two times during the week prior to discharge. Every effort will be made to assure that these contacts occur on a face-to-face basis. If appropriate, the ICC/ENCC Care Coordinator will arrange a warm handoff for Members if they will be transferred to another relevant care Provider during the transition-in-care. For Members in acute care, ICC/ENCC coordinators shall have contact with the Member, preferably on a face-to-face basis, within one business day of admission, and two times per week until discharge. Per ICC/ENCC standards, Members will be timely reassessed in the event of triggering criteria.

E.3.k. How will Applicant manage discharge planning, knowing that good discharge planning begins from the moment a Member enters services? (and) E.3.l. What steps will Applicant take to ensure Care Coordination involvement for ICC Members while they are in other systems (e.g., Hospital, sub-cute, criminal justice facility)? Questions E.3.K and E.3.l will be answered in unison. By design, the ICC/ENCC services that are embedded in ACT are long-term, if not life-long, in nature. For this reason, engagement, and not discharge planning, begins at the moment the Member enters ICC/ENCC services.
Nonetheless, skilled ACT Team members know that premature discharge from ICC/ENCC services on which a Member has grown to be rightfully reliant, can be de-stabilizing at best, and catastrophic at worst. To that end, discharge planning is approached very carefully with the Member and with the Member's support systems, when available and when permitted by HIPAA. Discharge planning from ICC/ENCC services is akin to the planned termination of psychotherapy, in which a strong therapeutic alliance has been developed between the patient and the therapist. The way in which therapeutic alliances are brought to termination can have clinical, ethical, and legal implications. Nonetheless, termination presents the opportunities to process ending an important relationship in a healthy way, and demonstrating skills gained in managing feelings of anxiety, grief, or loss. To this end, ICC/ENCC discharge planning will be led by the clinical member of the ACT Team and will be given the same emphasis and consideration as was devoted to the initial establishment of a therapeutic alliance. Discharge planning only occurs when the Member concludes that (s)he is no longer in need of ICC/ENCC services, or the ACT Team and its clinical supervisor agree that the Member is no longer benefitting from ICC/ENCC services, or the Member will lose eligibility for these services through re-location, changes in Medicaid eligibility status, or death. Discharge planning will always be trauma-informed.

E.3.m. Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement. Most ICC/ENCC Care Coordination services will be provided through ACT Teams, although the CCO will retain three Care Coordinators to serve priority populations whose needs exclude Behavioral Health. Advanced Health's Senior ICC/ENCC Executive is responsible for the assignment of all Members to ICC/ENCC Care Coordinators and will consistently have an up-to-date roster of assignments, in much the same way as the CCO maintains currently accurate records of Member assignments to Primary Care Providers. Except under the most emergent of Community circumstances, policies adopted by Advanced Health's Board of Directors prohibit any ICC/ENCC assignments that exceed the 15:1 ratio. This policy will be enforced through vigilant monitoring, described in E.3.f.

E.3.n. Which outcome measure tool for Care Coordination services will Applicant use? What other general ways will Applicant use to measure for Care Coordination? Advanced Health will use elements from the Medicaid Core Sets for evaluating the effectiveness of its Care Coordination services with specific reference to, and inclusion of: (i) preventing unnecessary hospitalizations and readmissions; (ii) support for consumers' preferences and choices; and, (iii) effective care transitions. In addition to these Core Sets, and any others that may be added at the OHA's request, Advanced Health will evaluate the effectiveness of its Care Coordination program through patient satisfaction surveys (that may incorporate the use of focus groups, rather than printed or electronic survey tools), with a particular emphasis given in the survey process to Members' assessments of
improved health, and the degree to which services were provided in a culturally-responsive and trauma-informed manner.

E.3.o. How will Applicant ensure that Member information is available to Primary Care Providers, specialists, Behavioral Health Providers, care managers, and other appropriate parties (e.g., caregivers, Family) who need the information to ensure the Member is receiving needed services and Care Coordination. ICC/ENCC Care Coordinators are required to extract treatment plans from Primary Care Providers, inclusive of medication lists and include this information in each ICC/ENCC Member's plan of care. The plan of care will further identify all Network Providers who play a role in, or are assigned to, the ICC/ENCC Member. All ICC/ENCC plans of care exist in Advanced Health's Pre-manage/Community EHR system, are updated on the occasion of every ICC/ENCC contact with the Member, and can be electronically and remotely accessed by any Provider, case manager, or Care Coordinator within Advanced Health's network, in a HIPAA-compliant, need-to-know basis. If the Member has given written consent for specifically-identified individuals, in compliance with HIPAA regulations, to access his or her plan of care, that information will be readily shared and made available at the Member's request.

4.a. How will Applicant work with OHA, other state agencies, and other state-funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved? There is no glaring need to identify areas where treatment and services for adult Members with SPMI can be improved, as the examples of failed mental health service delivery systems are omnipresent. Every year produces an increase in the annual count of persons who are homeless, and a late-night walk down the streets of Coos Bay are no different than those in Portland or Eugene. The persons who are homeless and taking shelter on those streets, both day and night, evidence frank indicators of psychosis and other SPMIs, and are made outcasts by their overt symptoms of unaddressed delusions and Asperger's Syndrome, or the self-administration of alcohol, often to excess and inebriation, to quiet the symptoms of paranoia, or psychostimulants to counteract depression. County jails and state prisons have become the default mental health system in Oregon.

For decades, Oregon's mental health programs were administered in partnerships with county units of government. While citizens with physical health needs could walk through the oft-times plush and inviting offices of physicians in private practice, those who suffered from mental illness were afforded only one door, and in a total absence of privacy or respect, that door was labeled "County Mental Health Program." Once inside those doors, mental health patients sat in sparse waiting rooms on wooden or folding chairs that had been cast-off by school districts or shuttered auditoria and waited for their appointment with a "qualified mental health professional." Even after Oregon established a series of licensing boards for
clinical social workers, marriage and family therapists, and professional counselors, county mental health programs were permitted to continue to use unlicensed therapists, who had little or no training in differential diagnosis or theories of change, and no supervised clinical practicum experience, operating under the euphemism of qualified mental health professionals. And, for the majority, our qualified mental health professionals were members of public employee unions with union-negotiated contracts that delimited their availability on all major holidays, week-ends, and after-hours. Earlier models of slot-funding and carve-outs practically assured that county mental health programs would be chronically under-funded.

Today, we are left to repair a mental health service delivery system that is sub-standard, inadequate, and ineffective. Advanced Health accepts and welcomes this challenge and opportunity, because those individuals we encounter every night on our streets are our neighbors, our Members, or eligible to become CCO Members. More importantly, they are human beings who deserve our love and compassion and the highest standards of evidence-based services, delivered by licensed mental health professionals, that we can muster. If we do any less, we make that late-night walk down our hometown streets extremely difficult, painful, and guilt-laden.

Albeit initially expensive and ambitious, Advanced Health will meet the overwhelming preponderance of needs for those adult Members with SPMI through a combined treatment and intensive Care Coordination model that is vested to fidelity in ACT Teams. Advanced Health will begin with the three ACT Teams that are currently in place. In May of 2019, Advanced Health will issue solicitations for ACT Planning Grants to stand-up an additional eight-to-ten ACT Teams (in much the same way as the OHA provided seed money to initiate ACT planning and early implementation in most communities). Planning grants will require each new ACT Team to meet fidelity standards within six months. Advanced Health will repeat the cycle of ACT Planning Grants in 2000, for implementation by 2021. Advanced Health will underwrite costs associated with bringing technical advisors from the Oregon Center of Excellence for Assertive Community Treatment (OCEACT) to assist in developing the planning grant solicitations, selecting applicants arising from that solicitation, and working with successful bidders to ensure the launch of their ACT programs at a high level of fidelity.

Over time, as ACT capacity grows, Advanced Health envisions developing specialized ACT Teams that will work with targeted populations, e.g., adult Members who are diagnosed with SPMI and who are veterans, or involved in the child welfare system, or involved in the criminal justice system, or chronically unstably housed, or transitioning from the Children's System of Care to early adulthood, or suffering the confounding effects of serious chronic physical illness, or living out the balance of their lives in group homes or long-term care facilities. Through this effort, when combined with integrated Behavioral Health services in
the primary care setting, there will be no wrong door through which to enter the "mental health system." Rather, that "system" will be ubiquitous, seamless, and operating in diverse settings within the Community. Advanced Health will work with any and every public and private organization or institution that will commit itself to the mutual work of improving treatment and services: schools; colleges; veterans' service offices and officers; corrections; courts; group homes; long-term care facilities; medical practices; shelters for persons who are homeless; child welfare; Aging and Persons with Disabilities; Community-based organizations; employers offering supported employment; and others.

Finally, over time and without creating deficits in the available workforce, to emphasize clinical quality, Advanced Health will phase-out the use of unlicensed personnel in clinical positions within the mental health service delivery system. Persons currently working as qualified mental health professionals will be offered scholarship assistance to complete the locally-available and partially-distance-learning Master of Social Work program that has been developed jointly by SOCC and PSU, and to matriculate through approved supervised internships, to licensure. Persons currently working as qualified mental health associates will be assisted in securing certification as traditional health workers, and the scope of their practice will be limited to that defined in rule for traditional health workers.

4.b. How will Applicant provide oversight, Care Coordination, transition planning, and management for Members receiving Behavioral Health services, including Mental Health Rehabilitation Services, Personal Care Services and Habilitation Services, in licensed and non-licensed home and Community-based settings, to ensure individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person? All adult Members with SPMI who are willing to accept the involvement of an ACT Team will be assigned to an ACT Team in which both treatment and intensive Care Coordination services are provided. Each ACT Team will be held accountable for Care Coordination, transition planning, mental health rehabilitation services (as appropriate), personal care services (as appropriate), and habilitation services. The ACT Teams will operate under the supervision of SWOIPA's Behavioral Health Services Director who will be primarily responsible for the provision of appropriate levels of monitoring and oversight. Advanced Health will enter into contractual agreements with local CMHPs for all residential services, as the CMHPs are the most familiar and experienced with residential services and the operators of those services. ACT Teams will work with Members and the CMHP to ensure that Members who are no longer in need of residential placements, and particularly out-of-area residential placements, can be transitioned to either a non-residential placement, or a continuing but near-to-home residential placement. Details of the interactions among the ACT Team, Member, and CMHP are recorded in each
Members' plan of care, that is made available to the Member, family members of Member, and Providers participating in the care of the Member.

4.c. and 4.d. How will Applicant ensure Members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing Member's housing needs? How will Applicant assist Members with SPMI to obtain housing, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice? Most adult Members with SPMI will receive concurrent treatment and Care Coordination through their ACT Team. ACT Teams are expected to assist Members in securing and maintaining appropriate housing, although it is granted that an acute affordable housing shortage in Coos and Curry Counties renders this task extremely complex. In some circumstances, it is first necessary to assist Members in qualifying for disability benefits, HUD housing vouchers (that are in short supply with two-year wait lists), or other benefits in order to assure that the Member has the financial resources with which to afford continuing rental housing. In other circumstances, and if consistent with Member choice, housing may be developed within the Member's extended family or through group homes. A very limited number of supported housing slots exist in the local Community. Transitional housing has ceased to be "transitional" as there is no other affordable housing to accommodate the needs of those individuals who are ready to "transition" (This topic continues in 4.j.).

4.e. How will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255? ACT is the primary service delivery mechanism within Advanced Health's plan for the delivery of integrated treatment and intensive Care Coordination services. It is Advanced Health's desire that all Members with SPMI who desire the services and supports of ACT receive those services and supports. It will require some time to develop enough ACT Teams to meet needs and demands. In June of 2019, Advanced Health will enter into contracts with successful bidders to stand-up an additional eight-to-ten ACT Teams, and a similarly-sized solicitation will be issued in 2020. In the interim time, while capacity is being purposefully built, Advanced Health will work with OHA to permit ACT-like Teams to be provisionally permitted during the period in which the ACT-like Team is seeking fidelity-based recognition.

4.f. How will Applicant determine (and report) whether ACT team denials are appropriate and be responsible for inappropriate denials. If denial is appropriate for that particular team, but Member is still eligible for ACT, how will Applicant find or create another team to serve Member? All assignments to ACT Teams are made solely by Advanced Health's Senior ICC/ENCC Executive. No contracted entity or ACT Team is authorized to deny ACT services to eligible Members. When the Senior ICC/ENCC Executive finds
that it is necessary to deny ACT services, a second review of that decision is made by Advanced Health's consulting clinical psychologist or psychiatrist. If a denial for ACT services is made, the Member is advised in the precise same way as a Prior Authorization Request is denied, and the Member is provided with appeal rights and information. In the process of assigning Members to ACT Teams, Members are provided with information about the composition of each ACT Team that has available capacity and are given the option to choose their ACT Team. If the Member becomes dissatisfied with the assigned ACT Team, the Member will be assisted in selecting an alternate ACT Team.

4.g. How will Applicant engage all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation as required by the Contract? When an eligible Member declines participation in the ACT program, Advanced Health's Senior ICC/ENCC Executive will conduct a review of the Member's health records to identify any one person (Primary Care Provider, mental health therapist, Community health worker, family member) with whom the Member most identifies, or who is able to positively influence the Member's decision-making. That individual will be asked to intervene to assist the Member in reversing his or her decision, or at a minimum, to come to understand the Member's reasoning for making a non-participating decision. Every effort will be made to identify and overcome barriers, such that the Member welcomes participation in ACT.

4.h. How will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include Care Coordination? Even under those circumstances in which a Member declines participation in ACT, the Member will still be assigned to an ICC/ENCC Care Coordinator who operates independently and is unaffiliated with ACT Teams. If it is helpful to the Member, alternative ICC/ENCC Providers may be considered, such as a registered nurse at the Members' primary care practice where the Member has established a trusting relationship. The ICC/ENCC coordinator will work with the Member to establish a plan of care that is ego-syntonic to the Member. If permitted by the Member, the plan of care will include periodic re-visiting of the Member's decision to decline ACT services. The Agency for Healthcare Research and Quality (AHRQ) recognizes intensive Care Coordination as an evidence-based practice that closes the quality gap.

4.i. How will Applicant work with Secure Residential Treatment Facilities (SRTFs) to expeditiously move a civilly committed Member with SPMI, who no longer needs placement in a SRTF, to a placement in the most integrated Community setting appropriate for that person? Columbia Care is under contract to the local CMHPs for the provision of SRTF services. Columbia Care operates Fairview Firs (a four-bed, SRTF that serves individuals with concurrent SPMI and exceptional medical needs) Johnson Creek (an eight-bed
SRTF that promotes Community safety and psychiatric recovery), and The Beckett Center (a beautiful, 14-bed, secure licensed crisis residential treatment facility that offers expert services and supports for adults with SPMI who are experiencing a crisis). Each of these facilities is out-of-area, and Coos and Curry Counties share these precious residential resources with multiple CCOs from southern Oregon. Advanced Health recognizes the greatest common good in assuring that beds are occupied by those with the greatest need and vacated by those for whom SRTF is no longer appropriate. ICC/ENCC Care Coordinators are in near-daily communication with clinical staff members at SRTFs, and with court officers when the courts are involved, and release or discharge dates are negotiated and anticipated as far in advance as is practical. Member and family preferences, along with Member and Community safety will be of paramount consideration when Care Coordinators assist Members in returning to the Community and making the transition to the most integrated Community setting that is appropriate for the Member.

4.j. How will Applicant work with housing providers and housing authorities to assure sufficient supportive and Supported Housing and housing support services are available to Members with SPMI?

In 2018, Advanced Health provided the lion's share of costs associated with retaining an independent consulting firm to develop separate housing needs assessment studies in both Coos and Curry Counties. This effort brought together the leadership from both counties and involved county commissioners, city managers and councilors, housing authorities, business leaders, social service agencies, and advocates. Long after the needs assessment studies were completed, the housing leadership group has continued to remain engaged and is developing innovative solutions, including re-zoning and the potential creation of a local Community housing trust fund. To facilitate these continuing efforts, Advanced Health paid the full cost of retaining a consulting firm to work with the local housing leadership group in developing a strategic plan for housing. This strategic plan (scheduled for completion by December 2019), among other strategies, will specifically advise Advanced Health about needs, investments, and strategies related to supported housing. Separately, SWOIPA owns a one-square-block of commercial space in which its offices were previously located, and the consultant will advise whether this facility could be cost-effectively converted to supported housing. Subject to the continuing approval of the CACs and Aggregate Panel of Advisors, it is Advanced Health’s intent to invest fully one-half of all Social Determinants of Health spending in sorely needed supported housing, subject to any restrictions that may be imposed by CMS or OHA on capital investments.

4.k. Provide details on how Applicant will ensure appropriate coverage of and service delivery for Members with SPMI in acute psychiatric care, an Emergency Department, and peer-directed services, in alignment with requirements in the Contract.

Advanced Health, through SWOIPA, contracts with Bay Area Hospital that operates an accredited and secure acute psychiatric...
unit. In emergent circumstances, Members with psychiatric needs who enter through any one of the three critical access (rural) Hospitals in Advanced Health's service delivery are transported to Bay Area Hospital. Averaged over years, Advanced Health has historically under-utilized its available slots at the state Hospital and intends to continue this trend. Advanced Health provides 24/7 mobile mental health crisis services, and when necessary, the crisis team can arrange ambulance transport to the emergency department at Bay Area Hospital. Advanced Health prefers Members to contact their ACT Team (also available 24/7), the mobile crisis unit, or their Primary Care Provider before presenting themselves at the emergency department; however, Members and their families are not always compliant with this preference. The mobile crisis unit can respond to the emergency departments to provide back-up services if the emergency department expects delays or lengthy wait periods while medical professionals are attending to live-saving needs. The provision of peer-directed services was extensively discussed in A.11 and A.12, earlier.

5.a. How will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an Emergency Department in a six-month period? The management plan must show how Applicant plans to reduce admissions to Emergency Departments, reduce readmissions to Emergency Departments, reduce the length of time Members spend in Emergency Departments, and ensure adults with SPMI have appropriate connection to Community-based services after leaving an Emergency Department and will have a follow-up visit within three days. Advanced Health and each of the four Hospitals within its service delivery area subscribe to Hospital event notification programs. Under contract, Hospitals are required to make concurrent entries into the Hospital event notification system at the time that they attend to the medical or psychiatric needs of Advanced Health's Members in the emergency department. Each morning, SWOIPA's Behavioral Health director, or designee, scrubs entries in the Hospital event notification system to identify: all emergency department visits for psychiatric reasons; any emergency department visit by an adult who is known to be diagnosed with SPMI; and all readmissions by any Member, regardless of diagnosis, who evidenced a prior emergency department visit within the last six months. If a Member meets one of these three inclusionary criteria, and is current assigned to an ACT Team, the ACT Team is alerted and one member of the ACT Team is required to outreach to the Member that same day and to make an entry in Pre-manage/Community EHR, confirming the outreach contact and resulting plan. If a Member meets one of the three inclusionary criteria, but is not assigned to an ACT Team, within three days, and preferably on the same day, the Behavioral Health director will deploy one of SWOIPA's ICC/ENCC Care Coordinators to make contact and engage the Member, and to make an entry in Pre-manage/Community EHR to confirm the contact and resulting plan. That plan may include assignment to an ACT Team. Through these strategies, Advanced
Health will proactively reduce admission and readmissions to emergency departments, while simultaneously ensuring that Members with SPMI have appropriate connections to Community-based services through ACT programming. The ability to deploy the mobile crisis units to emergency departments will assist in decreasing wait times spent in emergency departments.

6.a. How will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI? The responses to these two questions will be addressed concurrently. At the time of admission, every adult Member who is an in-patient at Oregon State Hospital is assigned to an ICC/ENCC Care Coordinator, if not already so-assigned. Advanced Health requires its ICC/ENCC Care Coordinators, whether embedded in ACT Teams or operating independently of ACT Teams, to make at least two contacts per week with each Member who is an inpatient at Oregon State Hospital. One of these weekly contacts must be on a face-to-face basis. The ICC/ENCC Care Coordinators are required to confer at least weekly, and more frequently as the patient's discharge date approaches, with professionals at Oregon State Hospital to monitor the patient's progress and engage in discharge planning from the earliest opportunity.

6.b. How will Applicant coordinate care for Members receiving Behavioral Health treatment while admitted to the State Hospital during discharge planning for the return to Applicant's Service Area when the Member has been deemed ready to transition? As the discharge date approaches, the ICC/ENCC Care Coordinator will convene a discharge planning session, at Oregon State Hospital, that includes: the Member; the Member's designated family member or other primary support person (with transportation to the Oregon State Hospital provided with NEMT resources for this person); and a clinical professional from Oregon State Hospital who is familiar with the Member's treatment. A written discharge plan will be developed in concert with the Member's and Member's family's preferences, and will at the minimum address: the Member's return transportation from Oregon State Hospital to the Community; the Member's housing needs upon return to the Community; medication reconciliation and prescription renewal upon return to the Community; any particular concerns or anxieties that the Member may have about being returned to the Community; assignment to an ACT Team (if previously unassigned); and, provisions for check-in with an ACT Team or ICC/ENCC Care Coordinator within 24 hours of returning to the Community. At the time of the check-in visit, the Member's ICC/ENCC plan of care will be updated to reflect and address any post-hospitalization, stabilization, re-entry, or Community integration needs.

7.a. How will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295? Advanced Health seeks to provide
supported employment, with an emphasis on competitive employment, for every individual who is interested in work, regardless of symptoms, SUD, treatment decisions, or any other issue. Each ACT Team in includes a part-time skills trainer/supported employment developer, thereby ensuring that employment services are integrated with mental health treatment and Care Coordination. Using skills training, the supported employment developer works with the Member to prepare the Member for a successful job search as soon as the Member expresses an interest in work. The supported employment developer systematically visits employers who are selected based on the Member’s work preferences and provides job supports for as long as those are needed. Transportation to and from the work setting is arranged. For those Members who are not involved with ACT, independent supported employment services are available, under contract, from the two CMHPs.

8. Children's System of Care: Preface: System of Care (SOC) is a strength/needs-based approach that was historically designed to aid child welfare practice that seeks safety, permanency, and well-being for every child involved with the State's child welfare programs. The Statewide Wraparound Initiative, on the other hand, seeks to build a coordinated system of services for children with complex Behavioral Health needs and their families. Because of the overlap between the two programs, SOC/Wraparound have been jointly operated in Coos and Curry Counties, with SOC services primarily reserved for children in child welfare programs, and Wraparound made available to all eligible children, many of whom are also SOC-involved.

System of Care (SOC) and Wraparound Services in Coos and Curry Counties are not working. Prior to the onset of CCOs, the local CMHP was operating an Intensive Services Array program and a wraparound program for children. These two programs were morphed into a SOC/Wraparound program but failed to adequately incorporate many of the required SOC elements. Advanced Health has sought and received on-site technical assistance from Kathleen Burns at OHA and from PSU. Despite these efforts, known problems have not been resolved. To this end, Advanced Health will start anew and completely reconfigure its SOC/Wraparound services. By describing the improvement and replacement plan for SOC/Wraparound Services at the onset of this discussion, it is believed that the reader will be accorded with background information needed to evaluate Advanced Health's responses to specific questions.

- In May, 2019, SWOIPA's Behavioral Health director shall convene a new SOC/Wraparound executive council that is comprised of the Behavioral Health director, one state child welfare administrator who is assigned to the regional office; one CMHP representative; one representative from juvenile justice; one representative from OYA; one representative from special education or I/DD; three young adult peer support specialists; three family
partner peer support specialists; and one advocacy representative. The financial resources required to carry out SOC/Wraparound programming and responsibilities shall be placed under the authority of the executive council, subject to SWOIPA's review and approval.

- In June 2019, the SOC/Wraparound executive council, benefitting from extensive consultation with Ms. Burns or PSU technical advisors, will establish their preferred model for SOC/Wraparound programming, and issue a solicitation to identify a responsive contractor for these services.
- In August 2019, and in partnership with the OHA and PSU, the executive council shall select from the solicitation process its preferred Provider for SOC/Wraparound services. If no qualified Provider is identified, SWOIPA will directly operate the SOC/Wraparound program in compliance with rules. The successful SOC/Wraparound Provider will not be retained under a standard contractual agreement, but instead, under a cooperative agreement through which Advanced Health, SWOIPA, and the executive council will exercise considerable oversight and involvement.
- Working together from September through December, 2019, Advanced Health, SWOIPA, the SOC/Wraparound Provider, and the SOC/Wraparound executive council will: (a) seat a practice-level workgroup that includes I/DD, special education, child welfare, juvenile justice, and Behavioral Health representatives, yet is comprised in the majority of youth and family representatives; (b) seat an advisory committee that includes I/DD, child welfare, OYA, and Behavioral Health representatives, yet is comprised in the majority of youth and family representatives; (c) develop written policies and procedures, consistent with rule and evidence-based best practices, to guide and direct the SOC/Wraparound program; and (d) assist the SOC/Wraparound Provider in working with PSU to attain an acceptable fidelity score for the its SOC/Wraparound program and services. Going forward, it is recognized that a single, centralized, two-county SOC/Wraparound program will be ineffective in addressing needs across a vast geography that comprises 3,223 square miles and supports large sparsely-populated Rural and frontier areas. To this end, it is envisioned that SOC/Wraparound will be delivered through SOC Teams, appropriately comprised of a SOC/Wraparound ICC/ENCC coordinator, family partner, and youth partner, and that no SOC/Wraparound Team will serve more than 15 families.

8.a. What community resources will Applicant be using or collaborating to support a fully implemented System of Care? Advanced Health will be collaborating with child welfare, juvenile justice, educational systems, family partners, youth partners, advocacy organizations, and myriad Community-based social service agencies (tutors, mentors, coaches, athletic programs, summer camps, faith-based organizations, music programs, dance programs, art programs, outdoor
education programs, youth development programs) in supporting its fully-implemented System of Care.

8.b. Please provide detail on how Applicant will utilize the practice-level work group, advisory council, and executive council. The practice-level work group will review practice barriers, remove barriers when possible, and submit barriers that remain unresolved to the executive council for resolution or advancement to the State SOC Steering Committee. The advisory committee will advise on policy development, implementation, reviews of fidelity scores and outcomes, and provide oversight consistent with its strategic plan. The executive council shall develop and approve program policies and procedures, engage in shared decision-making regarding funding and resource development, review project outcomes, identify unmet needs in the Community to support the expansion of the service array, and resolve barrier that are brought to its attention by the advisory committee.

8.c. How does Applicant plan to track submitted, resolved, and unresolved barriers to a SOC? Minutes of the meetings of the advisory committee and executive council will document barriers that have been identified or submitted, as well as efforts of those groups that have the effect of resolving a barrier. Barriers that remain unresolved will be reported to the State SOC Steering Committee.

8.d. What strategies will Applicant employ to ensure that governance groups are comprised of youth, families, DHS (child welfare, I/DD), special education, juvenile justice, Oregon Youth Authority, Behavioral Health, and youth and Family voice representation at a level of at least 51 percent? The composition of governance groups is discussed in the bulleted points on the two preceding pages of this section.

9.a. Provide details on how Applicant plans to ensure administration of the Wraparound Fidelity Index Short Form (WFI-EZ)? SOC/Wraparound Teams, each serving no more than 15 Members, are required to submit a completed WFI-EZ for each youth and caregiver enrolled in Wraparound after six months from the date of Enrollment. SWOIPA’s Behavioral Health director, along with the SOC/Wraparound executive council, and responsible for enforcing this requirement with the SOC/Wraparound Provider. Failures to timely gather and submit WFI-EZ documents will result in corrective action and sanctions.

9.b. How will Applicant communicate WFE-EZ and other applicable data to the SOC Advisory Council? Aggregate data from WFE-EZ and other applicable data (i.e., aggregate utilization, CANS, and SOC/Wraparound Team performance data) will be aggregated by SWOIPA’s Behavioral Health director and submitted for review and analysis to the SOC advisory council and the SOC/Wraparound executive council at quarterly intervals. The SOC/Wraparound practice-level work
group, sans the youth and family members, will serve as the Wraparound review committee, and will also receive these quarterly reports.

9.c. How does Applicant plan to receive a minimum 35 percent response rate from youth? If needed, SOC/Wraparound Teams will hand-deliver WFE-EZ forms to youth for completion and will identify neutral individuals (such as a classroom teacher) to assist youth in completing the survey instruments. If needed, SOC/Wraparound Teams may offer incentives for the completion of WFE-EZ forms.

9.d. How will Applicant's Wraparound policy address: (1) How Wraparound services are implemented and monitored by Providers; and, (2) How Applicant will ensure Wraparound services are provided to Members in need, through Applicant's providers? (1) Rather than to engage Wraparound Providers through a standard contractual mechanism, the SOC/Wraparound Provider will be engaged through a cooperative agreement in which Advanced Health, SWOIPA, and the SOC/Wraparound executive council will be extensively involved in the oversight and monitoring of the program's administration, finances, programming, and outcomes. (2) Under to cooperative agreement, Advanced Health and SWOIPA will play a direct role in convening regular meetings of the Wraparound review committee and will exercise rigorous oversight of that committee to assure that all Members who are in need gain admission to Wraparound.

9.e. Describe Applicant's plan for serving all eligible youth in Wraparound services so that no youth is placed on a waitlist. Describe Applicant's strategy to ensure there is no waitlist for youth who meet criteria. As of this writing, local SOC/Wraparound services are under-utilized. As a new Provider is identified, it is anticipated that line-level SOC/Wraparound personnel currently employed can and will be redeployed under the new Provider, thereby creating immediate additional capacity. Through its involvement with the Wraparound review committee, Advanced Health will be able to monitor the degree to which referrals are being made to the program, thereby anticipating future needs. Advanced Health and SWOIPA will release additional resources to the SOC/Wraparound executive committee, as needed, to stand-up additional SOC/Wraparound Teams, using a just-in-time approach to assure that resources are not wasted on idle Teams.

9.f. Describe Applicant's strategy to ensure that Applicant has the ability to implement Wraparound services to fidelity. This includes ensuring access to Family and youth Peer support and that designated roles are held by separate professionals as indicated (for example: Wraparound coaches and Wraparound supervisors are filled by two different individuals). Throughout the planning phase (2019) and early implementation phase (2020) for the SOC/Wraparound program, Advanced Health will purchase
technical assistance services from the National Wraparound Initiative at Portland State University to assure that the newly reconfigured program is being planned and implemented to fidelity for all criterion for which fidelity is measured, including appropriate ratios, ensuing appropriate access to family and youth peer support, and compliant staffing patterns.
A. Evaluate CCO Performance to Inform CCO-Specific Profit Margin Beginning in CY 2022

A.1. Does the Applicant have internal measures of clinical value and efficiency that will inform delivery of services to Members? If so, please describe. Advanced Health uses and will use a variety of internal measures of clinical value and efficiency to inform delivery of services. Measures are fundamental to value-based payments (VBP) because they operationalize value to the purchaser (i.e., the Oregon Health Authority and Advanced Health). Constrained by the availability of measures, the current Advanced Health model relies on EHR, chart- or encounter-based clinical process-of-care measures, which were originally intended to steer Quality Improvement (QI) efforts, and self-reported Member experience. Over time, chart- or encounter-based clinical process-of-care measures have evolved to not only include, but to emphasize, outcomes. Value is increased by improving the quality and efficiency obtained from any given Provider, or by shifting Member volume to more efficient Providers. Advanced Health is concerned about the total payments made for all Covered Services delivered to a Member, and recognizes that total payments encompass a range of services delivered over time and throughout the continuum of care. Hence, relative quality, cost, and value are, ultimately, critical characteristics of Advanced Health's entire healthcare delivery system, involving potentially avoidable and substitutable services. To this end, in addition to tracking clinical quality incentive measure outcome data, Advanced Health tracks 30-day post-Hospital-discharge readmission rates. Other measures that could be tracked include: 30-day post-Hospital discharge ambulatory visits; 30-day post-Hospital discharge Emergency Department visits, minor complication rates; major complication rates; and mortality rates.

Moving from the theoretical to the operational, and by way of illustration, in 2017 Advanced Health introduced an internal metric in which access was plotted on a per-physician basis, using the Member complaint system as the informing methodology. Physicians were provided with quarterly dashboards that provided unique access information, as well as comparative data for their cohort (according to primary care or medical specialty). Through this process, Advanced Health learned that the highest number of access complaints were for those physicians who also functioned as hospitalists. This made sense, because hospitalists are absent from their practice one week per month while performing Hospital-based services. Even though all hospitalists arrange for coverage of their office-based practices using mid-level practitioners during their one-time-per-month rotation as hospitalists,
access remained at issue for Members, and brought into question whether Advanced Health should decrease the number of Members assigned to those physicians who also serve as hospitalists.

A.2. What tools does the Applicant plan to deploy to identify areas of opportunity to eliminate Waste and inefficiency, improve quality and outcomes, and lower costs? Advanced Health employs a variety of process improvement tools, including PDSA, DMAIC, impact analysis, project management, root cause analysis, and other lean tools and principals. The process improvement method(s) used depend on the needs of the specific project. Quality Improvement department staff at Advanced Health are trained in these process improvement tools and work collaboratively within the CCO and throughout the Provider Network to provide technical assistance, training, and facilitation for initiatives to eliminate Waste and inefficiency, improve quality and outcomes, and lower costs. This can include efforts such as identifying and eliminating redundant medical diagnostic testing, working with Members to avoid inappropriate medical utilization, and engaging Members to increase their use of lower-cost preventive health care services.

A robust program of Utilization Review is in place to ensure that high quality, Medically Appropriate services are delivered to all members, including those with special health care needs. A number of mechanisms are in place to monitor for both under- and over-utilization of services. The Utilization Review team reviews Prior Authorization requests to ensure that treatments follow the Prioritized List of Health Services and the associated Evidence-Based guidelines. The list of services requiring Prior Authorization is reviewed annually for opportunities to reduce administrative burden to Providers while still ensuring that care is delivered locally when possible, in a cost-effective manner, and consistent with medical evidence.

Advanced Health works closely with Quality Improvement staff employed by Subcontractors and Providers, offering regular feedback on quality measure performance and technical assistance to implement improvement strategies. Advanced Health also uses the Performance Improvement Project (PIP) process as well as the required components of the Transformation and Quality Strategy (TQS) as an opportunity to engage Providers and Community partners in collaboratively working toward a common goal to improve quality and outcomes, reduce costs, and improve efficiencies at all levels of the health delivery system. For example, as a current PIP, Advanced Health is working with physical health (primary care and hospital), Behavioral Health, and oral health contracted Providers and partners to reduce inappropriate use of the Emergency Department (ED). Reducing preventable ED use, will both lower the cost of care and also improve the quality of care and outcomes by ensuring Members are receiving the right care at the right time and in the right place. Key initiatives for the PIP include:
- Improve follow-up for Members after discharge from the ED using PreManage to share information.
- Improve health system navigation and coordination through use of a Community Health Worker for Members in the ED (especially those not well-connected with their medical home)
- Targeted education to Members about alternative options for health questions or urgent care needs. Materials may be targeted around specific conditions or populations determined to be at risk for preventable ED use.
- Integration of physical and oral health care into a Behavioral Health setting to better engage members in preventive services.

Another aspect of Advanced Health's plan for containing cost, improving quality, and reducing waste is its value-based payment (VBP) strategy. Advanced Health has already incorporated several alternative payment models into its contracts. Prior to and during the contract period, Advanced Health will rapidly increase its LAN Category 2C and higher VBP contracts. By 2024, 70% of Advanced Health's Health-Related Spending will be paid under VBP contracts. These contracts will consist mostly of shared savings and risk contracts (LAN 3B) and per-member-per-month partial capitation (LAN 4A) contracts. All VBPs will have a clear link to quality and will be supported by Advanced Health's investments in health information technology. Giving Providers more financial responsibility, while tying payment to quality, strongly incentivizes cost-containment, Waste-reduction, and Quality Improvement. For more details on Advanced Health VBP strategy, see Attachment 8.

Advanced Health will conduct regular, ongoing quality reviews with Subcontractors and Providers to identify opportunities to eliminate Waste and inefficiency, improve quality and outcomes and lower costs. Below is the table of contents of a typical quality review engagement. All or some of these sections may be completed depending on the engagement.

[Table of Contents begins on next page]
A.3. Does the Applicant have a strategy to use Health-Related Services to reduce avoidable health care services utilization and cost? If so, please describe. Yes, Advanced Health uses Health-Related Services that are purposed, in part, at reducing avoidable health care services utilization and cost. Under the sub-category of Flexible Services to Members, multiple Health-Related Services are employed. Advanced Health supports multiple employment positions that are purposed at Community engagement, in the belief that engaged Members will become better able to engage the health care system in appropriate and cost-saving ways. Advanced Health makes the services of navigators available to all Members, believing that navigators can appropriately direct Members to the right service and the right time, again resulting in a reduction in the inappropriate and costly use of the wrong service at the wrong time (i.e., emergency department). Resources are expended on intensive and exceptional needs care management, again with the goal of preventing emergent circumstances and directing the Member to the right service at the right time. Flexible services and spending permits case managers and Care Coordinators to make individual investments in Members, according to plans of
care, that are deemed to be more cost-effective than what might be considered Medically Appropriate. For example, following Hospital discharge, a Member who is homeless might be provided with temporary and transient lodging in a warm and dry hotel accommodation, rather than to face the harsh winter elements that create an infectious situation for a surgical wound. The nurse call line provides Members with the option of speaking to a registered nurse to learn if their situation is emergent or can wait until the next morning and be attended by the Primary Care Provider. In some circumstances, like the common cold, no professional care is indicated at all, and the nurse can provide home-care instructions. Finally, investments made in wellness programs are expected to return long-term benefits for both the Member and the CCO.

Under the sub-category of Community Benefit Initiatives, additional Health-Related Services are provided with the goal of reducing avoidable health care utilization and cost. Community Benefit activities include nurse home visits, warming centers during winter months for persons who are unstably housed, and other engagement strategies recommended by, and under the direction of, the Community Advisory Council. These include strategies to address the opioid crisis, resolving root-cause issues brought about by adverse childhood experiences, increasing access to preventative care, suicide prevention, and health equity. While a handful of these strategies are immediate in their influence on medical utilization and costs (i.e., nurse home visits), most are longer-term investments that are not expected to produce early results.

A.4. What is the Applicant's strategy for spending on Health-Related Services to create efficiency and improved quality in service delivery? Advanced Health's policies for health-related services are consistent with OAR 410-141-3150. That is, spending on Health-Related Services must be purposed at improving health outcomes, preventing avoidable Hospital readmission, improving patient safety, reducing medical error, lowering infection and mortality, or promoting increased wellness. Advanced Health does not engage in Health-Related Services that fail to address one or more of these purposes. Each of Advanced Health's strategies, as itemized in greater detail in the response to Question A.3. above, in one or more ways creates efficiencies (i.e., through navigation) or improves the quality of care (i.e., by attending to social needs identified through Social Determinant of Health screening).

A.5. What process and analysis will the Applicant use to evaluate investments in Health-Related Services and initiatives to address the Social Determinants of Health & Health Equity (SDOH-HE) in order to improve the health of Members? Most of Advanced Health's Health-Related Services, and particularly those activities that fall under Community Benefit Activities, are provided through Community-based, non-clinical, social service agencies. For example, the Devereux Center operates programming and a warming
center for persons who are unstably housed. A Community-based Adverse Childhood Experiences (ACEs) program provides awareness and training on trauma-informed practices. The Every Child agency provides special services for children in the child welfare system and assists in offsetting the Community's acute shortage of foster care parents by recruiting new foster care providers. The local United Way is working with Advanced Health to improve the capacity of the Community's social service agencies.

During the first year or two of Advanced Health's engagement with non-clinical social service agencies, Advanced Health extends assistance in the form of a formal grant agreement. The grant agreement establishes a time-frame during which the social service agency will develop data collection capabilities, establish baseline data, develop a logic model, and negotiate process and outcome objectives with Advanced Health. At the conclusion of the grant-funded period, and when logic models and outcome objectives have been clearly stated, the grant agreement is converted to a performance-based contract. Advanced Health retains the services of an independent program evaluation specialist who is charged with the responsibility of evaluating the efficacy of each of Advanced Health's contracted Health-Related Services investments. The amount budgeted for formal program evaluation ranges from eight-to-fifteen percent of the value of each contract with a social service agency. In all cases, the evaluation criteria are tied to measurable, time-framed, outcome objectives.

B. Qualified Directed Payments to Providers

B.1. Does Applicant currently measure, track, or evaluate quality or value of Hospital services provided to its enrollees? If so, please describe. Therefore, it is critical to the overall value and quality of services provided to Advanced Health Members for Advanced Health to ensure Members are receiving care of the utmost quality and value. Advanced Health has a strong history of measuring, tracking, and evaluating the quality and value of Hospital services provided to Advanced Health Members.

- Advanced Health Quality Improvement and Accountability personnel use electronic dashboards that show ED utilization and length of stay, compiled from claims data. The ED Utilization dashboard can filter data by age, Hospital, primary diagnosis, assigned PCP, and if the Member has mental illness diagnoses. Readmissions are monitored regularly by internal reports and an OHA provided monthly dashboard.
- Advanced Health's review of aforementioned data informed its decision to, through its Subcontractor, Southwest Oregon IPA, Inc., contract with a physician to develop and implement initiatives to reduce unnecessary ED visits and revisits for Advanced Health Members. As part of this process, the
Advanced Health will document the process improvements, policies and procedures related to ED visits and revisits for Advanced Health Members. Advanced Health, its Subcontractors, Providers, and Community partners utilize PreManage. PreManage is a product that allows Hospital information (ED visits, and inpatient admissions and discharges, and other critical information) to be sent real time to CCOs and Provider groups for certain Members or patient populations. Care managers can also share care plan information with Hospital Providers. This improved communication and information sharing allows Hospitals and Providers to provide higher quality care to Members, identify Members at risk for Hospital readmission, reduce duplication of tests, and ultimately reduce reliance on costly ED visits.

- Advanced Health also participates in Bay Area Hospital's Transitions of Care Committee. At this meeting, the Advanced Health representative works with the hospital and other care partners to investigate and address hospital service outliers in utilization, readmissions and length of stay.

C. Quality Pool Operation and Reporting

C.1 Does the Applicant plan to distribute Quality Pool earnings to any public health partners or non-clinical providers, such as SDOH-HE partners or other Health Related Services Providers? If so, please specify the types of organizations and providers that will be considered. Yes, Advanced Health plans to distribute Quality Pool earnings outside of Advanced Health's clinical Provider network on a relevant and proportional basis. To accomplish this end, Advanced Health's Clinical Advisory Panel will identify non-clinical Providers and Community partners with a potential to impact quality measure performance and then determine the degree to which each non-clinical Provider contributed to the attainment of individual measure targets. For example, when considering metrics related to childhood immunizations, local public health entities are considered relevant and play a significant role in metric attainment. When considering timely assessments for children in DHS custody, the local DHS field office plays a crucial role in timely notification to and coordination with the CCO, and may aid in outreach to foster parents, and thus is a relevant entity with whom to share Quality Pool earnings. While Advanced Health has evidenced superior measure performance related to dental sealants on permanent molars for children, that success is based largely on the willingness of local public-school districts to host dental screening clinics. Accordingly, local public-school districts would be considered relevant and would receive a proportional distribution of the Quality Pool earnings. The types of organizations and Providers that will be considered includes, but is not limited to: local units of government (including public health); special districts, including school districts and rural health districts (but not hospital districts, as these are included in Advanced Health's network), federal and state agencies (including DHS); SDOH-HE partners; advocacy organizations; national associations represented in the local community (National
C.2. How much of the Quality Pool earnings does Advanced Health plan on distributing to clinical Providers versus non-clinical Providers? Please discuss the approach as it relates to SDOH-HE partners, public health partners, or other Health-Related Services providers. While the final allocation of Quality Pool earnings will be evaluated and recommended by Advanced Health's Clinical Advisory Panel as described above, an estimate of the funding breakdown is presented below. Advanced Health believes it is critical to support Community partners in addressing public health, social determinants of health, and health equity. The details of Advanced Health's commitment, of which the following funding is a part, can be found in Attachment 10 of Advanced Health's application.

<table>
<thead>
<tr>
<th>Advanced Health Quality Pool Recipients</th>
<th>% Advanced Health and Subcontractors</th>
<th>% External Entities</th>
<th>% total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracted Clinical Providers</td>
<td>75%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Non-contracted clinical Providers</td>
<td>2%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Public Health Providers</td>
<td>5%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Social Determinants of Health partners</td>
<td>5%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Community Health Improvement plans</td>
<td>5%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Administrative fees</td>
<td>8%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>83%</strong></td>
<td><strong>17%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

C.3. How much of the Quality Pool earnings does the Applicant plan on investing outside its own organization? On what would the Applicant make such investments? The responses to these two questions will be concurrently addressed. Under its current practices, the Clinical Advisory Panel examines the total Quality Pool earnings and makes recommendations to Advanced Health's Board of Directors regarding the allocation and distribution of the Quality Pool. In years past, most of the Quality Pool was distributed in the form of direct incentives to Providers for rendering services necessary to attain performance benchmarks. This included in-network and out-of-network Providers. The value of the direct incentive payments has varied over time, taking into consideration factors such as past performance, distance from benchmarks, complexity of the measure, and Provider engagement necessary to achieve improvement. A portion of
the Quality Pool was also distributed through the Quality Innovation Incubator Fund, a competitive grant-style program, to support pilot programs and start-up investments in Quality Improvement initiatives. This program was open to contracted organizations. Non-contracted Community partners were encouraged to collaborate through contracted organizations to apply for funds.

In Advanced Health’s plan for the CCO 2.0 contracting period, the Clinical Advisory Panel will continue to review the Quality Pool earnings and make recommendations as to the relative value of each attained metric. For metrics for which there are contributing, or potentially contributing, non-clinical SDOH-HE entities, the Clinical Advisory Panel will identify those non-network contributors and make recommendations regarding each such entity's proportional share of the Quality Pool distribution. In those circumstances in which the Clinical Advisory Panel determines that there are non-clinical SDOH-HE entities, the amount allocated to those entities, on a metric-by-metric basis, will generally range up to 50 percent. For example, in the case mentioned in answer to question C.1. of this attachment, wherein school districts contributed significantly to the attainment of preventative dental metrics, school districts may be awarded up to 50 percent of the Quality Pool value for that metric. Advanced Health recognizes that education is a significant contributor to offsetting SDOH-HE determinants. In another scenario, in which it may be determined that locally broadcast colorectal screening public service announcements, sponsored by the American Cancer Society, played only a minor role in the attainment of the colorectal cancer screening metric, the local chapter of the American Cancer Society could be awarded just 25 percent of the Quality Pool value for that metric.

Looking forward, as new metrics are introduced, such as the multi-sector intervention attestation for the obesity prevention and reduction metric, Advanced Health anticipates the distribution of Quality Pool resources may favor non-clinical SDOH-HE entities over clinical Network Providers, and in consultation with the Clinical Advisory Panel, might allocate as much as 100 percent of Quality Pool value for that measure to non-network SDOH-HE partners.

C.4. How will the Applicant decide and govern its spending of the Quality Pool earnings? Advanced Health turns to its Clinical Advisory Panel to make recommendations to the governing board regarding the distribution of Quality Pool earnings. The members of the Clinical Advisory Panel take their work seriously. Advanced Health recognizes and appreciates the seriousness with which the members of the advisory group contemplate their decision-making and have not yet failed to adopt Quality Pool distribution recommendations that have been forthcoming from the Clinical Advisory Panel.

C.5 When will the Applicant invest its Quality Pool earnings, compared with when these earnings are received? Quality Pool earnings are distributed
within three months of receipt. When Advanced Health is notified by OHA of the final performance for the measurement year and the Quality Pool earnings associated with that performance, the Clinical Advisory Panel reviews the results and formulates its recommendations to the Advanced Health governing board. The Board reviews the recommendation and makes the final decision on allocation and distribution of the Quality Pool earnings.

C.6. Does Advanced Health have sufficient cash resources to be able to manage a withhold of a portion of its Capitation Payments? Yes. Advanced Health maintains adequate cash resources.

D. Transparency in Pharmacy Benefit Management Contracts

D.1. Please describe the PBM arrangements the Applicant will use for its CCO Members. Advanced Health plans to use MedImpact Healthcare Systems as its Pharmacy Benefit Manager, through the contractual arrangement described in Attachment 7 to this Application. Advanced Health has a longstanding relationship with MedImpact has long provided for Pharmacy Benefit Management services for Advanced Health Members.

D.2. Does the Applicant currently have a “no-spread” arrangement with its PBM? If not, please describe the steps the Applicant will take to ensure its contracts are compliant with these requirements and the intended timing of these changes. If changes cannot be made by January 1, 2020, please explain why and what interim steps Applicant will take to increase PBM transparency in CY 2020. (In order for an extension in the timeline to be considered, Applicant must show it is contractually obligated to use non-compliant PBM and shall provide OHA a copy of PBM agreement as justification along with a plan to ensure compliance with transparency requirements at the earliest date possible.) Yes, Advanced Health currently has a “no-spread” arrangement with MedImpact for Pharmacy Benefit Management services. Pharmacy pricing is a 100% pass-through without any spread retained by MedImpact. A Pharmacy Benefit Management Consultant, Excelsior Solutions, validates that all pricing is compliant with the contract terms which are reported quarterly and reconciled annually.

D.3. Does the Applicant obtain 3rd party market checks or audits of its PBM arrangement to ensure competitive pricing? If not, does the Applicant have a plan to receive this analysis? If so, how often are these analyses performed, what is done with this third-party data and what terms inside of your PBM contract allow this analysis to have power for the CCO to ensure its pharmacy contract remains competitive? Yes, Advanced Health obtains 3rd party market checks of its PBM arrangement to ensure competitive pricing. Current language in the Service Agreement with MedImpact
allows for one market check per four-year contract term; however, Advanced Health has received confirmation from MedImpact that MedImpact will agree to annual market checks beginning in the 2020 calendar year, and it will enter into an amendment to the Service Agreement to reflect this change prior to January 1, 2020. The 3rd party market check is evaluated in comparison to the guarantees in the Service Agreement. If the market check reflects a minimum cost difference of three percent, an adjustment in contract rates will be negotiated.

D.4. Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements? No, Advanced Health does not currently plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements currently. Based on the most recent financial analysis provided by MedImpact and Excelsior Solutions in 2018, Advanced Health's current contract rates with MedImpact are superior to those offered through the Oregon Prescription Drug Program. It would therefore be more costly to provide pharmacy benefits to Advanced Health Members using the Oregon Prescription Drug Program. If contract rates offered through the Oregon Prescription Drug Program became more competitive than the rates offered through our PBM arrangement, Advanced Health would certainly consider transitioning to the Oregon Prescription Drug Program.

E. Alignment Preferred Drug List (PDLs) and Prior Authorization Criteria

E.1. Does the Applicant currently publish its PDL? If not, please describe the steps the Applicant will take to ensure its PDL is publicly accessible concurrent or in advance of the Year 1 Effective Date for prescribers, patients, dispensing pharmacies, and OHA. Yes, the Advanced Health formulary is posted on the Advanced Health website and is organized both alphabetically and by therapeutic class.

E.2. Does the Applicant currently publish its pharmacy coverage and Prior Authorization criteria concurrently with or in advance of changes made? If not, please describe the steps the Applicant will take to ensure its pharmacy coverage and PA criteria are both publicly accessible for prescribers, patients, dispensing pharmacies, and OHA and updated in a timely manner. Advanced Health currently publishes its "Most Commonly Requested Medications" Prior Authorization criteria on the Advanced Health website, with formularies organized both alphabetically and by therapeutic class. Advanced Health is currently in the process of having all drug use criteria updated and reviewed by the Advanced Health Pharmacy and Therapeutics Committee for publishing to the Advanced Health website to ensure public accessibility for prescribers, patients, dispensing pharmacies, and OHA. A robust tracking process is being developed to ensure updates are made in a timely manner.
E.3. To what extent is the Applicant's PDL aligned with OHA's fee-for-service PDL? Please explain whether and how supplemental rebates or other financial incentives drive differences in the Applicant's PDL as compared to the fee-for-services PDL. Advanced Health expects that a great deal of alignment exists between OHA's fee-for-service PDL and its formulary. However, a formulary extract or spreadsheet of the FFS PDL is needed to compare directly with Advanced Health formulary to accurately identify any discrepancies. An NDC level formulary file has been requested from OHA to complete this analysis but has not been provided to date. Advanced Health already aligns with the OHA PDL and drug use criteria for several high-cost therapeutic drug classes including biologics for autoimmune conditions, multiple sclerosis, hepatitis C, phenylketonuria and pulmonary hypertension agents.

Advanced Health receives minimal supplemental rebates; therefore its formulary decisions are determined based on clinical evidence supporting effective treatment options and the lowest net cost agent. This strategy successfully incentivizes utilization of low cost generic agents and least costly alternative treatments whenever available. Advanced Health uses Evidence-Based principles to guide formulary decision making and drug use criteria development.

Similar Evidence-Based principles are employed for managing the FFS PDL as our Advanced Health formulary; however, in contrast, OHA also appears to utilize a rebate optimization strategy for PDL development. Regardless of the strategy utilized for PDL or formulary management, it is expected a great deal of alignment already exists between the Advanced Health formulary and the FFS PDL, as both have high generic utilization. For therapeutic classes that do not have compelling clinical difference or significant cost-advantages between agents, Advanced Health already chooses to align coverage with the FFS PDL.

E.4. Does the Applicant plan to fully align its PDL with the fee-for-service PDL? If not, please describe exceptions. If full alignment with the FFS PDL is an expectation for CCO contracting in 2020, Advanced Health will fully align with the FFS PDL. It is a concern, however, that upfront pharmacy expenditures for the CCOs could increase through PDL alignment as CCO Membership transition to medications that are more expensive to the CCOs at point of sale, but may have overall cost advantages to OHA after rebate. As rebate information is confidential and proprietary to the pharmaceutical manufacturer and OHA, Advanced Health has no insight into the net cost after rebate of the medications covered. This could create difficulty for Advanced Health in determining least costly alternatives and offer treatment recommendations to Providers serving the Members. It is recommended that OHA collaborate with successful CCO applicants to develop a process for increasing drug pricing transparency and to offset increased costs to the CCO due to PDL alignment.
F. Financial Reporting Tools and Requirements

F.1. Does Applicant or any Affiliate of Applicant currently report on NAIC health insurance forms? If so, please describe the reporting company or companies and its relationship with Applicant. Advanced Health does not currently report on NAIC health insurance forms. However, Advanced Health contracts with a health insurance consulting firm with direct and ongoing experience completing these forms. Advanced Health also has a longstanding contract with an accounting consulting firm with experience completing NAIC health insurance forms. Additionally, Advanced Health has invested in training and educational materials to support the CCO 2.0 financial reporting requirements. Advanced Health anticipates these resources will be sufficient to complete all required NAIC health insurance forms.

F.2. Does the Applicant currently participate and file financial statements with the NAIC? Advanced Health does not currently participate and file financial statements with the NAIC. However, Advanced Health contracts with a health insurance consulting firm with direct and ongoing experience participating and filing financial statements with the NAIC. Advanced Health also has a longstanding contract with an accounting consulting firm with experience participating and filing financial statements with the NAIC. Additionally, Advanced Health has invested in training and educational materials to support the CCO 2.0 financial reporting requirements. Advanced Health anticipates these resources will be sufficient to meet all NAIC requirements.

F.3. Has the Applicant prepared a financial statement which includes a RBC calculation? If so, please submit. Nine RBC calculations have been prepared for each year represented on the pro forma financial statements in this application.

F.4. Does the Applicant currently have experience reporting in SAP either directly or through any Affiliate of Applicant? Advanced Health does not have prior experience reporting in SAP. However, Advanced Health contracts with a health insurance consulting firm with direct and ongoing experience reporting in SAP. Advanced Health also has a long-standing contract with an accounting consulting firm with experience reporting in SAP. Additionally, Advanced Health has invested in training and educational materials to support the CCO 2.0 SAP reporting requirements. Advanced Health anticipates these resources will be sufficient to meet all SAP reporting requirements.

F.5. Does the Applicant seek an exemption from SAP and NAIC reporting for 2020? If yes, please explain in detail (a) the financial hardship related to converting to SAP for the filing, and (b) Applicant's plan to be ready to use SAP in 2021. Advanced Health believes currently contracted consulting
resources and training programs will be sufficient to support converting to SAP and NAIC reporting in 2020. Advanced Health will not seek a hardship exemption.

F.6. Please submit pro forma financial statements of Applicant's financial condition for three years starting in 2020, using Enrollment, rates and cost projections that presume Applicant is awarded a Contract under this RFA. If OHA expects there may be more than two CCOs in Applicant's Service Area, OHA may require Applicant to submit additional pro forma financials based on the expected number of CCOs. OHA will evaluate Applicant's pro forma financials to assure that they provide a realistic plan of solvency. See the RFA Pro Forma Reference Document and UCAA Supplemental Financial Analysis workbook template for a complete description of the requirements and deliverables. The pro forma workbook templates and required supporting documents are excluded from the page limit. Pro forma financial statements are being submitted according to OHA RFA guidelines.

G. Accountability to Oregon's Sustainable Growth Targets

G.1. What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year? Advanced Health has maintained one of the lowest rates of growth among CCOs during the original CCO contract period. Between 2014 and 2017, Advanced Health's 3-year non-annualized rate of growth was -2.8 percent. During the same period, total CCO rate of growth was 24.6 percent. By leading the state in the capitated payment model, Advanced Health contributes to the sustainability of the Oregon Health Plan (OHP).

Advanced Health will employ several strategies to continue achieving sustainable expenditure growth year over year:

- Advanced Health regularly reviews the value and quality of services performed by Providers. These reviews help Advanced Health identify categories of service requiring improvement in value or quality. For example, Advanced Health has identified Hospital spending, particularly among the A & B Hospitals in its Service Area, as exceeding sustainable growth rates. Advanced Health, through its Subcontractors, is transitioning these contracts to value-based payments in 2019 in preparation to meet OHA VBP targets in 2020. These agreements will have shared savings and downside risk, along with quality of care incentives based on emergency department utilization and readmissions. As described in Attachment 8, Advanced Health will transition 70% of health services spending to VBP contracts by 2024.
- Advanced Health will also require new personnel investments in primary care case management, ICC/ENCC case management, and Traditional Health Workers effective in 2020. Advanced Health will employ ICC/ENCC
staff directly. As described in Attachment 8, Advanced Health will also pay a
per-member-per-month payment to PCPCHs to support the primary care case
management requirement. This increased coordination of care is expected to
increase the efficiency of care provided and result in long term savings.
Traditional Health Workers are expected to generate savings by routing
Members to the correct access points and freeing up more costly personnel to
focus on appropriate levels of care.
- PreManage is a product that allows Hospital information (ED and Inpatient
admissions and discharges) to be sent in real time to CCOs and Provider
groups for certain Members or patient populations. This improved
communication and information sharing allows Hospitals and Providers to
provide higher quality care to Members, identify Members at risk for
Hospital readmission, reduce duplication of tests, and ultimately reduce
reliance on costly ED visits.

G.2. How will the CCO allocate and monitor expenditures across all
categories of services? Advanced Health will monitor the utilization and
expenses across all categories of service on at least a quarterly basis. Advanced
Health currently monitors utilization and expenditures using a suite of on-demand
data dashboards. These dashboards allow Advanced Health to detect, evaluate, and
react to any significant changes in spending or utilization. Similar work is also
currently performed in service of the filing of Exhibit L reports. Advanced Health
will continue to use these tools to monitor expenditures for and allocate its Global
Budget to all categories of service. Advanced Health will also analyze the value of
services performed by Privileged Providers and VBP Subcontractors. These
analyses will help to detect under- and over-utilization, verify the provision of
contractually agreed-upon services, and to inform future Member assignments to
Providers and Subcontractor rates.

G.3. What strategies will the Applicant utilize related to Value-Based
Payment arrangements to achieve a sustainable expenditure growth?
Advanced Health has been a leader in the adoption of alternative payment models.
It is of critical importance for the U.S. health system to minimize the pay-for-
production payment model, in favor of a system that rewards Providers for
efficiency, quality, and patient engagement. Advanced Health recognizes this and
has worked to introduce alternative payment models wherever practical.

Nearly half of Advanced Health’s 2017 health-related spending was paid under a
sub-capitated contract. These contracts have contributed to Advanced Health’s
stellar rate of growth. Between 2014 and 2017, Advanced Health’s 3-year non-
annualized rate of growth was -2.8 percent. During the same period, total CCO rate
of growth was 24.6 percent. By leading the State in the capitated payment model,
Advanced Health contributes to the sustainability of the Oregon Health Plan
(OHP).
As outlined in Attachment 8, Advanced Health will rapidly increase its VBP spending to meet CCO 2.0 VBP spending targets. Advanced Health will focus on LAN Category 3B (shared savings and downside risk) and 4A (partial capitation) contracts. In year one, Advanced Health will transition its local DRG hospital, A & B hospitals, and substance use disorder contracts to OHA-compliant VBPs. By 2024, 70% of Advanced Health's health services spending will be paid under VBP contracts.

Advanced Health expects these additional VBPs to improve or maintain its low rate of growth of healthcare costs.

G.4. What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members? Advanced Health will contain costs while still ensuring quality care in the same ways that it meets the sustainable expenditure targets:

- As described in Attachment 8, Advanced Health will rapidly transition its health services spending to value-based contracts. The per-member-per-month and shared savings and risk models Advanced Health will employ incentivize efficiency and cost containment. A critical element of value-based payments is a clear link to quality. By tying payment to quality, VBP contracts ensure Contractors do not sacrifice quality of care in their efforts to reduce unnecessary utilization.
- Advanced Health will require new personnel investments in primary care case management, ICC/ENCC case management, and Traditional Health Workers effective in 2020. Increased case managers and Traditional Health Workers will result in more direct communication with the Members and a better understanding of their needs.
- PreManage allows for greater communication between a Member's PCP and hospitals. This improved communication and information sharing will allow hospitals and Providers to provide higher quality care to Members, identify patients at risk for Hospital readmission, and reduce duplication of tests.
- Many of Advanced Health's Subcontractors employ traditional cost containment strategies such as utilization review and authorization requirements to assess the validity and necessity of requested services, often suggesting more cost-effective treatments when appropriate. Quality of care is ensured through Advanced Health's robust Grievance and Appeal system as outlined in this application.

G.5. Has Advanced Health achieved per-Member expenditure growth target of 3.4% per year in the past? Please specify time periods. Between 2014 and 2017, Advanced Health's 3-year non-annualized rate of growth was -2.8 percent. During the same period, total CCO rate of growth was 24.6 percent.
Advanced Health maintained a rate of growth below 3.4% during the CY15/CY14 and CY17/CY16 measurements periods.

H. Potential Establishment of Program-wide Reinsurance Program in Future Years

H.1. What type of reinsurance policy does the Applicant plan on holding for 2020? Please include the specifics (e.g., attachment points, coinsurance, etc.). Advanced Health currently does not directly hold a reinsurance policy. Advanced Health has required certain Subcontractors to hold stop-loss reinsurance policies based on Advanced Health's assessment of risk to the system posed by the activities of the Subcontractor. This arrangement reflected Advanced Health's delegation model, in which Subcontractors were risk-bearing entities in physical health, Behavioral Health and oral health. As an example, Advanced Health's physical health Subcontractor, Southwest Oregon IPA, Inc., maintains a robust stop loss arrangement. The details of the policy are as follows:

In addition, Advanced Health has the contractual right, under its Subcontractor agreements, to review the financial health of the Subcontractors and Subcontractors are required to give Advanced Health notice of certain changes in their financial situation.

Beginning in 2020, as required by the 2020 Contract, Advanced Health will obtain direct stop-loss or reinsurance coverage against catastrophic and unexpected expenses related to Covered Services provided to Members. It anticipates that the stop-loss reinsurance policy for physical health will be quite similar to the policy described above, adjusted for Advanced Health's analysis of increased or decreased risk in this healthcare area. Advanced Health's insurance consultant is currently analyzing the risks associated with Behavioral Health and oral health, and will advise Advanced Health in time to have policies in place on January 1, 2020.
H.2. What is the Applicant's reasoning for selecting the reinsurance policy described above? Southwest Oregon IPA, Inc., the Subcontractor that currently holds the stop-loss reinsurance policy described above, maintained a longstanding relationship with a broker that evaluates its experience on an annual basis and compares this to market rates. It is anticipated that Advanced Health will retain the services of that broker. The most salient factors in the selection of the policy will be (A) ensuring that unexpected and catastrophic risks across the system are properly identified and quantified; and (B) quality of the insurance company providing the policy; and (C) cost.

H.3. What aspects of its reinsurance policy are the most important to the Applicant? Besides cost, the most important aspect of the reinsurance policy is the lag period in which claims can be paid beyond the contract end date. The expected policy will allow for a one-year run out of claims, which mirrors the internal policy for the maximum time allowed for submission of claims.

H.4. Does existing or previous reinsurance contract allow specific conditions or patients to be excluded, exempted, or lasered out from being covered? The current reinsurance policy does not allow for any specific conditions or patients to be excluded, and it is anticipated that Advanced Health's policy for 2020 will be the same.

H.5. Is the Applicant able to leave or modify existing reinsurance arrangements at any time or is Advanced Health committed to existing arrangements for a set period of time? If so, for how long is Advanced Health committed to existing arrangements? Are there early cancellation penalties? The current stop loss reinsurance arrangement is an annual contract that expires at December 31, 2019.

I. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk

I.1. Please describe the Applicant's past sources of capital. Advanced Health was initially capitalized in 2014 by equity owners, based on their respective percentage of membership units owned. Each year, a portion of Advanced Health’s net profit has been retained as capital.

I.2. Please describe the Applicant's possible future sources of capital. Advanced Health is an Oregon limited liability company, and its central governance agreement is called an “operating agreement.” All equity owners are bound by that operating agreement.
Other Community entities have from time to time expressed interest in participating as an equity owner of Advanced Health. Although no new equity owners have been admitted since the initial offering in 2014, with the consent of the equity owners, other entities could become equity owners for an appropriate capital contribution.

I.3. What strategies will the Applicant use to ensure solvency thresholds are maintained? Advanced Health’s Board of Directors and equity owners have consistently focused on the need to increase and maintain reserves at appropriate levels.

These reserves are in excess of proforma RBC requirements during that time period. Prior to 2020, Advanced Health anticipates Amending its operating agreement to clarity that its reserves are restricted.

I.4. Does Applicant have a parent company, Affiliate, or capital partner from which Applicant may expect additional capital in the event Applicant becomes undercapitalized? If so, please describe. As described in Question I.1.

J. Encounter Data Validation Study.

J.1. Please describe Applicant's capacity to perform regular Provider audits and claims review to ensure the timeliness, correctness, and accuracy of Encounter Data. Advanced Health's capacity to perform regular Provider audits and claims reviews to ensure the timeliness, correctness, and accuracy of encounter data is as follows:

- Inbound claims pass through a number of verification steps prior to adjudication at both the clearinghouse and EDI gateway levels to verify data completeness and (to a lesser degree) accuracy.
• Claims are subsequently reviewed (either manually, systematically, or both) upon submission in accordance with our internal procedures to monitor both the completeness and accuracy of the data provided, as well as timeliness.
• Claims that do not meet these standards are either denied or rejected and feedback is provided to the billing Provider.
• Advanced Health has developed monitoring tools such as reports and electronic dashboards to detect anomalies such as upcoding, under reporting, and claim submission lag.
• Advanced Health has additional capacity to perform focused, detailed provider audits and claims review as necessary. These audits may be in the form of ad hoc reporting, statistical analysis, site visits, or chart review.

J.2. Does Applicant currently perform any activities to validate Claims data at the chart level that the claims data accurately reflects the services provided? If yes, please describe those activities. Advanced Health currently performs several activities to validate claims at the chart level to ensure claims data accurately reflects services provided.

Advanced Health relies on Certified Professional Coders (CPC) to perform chart-level claim reviews. Currently, Advanced Health, through its Subcontractor, has access to one full-time CPC, as well as one part-time CPC with plans to train additional certified coders.

Standard procedures for claims review during and after adjudication include the manual processes of reviewing authorizations and spot checking for obvious coding and pricing mistakes. Automated claims review processes include the review of a system-generated error report after the initial adjudication. When an irregularity is identified in the course of the claims review procedures, a targeted coding audit is organized and a sample of the claims from the identified provider and/or organization is reviewed against the medical records for those encounters to determine whether the claims accurately reflect the services provided according to the chart documentation. For example, in 2019, a primary care practice was identified as an outlier from the rest of the Provider network with very high RVU production. Advanced Health's review team organized a sample chart audit of the Providers in question. The coding levels found in claims data were compared to charts for appropriateness and adequacy of documentation. In addition to the chart review, the aggregate distribution of visit level codes was compared to national benchmark data to evaluate the reasonableness of overall performance.

Advanced Health, as part of its commitment to continuously monitor and improve the accuracy and completeness of encounter data, will implement a routine chart audit program. The program will be supported by Advanced Health's analytics staff to identify appropriate sample sizes and randomization procedures. Chart documentation will be reviewed against claims data by Certified Professional
Coders. Results of the reviews will be analyzed and aggregated to establish rates of completeness and accuracy. Irregularities will be referred to Advanced Health's compliance officer for evaluation and potential investigation to prevent fraud, waste, and abuse.
Western Oregon Advanced Health, LLC

CONSOLIDATED FINANCIAL STATEMENTS
(Stand-alone financial statements)

For the Years Ended December 31, 2015 & 2014
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Western Oregon Advanced Health, LLC

CONSOLIDATED FINANCIAL STATEMENTS
(Stand-alone financial statements)

For the Years Ended December 31, 2016 and 2015
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Western Oregon Advanced Health, LLC

CONSOLIDATED FINANCIAL STATEMENTS
(Stand-alone financial statements)

For the Years Ended December 31, 2017 and 2016
Western Oregon Advanced Health, LLC (WOAH)
CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2017 and 2016

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BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health, LLC (dba Advanced Health)
289 LaClair St., Coos Bay, OR 97420
541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: Elena Middle: Suzanne Last: Crane

2. a. Are you a citizen of the United States?
   Yes [X] No 
   b. Are you a citizen of any other country?
   Yes [X] No 
   If yes, what country? ________________

3. Affiant's occupation or profession: CEO

4. Affiant's business address: 1750 Thompson Road, Coos Bay, OR 97420
   Business telephone: 541-269-0333 Business Email:_crcane@bayclinical.us

5. Education and training:

   College/University City/State Dates Attended (MM/YY) Degree Obtained
   Troy University Troy, AL 8/1978 - 7/1982 BS in Bus Admin

   Graduate Studies College/University City/State Dates Attended (MM/YY) Degree Obtained
   Troy University Columbus, GA 2000-2001 Master Management

   Other Training: Name City/State Dates Attended (MM/YY) Degree/Certification Obtained
   none

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon Medical Group Assoc.</td>
<td>Kathy Brown, Pres.</td>
<td>507 S 424 Conference Dr</td>
<td>971-673-1477</td>
</tr>
<tr>
<td>Medical Group Med. Assoc.</td>
<td></td>
<td>108 Inverness Terrace East, Englewood, CO 80112-3021</td>
<td>303-773-6432</td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

**Example Employment Records**

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY):</th>
<th>Employer’s Name:</th>
<th>Address:</th>
<th>City:</th>
<th>State/Province:</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/2017</td>
<td>Bay Clinic, PA</td>
<td>1750 Thompson Rd</td>
<td>Code</td>
<td>OR</td>
</tr>
<tr>
<td>02/2003 - 4/2011</td>
<td>Southeast Brain &amp; Spine Surgery, PC</td>
<td>1381 18th Ave, Ste 300</td>
<td>Columbus</td>
<td>GA</td>
</tr>
<tr>
<td>06/1993 - 12/2003</td>
<td>Rivertown Pediatrics, PC</td>
<td>2416 Capstone Ct</td>
<td>Columbus</td>
<td>GA</td>
</tr>
</tbody>
</table>

Type of Business:
- Private Medical Practice
- Supervisor/Contact:
  - Dr. Wendy Haack 503 360 4470
  - Dr. Michael Gorum
  - Dr. Kathryn Cheek
  - Drs. Merle or Doug Stringer
9. a. Have you ever been in a position which required a fidelity bond?

Yes [x]  No [ ]

If any claims were made on the bond, give details:

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ]  No [x]

If yes, give details: N/A

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: ___________________________  Address: ___________________________

City: ___________________________  State/Province: ___________________________  Country: ___________________________

License Type: ___________________________  License #: ___________________________

Date Issued (MM/YY): ___________________________

Date Expired (MM/YY): ___________________________

Reason for Termination: ___________________________

Non-Insurance Regulatory Phone Number (if known): ___________________________

Organization/Issuer of License: ___________________________  Address: ___________________________

City: ___________________________  State/Province: ___________________________  Country: ___________________________

License Type: ___________________________  License #: ___________________________

Date Issued (MM/YY): ___________________________

Date Expired (MM/YY): ___________________________

Reason for Termination: ___________________________

Non-Insurance Regulatory Phone Number (if known): ___________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes [ ]  No [x]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

...
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

e. Pleaded guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes [ ] No [X]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes [ ] No [X]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes [ ] No [X]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes [ ] No [X]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

[ ]

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

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Revised 03/26/18

FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details. N/A

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☒

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities. N/A

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☒

If yes, provide details: N/A

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☒

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes ☐ No ☒
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

N/A

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 29 day of March 2019 at Advanced Health. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos
The foregoing instrument was acknowledged before me this 29 day of March 2019 by Elana Crane and:

□ who is personally known to me, or

X who produced the following identification: Oregon DL

(Notary Public)

Katelyn Cotten
Notary Public
Printed Notary Name
July 26, 2019
My Commission Expires July 26, 2019

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 6 of 164
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information
(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health, LLC (dba Advanced Health)
289 La Clair St, Coos Bay, OR 97420
541-269-7400

1. Affiant's Full Name (Initials Not Acceptable): First: Suzanne Middle: Last: Crane

   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [X] No

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

   Beginning/Ending Date(s) Used (MM/YY) | Name(s) | Reason (If none, indicate such)
   3/31/40 - 12/26/75 | Last name: Mayhew | Maiden Name

   Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: [Redacted]

5. Foreign Student ID# (if applicable): [Redacted]
**Applicant Company Name:** Western Oregon Advanced Health

**NAIC No.:** None

**FEIN:** 46-1426946

6. **Date of Birth:** (MM/DD/YY)
   **Place of Birth, City:**
   **State/Province:**
   **Country:**

7. **Name of Affiant's Spouse (if applicable):**

8. **List your residences for the last ten (10) years starting with your current address, giving:**

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
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</table>

**Note:** Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 29 day of March, 2019 at 1750 Thompson Rd, Coos Bay, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

**Signature of Affiant:**

**State of:** Oregon **County of:** Coos

The foregoing instrument was acknowledged before me this 29 day of March, 2019 by Elana Crane and:

☐ who is personally known to me, or

☐ who produced the following identification: Oregon DL

**Official Stamp:**

KATELYN JO COTTEN
NOTARY PUBLIC-OREGON
COMMISSION NO. 941072
MY COMMISSION EXPIRES JULY 26, 2019

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health, [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Executive Program Manager, [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Elana S. Crane 1345 Fenwick Ave, Coos Bay, OR 97420
(Printed Full Name and Residence Address) 3-29-2019
(Received by)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 29 day of March, 2019 by Elana Crane, and:

☐ who is personally known to me, or
☐ who produced the following identification: Oregon DL

Katelyn Cotten
Offical Stamp
Katelyn Cotten, Notary Public
Printed Notary Name
My Commission Expires July 26, 2019

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Revised 03/26/18
FORM 11
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair St., Coos Bay, OR 97420
541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS “NO” OR “NONE,” SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Michael Middle: Kim Last: Rowley

2. a. Are you a citizen of the United States?
   Yes [x]  No [ ]
   b. Are you a citizen of any other country?
   Yes [ ]  No [x]
   If yes, what country? None

3. Affiant’s occupation or profession: Director of Coos Health & Wellness

4. Affiant’s business address: 281 LaClair Street, Coos Bay, OR 97420
   Business telephone: 541-266-6700
   Business Email: mike.rowley@chw.coos.or.us

5. Education and training:

   College/University  City/State  Dates Attended (MM/YY)  Degree Obtained
   Southern Oregon State College  Ashland, OR  09/84-06/90  BS in Business Admin

   Graduate Studies  College/University  City/State  Dates Attended (MM/YY)  Degree Obtained
   None

   Other Training: Name  City/State  Dates Attended (MM/YY)  Degree/Certification Obtained
   None

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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FORM 11
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)

NAIC No.: None

FEIN: 46-4926946

6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Board member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginnning/Ending Dates (MM/YY): 11/04 - Current

Employer’s Name: Coos County dba Coos Health & Wellness

Address: 281 LaClair Street

city: Coos Bay

State/Province: OR

Country: United States

Postal Code: 97420

Phone: 541-266-6700

Offices/Positions Held: Director of Coos Health & Wellness

Supervisor/Contact: Melissa Cribbins, Commissioner

Type of Business: County Government Dept

Beginnning/Ending Dates (MM/YY): 10/10 - 09/18

Employer’s Name: Subway of Phoenix

Address: 315 N Main St Suite A

city: Phoenix

State/Province: OR

Country: United States

Postal Code: 97535

Phone: 5415122566

Offices/Positions Held: Accountant

Supervisor/Contact: Terri McKay

Type of Business: Subway Franchise

Beginnning/Ending Dates (MM/YY): 01/02 - 08/04

Employer’s Name: Medford Women’s Clinic

Address: 555 Black Oak Dr

city: Medford

State/Province: OR

Country: United States

Postal Code: 97504

Phone: None

Offices/Positions Held: Accountant

Supervisor/Contact: None

Type of Business: OB-GYN clinic

Beginnning/Ending Dates (MM/YY): 08/90 - 12/01

Employer’s Name: Sterling Business Forms, Inc.

Address: 5300 Crater Lake Ave

city: Central Point

State/Province: OR

Country: United States

Postal Code: 97502

Phone: None

Offices/Positions Held: Comptroller

Supervisor/Contact: None

Type of Business: Business Forms Manufacturer

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Revised 03/26/18

FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 11 of 164
9. a. Have you ever been in a position which required a fidelity bond?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
<th></th>
</tr>
</thead>
</table>

If any claims were made on the bond, give details: None

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
<th></th>
</tr>
</thead>
</table>

If yes, give details: None

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

| Organization/Issuer of License: None | Address: None |
| City: None | State/Province: None | Country: None |
| License Type: None | License #: None | Date Issued (MM/YY): None |
| Date Expired (MM/YY): None | Reason for Termination: None |

| Organization/Issuer of License: None | Address: None |
| City: None | State/Province: None | Country: None |
| License Type: None | License #: None | Date Issued (MM/YY): None |
| Date Expired (MM/YY): None | Reason for Termination: None |

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
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</tr>
</thead>
</table>

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
<th></th>
</tr>
</thead>
</table>
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
   Yes ☐ No ☑

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
   Yes ☐ No ☑

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
   Yes ☐ No ☑

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
   Yes ☐ No ☑

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
   Yes ☐ No ☑

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
   Yes ☐ No ☑

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
   Yes ☐ No ☑

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
   Yes ☐ No ☑

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

None

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate...
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [x]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

None

If any of the shares of stock are pledged or hypothecated in any way, give details.

None

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [x]

If yes, provide details: None

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [x]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [x]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [x]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. None

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 4 day of April 2019 at 2:21pm. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: [County]

The foregoing instrument was acknowledged before me this 4 day of April 2019 by [Affiant's Name] and:

[ ] who is personally known to me, or

[ ] who produced the following identification:

[Signature]

[Official Stamp]
Advanced Health  541-269-7400
289 LaClair Street
Coos Bay, OR 97420

1. Affiant’s Full Name (Initials Not Acceptable): First: Michael Middle: Kim Last: Rowley

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?  
   Yes [ ] No [ ]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

   Beginning/Ending Date(s) Used (MM/YY)   Name(s)   Reason (If none, indicate such)
   01/1972 to current   First - Mike   Nickname

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
Applicant Company Name: Western Oregon Advanced Health LLC (d/b/a Advanced Health)

NAIC No. None
FEIN: 46-4926946

Beginning/Ending Dates (MM/YY)  Address  City  State/Province  Country  Postal Code

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 4 day of April , 2019 at 02:23 pm, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

✓ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon  County of: Coos

The foregoing instrument was acknowledged before me this 4 day of April , 2019 by Michael Rawley and:

✓ who is personally known to me, or

☐ who produced the following identification:

OFFICIAL STAMP
REBECCA LEE ANN HAYLETT
NOTARY PUBLIC-OREGON
COMMISSION NO. 979530
MY COMMISSION EXPIRES OCTOBER 3, 2022

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 17 of 164
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advance Health LLC (d/b/a Advanced Health) for licensure or a permit to organize an insurance company in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) regarding your background for review by insurance department in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Michael K. Rowley - 8207 Ave. Coos Bay, OR 97420
(Printed Full Name and Residence Address)
4/14/19
(Date)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 4 day of April, 2019 by Michael K. Rowley, and:

[Signature]

who is personally known to me, or

who produced the following identification:

Official Stamp
REBECCA LEE ANN HAYLETT
NOTARY PUBLIC-OREGON
COMMISSION NO. 979530
MY COMMISSION EXPIRES OCTOBER 3, 2022

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BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair St., Coos Bay, OR 97420
541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Gregory  Middle: Scott  Last: Brigham

2. a. Are you a citizen of the United States?
   Yes [x]  No [ ]
   b. Are you a citizen of any other country?
   Yes [ ]  No [x]

   If yes, what country?

3. Affiant’s occupation or profession: Psychologist / Administrator

4. Affiant’s business address: 621 W. Madrone St., Roseburg, OR 97470
   Business telephone: 541-672-2691  Business Email: Brigham@adaptoregon.org

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Ohio State University</td>
<td>Columbus/Ohio</td>
<td>1981-1985</td>
<td></td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Graduate Studies</th>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodist Theological School</td>
<td>Delaware/Ohio</td>
<td>1990</td>
<td>M.A.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Training: Name</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree/Certification Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Ohio State University</td>
<td>Columbus/Ohio</td>
<td>1996</td>
<td>Ph.D.</td>
</tr>
</tbody>
</table>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Revised 03/26/18
FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 19 of 164
Applicant Company Name: Western Oregon Advanced Health LLC (also Advanced Health)
NAIC No. None
FEIN: 46-4928946

9. a. Have you ever been in a position which required a fidelity bond?
   Yes ☐ No ☒

   If any claims were made on the bond, give details:

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes ☐ No ☒

   If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: Oregon Board of Psychology
   Address: 3218 Pringle Rd. SE, Suite 130
   City: Salem State/Province: OR Country: US Postal Code: 97302
   License Type: Psychologist License #: 2651 Date Issued (MM/YY): 01/16
   Date Expired (MM/YY): N/A Reason for Termination: N/A
   Non-Insurance Regulatory Phone Number (if known):

   Organization/Issuer of License: Ohio State Board of Psychology
   Address: 77 S. High St., St 1830
   City: Columbus State/Province: OH Country: US Postal Code: 43215
   License Type: Psychologist License #: 5248 Date Issued (MM/YY): 06/97
   Date Expired (MM/YY): N/A Reason for Termination: N/A
   Non-Insurance Regulatory Phone Number (if known):

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   Yes ☐ No ☒

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
   Yes ☐ No ☒
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details. N/A

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

N/A

If any of the shares of stock are pledged or hypothecated in any way, give details.

N/A

14. Have you ever been adjudged a bankrupt?

Yes [X] No [ ]

If yes, provide details:

In 1982, at the age of 25 and in my first year of recovery, I filed for personal bankruptcy.

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 La Clair St., Coos Bay, OR 97420
541-269-7400

1. Affiant's Full Name (Initials Not Acceptable): First: Gregory Middle: Scott Last: Brigham
   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [X] No 
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

   Beginning/Ending Date(s) Used (MM/YY) Name(s) Reason (If none, indicate such)
   1974 Gregory S. Brigham I began using only an initial for my middle name

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the biographical affidavit personal supplemental information.

3. Affiant's Social Security Number: ____________________________

4. Government Identification Number if not a U.S. Citizen: ____________________________

5. Foreign Student ID# (if applicable): ____________________________

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Revised 03/26/18
FORM 11
Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 22 of 164
6. Date of Birth: (MM/DD/YY):
   State/Province:
   Place of Birth, City:
   Country:

7. Name of Affiant’s Spouse (if applicable):

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
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</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 11 day of April, 2019 at 289 Locust St, CB, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 11 day of April, 2019 by Gregory Brigham and:

☐ who is personally known to me, or

☐ who produced the following identification: Oregon DL

OFFICIAL STAMP
KATELYN JO COTTEN
NOTARY PUBLIC-OREGON
COMMISSION NO. 941072
MY COMMISSION EXPIRES JULY 28, 2019

Kathlyn Cotten
Notary Public
Printed Notary Name
July 26, 2019
My Commission Expires
Applicant Company Name: Western Oregon Advanced Health LLC d/b/a Advanced Health

NAIC No.: None

FEIN: 46-4926946

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health LLC d/b/a Advanced Health (company name) (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Executive Program Director, Advanced Health, Company’s designated person, position, or department, address and phone: 289 LaClair St, Coos Bay, OR 97420 541-269-4560

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Gregory S. Brigham, 85280 Ridgeway Dr, Eugene, OR

[Signature]

(Printed Full Name and Residence Address) 4/15/19

(Date)

State of Oregon County of Coos

The foregoing instrument was acknowledged before me this 11 day of April, 2019 by

Gregory Brigham

who is personally known to me, or

who produced the following identification: Oregon ID

Katelyn Cotton

Notary Public

My Commission Expires July 21, 2019

©2019 National Association of Insurance Commissioners

Revised 03/26/18

FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair St., Coos Bay, OR 97420
541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Anna Middle: Louise Last: Warner

2. a. Are you a citizen of the United States?
   Yes [x] No [ ]
   b. Are you a citizen of any other country?
   Yes [ ] No [x]
   If yes, what country? none

3. Affiant’s occupation or profession: Executive Program Director

4. Affiant’s business address: 289 LaClair St, Coos Bay, OR 97420
   Business telephone: 541-269-4560 Business Email: anna.warner@advancedhealth.com

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice University</td>
<td>Houston, TX</td>
<td>80/95 - 05/99</td>
<td>BSME</td>
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</table>

Graduate Studies

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Training: Name | City/State | Dates Attended (MM/YY) | Degree/Certification Obtained
National Association for Healthcare Quality | online program | 10/18 | Certified Professional in Healthcare Quality (CPHQ)

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Association for Healthcare Quality</td>
<td></td>
<td>6600 W. Bryn Mawr Avenue, Suite 710 N. Chicago, IL 60631</td>
<td>847.375.4720</td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: **Executive Program Director**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

**Advanced Health**

- **Beginning/Ending Dates**: 07/18 - current
- **Employer's Name**: Advanced Health
- **Address**: 289 LaClair St, Coos Bay, OR
- **Country**: USA
- **Postal Code**: 97420
- **Phone**: 541-269-7400
- **Supervisor/Contact**: Ben Messner
- **Offices/Positions Held**: Executive Program Director

**Southwest Oregon IPA**

- **Beginning/Ending Dates**: 11/15 - current
- **Employer's Name**: Southwest Oregon IPA
- **Address**: 289 LaClair St, Coos Bay, OR
- **Country**: USA
- **Postal Code**: 97420
- **Phone**: 541-269-7400
- **Supervisor/Contact**: Ben Messner
- **Offices/Positions Held**: Director of Quality

**South Coast Hospice**

- **Beginning/Ending Dates**: 04/15 - 11/15
- **Employer's Name**: South Coast Hospice
- **Address**: 1620 Thompson Rd, Coos Bay, OR
- **Country**: USA
- **Postal Code**: 97420
- **Phone**: 541-269-2986
- **Supervisor/Contact**: Linda Furman-Grile
- **Offices/Positions Held**: Manager, Quality, Compliance, HR

**Hardin Optical Company**

- **Beginning/Ending Dates**: 02/05 - 12/14
- **Employer's Name**: Hardin Optical Company
- **Address**: 87679 Kehl Rd, Bandon, OR
- **Country**: USA
- **Postal Code**: 97411
- **Phone**: 541-347-9467
- **Supervisor/Contact**: Michael Hardin
- **Offices/Positions Held**: Production Manager, Process Improvement Coordinator
Applicant Company Name: ____________________________

NAIC No.: _________
FEIN: ____________

6. List of memberships in professional societies and associations:

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<tr>
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<td>312.375.4720</td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Executive Program Director

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<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Employer’s Name</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
<th>Phone</th>
<th>Offices/Positions Held</th>
<th>Supervisor/Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/00 - 06/04</td>
<td>Kirkwood Mountain Resort</td>
<td>1501 Kirkwood Meadows Dr</td>
<td>Kirkwood</td>
<td>CA</td>
<td>USA</td>
<td>95646</td>
<td>209-258-6000</td>
<td>Ticket and Season Pass Office Manager</td>
<td>Mike Frye</td>
</tr>
<tr>
<td>05/00 - 10/00</td>
<td>Meir &amp; Frank</td>
<td>9300 SW Washington Square Rd</td>
<td>Portland</td>
<td>OR</td>
<td>USA</td>
<td>97223</td>
<td>503-620-3311</td>
<td>Sales Associate</td>
<td>Human Resources</td>
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</table>

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Revised 03/26/18
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9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [x]
   If any claims were made on the bond, give details: n/a

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [x]
   If yes, give details: n/a

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   none

   Organization/Issuer of License: __________________________
   Address: __________________________
   City: __________________________
   State/Province: ________
   Country: ________
   Postal Code: ________
   License Type: ________
   License #: ________
   Date Issued (MM/YY): ________
   Date Expired (MM/YY): ________
   Reason for Termination: ______________________________________________________
   Non-Insurance Regulatory Phone Number (if known): __________________________

   Organization/Issuer of License: __________________________
   Address: __________________________
   City: __________________________
   State/Province: ________
   Country: ________
   Postal Code: ________
   License Type: ________
   License #: ________
   Date Issued (MM/YY): ________
   Date Expired (MM/YY): ________
   Reason for Termination: ______________________________________________________
   Non-Insurance Regulatory Phone Number (if known): __________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes [ ] No [x]
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
Applicant Company Name: Western Oregon Advanced Health, LLC [join Advanced Health]

NAIC No. None
FEIN: 46-4926946

Yes [ ] No [x]
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [x]
d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [x]
e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [x]
f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [x]
g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes [ ] No [x]
h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes [ ] No [x]
i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes [ ] No [x]
j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes [ ] No [x]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

n/a

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
Applicant Company Name: Evergreen Advanced Health, LLC (Zenith Advanced Health)

NAIC No. None  
FEIN: 46-4926496

Office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. None

If any of the stock is pledged or hypothecated in any way, give details. n/a

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ]  No [x]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

n/a

If any of the shares of stock are pledged or hypothecated in any way, give details.

n/a

14. Have you ever been adjudged a bankrupt?

Yes [ ]  No [x]

If yes, provide details: n/a

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ]  No [x]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ]  No [x]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ]  No [x]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. 

n/a

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 15th day of April 2019 at 11:01 . I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 15th day of April 2019 by Anna L. M. Warner

and:

who is personally known to me, or

do who produced the following identification:

OFFICIAL STAMP
Selia Colvin
NOTARY PUBLIC-OREGON
COMMISSION NO. 964526
MY COMMISSION EXPIRES JULY 18, 2021

© 2019 National Association of Insurance Commissioners

Revised 03/26/18

FORM 11
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health, LLC (dba Advanced Health)  
289 LaClair St, Coos Bay, OR 97420  
541-269-7400

1. Affiant’s Full Name (Initials Not Acceptable): First: Anna Middle: Louise Muffett Last: Warner  
(If ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?  
Yes □ No □  
If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s)</th>
<th>Reason (If none, indicate such)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/77 - 07/04</td>
<td>Anna Louise Muffett</td>
<td>maiden name</td>
</tr>
<tr>
<td>07/04 - present</td>
<td>Anna Louise Warner</td>
<td>sometimes it is difficult to use two middle names</td>
</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: [Redacted]

5. Foreign Student ID# (if applicable): [Redacted]
Applicant Company Name: Watern Otegon AdwrO&d H.arth LLC (dba Advanced Heatth)

6. Date of Birth: (MM/DD/YY): [Blacked out]
   State/Province: [Blacked out]
   Place of Birth, City: [Blacked out]

7. Name of Affiant’s Spouse (if applicable): [Blacked out]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/DD/YYYY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
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</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 15th day of April, 2019 at 11:01. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon        County of: Coos

The foregoing instrument was acknowledged before me this 15th day of April, 2019 by Anna Warner, who is personally known to me, or

[ ] who produced the following identification:

OFFICIAL STAMP
SELIA COLVIN
NOTARY PUBLIC-OREGON
COMMISSION NO. 964524
MY COMMISSION EXPIRES JULY 18, 2021

Selia Colvin
Notary Public
Printed Notary Name
7-18-2021
My Commission Expires

©2019 National Association of Insurance Commissioners

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact [Executive Program Director, Advanced Health, company's designated person, position, or department, address and phone].

Attached for your information is a summary of your rights under the Fair Credit Reporting Act.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Anna Warner, 95886 Templeton Ln, North Bend, OR 97459

(Signature)

(Printed Full Name and Residence Address)

(Date)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 15th day of April , 2019 by Anna Warner , and:

who is personally known to me, or

who produced the following identification:

[Notary Stamp]

Selia Colvin
Notary Public

My Commission Expires

FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 34 of 164
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair St., Coos Bay, OR 97420
541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS “NO” OR “NONE,” SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: Jason Middle: Scott Last: Bell

2. a. Are you a citizen of the United States?
   Yes [x] No [ ]

   b. Are you a citizen of any other country?
   Yes [ ] No [x]

   If yes, what country? [ ]

3. Affiant's occupation or profession: Physician

4. Affiant's business address: 2699 North 17th Street, Coos Bay, OR 97420
   Business telephone: 541-266-3600
   Business Email: jbell@scoastortho.com

5. Education and training:

   College/University  City/State       Dates Attended (MM/YY)  Degree Obtained

   Graduate Studies  College/University City/State Dates Attended (MM/YY) Degree Obtained
   University of CA,  Irvine, CA         6/1995-6/1999       MD

   Other Training: Name City/State Dates Attended (MM/YY) Degree/Certification Obtained

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
6. List of memberships in professional societies and associations:

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</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Secretary, Board of Directors

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

**South Coast Orthopaedic Associates**

- **Employer's Name:** South Coast Orthopaedic Associates
- **Address:** 2699 N. 17th St.
- **City:** Coos Bay
- **State/Province:** OR
- **Country:** USA
- **Postal Code:** 97420
- **Phone:** 541-266-3600
- **Offices/Positions Held:** Partner
- **Supervisor/Contact:** Kathy Noel
- **Beginning/Ending Dates (MM/DD):** 07/15 - 01/16

**Waiketo District Health Board**

- **Employer's Name:** Waiketo District Health Board
- **Address:** Pembroke Street, Private Bag 3200
- **City:** Hamilton
- **State/Province:** New Zealand
- **Country:** New Zealand
- **Postal Code:** 3240
- **Phone:** 07-839-8899 ext 98704
- **Offices/Positions Held:** Orthopaedic Consultant
- **Beginning/Ending Dates (MM/DD):** 07/04 - 07/08

**USAF**

- **Employer's Name:** USAF
- **Address:** 481 Sugar Maple Drive
- **City:** Wright-Patterson AFB
- **State/Province:** OH
- **Country:** USA
- **Postal Code:** 45433
- **Phone:** 937-257-0837
- **Offices/Positions Held:** Orthopedic Surgeon
- **Type of Business:** Military Hospital
- **Supervisor/Contact:**
- **Beginning/Ending Dates (MM/DD):** 06/99 - 06/04

**University of CA, Irvine**

- **Employer's Name:** University of CA, Irvine
- **Address:** 101 The City Drive South
- **City:** Orange
- **State/Province:** CA
- **Country:** USA
- **Postal Code:** 92868
- **Phone:** Orthopaedic residency
- **Offices/Positions Held:**
- **Type of Business:** Hospital
- **Supervisor/Contact:**
- **Beginning/Ending Dates (MM/DD):** 07/04 - 07/08
9. a. Have you ever been in a position which required a fidelity bond?
   Yes ☐ No ☒
   If any claims were made on the bond, give details:

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes ☐ No ☒
   If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: Oregon Medical Board
   Address: 1500 S.W. 1st Avenue, Suite 620
   City: Portland
   State/Province: OR
   Country: USA
   Postal Code: 97201-5847
   License Type: Medical
   License #: MD28080
   Date Issued (MM/YY): 03/08
   Date Expired (MM/YY): Current
   Reason for Termination: N/A
   Non-Insurance Regulatory Phone Number (if known): 971-647-2700

   Organization/Issuer of License: The Medical Board of California
   Address: 2005 Evergreen Street, Suite 1200
   City: Sacramento
   State/Province: CA
   Country: USA
   Postal Code: 95815
   License Type: Medical
   License #: A73647
   Date Issued (MM/YY): 12/00
   Date Expired (MM/YY): 12/31/16
   Reason for Termination: Not practicing in CA
   Non-Insurance Regulatory Phone Number (if known): 916-263-2382

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes ☐ No ☒
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
      Yes ☐ No ☒
Applicant Company Name: Western Oregon Advanced Health, LLC (also Advanced Health).

NAIC No. None
FEIN: 46-4926846

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☒

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☒

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☒

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☒

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☒

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
Applicant Company Name: Westem Coagel Advanced Health (LLC, other Advanced Health)

NAIC No.: None

FEIN: 46-4926946

Office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. None

If any of the stock is pledged or hypothecated in any way, give details. N/A

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities. N/A

If any of the shares of stock are pledged or hypothecated in any way, give details. N/A

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details: N/A

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

N/A

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 11 day of April 2019 at 289 La Clair CB. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 11 day of April 2019 by Jason Bell and:

☐ who is personally known to me, or

☒ who produced the following identification: Oregon DL

Katelyn Cotten
Notary Public
Printed Notary Name

My Commission Expires July 26, 2019
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Applicant Company Name: Western Oregon Advanced Health, LLC (dba Advanced Health)
289 LaClair St, Coos Bay, OR 97420
541-269-7400

1. Affiant's Full Name (Initials Not Acceptable): First: Jason Middle: Scott Last: Bell
   If answer is "none," so state.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [X]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s)</th>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: [redacted]

4. Government Identification Number if not a U.S. Citizen: [redacted]

5. Foreign Student ID# (if applicable): [redacted]
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)

6. Date of Birth: (MM/DD/YY) __________________________ Place of Birth, City __________________________ State/Province __________________________ Country __________________________

7. Name of Affiant's Spouse (if applicable): __________________________

8. List your residences for the last ten (10) years starting with your current address, giving:

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<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
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<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this ___ day of __________, 2019 at __________________________, __________________________. I hereby certify under penalty of perjury that I acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

________________________
(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this ___ day of __________, 2019 by Jason Bell

and:

☐ who is personally known to me, or

☐ who produced the following identification: Oregon DL

________________________
Katelyn Cotten
Notary Public

Printed Notary Name

________________________
Katelyn Cotten

My Commission Expires July 26, 2019

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health LLC (the "Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact the Company's designated person, position, or department, address and phone:

Executive Program Director, Advanced Health
1257 Laurel Ave, Coos Bay, OR 97420 541-269-4570

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Signature: Jason Scott Bell
(Printed Full Name and Residence Address)

Date: 4/11/19

State of: OR
County of: Coos

The foregoing instrument was acknowledged before me this 11 day of April, 2019 by

Jason Bell, and:

☐ who is personally known to me, or

☐ who produced the following identification:

OFFICIAL STAMP
KATELYN JO COTTON
NOTARY PUBLIC-OREGON
COMMISSION NO. 941072
MY COMMISSION EXPIRES JULY 26, 2019

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Revised 03/26/18
FORM 11
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)

289 LaClair St., Coos Bay, OR 97420

541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Sam Middle: E Last: Scott

2. a. Are you a citizen of the United States?
   Yes [X] No [ ]

   b. Are you a citizen of any other country?
   Yes [ ] No [X]

   If yes, what country?

3. Affiant’s occupation or profession: DENTIST

4. Affiant’s business address: 833 W. ANDERSON ST. COOS BAY, OR 97420
   Business telephone: (541) 267-3447

Business Email: scott@samscottmd.com

5. Education and training:

College/University  City/State  Dates Attended (MM/YY)  Degree Obtained

UNIVERSITY OF OREGON  EUGENE, OR  09/80 - 12/82  BS

Graduate Studies  College/University  City/State  Dates Attended (MM/YY)  Degree Obtained

DENTAL  OHSU, SD  PORTLAND, OR  09/84 - 06/88  DMD

Other Training: Name  City/State  Dates Attended (MM/YY)  Degree/Certification Obtained

Note: If affiant attended a foreign school, please provide full name and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>OREGON DENTAL ASSOC.</td>
<td>?</td>
<td>8699 SW Sun Place Wilsonville, OR 97070</td>
<td>503-219-2100</td>
</tr>
<tr>
<td>AMERICAN DENTAL ASSOC.</td>
<td>?</td>
<td>211 East Chicago Ave Chicago, IL 60611</td>
<td>312-440-2500</td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: BOARD MEMBER

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending Dates (MM/YY): 11/88 - PRESENT
Employer’s Name: SELF EMPLOYED
Address: 833 W. ANDERSON City: COOS BAY State/Province: OREGON
Country: USA Postal Code: 97420 Phone: 267-3447 Offices/Positions Held: OWNER
Type of Business: DENTIST Supervisor/Contact:

Beginning/Ending Dates (MM/YY): ______ - ______
Employer’s Name:
Address: ______ City: ______ State/Province:
Country: ______ Postal Code: ______ Phone: ______ Offices/Positions Held:
Type of Business: ______ Supervisor/Contact:

Beginning/Ending Dates (MM/YY): ______ - ______
Employer’s Name:
Address: ______ City: ______ State/Province:
Country: ______ Postal Code: ______ Phone: ______ Offices/Positions Held:
Type of Business: ______ Supervisor/Contact:

Beginning/Ending Dates (MM/YY): ______ - ______
Employer’s Name:
Address: ______ City: ______ State/Province:
Country: ______ Postal Code: ______ Phone: ______ Offices/Positions Held:
Type of Business: ______ Supervisor/Contact:

Beginning/Ending Dates (MM/YY): ______ - ______
Employer’s Name:
Address: ______ City: ______ State/Province:
Country: ______ Postal Code: ______ Phone: ______ Offices/Positions Held:
Type of Business: ______ Supervisor/Contact:

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Revised 03/26/18
Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X] 
   If any claims were made on the bond, give details: N/A

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X] 
   If yes, give details: N/A

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. Include the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: OR BOARD OF DENTISTRY
   Address: 1500 SW 1ST STREET
   City: PORTLAND State/Province: OREGON Country: USA Postal Code: 97201
   License Type: DMD License #: D6512 Date Issued (MM/YY): 06/83
   Date Expired (MM/YY): [ ] Reason for Termination: [ ]
   Non-Insurance Regulatory Phone Number (if known): [ ]

   Organization/Issuer of License: __________________________ Address: __________________________
   City: __________________________ State/Province: __________________________ Country: __________________________ Postal Code: __________________________
   License Type: __________________________ License #: __________________________ Date Issued (MM/YY): __________________________
   Date Expired (MM/YY): __________________________ Reason for Termination: __________________________
   Non-Insurance Regulatory Phone Number (if known): __________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes [ ] No [X]
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
      Yes [ ] No [X]
Applicant Company Name: Western Oregon Advanced Health LLC (its Advanced Health).

NAIC No.: None

FEIN: 46-4628946

Yes ☐ No ☒
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☒
d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒
e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒
f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒
g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☒
h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☒
i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☒
j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☒

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

N/A

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

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Revised 03/26/18
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

\[\text{NONE}\]

If any of the stock is pledged or hypothecated in any way, give details. \(\text{N/A}\)

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [x]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

\(\text{N/A}\)

If any of the shares of stock are pledged or hypothecated in any way, give details.

\(\text{N/A}\)

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [x]

If yes, provide details: \(\text{N/A}\)

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [x]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [x]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [x]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. N/A

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 8 day of April 2019 at . I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Clackamas

The foregoing instrument was acknowledged before me this 8 day of April, 2019 by Sam Scott.

☐ who is personally known to me, or

☒ who produced the following identification: Oregon DL

OFFICIAL STAMP
KATELYN JO COTTEN
NOTARY PUBLIC-OREGON
COMMISSION NO. 941072
MY COMMISSION EXPIRES JULY 26, 2019

KATELYN COTTEN
Printed Notary Name

July 26, 2019
My Commission Expires

©2019 National Association of Insurance Commissioners
Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

WESTERN OREGON ADVANCED HEALTH (DBA ADVANCED HEALTH)
289 LACLEA STREET - COOS BAY - OR - 97420
(541) 269-7400

1. Affiant’s Full Name (Initials Not Acceptable): First: **SAM** Middle: **E** Last: **SCOTT**

   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

   Yes ☐ No ☒

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
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<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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</tbody>
</table>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: __________________________________________

4. Government Identification Number if not a U.S. Citizen: __________________________

5. Foreign Student ID# (if applicable): __________________________________________
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)

NAIC No. 
FEIN: 46-4926946

6. Date of Birth: (MM/DD/YY)  
Place of Birth, City:  
State/Province:  
Country:  

7. Name of Affiant's Spouse (if applicable):  

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 8 day of April, 2019 at ___________________________. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

___ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon  
County of: Coos  

The foregoing instrument was acknowledged before me this 8 day of April, 2019 by Sam Scott and:

□ who is personally known to me, or

✓ who produced the following identification: Oregon DL  

©2019 National Association of Insurance Commissioners
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS  
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health LLC (dba Advanced Health) [company name] (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency (“CRA”) that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact [company’s designated person, position, or department, address and phone].

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[Signature] 
(Printed Full Name and Residence Address)  
4.08.2019  
(Date)

State of: Oregon  County of: Coos

The foregoing instrument was acknowledged before me this 8 day of April 2019 by [Signature], and:

[ ] who is personally known to me, or

[ ] who produced the following identification:

Oregon

[Signature]

KATRYN COTTON  
Notary Public

Printed Notary Name

July 26, 2019

My Commission Expires

©2019 National Association of Insurance Commissioners

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health dba Advanced Health, 289 LaClair St., Coos Bay, OR 97420

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: Keith Middle: Bradford Last: Lowther

2. a. Are you a citizen of the United States?
   Yes [x] No [ ]

   b. Are you a citizen of any other country?
   Yes [ ] No [x]

   If yes, what country?

3. Affiant's occupation or profession: accounting

4. Affiant's business address: 289 LaClair St., Coos Bay, Oregon 97420
   Business telephone: 541-269-0495 Business Email: keith.lowther@advancedhealth.com

5. Education and training:

   College/University City/State Dates Attended (MM/YY) Degree Obtained
   Ohio University Athens, Ohio 09/1987 to 06/1990 Bachelor of Business Administration

   Graduate Studies College/University City/State Dates Attended (MM/YY) Degree Obtained
   Ohio University Athens, Ohio 04/2012-3/2014 Master of Health Admin.

   Other Training: Name City/State Dates Attended (MM/YY) Degree/Certification Obtained
Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

6. List of memberships in professional societies and associations:

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<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
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7. Present or proposed position with the Applicant Company: Chief Financial Officer

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending Dates (MM/YY): 10/2015-current
Employer's Name: Western Oregon Advanced Health dba Advanced Health
Address: 289 LaClair St
City: Coos Bay
State/Province: Oregon
Country: US Postal Code: 97420 Phone: 541-269-0495 Offices/Positions Held: Chief Financial Officer
Type of Business: Coordinated Care Organization Supervisor/Contact: Ben Messner, CEO

Beginning/Ending Dates (MM/YY): 02/2014-09/2015
Employer's Name: Coquille Valley Hospital
Address: 940 E 5th St
City: Coquille
State/Province: Oregon
Country: US Postal Code: 97423 Phone: 541-396-5760 Offices/Positions Held: Chief Financial Officer
Type of Business: Hospital Supervisor/Contact: Human Resources, supervisors no longer there

Employer's Name: Jefferson Healthcare
Address: 834 Sheridan
City: Port Townsend
State/Province: Washington
Country: US Postal Code: 98368 Phone: 360-385-2200 Offices/Positions Held: Controller
Type of Business: Hospital Supervisor/Contact: Hilary Whittington

Employer's Name: Hagen Kurth Perman & Co PS
Address: 1111 Third Avenue, Suite 800
City: Seattle
State/Province: Washington
Country: US Postal Code: 98101 Phone: 206-281-4444 Offices/Positions Held: Tax supervisor
Type of Business: Public accounting Supervisor/Contact: Philip Laube
Applicant Company Name: Western Oregon Advanced Health dba Advanced Health
NAIC No. 
FEIN: 46-4926946

Employer's Name: RSM McGladrey

Address: 600 University St. Suite 1100
City: Seattle
State/Province: Washington
Country: US
Postal Code: 98101
Phone: 206-281-4444
Offices/Positions Held: Tax supervisor

Type of Business: Public accounting
Supervisor/Contact: Human Resources

Employer's Name: Trainer Wright & Paterno

Address: 218 13th Street
City: Huntington
State/Province: West Virginia
Country: US
Postal Code: 25701
Phone: 304-697-7083
Offices/Positions Held: Tax supervisor

Type of Business: Public accounting
Supervisor/Contact: Brent Hart

9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X]
   If any claims were made on the bond, give details:
   ____________________________________________________________

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X]
   If yes, give details:
   ____________________________________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.
   
   Organization/Issuer of License: West Virginia Board of Accountancy
   Address: 405 Capitol Street, Suite 908
   City: Charleston
   State/Province: West Virginia
   Country: US
   Postal Code: 25301
   License Type: CPA
   License #: WV 003604
   Date Issued (MM/YY): 07/95
   Date Expired (MM/YY): Current
   Reason for Termination: 
   Non-Insurance Regulatory Phone Number (if known): 304-558-3557
   
   Organization/Issuer of License: Oregon Board of Accountancy
   Address: 3218 Pringle Rd SE #110
   City: ______ State/Province: _______ Country: _______ Postal Code: _______
Applicant Company Name: Western Oregon Advanced Health dba Advance Health

FEIN: 46-4926946

City: Salem  State/Province: Oregon  Country: US  Postal Code: 97302

License Type: CPA  License #: 15926  Date Issued (MM/YY): 07/18

Date Expired (MM/YY): Current  Reason for Termination:

Non-Insurance Regulatory Phone Number (if known): 503-378-4181

Organization/Issuer of License: Washington Board of Accountancy

Address: 711 Capitol Way S.


License Type: CPA  License #: 22715  Date Issued (MM/YY): 02/09/2001

Date Expired (MM/YY): 06/30/2017  Reason for Termination: Allowed to lapse since not working in Washington

Non-Insurance Regulatory Phone Number (if known): 360-753-2586

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   
   Yes [ ]  No [x]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
   
   Yes [ ]  No [x]

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
   
   Yes [ ]  No [x]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
   
   Yes [ ]  No [x]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
   
   Yes [ ]  No [x]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
   
   Yes [ ]  No [x]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes [ ] No [X]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes [ ] No [X]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes [ ] No [X]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.
Applicant Company Name: Western Oregon Advanced Health dba Advance Health

14. Have you ever been adjudged a bankrupt?
   Yes  [ ]  No  [X]  
   If yes, provide details: ________________________________________________

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?
   a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?
      Yes  [ ]  No  [X]  
   b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?
      Yes  [ ]  No  [X]  
   c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?
      Yes  [ ]  No  [X]  
   If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. ______

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 11th day of April 2019 at 295 La Claire St, CB, OR I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

[Signature of Affiant]

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

State of: Oregon  County of: Coos
Applicant Company Name: Western Oregon Advanced Health dba Advanced Health

FEIN: 46-4926946

The foregoing instrument was acknowledged before me this 11th day of April, 2019 by Keith Lowther and:

who is personally known to me, or

who produced the following identification: Oregon DL ________

[SEAL]

KATELYN JO COTTEN
NOTARY PUBLIC-OREGON
COMMISSION NO. 941072
MY COMMISSION EXPIRES JULY 26, 2019

My Commission Expires
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health dba Advanced Health, 289 LaClair St, Coos Bay, OR 97420 541-269-0495

| 1. Affiant's Full Name (Initials Not Acceptable): First: Keith Middle: Bradford Last: Lowther
| 2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases? Yes ☐ No ☒

If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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<th>Beginning/Ending Date(s) Used (MM/YY)</th>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security

4. Government Identification Number if not a U.S. Citizen

5. Foreign Student ID# (if applicable)
Applicant Company Name: Western Oregon Advanced Health dba Advanced Health NAIC No. 46-4926946

6. Date of Birth: (MM/DD/YY): ______________ Place of Birth: ______________
   State/Province: ______________ Country: ______________

7. Name of Affiant’s Spouse (if applicable): ______________________

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this ___ day of April, 2019 at 2981 Chirr St. Coos, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this ___ day of April, 2019 by Kathlyn Lautner

who is personally known to me, or

who produced the following identification: Oregon DL

[SEAL]

OFFICIAL STAMP
KATELYN JO COTTEN
NOTARY PUBLIC-OREGON
COMMISSION NO. 941072
MY COMMISSION EXPIRES JULY 26, 2019

©2019 National Association of Insurance Commissioners
Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health dba Advance Health ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact [Executive Program Director] [company’s designated person, position, or department, address and phone].

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Keith Bradford Lowther 1027 Seabird Dr SW Bandon OR 97411
(Painted Full Name and Residence Address) 4-11-2019
(Signature) (Date)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 11 day of April, 2019 by

[SEAL]

KATELYN JO COTTEN
NOTARY PUBLIC-OREGON
COMMISSION NO. 941072
MY COMMISSION EXPIRES JULY 26, 2019

©2019 National Association of Insurance Commissioners
Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 63 of 164
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)

289 LaClair St., Coos Bay, OR 97420

541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Benjamin Middle: John Last: Messner

2. a. Are you a citizen of the United States?

   Yes [X]  No 

   b. Are you a citizen of any other country?

   Yes [ ]  No [X]

   If yes, what country? N/A

3. Affiant’s occupation or profession: Healthcare Administration

4. Affiant’s business address: 289 LaClair St., Coos Bay, OR 97420

   Business telephone: 541-269-4566  Business Email: ben.messner@advancedhealth.com

5. Education and training:

   College/University  City/State  Dates Attended (MM/YY)  Degree Obtained
   Southern Oregon University  Ashland, OR  10/97 - 12/01  B.S.

   Graduate Studies  College/University  City/State  Dates Attended (MM/YY)  Degree Obtained
   Business Administration  University of Phoenix  Phoenix, AZ  10/09 - 05/11  M.B.A.

Other Training: Name  City/State  Dates Attended (MM/YY)  Degree/Certification Obtained

N/A

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 64 of 164
Applicant Company Name: Western Oregon Advanced Health, LLC

NAIC No.: None
FEIN: 46-4926946

6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Presently Chief Executive Officer.

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or offices). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Employer's Name</th>
<th>Address:</th>
<th>City:</th>
<th>State/Province:</th>
<th>Country:</th>
<th>Postal Code</th>
<th>Phone</th>
<th>Offices/Positions Held</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/18 - Present</td>
<td>Western Oregon Advanced Health, LLC</td>
<td>289 LaClair St.</td>
<td>Coos Bay</td>
<td>OR</td>
<td>USA</td>
<td>97420</td>
<td>541-269-7400</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td></td>
<td>Supervisor/Contact:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rajesh Ravuri, MD</td>
</tr>
<tr>
<td>04/15 - Present</td>
<td>Southwest Oregon IPA, Inc.</td>
<td>289 LaClair St.</td>
<td>Coos Bay</td>
<td>OR</td>
<td>USA</td>
<td>97420</td>
<td>541-269-7400</td>
<td>Chief Executive Officer, Director of Quality</td>
</tr>
<tr>
<td></td>
<td>Supervisor/Contact:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jane Gilbert, MD</td>
</tr>
<tr>
<td>07/18 - Present</td>
<td>DOCS Management Services, LLC</td>
<td>289 LaClair St.</td>
<td>Coos Bay</td>
<td>OR</td>
<td>USA</td>
<td>97420</td>
<td>541-269-7400</td>
<td>Member, Board of Managers, COO</td>
</tr>
<tr>
<td></td>
<td>Supervisor/Contact:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jane Gilbert, MD</td>
</tr>
<tr>
<td>07/14 - 04/15</td>
<td>Asante Physician Partners</td>
<td>2620 E. Barnett Rd.</td>
<td>Medford</td>
<td>OR</td>
<td>USA</td>
<td>97504</td>
<td>541-789-2559</td>
<td>Practice Manager</td>
</tr>
<tr>
<td></td>
<td>Supervisor/Contact:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HR, Supervisor no longer there</td>
</tr>
</tbody>
</table>
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Presently Chief Executive Officer.

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient.

- **Samaritan Health Services**
  - **Employer’s Name:** Samaritan Health Services
  - **Address:** 930 SW Abbey St., Newport, OR 97365
  - **Phone:** 541-265-8816
  - **Offices/Positions Held:** Clinic Manager
  - **Type of Business:** Healthcare
  - **Supervisor/Contact:** HR, Supervisor no longer there
  - **Beginning/Ending Dates (MM/YY):** 04/13 - 07/14

- **Accelecare Wound Care Centers**
  - **Employer’s Name:** Accelecare Wound Care Centers
  - **Address:** 2865 Daggett Ave., Klamath Falls, OR 97601
  - **Phone:** N/A
  - **Offices/Positions Held:** Program Director
  - **Type of Business:** Healthcare
  - **Supervisor/Contact:** Business was sold
  - **Beginning/Ending Dates (MM/YY):** 02/09 - 07/11

- **Pacific Sleep and Respiratory Diagnostics**
  - **Employer’s Name:** Pacific Sleep and Respiratory Diagnostics
  - **Address:** 1950 Waite St., North Bend, OR 97459
  - **Phone:** N/A
  - **Offices/Positions Held:** Clinic Manager
  - **Type of Business:** Healthcare
  - **Supervisor/Contact:**
  - **Beginning/Ending Dates (MM/YY):** 01/08 - 02/09

- **Ken Ware Motor Company**
  - **Employer’s Name:** Ken Ware Motor Company
  - **Address:** 1595 Newmark Ave., North Bend, OR 97459
  - **Phone:** N/A
  - **Offices/Positions Held:** Business Manager
  - **Type of Business:** Automotive
  - **Supervisor/Contact:**
  - **Beginning/Ending Dates (MM/YY):** 06/05 - 12/07

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Revised 03/26/18
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Presently Chief Executive Officer.

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY):</th>
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<th>City:</th>
<th>State/Province:</th>
<th>Country:</th>
<th>Postal Code:</th>
<th>Phone:</th>
<th>Offices/Positions Held:</th>
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</thead>
<tbody>
<tr>
<td>01/02 - 01/05</td>
<td>Coos Country Club</td>
<td>93884 Coos Sumner LN.</td>
<td>Coos Bay</td>
<td>OR</td>
<td>USA</td>
<td>97420</td>
<td></td>
<td>General Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>City: Coos Bay</td>
<td>State/Province: OR</td>
<td></td>
<td>Country: USA</td>
<td>Postal Code: 97420</td>
<td>Phone:</td>
<td>General Manager</td>
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<td></td>
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<td>Contacts/Contact:</td>
<td></td>
<td>Type of Business: Golf Course and Country Club</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>N/A (Attended College)</td>
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<td>Employer’s Name:</td>
<td>Contacts/Contact:</td>
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<tr>
<td></td>
<td></td>
<td>Employer’s Name:</td>
<td>Contacts/Contact:</td>
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<td>Contacts/Contact:</td>
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<td>Type of Business: Golf Course and Country Club</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X]
   If any claims were made on the bond, give details: N/A

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X]
   If yes, give details: N/A

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: N/A
   Address: ________________________________
   City: ______ State/Province: ______ Country: ______ Postal Code: _____
   License Type: ______ License #: ______
   Date Issued (MM/YY): ______
   Date Expired (MM/YY): ______
   Reason for Termination: _____________________
   Non-Insurance Regulatory Phone Number (if known): ________________________

   Organization/Issuer of License: ______________________
   Address: ________________________________
   City: ______ State/Province: ______ Country: ______ Postal Code: _____
   License Type: ______ License #: ______
   Date Issued (MM/YY): ______
   Date Expired (MM/YY): ______
   Reason for Termination: _____________________
   Non-Insurance Regulatory Phone Number (if known): ________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes [ ] No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
Applicant Company Name: Western Oregon Advanced Health, LLC

NAIC No. None
FEIN: 46-4926946

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☒

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☒

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☒

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☒

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☒

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

N/A

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. N/A

If any of the stock is pledged or hypothecated in any way, give details. N/A

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes    No X

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

N/A

If any of the shares of stock are pledged or hypothecated in any way, give details.

N/A

14. Have you ever been adjudged a bankrupt?

Yes    No X

If yes, provide details: N/A

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes    No X

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes    No X

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes    No X
Applicant Company Name: Western Oregon Advanced Health, LLC

NAIC No. None

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

N/A

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 15 day of April 2019 at CoosBay OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 15 day of April 2019 by Benjamin Mezner

and:

☐ who is personally known to me, or

☒ who produced the following identification: Oregon DL

Official Stamp
Katelyn Jo Cotten
Notary Public
Printed Notary Name
July 24, 2019
My Commission Expires
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health, LLC, 289 LaClair St, Coos Bay, OR, 97420, 541-269-7400

<table>
<thead>
<tr>
<th>1. Affiant’s Full Name (Initials Not Acceptable): First:</th>
<th>Benjamin</th>
<th>Middle:</th>
<th>John</th>
<th>Last:</th>
<th>Messner</th>
</tr>
</thead>
</table>

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   - Yes [ ]
   - No [x]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s)</th>
<th>Reason (If none, indicate such)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number:

4. Government Identification Number if not a U.S. Citizen:

5. Foreign Student ID# (if applicable):
Applicant Company Name: Western Oregon Advanced Health, LLC

6. Date of Birth: (MM/DD/YY): [Redacted]
   Place of Birth, City: [Redacted]

7. Name of Affiant's Spouse (if applicable): [Redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Date</td>
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<td>Date</td>
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</tr>
<tr>
<td>Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 15 day of April, 2019 at Coos Bay, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 15 day of April, 2019 by Benjamin Messner and:

[ ] who is personally known to me, or

[ ] who produced the following identification: Oregon DL

[OFFICIAL STAMP]

KATELYN JO COTTON
NOTARY PUBLIC-OREGON
COMMISSION NO. 94072
MY COMMISSION EXPIRES JULY 28, 2019

Printed Notary Name

KATELYN COTTON
July 21, 2019

My Commission Expires

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Revised 03/26/18

FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS  
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health, LLC [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Executive Program Director [company's designated person, position, or department, address and phone].

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Benjamin John Messner, 66634 Glasgow LN, North Bend, OR 97459  
(Printed Full Name and Residence Address)

4/15/2019  
(Date)

State of: Oregon  
County of: Clackamas

The foregoing instrument was acknowledged before me this 15 day of April 2019 by Benjamin Messner, and:

☐ who is personally known to me, or

☒ who produced the following identification: Oregon DL

Katelyn Cotten  
Notary Public

Printed Notary Name

July 26, 2019

My Commission Expires

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### BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

**Western Oregon Advanced Health (dba Advanced Health)**

289 LaClair St., Coos Bay, OR 97420

541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. **Affiant's Full Name (Initials Not Acceptable):**
   - First: John
   - Middle: Steven
   - Last: Burles

2. a. **Are you a citizen of the United States?**
   - Yes [x] No

   b. **Are you a citizen of any other country?**
   - Yes [ ] No [x]

   If yes, what country?

3. **Affiant's occupation or profession:**
   - CEO

4. **Affiant's business address:**
   - 1900 Woodland Drive, Coos Bay, OR 97420
   - Business telephone: 541.266.1258
   - Business Email: john.burles@nbmchealth.com

5. **Education and training:**

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon State University</td>
<td>Corvallis, OR</td>
<td>09/65 - 06/69</td>
<td>BSIE</td>
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   **Graduate Studies**

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
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<th>Degree Obtained</th>
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</tr>
</tbody>
</table>

   **Other Training:**

<table>
<thead>
<tr>
<th>Name</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree/Certification Obtained</th>
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</thead>
<tbody>
<tr>
<td>none</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Revised 03/26/18

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)

<table>
<thead>
<tr>
<th>NAIC No.</th>
<th>FEIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>46.4926946</td>
</tr>
</tbody>
</table>

6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

- **North Bend Medical Center Inc**
  - **Beginning/Ending Dates (MM/YY):** 01/13 - Present
  - **Employer’s Name:** North Bend Medical Center Inc
  - **Address:** 1900 Woodland Dr
  - **City:** Coos Bay
  - **State/Province:** OR
  - **Country:** USA
  - **Postal Code:** 97420
  - **Phone:** 541.288.1258
  - **Offices/Positions Held:** CWO
  - **Supervisor/Contact:** Board Chair Dr Shimotakahara

- **Self**
  - **Beginning/Ending Dates (MM/YY):** 06/74 - 12/12
  - **Employer’s Name:** Self
  - **Address:** 2110 N Lake Rd
  - **City:** Lakeside
  - **State/Province:** OR
  - **Country:** USA
  - **Postal Code:** 97449
  - **Phone:** 541.759.3807
  - **Offices/Positions Held:** Owner/CPA
  - **Supervisor/Contact:** None

- **_______**

- **_______**

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Revised 03/26/18
FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [X] No [ ]
   If any claims were made on the bond, give details: none

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X]
   If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: Oregon Board of Accountancy
   Address: 3218 Pringle Rd SE #110
   City: Salem State/Province: OR Country: USA Postal Code: 97302
   License Type: CPA License #: 2615 Date Issued (MM/YY): 05/1975
   Date Expired (MM/YY): current Reason for Termination: N/A
   Non-Insurance Regulatory Phone Number (if known): 503-378-4181

   Organization/Issuer of License:
   Address:
   City: State/Province: Country: Postal Code:
   License Type: License #: Date Issued (MM/YY):
   Date Expired (MM/YY): Reason for Termination:
   Non-Insurance Regulatory Phone Number (if known):

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes [ ] No [X]
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
Applicant Company Name: "\nNAIC No. None \nFEIN: 46-4926946 

--- 

1. c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? 

Yes [ ] No [x] 

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? 

Yes [ ] No [x] 

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? 

Yes [ ] No [x] 

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? 

Yes [ ] No [x] 

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? 

Yes [ ] No [x] 

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? 

Yes [ ] No [x] 

j. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? 

Yes [ ] No [x] 

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate. 

--- 

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or cr
Applicant Company Name: [Western Genus Advanced Health LLC (St. Louis Advanced Health)]

NAIC No. None

FEIN: 46-4926946

office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

none

If any of the stock is pledged or hypothecated in any way, give details. none

13. Do you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [x] No

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

none

If any of the shares of stock are pledged or hypothecated in any way, give details.

none

14. Have you ever been adjudged a bankrupt?

Yes [x] No

If yes, provide details: none

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [x] No

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [x] No

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [x] No
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

N/A

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 05 day of April 2019 at Coos Bay OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

[Signature of Affiant]

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 05 day of April 2019 by John Andrews and:

[ ] who is personally known to me, or

[ ] who produced the following identification: ________________________________

[Stamp]

OFFICIAL STAMP
KELLY LYNN WALTERS
NOTARY PUBLIC-OREGON
COMMISSION NO. 953747
MY COMMISSION EXPIRES AUGUST 21, 2020
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)

289 LaClair St., Coos Bay, OR 97420

541-269-7400

I. Affiant's Full Name (Initials Not Acceptable): First: John Middle: Steven Last: Burles

IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes [ ] No [x]

If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s)</th>
<th>Reason (If none, indicate such)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: [redacted]

4. Government Identification Number if not a U.S. Citizen: [redacted]

5. Foreign Student ID# (if applicable): [redacted]
Applicant Company Name: Western Oregon Advanced Health LLC (the Advanced Health)

NAIC No.: None
FEIN: 46-4926946

6. Date of Birth: (MM/DD/) Place of Birth, City: 
   State/Province Country:

7. Name of Affiant's Spouse (if applicable):

8. List your residences for the last ten (10) years starting with your current address, giving:

   | Beginning/Ending State/ | State/ |
   |-------------------------|
   |                         |
   |                         |
   |                         |
   |                         |

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 05 day of April 2019 at Coos Bay, Oregon, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 30th day of April, 2019 by John Burns, who is personally known to me, or

who produced the following identification:

OFFICIAL STAMP
KELLY LYNN WALTERS
NOTARY PUBLIC-OREGON
COMMISSION NO. 963747
MY COMMISSION EXPIRES AUGUST 21, 2020

Kelly Walters
Printed Notary Name
8/31/2020
My Commission Expires
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS  
(All states except California, Minnesota and Oklahoma)  

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of [company name] with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency (“CRA”) that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Ben Massner, CEO, Advanced Health [company’s designated person, position, or department, address and phone]. 281 LaClair St Coos Bay, OR 97420 541-261-7600

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

John S Burles, 1784 Koos Bay Blvd, Coos Bay, OR 97420

(Signature)

(Printed Full Name and Residence Address)  

State of: Oregon   County of: Coos

(Date)

The foregoing instrument was acknowledged before me this 5th day of April 2019 by John Burles, and:

who is personally known to me, or

who produced the following identification:

OFFICIAL STAMP
KELLY LYNN WALTERS
NOTARY PUBLIC-OREGON
COMMISSION NO. 953747
MY COMMISSION EXPIRES AUGUST 21, 2020

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Revised 03/26/18

FORM 11
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)

289 LaClair St., Coos Bay, OR 97420

541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: Mary  Middle: Lynn  Last: Moore

2. a. Are you a citizen of the United States?
   Yes [ ]  No [ ]

   b. Are you a citizen of any other country?
   Yes [ ]  No [ ]

   If yes, what country? N/A

3. Affiant's occupation or profession: Pediatrician

4. Affiant's business address: 1750 Thompson Rd., Coos Bay, OR 97420

   Business telephone: (541) 269-0333  Business Email: mmoore@bayclinic.net

5. Education and training:

   College/University  City/State  Dates Attended (MM/YY)  Degree Obtained
   Oregon State University  Corvallis, OR  09/78 - 06/81  BS Biology

   Graduate Studies  College/University  City/State  Dates Attended (MM/YY)  Degree Obtained
   Medicine  OHSU  Portland, OR  09/81 - 06/85  MD

   Other Training; Name  City/State  Dates Attended (MM/YY)  Degree/Certification Obtained
   Pediatric Residency  Chicago, IL  07/85 - 10/88  Pediatrics

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Academy of Pediatrics</td>
<td></td>
<td>345 Park Blvd, Tuscar, IL 800-433-9016</td>
<td></td>
</tr>
<tr>
<td>Oregon Pediatric Society</td>
<td></td>
<td>915 SW Barnes Rd, Suite 933 503-334-1581</td>
<td>Portland, OR</td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Employer's Name</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
<th>Phone</th>
<th>Offices/Positions Held</th>
<th>Supervisor/Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/09 - present</td>
<td>Bay Clinic, LLP</td>
<td>1750 Thompson Rd</td>
<td>Coos Bay</td>
<td>OR</td>
<td>US</td>
<td>97401</td>
<td>844-264-0933</td>
<td>Pediatrician</td>
<td>Heather Huntley</td>
</tr>
<tr>
<td>01/2012 - present</td>
<td>Bay Area Hospital, Hope Center</td>
<td>1755 Thompson Rd</td>
<td>Coos Bay</td>
<td>OR</td>
<td>US</td>
<td>97420</td>
<td>541-264-8111</td>
<td>Designated Medical Provider</td>
<td>Ashley Matrini</td>
</tr>
<tr>
<td>04/12 - 03/18</td>
<td>SVOPA</td>
<td>289 Tachuer St</td>
<td>Coos Bay</td>
<td>OR</td>
<td>US</td>
<td>97420</td>
<td>541-264-7400</td>
<td>Board Member</td>
<td>Jane Gilbert</td>
</tr>
<tr>
<td>01/20 - present</td>
<td>Bay Area Hospital</td>
<td>1755 Thompson Rd</td>
<td>Coos Bay</td>
<td>OR</td>
<td>US</td>
<td>97420</td>
<td>541-264-8111</td>
<td>CME Director</td>
<td>Victoria McNeely</td>
</tr>
</tbody>
</table>
09/93 - 01/09  
Employer: Park Ridge Pediatrics

101 S Washington Park Ridge IL US 60068 847-672-6628

Pediatrician  
Contact: Maria Hrycelak, MD
RFA 4690

9. a. Have you ever been in a position which required a fidelity bond?
   
   Yes □ No □

   If any claims were made on the bond, give details: ____________________________

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   
   Yes □ No □

   If yes, give details: ____________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing agency that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: Oregon Medical Board
   Address: 1500 SW 1st Ave
   License Type: MD License #: MD20949 Date Issued (MM/YY): 01/09
   Date Expired (MM/YY): CURRENT Reason for Termination: N/D
   Non-Insurance Regulatory Phone Number (if known): 971-673-2700

   Organization/Issuer of License: State of Illinois
   Address: 100 W Randolph St, El 9
   City: Chicago State/Province: IL Country: US Postal Code: 60601
   License Type: MD License #: ——- Date Issued (MM/YY): 06/89
   Date Expired (MM/YY): 01/89 Reason for Termination: Moved to Oregon
   Non-Insurance Regulatory Phone Number (if known): 

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:
   
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   
   Yes □ No □

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
Applicant Company Name: Western Oregon Advanced Health LLC (Risa Advanced Health)

NAIC No. None
FEIN: 46-4926946

Yes ☐ No ☑
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☑
d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☑
e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☑
f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☑
g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☑
h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☑
i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☑
j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☑

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

None

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

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Revised 03/26/18
FORM 11
Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. **none**

If any of the stock is pledged or hypothecated in any way, give details. **none**

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [ √ ]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities. **none**

If any of the shares of stock are pledged or hypothecated in any way, give details. **none**

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [ √ ]

If yes, provide details: **none**

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [ √ ]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [ √ ]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [ √ ]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. 

none

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this ___ day of April, 2019 at 1:40 p.m. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

✓ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

Mary L. Moore
(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 9 day of April, 2019 by Mary L. Moore, MD

☐ who is personally known to me, or

☐ who produced the following identification:

[Stamp and signature of Notary Public]

My Commission Expires March 02, 2021
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health, LLC (dba Advanced Health)
289 LaClair St, Coos Bay, OR 97420
541-269-7400

1. Affiant’s Full Name (Initials Not Acceptable): First: Mary Middle: Lynn Last: Moore

IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes ☐ No ☐

If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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<tr>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: [Redacted]

5. Foreign Student ID# (if applicable): [Redacted]
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)
NAIC No. None
FEIN: 46-4926946

6. Date of Birth: (MM/DD/YY): _________ Place of Birth, City: _________
State/Province: _________ Country: _________

7. Name of Affiant’s Spouse (if applicable): _________

8. List your residences for the last ten (10) years starting with your current address, giving:

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<tr>
<th>Beginning</th>
<th>Ending</th>
<th>State/Province</th>
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<td>_______</td>
</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this ___ day of ______, 20___ at ___:___ PM. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

______________________________
(Signature of Affiant)

State of: Oregon County of: Coos
The foregoing instrument was acknowledged before me this ___ day of ______, 20___ by _____________________
and:
who is personally known to me, or
who produced the following identification:

______________________________
Notary Public
Printed Notary Name: _____________________
My Commission Expires: March 02, 2021
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS  
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health LLC (the Advanced Health) [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Company's designated person, position, or department, address and phone: 289 Laclede St, Coos Bay, OR 97420 541-269-4560

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Mary Lynn Moore, 93625 Links Lane, Coos Bay, OR 97420

(Printed Full Name and Residence Address) 4-9-19

Signature) (Date)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 9 day of April, 2019 by Mary Lynn Moore, H.D., and:

[ ] who is personally known to me, or

[ ] who produced the following identification:

OFFICIAL STAMP
HEATHER S HUNTLEY
NOTARY PUBLIC-OREGON
COMMISSION NO. 959584
MY COMMISSION EXPRESSES MARCH 02, 2021

©2019 National Association of Insurance Commissioners Revised 03/26/18
FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 93 of 164
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)

289 LaClair St., Coos Bay, OR 97420

541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: William Middle: Wallace Last: Webster

2. a. Are you a citizen of the United States?

   Yes [x] No

   b. Are you a citizen of any other country?

   Yes No [x]

   If yes, what country? N/A

Physician

3. Affiant's occupation or profession:

4. Affiant's business address:

   1900 Woodland Dr

   Business telephone: 5412661522

   Business Email: dr.webster@nbmconline.com

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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<tbody>
<tr>
<td>University of Nebraska Lincoln NE</td>
<td>9/1990-5/1995</td>
<td>BS</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Kansas Med Center Kansas City KS</td>
<td>9/1998-5/2002</td>
<td>MD</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree/Certification Obtained</th>
</tr>
</thead>
</table>

   Kaiser Permanente Oakland CA 7/2002-6/2007 OTO/Head and Neck Surgery

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
Weatam Ortgon Adv•nced Heatlh LL C (dba Advanced Health)

NAIC No. Applicant Company Name: None

FEIN: 46-4926946

6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Academy of Otolaryngology/Head and Neck Surgery</td>
<td>None</td>
<td>1650 Diagnol Rd. Alexandria, VA 22314</td>
<td>703-836-4444</td>
</tr>
<tr>
<td>American Academy of Facial Plastic and Reconstructive Surgery</td>
<td>Patricia Adair</td>
<td>310 S Henry St, Alexandria, VA 22314</td>
<td>703-299-9291</td>
</tr>
<tr>
<td>American Rhinology Society</td>
<td>None</td>
<td>PO Box 269, Oak Ridge, NJ 07438</td>
<td>973-545-2735</td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending Dates (MM/YY): 8/2007 - Current

Employer's Name: self employed

Address: 1900 Woodland Dr

City: Coos Bay

State/Province: OR

Country: USA

Postal Code: 97420

Phone: 541-266-1522

Offices/Positions Held: owner

Type of Business: medical

Supervisor/Contact: none


Employer's Name: Kaiser Permanente

Address: 3600 Broadway

City: Oakland

State/Province: CA

Country: USA

Postal Code: 94611

Phone: 510-752-1000

Offices/Positions Held: resident

Type of Business: medical hospital

Supervisor/Contact: 

Beginning/Ending Dates (MM/YY): n/a - n/a

Employer's Name: n/a

Address: n/a

City: n/a

State/Province: n/a

Country: n/a

Postal Code: n/a

Phone: n/a

Offices/Positions Held: n/a

Type of Business: n/a

Supervisor/Contact: 

Beginning/Ending Dates (MM/YY): n/a - n/a

Employer's Name: n/a

Address: n/a

City: n/a

State/Province: n/a

Country: n/a

Postal Code: n/a

Phone: n/a

Offices/Positions Held: n/a

Type of Business: n/a

Supervisor/Contact: 

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Revised 03/26/18

FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 95 of 164
9. a. Have you ever been in a position which required a fidelity bond?
   
   Yes [ ] No [X]

   If any claims were made on the bond, give details: [ ]

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   
   Yes [ ] No [X]

   If yes, give details: [ ]

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public
    or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held
    in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of
    the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license
    number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that
    are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is
    represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional
    pages if the space provided is insufficient.

   Oregon Medical License

   Organization/Issuer of License: Oregon Medical Board
   Address: 1500 SW 1st Ave Ste. 62
   City: Portland
   State/Province: OR
   Country: USA
   Postal Code: 97201

   License Type: MD
   License #: MD 27455
   Date Issued (MM/YY): 1/1/18
   Date Expired (MM/YY): 12/31/2019
   Reason for Termination: current

   Non-Insurance Regulatory Phone Number (if known): 971-673-2700

   Organization/Issuer of License:
   Address:
   City:
   State/Province:
   Country:
   Postal Code:

   License Type: 
   License #: 
   Date Issued (MM/YY):

   Date Expired (MM/YY): 
   Reason for Termination:

   Non-Insurance Regulatory Phone Number (if known):

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that
    the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public
      administrative, or governmental licensing agency?

      Yes [ ] No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial,
      administrative, regulatory, or disciplinary action?

      Yes [ ] No [X]
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

| Yes | No | X |

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

| Yes | No | X |

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

| Yes | No | X |

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

| Yes | No | X |

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

| Yes | No | X |

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

| Yes | No | X |

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

| Yes | No | X |

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

| Yes | No | X |

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

N/A

**12.** List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
Applicant Company Name: Midwest Oregon Advanced Health LLC (the Advanced Health)  
NAIC No. None  
FEIN: 46-4925946

Office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

none.

If any of the stock is pledged or hypothecated in any way, give details. N/A

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes No x

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

N/A

If any of the shares of stock are pledged or hypothecated in any way, give details.

N/A

14. Have you ever been adjudged a bankrupt?

Yes No x

If yes, provide details: N/A

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes No x

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes No x

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes No x
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. 

N/A

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 05 day of April 2019 at __________________. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Linn
The foregoing instrument was acknowledged before me this 05 day of April 2019 by W. Wallace Webster, and:

X who is personally known to me, or

□ who produced the following identification:

OFFICIAL STAMP
KELLY LYNN WALTERS
NOTARY PUBLIC-OREGON
COMMISSION NO. 953747
MY COMMISSION EXPIRES AUGUST 21, 2020

KELLY LYNN WALTERS
Printed Notary Name
81219020
My Commission Expires August 21, 2020
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Advance Health
289 Laclede St
Coos Bay OR 97420
541-269-7400

1. Affiant’s Full Name (Initials Not Acceptable):
   First: William Middle: Wallace Last: Webster
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [X]
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

   Beginning/Ending
   Date(s) Used (MM/YY) Specify: First, Middle or Last Name Reason (If none, indicate such)
   N/A

   Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Blacked Out]

4. Government Identification Number if not a U.S. Citizen:

5. Foreign Student ID# (if applicable): [Blacked Out]
8. List your residences for the last ten (10) years starting with your current address, giving:

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</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 5th day of April, 2019 at nanc, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Cops

The foregoing instrument was acknowledged before me this 5th day of April, 2019 by

☐ who is personally known to me, or

☐ who produced the following identification:

OFFICIAL STAMP

KELLY LYNN WALTERS
NOTARY PUBLIC, OREGON
COMMISSION NO. 953747
MY COMMISSION EXPIRES AUGUST 21, 2020

Kelly Walters
Printed Notary Name
6/1/2020
My Commission Expires
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health LLC (the "Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact Executive Program Director [company’s designated person, position, or department, address and phone].

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[Signature]

(Printed Full Name and Residence Address)

[Date]

(State of: OREGON County of: COOS)

The foregoing instrument was acknowledged before me this 5th day of April, 2019 by

[Signature]

who is personally known to me, or

☐ who produced the following identification:

[Signature]

(Printed Notary Name)

My Commission Expires

[Signature]

©2019 National Association of Insurance Commissioners

FORM 11

Revised 03/26/18

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 102 of 164
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names):________________________

Western Oregon Advanced Health (dba Advanced Health)

289 LaClair St., Coos Bay, OR 97420

541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: ___________________ Middle: ___________________ Last: ___________________

2. a. Are you a citizen of the United States? 
   Yes [x] No ____________

   b. Are you a citizen of any other country? 
   Yes ____________ No [x]

   If yes, what country? ______________

3. Affiant's occupation or profession: Chief Information Officer

4. Affiant's business address: 289 LaClair St., Coos Bay, OR 07420

   Business telephone: 541-266-6503 Business Email: erica.hubbard@advancedhealth.com

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon Institute of Technology Klamath Falls, OR 09/11-06/15</td>
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<td>09/11-06/15</td>
<td>BS - Health Informatics</td>
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</tbody>
</table>

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<tr>
<th>Graduate Studies</th>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of South Florida, Morsani College of Medicine, Tampa, FL 08/16-08/17</td>
<td>Tampa, FL</td>
<td>08/16-08/17</td>
<td>Master's in Medical Sciences - Health Informatics</td>
<td></td>
</tr>
</tbody>
</table>

Other Training: Name __________________ City/State __________________ Dates Attended (MM/YY) ______________ Degree/Certification obtained: NONE

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 103 of 164
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)  
NAIC No.: None  
FEIN: 46-4926946

6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Chief Information Officer

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

- **Western Oregon Advanced Health (dba Advanced Health)**
  - **Employer's Name:** Western Oregon Advanced Health (dba Advanced Health)
  - **Beginning/Ending Dates:** 07/18 - Present
  - **Address:** 289 LaClair St
  - **City:** Coos Bay
  - **State/Province:** OR
  - **Country:** USA
  - **Postal Code:** 97420
  - **Phone:** 541-269-7400
  - **Type of Business:** CCO
  - **Supervisor/Contact:** Ben Messner

- **Southwest Oregon IPA**
  - **Employer's Name:** Southwest Oregon IPA
  - **Beginning/Ending Dates:** 11/16 - Present
  - **Address:** 289 LaClair St
  - **City:** Coos Bay
  - **State/Province:** OR
  - **Country:** USA
  - **Postal Code:** 97420
  - **Phone:** 541-269-7400
  - **Type of Business:** Independent Practice Association (IPA)
  - **Supervisor/Contact:** Ben Messner

- **Coquille Valley Hospital**
  - **Employer's Name:** Coquille Valley Hospital
  - **Beginning/Ending Dates:** 06/15 - 11/16
  - **Address:** 940 E 5th St
  - **City:** Coquille
  - **State/Province:** OR
  - **Country:** USA
  - **Postal Code:** 97423
  - **Phone:** 541-366-3101
  - **Type of Business:** Hospital
  - **Supervisor/Contact:** Andy Hoyle

- **McKay's Market**
  - **Employer's Name:** McKay's Market
  - **Beginning/Ending Dates:** 6/13 - 12/14
  - **Address:** 418 8th St
  - **City:** Myrtle Point
  - **State/Province:** OR
  - **Country:** USA
  - **Postal Code:** 97458
  - **Phone:** 541-572-2442
  - **Type of Business:** Grocery Store
  - **Supervisor/Contact:** Roxanne Ligons

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 104 of 164
Continuation of Employment Records for the last twenty (20) years

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Employer's Name</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/14-07/14</td>
<td>Roseburg Forest Products</td>
<td>451 S Cedar Point Rd</td>
<td>Coquille</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Country: USA, Postal Code: 97423</td>
<td>Phone: 541-396-2131</td>
<td></td>
</tr>
<tr>
<td>Dryer Feeder</td>
<td></td>
<td>Supervisor/contact: Michael Whittaker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09/12-06/15</td>
<td>Oregon Institute of Technology</td>
<td>3201 Campus Dr</td>
<td>Klamath Falls</td>
<td>OR</td>
</tr>
<tr>
<td>Admissions Office</td>
<td></td>
<td>Country: USA, Postal Code: 97601</td>
<td>Phone: 541-885-1000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supervisor/contact: Carl Thomas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09/12-06/13</td>
<td>Oregon Institute of Technology</td>
<td>3201 Campus Dr</td>
<td>Klamath Falls</td>
<td>OR</td>
</tr>
<tr>
<td>Management Department</td>
<td></td>
<td>Country: USA, Postal Code: 97601</td>
<td>Phone: 541-885-1000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supervisor/contact: Jeff Dickson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09/12-09/13</td>
<td>Oregon Institute of Technology</td>
<td>3201 Campus Dr</td>
<td>Klamath Falls</td>
<td>OR</td>
</tr>
<tr>
<td>Campus Life</td>
<td></td>
<td>Country: USA, Postal Code: 97601</td>
<td>Phone: 541-885-1000</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>Supervisor/contact: Chris Frazier</td>
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</tr>
<tr>
<td>09/12-06/13</td>
<td>Oregon Institute of Technology</td>
<td>3201 Campus Dr</td>
<td>Klamath Falls</td>
<td>OR</td>
</tr>
<tr>
<td>Freshman Officer</td>
<td></td>
<td>Country: USA, Postal Code: 97601</td>
<td>Phone: 541-885-1000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supervisor/contact: Jane Rider</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9. a. Have you ever been in a position which required a fidelity bond?

   Yes [ ] No [X]

   If any claims were made on the bond, give details: NONE

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

   Yes [ ] No [X]

   If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   NONE

   Organization/Issuer of License: __________________________ Address: __________________________

   City: __________________________ State/Province: ____________ Country: __________________________ Postal Code: ____________

   License Type: ____________ License #: ____________ Date Issued (MM/YY): ____________

   Date Expired (MM/YY): ____________ Reason for Termination: __________________________

   Non-Insurance Regulatory Phone Number (if known): __________________________

   Organization/Issuer of License: __________________________ Address: __________________________

   City: __________________________ State/Province: ____________ Country: __________________________ Postal Code: ____________

   License Type: ____________ License #: ____________ Date Issued (MM/YY): ____________

   Date Expired (MM/YY): ____________ Reason for Termination: __________________________

   Non-Insurance Regulatory Phone Number (if known): __________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

      Yes [ ] No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

      [Blank]
Applicant Company Name: [Western Oregon Advanced Health LLC]

NAIC No. None
FEIN: 46-4920946

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☒

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☒

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☒

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☒

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☒

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

NONE

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

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Revised 03/26/18
FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
Applicant Company Name: Western Oregon Advanced Health, LLC (dba Advanced Health)

NAIC No. None
FEIN: 46-4926946

Office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

13. Do you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [x]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

NONE

If any of the shares of stock are pledged or hypothecated in any way, give details.

NONE

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [x]

If yes, provide details: NONE

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [x]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [x]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [x]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

NONE

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 15th day of April 2019 at 9:40 am. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

[Signature of Affiant]

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 15th day of April 2019 by Erica A. Tesdahl-Hubbard and:

[Signature of Affiant]

who is personally known to me, or

☐ who produced the following identification:

OFFICIAL STAMP
SELLIA COVYN
NOTARY PUBLIC-OREGON
COMMISSION NO. 964526
MY COMMISSION EXPIRES JULY 18, 2021

Printed Notary Name

Selita Cohn

Notary Public

My Commission Expires

1-18-2021
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

**Western Oregon Advanced Health (dba Advanced Health)**
289 LaClair St., Coos Bay, OR 97420
541-269-7400

1. Affiant's Full Name (Initials Not Acceptable): First: **Erica** Middle: **Annella** Last: **Tesdahl-Hubbard**
   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?  
   Yes ☑  No ☐
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/93-07/15</td>
<td>Erica Annella Tesdahl</td>
<td>Married in July 2015</td>
</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the biographical affidavit personal supplemental information.

3. Affiant’s Social Security Number: [Redacted]
4. Government Identification Number if not a U.S. Citizen: [Redacted]
5. Foreign Student ID# (if applicable): [Redacted]
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)

Date of Birth: (MM/DD/YY) : 

Place of Birth, City, Country: 

Name of Affiant's Spouse (if applicable): 

List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
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</thead>
<tbody>
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</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 15th day of April, 2019 at 9:40 AM. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

Signature of Affiant

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 15th day of April, 2019 by Erica A. Tesdahl Hubbard and:

X who is personally known to me, or

who produced the following identification:

Notary Public

Printed Notary Name

My Commission Expires
Continuation of residences for the last ten (10) years

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
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</tbody>
</table>

Page 8.1
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact: [Executive Program Director, Advanced Health Co]'s designated person, position, or department, address and phone: [Executive Program Director, Advanced Health Co] 541-269-4576.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Erica Annella Tesdahl-Hubbard 668 7th St Myrtle Point, OR 97458

(Printed Full Name and Residence Address)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 15th day of April, 2019 by Erica A. Tesdahl-Hubbard, and:

[ ] who is personally known to me, or

[ ] who produced the following identification:

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Revised 03/26/18
FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 113 of 164
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 La Clair St., Coos Bay, OR 97420
541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Wendy Middle: Gaile Last: Haack

2. a. Are you a citizen of the United States?  
   Yes [x] No [ ]

   b. Are you a citizen of any other country?  
   Yes [ ] No [x]

   If yes, what country? None

3. Affiant’s occupation or profession: Physician

4. Affiant’s business address: 1750 Thompson Rd., Coos Bay, OR 97420  
   Business telephone: 541-269-0333  
   Business Email: whaack@bayclinic.net

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lane Community College</td>
<td>Eugene, OR</td>
<td>Graduated 06/84</td>
<td>Associate of Science, Nursing</td>
</tr>
<tr>
<td>University of Utah</td>
<td>Salt Lake City, UT</td>
<td>Graduated 12/78</td>
<td>BS, Community Health/Health Education</td>
</tr>
<tr>
<td>Des Moines University</td>
<td>Des Moines, IA</td>
<td>Graduated 05/77</td>
<td>D.O.</td>
</tr>
<tr>
<td>University of Washington</td>
<td>Seattle, WA</td>
<td>Graduated 06/16</td>
<td>Master of Nursing</td>
</tr>
<tr>
<td>Oregon Health Sciences University</td>
<td>Portland, OR</td>
<td>Graduated 06/92</td>
<td>Master of Nursing</td>
</tr>
<tr>
<td>Legacy Emanuel Internal Medicine Training Portland, OR</td>
<td>06/18-2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legacy Emanuel Internal Medicine Training Portland, OR</td>
<td>06/17-06/18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attachment foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 114 of 164
Applicant Company Name: Wealem Oregon Advanced Health LLC (dba Advanced Health)

6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sigma Sigma Phi - National Osteopathic Honor Society</td>
<td>Debbie Taubert</td>
<td>PO Box 4006, Cedar Park, TX 78613</td>
<td>512-528-6874</td>
</tr>
<tr>
<td>American College of Physicians</td>
<td>None</td>
<td>190 North Independence Mall West, Philadelphia, PA 19106</td>
<td>215-351-2400</td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

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<th>Beginning/Ending Dates (MM/YY)</th>
<th>Employer's Name</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Type of Business</th>
<th>Supervisor/Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/10 current</td>
<td>self employed</td>
<td>1750 Thompson Rd</td>
<td>Coos Bay</td>
<td>OR</td>
<td>medical practice</td>
<td>Elana Crane, CEO Bay Clinic</td>
</tr>
<tr>
<td>06/18 current</td>
<td>OHSU Internal Medicine Resident Program, Bay Area Hospital</td>
<td>1775 Thompson Rd</td>
<td>Coos Bay</td>
<td>OR</td>
<td>Medical Resident Program</td>
<td>OHSU - Dr. Desai</td>
</tr>
<tr>
<td>06/18 current</td>
<td>Advanced Health</td>
<td>289 LaClair St</td>
<td>Coos Bay</td>
<td>OR</td>
<td>CCO</td>
<td>Ben Messner, CEO</td>
</tr>
<tr>
<td>2010 current</td>
<td>Bay Area Hospital</td>
<td>1775 Thompson Rd</td>
<td>Coos Bay</td>
<td>OR</td>
<td>Hospital</td>
<td>Bay Clinic</td>
</tr>
<tr>
<td>2018 current</td>
<td>Advanced Health</td>
<td>289 LaClair St</td>
<td>Coos Bay</td>
<td>OR</td>
<td>Board Member</td>
<td></td>
</tr>
</tbody>
</table>

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company:

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

- **Southwest Oregon Independent Practice Association**
  - Beginning/Ending Dates: 2017 - current
  - Employer's Name: Southwest Oregon Independent Practice Association
  - Address: 289 LaClair St
  - City: Coos Bay
  - State/Province: OR
  - Country: USA
  - Postal Code: 97420
  - Phone: 541-269-7400
  - Supervisor/Contact: Board of Directors
  - Position: Ben Messner, CEO

- **Southwest Oregon Community College**
  - Beginning/Ending Dates: 09/15 - current
  - Employer's Name: Southwest Oregon Community College
  - Address: 1988 Newmark Ave
  - City: Coos Bay
  - State/Province: OR
  - Country: USA
  - Postal Code: 97420
  - Phone: 541-888-2525
  - Supervisor/Contact: Human Resources

- **Des Moines University**
  - Beginning/Ending Dates: 2003 - 2005
  - Employer's Name: Des Moines University
  - Address: 3200 Grand Ave
  - City: Des Moines
  - State/Province: IA
  - Country: USA
  - Postal Code: 50312
  - Phone: 515-271-1400
  - Supervisor/Contact: Human Resources

- **Bay Area Hospital**
  - Beginning/Ending Dates: 2015 - 2017
  - Employer's Name: Bay Area Hospital
  - Address: 1775 Thompson Rd
  - City: Coos Bay
  - State/Province: OR
  - Country: USA
  - Postal Code: 97420
  - Phone: 541-269-8111
  - Supervisor/Contact: Chief of Staff
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company:

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

```
<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Employer’s Name</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
<th>Phone</th>
<th>Offices/Positions Held</th>
<th>Supervisor/Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/01 - 08/03</td>
<td>Pacific Heart Associates</td>
<td>300 N Graham St Ste 100</td>
<td>Portland</td>
<td>OR</td>
<td>USA</td>
<td>97227</td>
<td>503-281-0448</td>
<td>Cardiology Nurse Practitioner</td>
<td>human resources</td>
</tr>
<tr>
<td>03/00 - 06/01</td>
<td>Mark Hattenhauer, MD</td>
<td>3181 SW Sam Jackson Park Rd</td>
<td>Portland</td>
<td>OR</td>
<td>USA</td>
<td>97239</td>
<td>503-494-8750</td>
<td>Cardiology Nurse Practitioner</td>
<td>Mark Hattenhauer, MD</td>
</tr>
<tr>
<td>03/97 - 02/00</td>
<td>Morrow County Health District</td>
<td>PO Box 9</td>
<td>Heppner</td>
<td>OR</td>
<td>USA</td>
<td>97836</td>
<td>541-676-9133</td>
<td>Family Nurse Practitioner</td>
<td></td>
</tr>
<tr>
<td>10/98 - 05/99</td>
<td>Pioneer Memorial Nursing Home</td>
<td>564 E Pioneer Memorial Dr</td>
<td>Heppner</td>
<td>OR</td>
<td>USA</td>
<td>97836</td>
<td>541-676-9133</td>
<td>Interim Nursing Home Administrator</td>
<td></td>
</tr>
</tbody>
</table>
```
9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [x]

If any claims were made on the bond, give details: n/a

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ] No [x]

If yes, give details: n/a

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

**Organization/Issuer of License: Oregon Medical Board**

Address: 1500 SW 1st Ave Ste 620

Portland OR USA Postal Code: 97201

License Type: Oregon State Medical License

License #: DO29304

Date Issued (MM/YY): 05/09

Date Expired (MM/YY): current

Reason for Termination: n/a

Non-Insurance Regulatory Phone Number (if known): 971-673-2700

**Organization/Issuer of License: Iowa Board of Nursing**

Address: 400 SW 8th Street, suite B

Des Moines IA USA Postal Code: 50309

License Type: Advanced Nurse Practitioner

License #: __________

Date Issued (MM/YY): 2003

Date Expired (MM/YY): 2006

Reason for Termination: expired

Non-Insurance Regulatory Phone Number (if known): 515-281-3255

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes [ ] No [x]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
Applicant Company Name: _______________

FEIN: __________________________

9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [ ]

If any claims were made on the bond, give details:

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ] No [ ]

If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits). Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: Oregon State Board of Nursing

Address: 17938 SW Upper Boones Ferry Road
City: Portland
State/Province: OR
Country: USA
Postal Code: 97224

License Type: NP-PP Family
License #: 084051608N1
Date Issued (MM/YY): 10/96
Reason for Termination: expired
Non-Insurance Regulatory Phone Number (if known): 971-673-0684

Organization/Issuer of License: Oregon State Board of Nursing

Address: 7938 SW Upper Boones Ferry Road
City: Portland
State/Province: OR
Country: USA
Postal Code: 97224

License Type: RN
License #: 084051608RN
Date Issued (MM/YY): 08/84
Reason for Termination: expired
Non-Insurance Regulatory Phone Number (if known): 971-673-0684

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes [ ] No [ ]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 119 of 164
9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [ ]

If any claims were made on the bond, give details:

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ] No [ ]

If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional-license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Organizations/Issuers of License: Washington State Department of Health

City: Tumwater State/Province: WA Country: USA Postal Code: 98501

Address: 111 Israel Rd SE

License Type: Advanced Registered Nurse Practitioner

License #: AP30004036 Date Issued (MM/YY): 1996

Date Expired (MM/YY): 2004 Reason for Termination: expired

Non-Insurance Regulatory Phone Number (if known): 360-236-4700

Organization/Issuer of License: Montana Board of Nursing

City: Helena State/Province: MT Country: USA Postal Code: 59620

Address: 301 South Park, Suite 401, PO Box 200513

License Type: RN License #: Date Issued (MM/YY): 1992

Date Expired (MM/YY): 1994 Reason for Termination: expired

Non-Insurance Regulatory Phone Number (if known): 406-841-2300

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes [ ] No [ ]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
Applicant Company Name: [Mention Company Name]

NAIC No.: None

FEIN: 46-4926946

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate...
Applicant Company Name: Western Property & Casualty Inc.

NAIC No.: None
FEIN: 46-4926946

Office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. None.

If any of the stock is pledged or hypothecated in any way, give details. n/a.

13. Do you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [X] No

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

n/a

If any of the shares of stock are pledged or hypothecated in any way, give details.

n/a

14. Have you ever been adjudged a bankrupt?

Yes [X] No

If yes, provide details: n/a

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental licensing agency?

Yes [X] No

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [X] No

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [X] No
Applicant Company Name: Wilson Oregon Advanced Health LLC (dba Advanced Health)  
NAIC No. None  
FEIN: 46-4926946

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. n/a

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 11 day of April 2019 at Coos Bay, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon  
County of: Coos

The foregoing instrument was acknowledged before me this 11 day of April 2019 by Wendy Hoack and:

□ who is personally known to me, or

□ who produced the following identification: Oregon DL

OFFICIAL STAMP  
KATELYN JO COTTEN  
NOTARY PUBLIC-OREGON  
COMMISSION NO. 941072  
MY COMMISSION EXPIRES JULY 26, 2019

Katelyn Cotten  
Printed Notary Name

My Commission Expires  

July 26, 2019
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair St., Coos Bay, OR 97420
541-269-7400

1. Affiant's Full Name (Initials Not Acceptable): First: Wendy Middle: Gayle Last: Haack
   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [ ]
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

   Beginning/Ending Name(s) Reason (If none, indicate such)
   Date(s) Used (MM/YY) Specify: First, Middle or Last Name
   1997-10/81 Last Name: Atwood briefly married

   __________ __________ __________

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: ____________________________

4. Government Identification Number if not a U.S. Citizen: ____________________________

5. Foreign Student ID# (If applicable): ____________________________

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 124 of 164
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)

6. Date of Birth: (MM/DD/YY) [Redacted], [Redacted] of Birth, City [Redacted]
   State/Province: [Redacted] County [Redacted]

7. Name of Affiant’s Spouse (if applicable): [Redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
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</tr>
<tr>
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<td>[Redacted]</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 11th day of April, 2019 at Coos Bay, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 11th day of April, 2019 by Wendy Haeck and:

☐ who is personally known to me, or
☐ who produced the following identification: Oregon DL

[Notary Public Seal]

Katelyn Cotton
Notary Public
Printed Notary Name
July 21st, 2019
My Commission Expires July 21, 2019

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Revised 03/26/18
Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health LLC (dba Advanced Health) [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Wendy Haack
1345 Shenwood Dr, Milwaukie, OR 97267
(Printed Full Name and Residence Address)
4/11/19
(Date)

State of Oregon County of Clackamas

The foregoing instrument was acknowledged before me this 11 day of April, 2019 by Wendy Haack, and:

☐ who is personally known to me, or

☐ who produced the following identification:

Oregon Driver's License

Katelyn Jo Cotten
Katelyn Jo Cotten
Notary Public
Printed Notary Name
My Commission Expires July 30, 2019

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 126 of 164
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair St., Coos Bay, OR 97420
541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Kenton Middle: Douglas Last: Sharman

2. a. Are you a citizen of the United States?
   Yes [X] No [ ]

   b. Are you a citizen of any other country?
   Yes [ ] No [X]
   If yes, what country?

3. Affiant’s occupation or profession: physician

4. Affiant’s business address: Western Oregon Medical College, Coos Bay OR 97420
   Business telephone: 541-267-5151
   Business Email: dr.sharman@womchealth.com

5. Education and training:

   College/University: UC Davis
   City/State: Davis CA
   Dates Attended (MM/YY): 09/72 - 06/76
   Degree Obtained: BSc

   Graduate Studies: Albany Medical College
   City/State: Albany NY
   Dates Attended (MM/YY): 09/76 - 06/80
   Degree/Certification Obtained: MD

Other Training: Name [NA]
   City/State
   Dates Attended (MM/YY)
   Degree/Certification Obtained

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Suppilmentary Information.
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
</table>
| Oregon Medical Association  | 1140 SW 6th Pl.
|                             | 503.691.8000 |
| Oregon Academy of Family Medicine | 1716 NE 42
|                             | Ave 503.528.0961 |
| American Academy of FM.     | P.O. Box 11210
|                             | Springfield, OR 97477 |

7. Present or proposed position with the Applicant Company: Chief Medical Officer

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

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<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Employer’s Name:</th>
<th>Address:</th>
<th>City:</th>
<th>State/Province:</th>
<th>Country:</th>
<th>Postal Code:</th>
<th>Phone:</th>
<th>Offices/Positions Held:</th>
<th>Type of Business:</th>
<th>Supervisor/Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/01/19 to present</td>
<td>North Bend Medical Center</td>
<td>1900 Woodlark Dr.</td>
<td>Coos Bay</td>
<td>OR</td>
<td>USA</td>
<td>97420</td>
<td>541-269-5151</td>
<td>Physician</td>
<td>Medical Service</td>
<td>N/A</td>
</tr>
<tr>
<td>12/26/19 to present</td>
<td>Advanced Health</td>
<td>289 LaClair St.</td>
<td>Coos Bay</td>
<td>OR</td>
<td>USA</td>
<td>97420</td>
<td>541-269-4000</td>
<td>CEO</td>
<td>Medical Director</td>
<td>Ben Messner, CEO</td>
</tr>
<tr>
<td>02/19 to present</td>
<td>NHA Southwest Oregon IPA</td>
<td>289 LaClair St.</td>
<td>Coos Bay</td>
<td>OR</td>
<td>USA</td>
<td>97420</td>
<td>541-269-4000</td>
<td>Medical Director</td>
<td>IPA</td>
<td>Ben Messner, CEO</td>
</tr>
</tbody>
</table>

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
9. a. Have you ever been in a position which required a fidelity bond?
   - Yes [x] No [ ]
   - If any claims were made on the bond, give details: N/A

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   - Yes [ ] No [x]
   - If yes, give details: N/A

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: Oregon Medical Board
   Address: 1500 SW First Ave Suite 620
   City: Portland State/Province: OR Country: USA Postal Code: 97201
   License Type: MD License #: 12419 Date Issued (MM/YY): 09/04
   Date Expired (MM/YY): 12/19 Reason for Termination: N/A
   Non-Insurance Regulatory Phone Number (if known): 971-673-2700

   Organization/Issuer of License: N/A
   Address: _____________________________
   City: _____________________________ State/Province: ______ _ Country: __________ Postal Code: ___________
   License Type: ___________________________
   License #: ___________________________
   Date Issued (MM/YY): ___________
   Date Expired (MM/YY): ___________
   Reason for Termination: ___________________________
   Non-Insurance Regulatory Phone Number (if known): ___________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   - Yes [ ] No [x]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
 Applicant Company Name: "Western Oregon Advanced Health, L.P. (the Advanced Health)."
 NAIC No. None
 FEIN: 46-4926946

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
   Yes ☐ No ☒

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
   Yes ☐ No ☒

e. Plead guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
   Yes ☐ No ☒

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
   Yes ☐ No ☒

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
   Yes ☐ No ☒

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
   Yes ☐ No ☒

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
   Yes ☐ No ☒

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
   Yes ☐ No ☒

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

NAIC

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

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Revised 03/26/18

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 130 of 164
Applicant Company Name: w.s1em
NAIC No. None
FEIN: 46-4926946

Office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. N/A

If any of the stock is pledged or hypothecated in any way, give details. N/A

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [ X ]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities. N/A

If any of the shares of stock are pledged or hypothecated in any way, give details. N/A

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [ X ]

If yes, provide details: N/A

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental licensing agency?

Yes [ ] No [ X ]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [ X ]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [ X ]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

N/A

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 12th day of April 2019 at 3:51 pm. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief. I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 12th day of April 2019 by Kent Sharrman, M.D., and:

☐ who is personally known to me, or

☐ who produced the following identification:
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair St., Coos Bay, OR 97420
541-269-7400

1. Affiant's Full Name (Initials Not Acceptable): First: Kenton Middle: Douglas Last: Sherman
   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [X]
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

   Beginning/Ending Date(s) Used (MM/YY) Name(s) Specify: First, Middle or Last Name Reason (If none, indicate such)
   [ ]

   Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number:

4. Government Identification Number if not a U.S. Citizen:

5. Foreign Student ID# (if applicable):

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 133 of 164
Applicant Company Name: Western Oregon Advanced Health LLC [the Advanced Health]
FEIN: 46-4926946
None

6. Date of Birth: (MM YY)
State/Province:
Place of Birth: City:
Country:

7. Name of Affiant's Spouse (if applicable):

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 14th day of April, 2019 at 1550. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

✓ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon
County of: Coos

The foregoing instrument was acknowledged before me this 14th day of April, 2019 by Kent Sherman, M.D.

who is personally known to me, or

who produced the following identification:

SELIA COLVIN
NOTARY PUBLIC-OREGON
COMMISSION NO. 964526
MY COMMISSION EXPRESSES JULY 15, 2021

Selia Colvin
Printed Notary Name
07-18-2021
My Commission Expires

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 134 of 164
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact [company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[Signature]

State of: Oregon   County of: [ ]

The foregoing instrument was acknowledged before me this [ ]th day of [ ] , [ ] by [ ], and:

[ ] who is personally known to me, or

[ ] who produced the following identification:

[Stamp]

Notary Public

[Stamp]

My Commission Expires [ ]
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair St., Coos Bay, OR 97420
541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Brian  Middle: Jones  Last: Moore

2. a. Are you a citizen of the United States?
   Yes [X]  No [ ]
   b. Are you a citizen of any other country?
   Yes [ ]  No [X]
   If yes, what country?

3. Affiant’s occupation or profession: President/CEO

4. Affiant’s business address: 1775 Thompson Road, Coos Bay, OR 97420
   Business telephone: 541-269-8124  Business Email: brian.moore@bayareahospital.org

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Central Florida, Orlando, FL</td>
<td>Orlando, FL</td>
<td>12/2001</td>
<td>MBA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Adventist University, Collegedale, TN</td>
<td>Collegedale, TN</td>
<td>05/1999</td>
<td>BBA</td>
</tr>
</tbody>
</table>

   Other Training: Name  City/State  Dates Attended (MM/YY)  Degree/Certification Obtained
   none

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
Applicant Company Name: __________ _
NAIC No. _________ _
FEIN: 454925945

6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>American College of Healthcare Executives</td>
<td></td>
<td>300 S. Riverside Plaza, Suite 1900, Chicago, IL 60606-6698</td>
<td>(312) 424-2800</td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Equity Member/Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Employer's Name</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Type of Business</th>
<th>Supervisor/Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/13 - 11/17</td>
<td>Centura Health - St. Mary Medical Center</td>
<td>1008 Minnequa Ave.</td>
<td>Pueblo</td>
<td>CO</td>
<td>Hospital</td>
<td>Margaret Sabin</td>
</tr>
<tr>
<td>05/12 - 06/13</td>
<td>Centura Health - South Denver Group</td>
<td>9395 Crown Crest Blvd</td>
<td>Parker</td>
<td>CO</td>
<td>Hospital</td>
<td>Randy Haffner</td>
</tr>
<tr>
<td>01/10 - 05/12</td>
<td>Centura Health - Parker Adventist Hospital</td>
<td>2350 Meadows Blvd</td>
<td>Castle Rock</td>
<td>CO</td>
<td>Hospital</td>
<td>Randy Haffner</td>
</tr>
<tr>
<td>12/01 - 07/03</td>
<td>Centura Health - Parker Adventist Hospital</td>
<td>9395 Crown Crest Blvd</td>
<td>Parker</td>
<td>CO</td>
<td>Hospital</td>
<td>Terry Forde</td>
</tr>
</tbody>
</table>
9. a. Have you ever been in a position which required a fidelity bond?
   Yes ☐ No ☒
   If any claims were made on the bond, give details: N/A

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes ☐ No ☒
   If yes, give details: N/A

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.
   none

   Organization/Issuer of License: __________________________
   Address: __________________________
   City: __________________________ State/Province: __________________________
   Country: __________________________ Postal Code: __________________________
   License Type: __________________________ License #: __________________________
   Date Issued (MM/YY): __________________________
   Date Expired (MM/YY): __________________________
   Reason for Termination: __________________________
   Non-Insurance Regulatory Phone Number (if known): __________________________

   Organization/Issuer of License: __________________________
   Address: __________________________
   City: __________________________ State/Province: __________________________
   Country: __________________________ Postal Code: __________________________
   License Type: __________________________ License #: __________________________
   Date Issued (MM/YY): __________________________
   Date Expired (MM/YY): __________________________
   Reason for Termination: __________________________
   Non-Insurance Regulatory Phone Number (if known): __________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes ☐ No ☒
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
      Yes ☐ No ☒
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [x]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [x]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [x]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [x]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [x]
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)  
NAIC No: None  
FEIN: 46-4926656

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. 

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 11th day of April 2019 at 3:45 p.m. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

☐ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon  County of: Coos  
The foregoing instrument was acknowledged before me this 11th day of April 2019 by Brian Moore.

☐ who is personally known to me, or

☒ who produced the following identification: Oregon Driver License

OFFICIAL STAMP  
DINA LASKEY  
NOTARY PUBLIC-OREGON  
COMMISSION NO. 946519  
MY COMMISSION EXPIRES JANUARY 24, 2020

My Commission Expires

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 141 of 164
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair Street, Coos Bay, OR 97420
541-269-7400

1. Affiant’s Full Name (Initials Not Acceptable): First: Brian Middle: Jones Last: Moore

IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes [ ] No [X] If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

| Beginning/Ending Name(s) Reason (If none, indicate such) |
| Date(s) Used (MM/YY) Specify: First, Middle or Last Name |

| N/A |

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the biographical affidavit personal supplemental information.

3. Affiant’s Social Security Number: 

4. Government Identification Number if not a U.S. Citizen: 

5. Foreign Student ID# (if applicable): 

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Revised 03/26/18
FORM 11

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)

| FEIN: | 45-4926946 |

6. Date of Birth: (MM/DD/YY):
   State/Province: __________ Place of Birth, City: __________ Country: __________

7. Name of Affiant's Spouse (if applicable): __________

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 11th day of April, 2019 at 3:45 p.m. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

☐ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

Brian Moore
(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 11th day of April, 2019 by Brian Moore and:

☐ who is personally known to me, or

☐ who produced the following identification: Oregon Driver License

[Notary Seal]

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attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 143 of 164
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS
(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health LLC (dba Advanced Health) for licensure or a permit to organize with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative of Company or of any business entities affiliated with Company for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact [company's designated person, position, or department, address and phone].

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Brian Moore, 2024 Cedar St, North Bend, OR 97459

(Signature) 4/11/2019

(Printed Full Name and Residence Address) (Date)

State of: Oregon  County of: Coos

The foregoing instrument was acknowledged before me this 17th day of April, 2019 by Brian Moore, and:

[ ] who is personally known to me, or

[ ] who produced the following identification:

Oregon Driver License

Dina M. Laskey

Notary Public

Printed Notary Name

January 24, 2020

My Commission Expires

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Revised 03/26/18

FORM 11
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).__________________________

Western Oregon Advanced Health, LLC (d/b/a Advanced Health)

289 LaClair Street

Coos Bay, OR 97420

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) If ANSWER IS “NO” OR “NONE,” SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Jeffrey Middle: Michael Last: Lang

2. a. Are you a citizen of the United States?
   Yes [X] No [ ]

   b. Are you a citizen of any other country?
   Yes [ ] No [X]

   If yes, what country?

3. Affiant’s occupation or profession: Hospital CEO

4. Affiant’s business address: 940 E 5th Street, Coquille, OR 97423
   Business telephone: (541) 396-1050
   Business Email: jeffl@cvhospital.org

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mankato State University, Mankato, MN</td>
<td>09/91 to 03/94</td>
<td>BS</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Graduate Studies</th>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of St. Thomas, Minneapolis, MN</td>
<td>08/01 to 12/03</td>
<td>MBA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Training: Name

   None

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Revised 03/26/18

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officeships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

**Coquille Valley Hospital District**

- **Employer's Name:** Coquille Valley Hospital District
- **Address:** 940 E 5th Street
- **City:** Coquille
- **State/Province:** OR
- **Country:** USA
- **Postal Code:** 97423
- **Phone:** (541) 365-1050
- **Offices/Positions Held:** CEO
- **Type of Business:** Hospital
- **Supervisor/Contact:** Dan Mast, Board Chair

**LifePoint Health**

- **Employer's Name:** LifePoint Health
- **Address:** 330 Seven Springs Way
- **City:** Brentwood
- **State/Province:** TN
- **Country:** USA
- **Postal Code:** 37027
- **Phone:** (615) 920-7000
- **Offices/Positions Held:** UPHS Portage CEO
- **Type of Business:** Hospital
- **Supervisor/Contact:** Victor Giovanetti

**United Hospital District**

- **Employer's Name:** United Hospital District
- **Address:** 515 S. Moore Street
- **City:** Blue Earth
- **State/Province:** MN
- **Country:** USA
- **Postal Code:** 56013
- **Phone:** (507) 526-3273
- **Offices/Positions Held:** CEO
- **Type of Business:** Hospital
- **Supervisor/Contact:** Melanie Humburg, Board Chair

**Milbank Area Hospital/Avera Health**

- **Employer's Name:** Milbank Area Hospital/Avera Health
- **Address:** 901 E Virgil Ave
- **City:** Milbank
- **State/Province:** SD
- **Country:** USA
- **Postal Code:** 57252
- **Phone:** (605) 432-4538
- **Offices/Positions Held:** Administrator/CEO
- **Type of Business:** Hospital
- **Supervisor/Contact:** Curt Hohman

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Revised 03/26/18

FORM 11
9. a. Have you ever been in a position which required a fidelity bond?
   
   Yes [ ] No [X]  
   
   If any claims were made on the bond, give details: N/A

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   
   Yes [ ] No [X]  
   
   If yes, give details: N/A

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-354-195” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: Michigan Department of Licensing and Regulatory Affairs
City: Lansing State/Province: MI Country: USA Postal Code: 48909
License Type: Nursing Home Administrator License #: 4801014131 Date Issued (MM/YY): 02/16
Date Expired (MM/YY): 10/18 Reason for Termination: Lapsed

Non-Insurance Regulatory Phone Number (if known): 

Organization/Issuer of License: Minnesota Board Of Nursing Home Examiners
City: Minneapolis State/Province: MN Country: USA Postal Code: 55414
License Type: NHA License #: 03214 Date Issued (MM/YY): 10/1996
Date Expired (MM/YY): 07/2004 Reason for Termination: Chose to not renew

Non-Insurance Regulatory Phone Number (if known): 

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
   
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   
   Yes [ ] No [X]  
   
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11) 147 of 164
Western Oregon Advanced Health, LLC (d/b/a Advanced Health)  
FEIN # 46-4926946  

Supplemental Information:  
Biographical Affidavit  
Jeffrey M. Lang, Director  

Employment Continued:  

Employer’s Name: Deer River Healthcare Center  
Address: 1002 Comstock Drive City: Deer River State/Province: MN  
Country: USA Postal Code: 56636 Phone: _______ Offices/Positions Held: Chief Operating Officer  
Type of Business: Hospital Supervisor/Contact: Jeff Stampohar, CEO  

Beginning/Ending Dates (MM/YY): 04/98 – 03/2002  
Employer’s Name: Arrowhead Senior Living Community  
Address: 1201 8th street S City: Virginia State/Province: MN  
Country: USA Postal Code: 55792 Phone: _______ Offices/Positions Held: Administrator/CEO  
Type of Business: Long Term Care Facility Supervisor/Contact: Robert Sundberg  

Professional Licenses Continued:  

Organization/Issuer of License: South Dakota State Board of Examiners for Nursing Facility Administrators  
Address: 307 S. Menlo Avenue, PO Box 632  
City: Sioux Falls State/Province: South Dakota Country: USA Postal Code: 57101  
License Type: Nursing Home Administrator License #:________________________  
Date Issued (MM/YY): 01/2001  
Date Expired (MM/YY): 12/2006 Reason for Termination: Chose to not renew
Yes [ ] No [X]  
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?  
Yes [ ] No [X]  
d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?  
Yes [ ] No [X]  
e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?  
Yes [ ] No [X]  
f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?  
Yes [ ] No [X]  
g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?  
Yes [ ] No [X]  
h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?  
Yes [ ] No [X]  
i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?  
Yes [ ] No [X]  
j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?  
Yes [ ] No [X]  

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.  

List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

None

If any of the stock is pledged or hypothecated in any way, give details. N/A

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities. N/A

If any of the shares of stock are pledged or hypothecated in any way, give details. N/A

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details: N/A

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

N/A

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 4th day of April 2019 at 11:49 AM. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

jeffrey m lang

(Signature of Affiant)

State of: Oregon County of: Clackamas

The foregoing instrument was acknowledged before me this 15th day of April 2019 by Jeffrey Lang.

☑ who is personally known to me, or

☐ who produced the following identification:

Cortney Nowotny

Notary Public

Printed Notary Name

My Commission Expires 04/22/2022

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Revised 03/26/18

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
BIOGRAphICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair St, Coos Bay, OR 97420
541-269-4566 541-269-7400

1. Affiant’s Full Name (Initials Not Acceptable): First: Jeffrey Middle: Michael Last: Lang
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [x ]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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<tbody>
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<td>N/A</td>
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</table>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: [Redacted]

5. Foreign Student ID# (if applicable): [Redacted]
Applicant Company Name: Coquille Valley Hospital District

NAIC No. None

FEIN: 46-4926946

6. Date of Birth: (MM/DD/YY): 
   State/Province: 
   Place of Birth, City: 
   Country: 

7. Name of Affiant’s Spouse (if applicable): 

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
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<tbody>
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</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 4 day of April, 2019 at 11:54 AM, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

jeffrey m lang 
Digitally signed by jeffrey m lang
Date: 2019.04.04 11:56:44 -07'00'

(Signature of Affiant)

State of: Oregon County of: Leos

The foregoing instrument was acknowledged before me this 15 day of April, 2019 by Jeffrey Lang,

and:

☐ who is personally known to me, or

☐ who produced the following identification:

[Stamp] Cortney Nowotny
Notary Public
Commission No. 973477
Expires April 22, 2022

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS  

(All states except California, Minnesota and Oklahoma)  

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of  

Advanced Health  

[company name] ("Company") for licensure or a permit to organize  

(“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a  

consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a  

department of insurance in any state where Company pursues an Application during the term of your functioning as, or  

seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of  

Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is  

required by a department of insurance reviewing any Application. Background Reports requested pursuant to your  

authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of  

living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background  
as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and  

Authorization will be maintained as confidential.  

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces  

them. You may also request more information about the nature and scope of such reports by submitting a written request to  

Company. To obtain contact information regarding CRA or to submit a written request for more information, contact  

Executive Program Director [company’s designated person, position, or department, address and phone]  

Advanced Health, 289 LaChar St, Coos Bay, OR 97420  

341-264-4560  

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”  

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above  

Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any  

state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing  
such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning  
me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing  
Background Reports, except records that have been erased or expunged in accordance with law.  

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that  

Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background  

Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of  
(i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the  
date of my signature below.  

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.  

Jeffrey M. Lamy, 812 Lakeshore Dr, Coos Bay, OR 97420  

(Printed Full Name and Residence Address)  

4/15/2019  

(Date)  

State of: Oregon  

County of: Coos  

The foregoing instrument was acknowledged before me this 15 day of April, 2019 by  

Jeffrey Lamy  

[Signature], and:  

☑ who is personally known to me, or  

☐ who produced the following identification:  

©2019 National Association of Insurance Commissioners
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)
289 LaClair St., Coos Bay, OR 97420
541-269-7400

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: RAJESH Middle: _ Last: RAVURU

2. a. Are you a citizen of the United States?
   Yes [X] No _

   b. Are you a citizen of any other country?
   Yes _ No [X]
   If yes, what country?

3. Affiant’s occupation or profession: PHYSICIAN

4. Affiant’s business address: NBMc, 1900 WOODLAND DR, COOS BAY, OR 97420
   Business telephone: 541-267-5151 Business Email: dr.ravuru@nbmchealth.com

5. Education and training: MD

   College/University City/State Dates Attended (MM/YY) Degree Obtained
   Andhra Medical College, AP, India Aug 1990 - Aug 1996 MD

   Graduate Studies College/University City/State Dates Attended (MM/YY) Degree Obtained
   N/A

   Other Training: Name City/State Dates Attended (MM/YY) Degree/Certification Obtained
   Resurrection Med Ctr, Pom Melrose Park, IL 06/99 - 06/00 Medical Internship
   Resurrection Med Ctr, Pom Melrose Park, IL 06/00 - 06/02 Medical Residency

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA</td>
<td></td>
<td>830 N. Wabash Ave, Ste 3900</td>
<td>312-464-4782</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chicago, IL 60611</td>
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<tr>
<td>ACP</td>
<td></td>
<td>140 N Independence Blvd West</td>
<td>215-351-2600</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Philadelphia, PA 19106</td>
<td></td>
</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: Chairman, Board of Directors

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending Dates (MM/YY): 7/24 - Present

Employer's Name: NBMC (North Bend Medical Center)
Address: 1900 Woodland Dr
City: Coos Bay
State/Province: OR
Postal Code: 97420
Phone: 541-265-5151
Office/Positions Held: MD
Type of Business: Medical Practice
Supervisor/Contact: CEO

Beginning/Ending Dates (MM/YY): 7/10 - Present

Employer's Name: BAH (Bay Area Hospital)
Address: 1775 Thompson Rd
City: Coos Bay
State/Province: OR
Postal Code: 97420
Phone: 541-269-8011
Office/Positions Held: Hospitalist
Type of Business: Hospital
Supervisor/Contact: CNO

Beginning/Ending Dates (MM/YY): 2006 - Present

Employer's Name: Avamere Hean-N-Gide
Address: 2625 Coos Bay Blvd
City: Coos Bay
State/Province: OR
Postal Code: 97420
Phone: 541-267-2161
Office/Positions Held: Medical Director
Type of Business: SNF
Supervisor/Contact: CEO

Beginning/Ending Dates (MM/YY): 2006 - Present

Employer's Name: Pacific Hospice & Home Health
Address: 155 S 4th St #3
City: Coos Bay
State/Province: OR
Postal Code: 97420
Phone: 541-266-7005
Office/Positions Held: Medical Director
Type of Business: Home Health/Hospice
Supervisor/Contact: CEO
9. a. Have you ever been in a position which required a fidelity bond?
   
   Yes [ ] No [X]

   If any claims were made on the bond, give details: [N/A]

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   
   Yes [ ] No [X]

   If yes, give details: [N/A]

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: Oregon Medical Board
   Address: 1500 SW 1st Ave, Ste. 620
   City: Portland State/Province: OR Country: USA Postal Code: 97201
   License Type: MD License #: MD23904 Date Issued (MM/YY): 07/02
   Date Expired (MM/YY): current Reason for Termination: N/A
   Non-Insurance Regulatory Phone Number (if known): 971-613-2700

   Organization/Issuer of License: State of Illinois
   Address: 100 West Randolph, 9th Floor
   City: Chicago State/Province: IL Country: USA Postal Code: 60601
   License Type: MD License #: 125-040085 Date Issued (MM/YY): 1999
   Date Expired (MM/YY): 06/02 Reason for Termination: expired, relocated
   Non-Insurance Regulatory Phone Number (if known): 1-800-560-6420

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

   Yes [ ] No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
RFA 4690

Applicant Company Name: Western Oregon Advanced Health, LLC (Oha Advanced Health)  
NAIC No. None  
FEIN: 46-4926646

9. a. Have you ever been in a position which required a fidelity bond?
   Yes ☐ No ☐

   If any claims were made on the bond, give details:

   ____________________________________________

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes ☐ No ☐

   If yes, give details:

   ____________________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: Andhra Pradesh Medical Council  
   Address: Prof. Dr. NTR University of Health Sciences
   City: Guntur  
   State/Province: Andhra Pradesh  
   Country: India  
   Postal Code: 520008
   License Type: Medical  
   License #: 39831  
   Date Issued (MM/YY): 1999
   Date Expired (MM/YY):  
   Reason for Termination: Relocated
   Non-Insurance Regulatory Phone Number (if known):

   Organization/Issuer of License:
   City:  
   State/Province:  
   Country:  
   Postal Code:
   License Type:  
   License #:  
   Date Issued (MM/YY):
   Date Expired (MM/YY):  
   Reason for Termination:
   Non-Insurance Regulatory Phone Number (if known):

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes ☐ No ☐
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
  Yes ☐ No ☑

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
  Yes ☐ No ☑

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
  Yes ☐ No ☑

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
  Yes ☐ No ☑

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
  Yes ☐ No ☑

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
  Yes ☐ No ☑

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
  Yes ☐ No ☑

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
  Yes ☐ No ☑

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

Other Licensure Action 07/2013, Completed correction. Restored 01/2016.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

N/A

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 15th day of April 2019 at Coos Bay, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 15th day of April, 2019 by Rajesh Rawuri and:

☐ who is personally known to me, or

☐ who produced the following identification: Oregon DL

[Stamp] Katelyn Jo Cotten
Notary Public
Printed Notary Name
July 26, 2019
My Commission Expires July 25, 2023
RFA 4690

Applicant Company Name: Western Oregon Advanced Health LLC (dba Advanced Health)

NAIC No. None

FEIN: 46-4928946

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Western Oregon Advanced Health (dba Advanced Health)

289 LaClair St, Coos Bay, OR 97420

541-280 541-269-7400

1. Affiant's Full Name (initials Not Acceptable): First: RAJESH Middle: --- Last: RAVUR

IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes [X] No

If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number:

4. Government Identification Number if not a U.S. Citizen:

5. Foreign Student ID# (if applicable):

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Revised 03/26/18

FORM 11
Applicant Company Name: Western Oregon Advanced Health LLC (the Advanced Health)

NAIC No. None

FEIN: 46-4926946

6. Date of Birth: (MM/DD/YY): [Redacted]
   Place of Birth, City: [Redacted]
   State/Province: [Redacted]
   Country: [Redacted]

7. Name of Affiant’s Spouse (if applicable): [Redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
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<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
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</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 15 day of April, 2019 at Coos Bay, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 15 day of April, 2019 by Rajesh Ravuri and:

☐ who is personally known to me, or

☐ who produced the following identification: Oregon DL

OFFICIAL STAMP
KATELYN JO COTTEN
NOTARY PUBLIC-OREGON
COMMISSION NO. 941072
MY COMMISSION EXPIRES JULY 26, 2019

Kathlyn Cottin
Notary Public
Printed Notary Name
July 26, 2019
My Commission Expires

©2019 National Association of Insurance Commissioners

Attachment 12 - NAIC Biographical Certificates (NAIC Form 11)
DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS  
(All states except California, Minnesota and Oklahoma) 

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Western Oregon Advanced Health LLC (dba Advanced Health) [company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiliate") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact [name of person, position, or department, address and phone level] Advanced Health 267 Laclede St, Coos Bay, Or 97422 541-269-4560. 

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiliate of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiliate. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[Signature]

(Printed Full Name and Residence Address)

[Date]

State of: Oregon County of: Coos

The foregoing instrument was acknowledged before me this 15 day of April, 2019 by Rajesh Ravuri, and:

☐ who is personally known to me, or

☒ who produced the following identification: Oregon DL

[Stamp]

[Signature]

[Printed Notary Name]

[Notary Public]

[My Commission Expires]

[Revised Date]

[Form Number]

©2019 National Association of Insurance Commissioners
UCAA Proforma Financial Statements
Health

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with first full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
7. For additional guidance, refer to the FAQ's on the UCAA webpage.

Enter the Applicant Company Name:

Year 1:

Year 2:

Year 3:

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets"

Updated: January 1, 2019
© 2019 National Association of Insurance Commissioners
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

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<tbody>
<tr>
<td><strong>Admitted Assets</strong></td>
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</tr>
<tr>
<td>1. Bonds</td>
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<tr>
<td>2. Stocks (Preferred &amp; Common)</td>
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<tr>
<td>3. Real Estate/Mortgage Loans on Real Estate</td>
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<tr>
<td>4. Cash/Cash Equivalents/Short-Term Investments</td>
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<tr>
<td>5. Other Invested Assets</td>
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<tr>
<td>6. Aggregate Write-Ins For Invested Assets</td>
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<td>7. All Other Assets</td>
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<td>8. Total Admitted Assets (1+2+3+4+5+6+7)</td>
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<td><strong>Liabilities</strong></td>
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<td>9. Losses (Unpaid Claims for Accident and Health Policies)</td>
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<td>10. Unpaid Claims Adjustment Expenses</td>
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<td>11. Aggregate Health Policy Reserves</td>
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<td>12. Ceded Reinsurance Premiums Payable</td>
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# Health Company

## Pro Forma Statutory Profit & Loss Statement (Nationwide)

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*Itemize in Assumptions*
# Pro Forma Statutory Cash Flow Statement

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(Health Company)
(Health Company)
Analysis of Operations by Line of Business
(In Whole Numbers)

Nationwide
Year 1

<table>
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<tr>
<th></th>
<th>Total</th>
<th>Comprehensive (Hospital &amp; Medical)</th>
<th>Medicare Supplement</th>
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</tr>
<tr>
<td>2. Change in Unearned Premium Reserves and Reserve For Rate Credit</td>
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<tr>
<td>3. Fee for service</td>
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<td>4. Risk revenue</td>
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<td>5. Aggregate Write-Ins for Other Health Care Related Revenues</td>
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<tr>
<td>6. Aggregate Write-Ins for Other Non-Health Care Related Revenues</td>
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<td>7. Total Revenues (1+2+3+4+5+6)</td>
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<tr>
<td>8. Hospital/Medical Benefits</td>
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<td>9. Other Professional Services</td>
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<td>10. Prescription Drugs</td>
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Nationwide

**Year 2**

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<td>2.</td>
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<td>Fee for service</td>
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<td>Aggregate Write-Ins for Other Health Care Related Revenues</td>
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Nationwide

Year 3

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(Health Company)
Analysis of Operations by Line of Business
(In Whole Numbers)

Nationwide
Year 1

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Nationwide

Year 2

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The Nationwide page will include projected premiums by line of business for a three year period for those states in which the company is already licensed and authorized to write business and three years of projected premiums by line of business for those states in which the company is applying to be licensed and authorized. The projected premiums for the lines of business in those states in which the company is authorized to write will be pulled in from the Authorized Premium By LOB tab and the projected premiums for the lines of business in which the Applicant Company is applying for will pull in from the individual state tabs.

### Nationwide

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List all of the relevant assumptions used to create the proformas.

Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

Advanced Health (AH)
Financial Plan of Operation notes
Proforma financials 2020-2022

Best Estimate Members
AH believes its best member estimate is to continue with its current population which includes 100% of the Coos County Medicaid population and approximately 50% of the Curry County Medicaid population. AH’s established provider and partner relationships are the basis for confidence in maintaining the current eligible population. However, should population become available in Curry County, AH is prepared to take them on as well.

Minimum Estimate Members
The estimated member population necessary to continue with established care services and meet the new CCO 2.0 requirements would be approximately 87% of AH’s best member estimates. This amount would allow for a narrow margin in 2020, and gradually increasing margins in future years of the proforma.

Maximum Estimate Members
AH believes a reasonable and potential maximum member estimate would include 100% of the estimated Medicaid population in both Coos and Curry Counties. AH’s current provider network provides services to the entire populations of Coos and Curry Counties.

Should a progressive initiative change the way healthcare is delivered in Oregon, AH could scale its’ operations to provide managed care to all residents of both counties.

General Proforma Financial Estimates
1. Revenue estimates were prepared from OHA issued member and rate estimates.
2. Advanced Health will continue to employ a standard strategy of spending roughly 89% of its revenue on health services, 9% to 10% on management and administration, and the remainder going to the margin to increase reserves and reward equity partners. Fluctuations in these percentages will vary slightly as social determinants of health and health related service programs are further expanded inside the CCO.
3. Services and Risks will be transferred to privileged providers through capitation agreements in 2020 as follows:
   A. Physical and mental health services through Southwest Oregon IPA, Inc.
   B. Dental services through Advantage Dental
   C. Non-emergent transportation services through HMW Services, Inc. DBA Bay Cities Brokerage
   D. Addiction Treatment through Adapt
4. General administrative expenses, including wages, have been increased year over year using a 3% inflation factor.
5. Investments will be in high grade bonds. Investment income was estimated to be approximately 3% of the average annual bond investment balances.
6. Claims expenses have been broken out on these proformas, but the expenses are incurred within a privileged provider.
Enter the Applicant Company Name:

Year 1: 

Year 2: 

Year 3: 

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets"

Updated: January 1, 2019
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### Pro Forma Statutory Balance Sheet (Nationwide)

#### (In Whole Numbers)

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#### Liabilities

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Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

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*Itemize in Assumptions
## Pro Forma Statutory Cash Flow Statement

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(Health Company)

Analysis of Operations by Line of Business

(In Whole Numbers)

Nationwide

Year 1

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<td>Net Premium Income</td>
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<td>2.</td>
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<td>5.</td>
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Nationwide
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**Nationwide**

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<td>21.</td>
<td>Total Underwriting Deductions (14 to 20)</td>
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<td>Net underwriting Gain or (Loss) (7-21)</td>
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</table>
The Nationwide page will include projected premiums by line of business for a three year period for those states in which the company is already licensed and authorized to write business and three years of projected premiums by line of business for those states in which the company is applying to be licensed and authorized. The projected premiums for the lines of business in those states in which the company is authorized to write will be pulled in from the Authorized Premium By LOB tab and the projected premiums for the lines of business in which the Applicant Company is applying for will pull in from the individual state tabs.

### Nationwide

#### Year 1

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(Health Company)  
**Authorized Premium by LOB (Aggregate) - Planned Premium Volume by Line of Business**  
*(Amounts in Whole Dollars)*

### Nationwide Year 1

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</table>
List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

Advanced Health (AH)
Financial Plan of Operation notes
Proforma financials 2020-2022

Best Estimate Members
AH believes its best member estimate is to continue with its current population which includes 100% of the Coos County Medicaid population and approximately 50% of the Curry County Medicaid population. AH’s established provider and partner relationships are the basis for confidence in maintaining the current eligible population. However, should population become available in Curry County, AH is prepared to take them on as well.

Minimum Estimate Members
The estimated member population necessary to continue with established care services and meet the new CCO 2.0 requirements would be approximately 87% of AH’s best member estimates. This amount would allow for a narrow margin in 2020, and gradually increasing margins in future years of the proforma.

Maximum Estimate Members
AH believes a reasonable and potential maximum member estimate would include 100% of the estimated Medicaid population in both Coos and Curry Counties. AH’s current provider network provides services to the entire populations of Coos and Curry Counties.

Should a progressive initiative change the way healthcare is delivered in Oregon, AH could scale its’ operations to provide managed care to all residents of both counties.

General Proforma Financial Estimates
1. Revenue estimates were prepared from OHA issued member and rate estimates.
2. Advanced Health will continue to employ a standard strategy of spending roughly 89% of its revenue on health services, 9% to 10% on management and administration, and the remainder going to the margin to increase reserves and reward equity partners. Fluctuations in these percentages will vary slightly as social determinants of health and health related service programs are further expanded inside the CCO.
3. Services and Risks will be transferred to privileged providers through capitation agreements in 2020 as follows:
   A. Physical and mental health services through Southwest Oregon IPA, Inc.
   B. Dental services through Advantage Dental
   C. Non-emergent transportation services through HMW Services, Inc. DBA Bay Cities Brokerage
   D. Addiction Treatment through Adapt
4. General administrative expenses, including wages, have been increased year over year using a 3% inflation factor.
5. Investments will be in high grade bonds. Investment income was estimated to be approximately 3% of the average annual bond investment balances.
6. Claims expenses have been broken out on these proformas, but the expenses are incurred within a privileged provider.
Instructions

1. Enter the Applicant Company Name below.
2. Enter the first full year of the proformas (start with first full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
7. For additional guidance, refer to the FAQ's on the UCAA webpage.

Enter the Applicant Company Name: ____________________________________________________

Year 1: ____________________________________________________________________________

Year 2: ____________________________________________________________________________

Year 3: ____________________________________________________________________________

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets"

Updated: January 1, 2019
© 2019 National Association of Insurance Commissioners
### Pro Forma Statutory Balance Sheet (Nationwide)

#### (In Whole Numbers)

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*Itemize in Assumptions
### Pro Forma Statutory Cash Flow Statement

**(In Whole Numbers)**

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(Health Company)
Analysis of Operations by Line of Business
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Nationwide
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Nationwide

**Year 2**

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8. Hospital/Medical Benefits | - |
9. Other Professional Services | - |
10. Prescription Drugs | - |
11. Aggregate Write-Ins For Other Hospital and Medical | - |

**12. Subtotal (8+9+10+11)** | - | - |

13. Net Reinsurance Recoveries | - | - |

**14. Total Hospital and Medical (12-13)** | - | XXX |

15. Non-Health Claims (Net) | - | XXX |
16. Claims Adjustment Expenses | - |
17. General Administrative Expenses | - |
18. Increase in Reserves for Accident and Health Contracts | - |
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Nationwide

**Year 3**

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(Health Company)
Analysis of Operations by Line of Business
(In Whole Numbers)

Nationwide
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21. Total Underwriting Deductions (14 to 20)
22. Net underwriting Gain or (Loss) (7-21)

Nationwide

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**Aggregate write in for Other Expenses**

**Total Underwriting Deductions (14 to 20)**

**Net underwriting Gain or (Loss) (7-21)**
### Increase in Reserves for Life Contracts

### Aggregate write in for Other Expenses

### Total Underwriting Deductions (14 to 20)

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<td>18.</td>
<td>Increase in Reserves for Accident and Health Contracts</td>
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<td>Total Underwriting Deductions (14 to 20)</td>
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-
The Nationwide page will include projected premiums by line of business for a three year period for those states in which the company is already licensed and authorized to write business and three years of projected premiums by line of business for those states in which the company is applying to be licensed and authorized. The projected premiums for the lines of business in those states in which the company is authorized to write will be pulled in from the Authorized Premium By LOB tab and the projected premiums for the lines of business in which the Applicant Company is applying for will pull in from the individual state tabs.

### Nationwide

#### Year 1

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<th>Description</th>
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(Health Company)
Authorized Premium by LOB (Aggregate) - Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

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UCAA Proforma Financial Statements
Assumptions

List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

Advanced Health (AH)
Financial Plan of Operation notes
Proforma financials 2020-2022

Best Estimate Members
AH believes its best member estimate is to continue with its current population which includes 100% of the Coos County Medicaid population and approximately 50% of the Curry County Medicaid population. AH’s established provider and partner relationships are the basis for confidence in maintaining the current eligible population. However, should population become available in Curry County, AH is prepared to take them on as well.

Minimum Estimate Members
The estimated member population necessary to continue with established care services and meet the new CCO 2.0 requirements would be approximately 87% of AH’s best member estimates. This amount would allow for a narrow margin in 2020, and gradually increasing margins in future years of the proforma.

Maximum Estimate Members
AH believes a reasonable and potential maximum member estimate would include 100% of the estimated Medicaid population in both Coos and Curry Counties. AH’s current provider network provides services to the entire populations of Coos and Curry Counties.

Should a progressive initiative change the way healthcare is delivered in Oregon, AH could scale its’ operations to provide managed care to all residents of both counties.

General Proforma Financial Estimates

1. Revenue estimates were prepared from OHA issued member and rate estimates.
2. Advanced Health will continue to employ a standard strategy of spending roughly 89% of its revenue on health services, 9% to 10% on management and administration, and the remainder going to the margin to increase reserves and reward equity partners. Fluctuations in these percentages will vary slightly as social determinants of health and health related service programs are further expanded inside the CCO.
3. Services and Risks will be transferred to privileged providers through capitation agreements in 2020 as follows:
   A. Physical and mental health services through Southwest Oregon IPA, Inc.
   B. Dental services through Advantage Dental
   C. Non-emergent transportation services through HMW Services, Inc. DBA Bay Cities Brokerage
   D. Addiction Treatment through Adapt
4. General administrative expenses, including wages, have been increased year over year using a 3% inflation factor.
5. Investments will be in high grade bonds. Investment income was estimated to be approximately 3% of the average annual bond investment balances.
6. Claims expenses have been broken out on these proformas, but the expenses are incurred within a privileged provider.
APPLICANT NAME: Western Oregon Advanced Health, LLC dba Advanced Health

INTRODUCTION: This supplemental report is to be completed in conjunction with the NAIC UCAA Form 13H.

CALENDAR YEAR: 2020
CALENDAR YEAR START DATE: 1/1/2020
CALENDAR YEAR ENDING DATE: 12/31/2020

INSTRUCTIONS:

1. Prior to completing the UCAA Form 13H, first complete the "Company Assumptions" tab of this template. Identify the geographic area (Desired Locations) and the corresponding Member Months to be used in developing the Pro Formas.

2. The UCAA Balance Sheet and P and L input data comes directly from Form 13H. Three separate Form 13H templates will need to be created and submitted with the application for each of the three scenarios described in the Reference Document. Copy and paste the values from Form 13H to the tabs in this template for each of the three scenarios.

3. Calculate and input the Authorized Control Level (ACL) into "UCAA Balance Sheet" Line 25 for each of the three years and each of the three scenarios (9 ACLs in total) as instructed in the Reference Document.

4. Enter your information in the yellow cells only. All other cells are calculated.
Western Oregon Advanced Health, LLC dba Advanced Health (Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide) (In Whole Numbers)

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**Administrative Costs:**

What is the total "fixed" administrative costs for CCO Operations?

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What is the variable administrative costs for CCO Operations on a Per Member Per Month basis:

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(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
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Western Oregon Advanced Health, LLC dba Advanced Health  
(Health Company)  
Pro Forma Statutory Balance Sheet (Nationwide)  
(In Whole Numbers)  

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<td>13. Amounts Due To Parents, Subsidiaries &amp; Affiliates</td>
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<td>25. Liabilities and Surplus (Lines 17+24)</td>
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COPY VALUES OVER FROM FORM 13H (BE MM)  
BASED ON BE MM IDENTIFIED IN ASSUMPTIONS  

Based on BE MM identified in assumptions.
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Western Oregon Advanced Health, LLC dba Advanced Health
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

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(Health Company)  
Pro Forma Statutory Balance Sheet (Nationwide)  
(In Whole Numbers)

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<td>2. Stocks (Preferred &amp; Common)</td>
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#### (In Whole Numbers)

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<td>33. Dividends to Stockholders</td>
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Western Oregon Advanced Health, LLC dba Advanced Health (Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide) (In Whole Numbers)

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<td>Avg Mo Unpd Clms to Res &amp; Surpl</td>
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<td>Avg Mo Unpd Clms to Res &amp; Surpl (excl minimum C&amp;S)</td>
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<td>Test #2 Combined Ratio plus 4 pts</td>
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<td>Additional underwriting expense</td>
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<td>Test #3 Combined Ratio plus 6 pts</td>
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<td>C&amp;S after test #3</td>
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### Admitted Assets

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### Liabilities

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<td>Ceded Reinsurance Premiums Payable</td>
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<td>Amounts Due To Parents, Subsidiaries &amp; Affiliates</td>
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<td>Total Liabilities (Lines 9+10+11+12+13+14+15+16)</td>
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### Capital and Surplus

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### Risk-Based Capital Analysis

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Based on Max MM identified in assumptions
COPY VALUES OVER FROM FORM 13H (MAX MM)
Western Oregon Advanced Health, LLC dba Advanced Health
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

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<td>13. Subtotal (Lines 9+10+11+12)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

| Less:                       |      |      |      |
| 14. Net Reinsurance Recoveries |      |      |      |
| 15. Total Hospital and Medical (Lines 13 - 14) |      |      |      |
| 17. Claims Adjustment Expenses |    |      |      |
| 18. General Administrative Expenses |      |      |      |
| 19. Increase In Reserves For Life & Accident And Health Contacts |      |      |      |
| 20. Total underwriting deductions (Lines 15+16+17+18+19) |      |      |      |
| 21. Net underwriting gain or loss (Lines 8 - 20) |      |      |      |
| 22. Net investment income earned |      |      |      |
| 23. Net investment gains (losses) (Lines 22 + 26) |      |      |      |
| 24. Aggregate write in for other income or expenses |      |      |      |
| 25. Federal and Foreign Income Taxes Incurred |      |      |      |
| 26. Net Realized Capital Gains (Losses) |      |      |      |
| 27. Less Capital Gains Tax  |      |      |      |
| 29. Capital and Surplus Prior Reporting Year |      |      |      |
| 30. Net Income or (Loss)    |      |      |      |
| 31. Capital Changes         |      |      |      |
| 32. Other Increases (Decreases) |    |      |      |
| 33. Dividends to Stockholders |      |      |      |
| 34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33) |      |      |      |

| Ratio Analysis              |      |      |      |
| 35 Medical Loss Ratio (as calculated for insurers) (Line 15 / Line 2) |      |      |      |
| 36 Claim Expense Ratio (Line 17 / Line 2) |      |      |      |
| 37 Administrative Expense Ratio (Line 18 / Line 2) |      |      |      |
| 38 Combined Medical Loss and Expense Ratio (Line 35 + Line 37) |      |      |      |
| 39 Ratio of Total Revenue to Capital and Surplus (Line 8 / Line 34) |      |      |      |
| 44 Authorized Control Level Risk-Based Capital |      |      |      |
| 45 Risk Based Capital Calculation |      |      |      |

COPY VALUES OVER FROM FORM 13H (MAX MM)
BASED ON MAX MM IDENTIFIED IN ASSUMPTIONS

RFA4690-Advanced Health-Att12-UCAA Supplemental Financial Analysis-REDACTED  Page 1 of 1  UCAA P and L (MAX MM)
## Financial Statement Data

<table>
<thead>
<tr>
<th>Financial Statement Data</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Admitted Assets</td>
<td>Bal 8</td>
<td>-</td>
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</tr>
<tr>
<td>Real Estate/Mortgage Loans on Real Estate</td>
<td>Bal 3</td>
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<tr>
<td>Stocks (Preferred &amp; Common)</td>
<td>Bal 2</td>
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</tr>
<tr>
<td>Restricted Reserve</td>
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<td>-</td>
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<tr>
<td>Liquid assets</td>
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<td>-</td>
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<tr>
<td>Aggregate Health Policy Reserves</td>
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<td>-</td>
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<tr>
<td>Ceded Reinsurance Premiums Payable</td>
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<td>-</td>
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<tr>
<td>Total claims reserves</td>
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</tr>
<tr>
<td>Total liabilities</td>
<td>Bal 17</td>
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<tr>
<td>Total capital and surplus</td>
<td>Bal 24</td>
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<tr>
<td>Capitol stock</td>
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<td>Surplus</td>
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<tr>
<td>Net Premium Income</td>
<td>P and L 2</td>
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<tr>
<td>Total Hospital and Medical (net)</td>
<td>P and L 15</td>
<td>-</td>
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<tr>
<td>Divided by months in year</td>
<td>12</td>
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<tr>
<td>Avg claims expense</td>
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</table>

## Ratio/Financial Analysis

<table>
<thead>
<tr>
<th>Ratio/Financial Analysis</th>
<th>2020</th>
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<th>2022</th>
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<tbody>
<tr>
<td>Primary Restricted Reserve</td>
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<tr>
<td>Secondary Restricted Reserve</td>
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<tr>
<td>Total Restricted Reserve Requirement</td>
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<tr>
<td>Minimum Net Worth Required</td>
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<tr>
<td>Working capital</td>
<td>given</td>
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<tr>
<td>Total Initial Required Net Worth</td>
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<td>500,000</td>
<td>500,000</td>
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<td>Liabilities to Liquid Assets</td>
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<tr>
<td>Capital &amp; Surplus/Liabilities</td>
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<td>#DIV/0!</td>
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<tr>
<td>Avg Mo Unpd Clms to Res &amp; Surpl</td>
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<tr>
<td>Avg Mo Unpd Clms to Res &amp; Surpl (excl minimum C&amp;S)</td>
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<td>#DIV/0!</td>
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## Stress Test Results

<table>
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<th>2020</th>
<th>2021</th>
<th>2022</th>
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<tbody>
<tr>
<td>Combined Medical Loss and Expense Ratio</td>
<td>P and L 38</td>
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<tr>
<td>Net underwriting gain or loss</td>
<td>P and L 21</td>
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<td>-</td>
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<tr>
<td>Test #1 Combined Ratio plus 2 pts</td>
<td>calculated</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
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<tr>
<td>Additional underwriting expense</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Test #2 Combined Ratio plus 4 pts</td>
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<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Additional underwriting expense</td>
<td>calculated</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Test #3 Combined Ratio plus 6 pts</td>
<td>calculated</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Additional underwriting expense</td>
<td>calculated</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>C&amp;S after test #1</td>
<td>calculated</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>C&amp;S after test #2</td>
<td>calculated</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>C&amp;S after test #3</td>
<td>calculated</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Please provide any text, tables, numbers, etc. that you would like to communicate but were not able to include within the preceding reports.

Advanced Health (AH)
Financial Plan of Operation notes
Proforma financials 2020-2022

**Best Estimate Members**

**Minimum Estimate Members**

**Maximum Estimate Members**

**General Proforma Financial Estimates**

...
Keith Lowther CFO
Attachment 13 — Attestations

Applicant Name: Western Oregon Advanced Health, LLC abn Advanced Health

Authorizing Signature: ____________________________
Printed Name: Benjamin J. Messner

Instructions: For each attestation, Applicant will check “yes,” or “no.” A “yes” answer is normal, and an explanation will be furnished if Applicant’s response is “no”. Applicant must respond to all attestations. If an attestation has more than one question and Applicant’s answer is “no” to any question, check “no” and provide an explanation.

These attestations must be signed by a representative of Applicant.

Unless a particular item is expressly effective at the time of Application, each attestation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract. Each section of attestations refers to a questionnaire in an Attachment, which may furnish background and related questions.

A. General Questions Attestations (Attachment 6)

1. Contract
   a. Is Applicant willing to enter into a Contract for 2020 in the form of Appendix B?
      □ Yes  □ No
      If “no” please provide explanation: ________________________________

   b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?
      □ Yes  □ No
      If “no” please provide explanation: ________________________________

2. Subcontracts
   a. Is Applicant willing to hold written agreements with Subcontractors that clearly describe the scope of work?
      □ Yes  □ No
      If “no” please provide explanation: ________________________________

   b. Is Applicant willing to provide to OHA an inventory of all work described in this Contract that is delegated or subcontracted and identify the entity performing the work?
      □ Yes  □ No
      If “no” please provide explanation: ________________________________

   c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?
      □ Yes  □ No
      If “no” please provide explanation: ________________________________
3. **Third Party Liability and Personal Injury Lien**
   
a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member’s Third Party Liability?
   
   Yes ☑ No □
   
   If “no” please provide explanation: ____________________________________________________

   
b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?
   
   Yes ☑ No □
   
   If “no” please provide explanation: ____________________________________________________

   
c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?
   
   Yes ☑ No □
   
   If “no” please provide explanation: ____________________________________________________

   
d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?
   
   Yes ☑ No □
   
   If “no” please provide explanation: ____________________________________________________

4. **Oversight and Governance**
   
a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or control stake?
   
   Yes ☑ No □
   
   If “no” please provide explanation: ____________________________________________________
B. Provider Participation and Operations Attestations (Attachment 7)

1. General Questions
   a. Will Applicant have an individual accountable for each of the operational functions described below?
      - 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
      - Behavioral Health (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
      - Quality Performance Improvement
      - Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
      - Traditional Health Workers Liaison
         □ Yes  □ No
         If “no” please provide explanation: ________________________________

   b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?
      □ Yes  □ No
      If “no” please provide explanation: ________________________________

   c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages 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?
      □ Yes  □ No
      If “no” please provide explanation: ________________________________
d. Will Applicant (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?

☑ Yes    ☐ No

If “no” please provide explanation: _______________________________


e. Will Applicant 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?

☐ Yes    ☐ No

If “no” please provide explanation: _______________________________


f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

☑ Yes    ☐ No

If “no” please provide explanation: _______________________________


g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

☑ Yes    ☐ No

If “no” please provide explanation: _______________________________


h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

☑ Yes    ☐ No

If “no” please provide explanation: _______________________________


i. Will Applicant’s contracts for administrative and management services contain the OHA required Contract provisions?

☑ Yes    ☐ No

If “no” please provide explanation: _______________________________
j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health 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.

☐ Yes ☐ No

If “no” please provide explanation: ________________________________

k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

☐ Yes ☐ No

If “no” please provide explanation: ________________________________

l. Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

☐ Yes ☐ No

If “no” please provide explanation: ________________________________

m. Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?

☐ Yes ☐ No

If “no” please provide explanation: ________________________________

n. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority’s comprehensive local plan for the delivery of mental health services (ORS 430.630)?

☐ Yes ☐ No

If “no” please provide explanation: ________________________________
o. Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO’s Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?

- Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;
- The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;
- Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;
- Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and
- Addressing diverse patient populations in a linguistically diverse and culturally competent manner.

☐ Yes    ☐ No

If “no” please provide explanation: ____________________________________________________________

p. Will Applicant establish policies, procedures, and standards that:

- Ensure 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 Members;
- Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;
- Communicate and enforce compliance by Providers with medical necessity determinations; and
- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.

☑ Yes    ☐ No

If “no” please provide explanation: ____________________________________________________________
q. Will Applicant 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?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

r. Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

s. Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].

☐ Yes  ☐ No

If “no” please provide explanation:

u. Is it true that 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, subsidiaries, or entities with an ownership stake, 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?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________
2. **Network Adequacy**
   
a. Is Applicant willing to monitor and evaluate the adequacy of its Provider Network?
   - Yes  [ ] No
   
   If “no” please provide explanation: ____________________________________________________

b. Is Applicant willing to remedy any deficiencies in its Provider Network within a specified timeframe when deficiencies are identified?
   - Yes  [ ] No
   
   If “no” please provide explanation: ____________________________________________________

   c. Is Applicant willing to report on its Provider Network in a format and frequency specified by OHA?
   - Yes  [ ] No
   
   If “no” please provide explanation: ____________________________________________________

   d. Is Applicant willing to collect data to validate that its Members are able to access care within time and distance requirements?
   - Yes  [ ] No
   
   If “no” please provide explanation: ____________________________________________________

   e. Is Applicant willing to collect data to validate that its Members are able to make appointments within the required timeframes?
   - Yes  [ ] No
   
   If “no” please provide explanation: ____________________________________________________

   f. Is Applicant willing to collect data to validate that its Members are able to access care within the required timeframes?
   - Yes  [ ] No

   g. Is Applicant willing to arrange for Covered Services to be provided by Non-Participating Providers if the services are not timely available within Applicant’s Provider Network?
   - Yes  [ ] No

3. **Fraud, Waste and Abuse Compliance**
   
a. Is Applicant willing to designate a Compliance Officer to oversee activities related to the prevention and detection of Fraud, Waste and Abuse?
   - Yes  [ ] No
   
   If “no” please provide explanation: ____________________________________________________
b. Is Applicant willing to send two representatives, including the Applicant’s designated Compliance Officer and another member of the senior executive team to attend a mandatory Compliance Conference on May 30, 2019?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

C. Value-Based Payment (VBP) Attestations (Attachment 8)

1. Have you reviewed the VBP Policy Requirements set forth in the VBP Questionnaire?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

2. Have you reviewed the VBP reference documents linked to the VBP Questionnaire?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

3. Can you implement and report on VBP as defined by VBP Questionnaire and the Health Care Payment Learning and Action Network’s (LAN’s) “Alternative Payment Model Framework White Paper Refreshed 2017” (https://hcp-lan.org/apm-refresh-white-paper/) and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

4. Will you begin CCO 2.0 – January 2020 – with at least 20% of your projected annual payments to your Providers under contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network’s (LAN’s) “Alternative Payment Model Framework White Paper Refreshed 2017” (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

5. Do you permit OHA to publish your VBP data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to your care delivery areas, Patient-Centered Primary Care Home (PCPCH) payments, and other information about VBPs required by this RFA? (OHA does not intend to publish specific payments amounts from an Applicant to a specific provider.)

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________
6. Do you agree to develop mitigation plans for adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and Members with complex health care needs, as well as populations at the intersections of these groups) and to report on these plans to OHA annually?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________

7. Do you agree to the requirements for VBP targets, care delivery areas and PCPCH clinics for years 2020 through 2024, as set forth in the VBP Questionnaire?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________

8. Do you agree to the requirements for VBP data reporting for years 2020 through 2024, as set forth in the VBP Questionnaire?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________

9. Should OHA contract with one or more other CCOs serving Members in the same geographical area, will you participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO’s VBP Provider contracts for common Provider types and specialties?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________

10. If, after the discussion described in the previous question, OHA informs you of the Provider types and specialties for which the performance measures apply, will you incorporate all selected measures into applicable Provider contracts?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________
D. Health Information Technology (HIT) Attestations (Attachment 9)

1. HIT Roadmap
   a. Does Applicant agree to participate in an interview/demonstration and deliver an HIT Roadmap with any refinements/adjustments agreed to with OHA during Readiness Review, for OHA approval?
      ☑ Yes ☐ No
      If “no” please provide explanation: ________________________________

   b. Does Applicant agree to provide an annual HIT Roadmap update for OHA approval to include status/progress on CCO-identified milestones, and any adjustments to the HIT Roadmap; as well as participate in an annual interview with OHA?
      ☑ Yes ☐ No
      If “no” please provide explanation: ________________________________

2. HIT Partnership
   a. Does Applicant agree to participate in the HIT Commons beginning 2020, including agreeing to do all of the following:
      • Maintaining an active, signed HIT Commons MOU and adhering to its terms,
      • Paying annual HIT Commons assessments, and
      • Serving, if elected, on the HIT Commons Governance Board or one of its committees?
      ☑ Yes ☐ No
      If “no” please provide explanation: ________________________________

   b. Does Applicant agree to participate in OHA’s HIT Advisory Group, (HITAG), at least once annually?
      ☑ Yes ☐ No
      If “no” please provide explanation: ________________________________

3. Support for EHR Adoption
   a. Will Applicant support EHR adoption for its contracted physical health Providers?
      ☑ Yes ☐ No
      If “no” please provide explanation: ________________________________
b. Will Applicant support EHR adoption for its contracted Behavioral Health Providers?
   ☑ Yes  ☐ No
   If “no” please provide explanation: _____________________________________________

c. Will Applicant support EHR adoption for its contracted oral health Providers?
   ☑ Yes  ☐ No
   If “no” please provide explanation: _____________________________________________

d. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted physical health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?
   ☑ Yes  ☐ No
   If “no” please provide explanation: _____________________________________________

e. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted Behavioral Health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?
   ☑ Yes  ☐ No
   If “no” please provide explanation: _____________________________________________

f. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted oral health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?
   ☑ Yes  ☐ No
   If “no” please provide explanation: _____________________________________________

g. Will Applicant report to the state annually on which EHR(s) each of its contracted physical health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.
   ☑ Yes  ☐ No
   If “no” please provide explanation: _____________________________________________
**RFA 4690 - Advanced Health**

**h.** Will Applicant report to the state annually on which EHR(s) each of its contracted Behavioral Health Providers are using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See [https://chpl.healthit.gov/](https://chpl.healthit.gov/) and [https://www.healthit.gov/topic/certification-ehrs/2015-edition](https://www.healthit.gov/topic/certification-ehrs/2015-edition) for more information about Certified EHR Technology.

- [ ] Yes
- [ ] No

*If “no” please provide explanation: ________________________________

**i.** Will Applicant report to the state annually on which EHR(s) each of its contracted oral health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See [https://chpl.healthit.gov/](https://chpl.healthit.gov/) and [https://www.healthit.gov/topic/certification-ehrs/2015-edition](https://www.healthit.gov/topic/certification-ehrs/2015-edition) for more information about Certified EHR Technology.

- [ ] Yes
- [ ] No

*If “no” please provide explanation: ________________________________

**4. Support for HIE**

**a.** Will Applicant ensure access to timely Hospital event notifications for its contracted physical health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

- [ ] Yes
- [ ] No

*If “no” please provide explanation: ________________________________

**b.** Will Applicant ensure access to timely Hospital event notifications for its contracted Behavioral Health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs.

- [ ] Yes
- [ ] No

*If “no” please provide explanation: ________________________________

**c.** Will Applicant ensure access to timely Hospital event notifications for its contracted oral health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs.

- [ ] Yes
- [ ] No

*If “no” please provide explanation: ________________________________
d. Will Applicant use Hospital event notifications within the CCO, for example to support Care Coordination and/or population health efforts?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

e. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted physical health Providers?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

f. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted Behavioral Health Providers?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

g. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted oral health Providers?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

h. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted physical health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

i. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted Behavioral Health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________
During Year 1, will Applicant report on the baseline of HIE access and use among its contracted oral health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☐ Yes    ☐ No

If “no” please provide explanation: ________________________________

Will Applicant report to the state annually on which HIE tool(s) each of its contracted physical health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☐ Yes    ☐ No

If “no” please provide explanation: ________________________________

Will Applicant report to the state annually on which HIE tool(s) each of its contracted Behavioral Health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☐ Yes    ☐ No

If “no” please provide explanation: ________________________________

Will Applicant report to the state annually on which HIE tool(s) each of its contracted oral health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☐ Yes    ☐ No

If “no” please provide explanation: ________________________________

### 5. Health IT for VBP and Population Management.

a. For the initial VBP arrangements, will Applicant have by the start of Year 1 the HIT needed to administer the arrangements (as described in its supporting detail)?

☐ Yes    ☐ No

If “no” please provide explanation: ________________________________

b. For the planned VBP arrangements for Years 2 through 5, does Applicant have a roadmap to obtain the HIT needed to administer the arrangements (as described in its supporting detail)?

☐ Yes    ☐ No

If “no” please provide explanation: ________________________________
c. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________


d. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with accurate and consistent information on patient attribution?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________


e. By the start of Year 1, will the Applicant identify for contracted Providers with VBP arrangements specific patients who need intervention through the year, so they can take action before the year end?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________


f. By the start of Year 1, will the Applicant have the capability to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________


g. By the start of each subsequent year for Years 2 through 5, will the Applicant CCO provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in the arrangement(s) in place for each year?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________


E. Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)

1. Social Determinants of Health and Health Equity Spending, Priorities, and Partnership

a. Is Applicant willing to direct a portion of its annual net income or reserves, as required by Oregon State Statute and defined by OHA in rule, to addressing health disparities and SDOH-HE?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________
b. Is Applicant willing to enter into written agreements with SDOH-HE partners that describe the following: any relationship or financial interest that may exist between the SDOH-HE partner and the CCO, how funds will be distributed, the scope of work including the domain of SDOH-HE addressed and the targeted population, whether CCO will refer Members to the SDOH-HE partner, the geographic area to be covered, how outcomes will be evaluated and measured, and how the CCO will collect and report data related to outcomes?

☑ Yes □ No

If “no” please provide explanation: _____________________________________________

____________________________________________________________________________

c. When identifying priorities for required SDOH-HE spending, is Applicant willing to designate, define and document a role for the CAC in directing, tracking and reviewing spending?

☑ Yes □ No

If “no” please provide explanation: _____________________________________________

____________________________________________________________________________

d. Is Applicant willing to align its SDOH-HE spending priorities with the priorities identified in the Community Health Improvement Plan and its Transformation and Quality Strategy, and to include at least one statewide priority (e.g. housing-related services and supports, including Supported Housing) in addition to its Community priorities?

☑ Yes □ No

If “no” please provide explanation: _____________________________________________

____________________________________________________________________________

2. Health-related Services

a. Is Applicant willing to align HRS Community benefit initiatives with Community priorities from the CCO’s Community Health Improvement Plan?

☑ Yes □ No

If “no” please provide explanation: _____________________________________________

____________________________________________________________________________

b. Is Applicant willing to align HRS Community benefit initiatives with a designated statewide priority should OHA require it?

☑ Yes □ No

If “no” please provide explanation: _____________________________________________

____________________________________________________________________________
c. Is Applicant willing to designate, define and document a role for the CAC when determining how Health-Related Services Community benefit initiatives decisions are made?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

3. Community Advisory Council membership and role

a. Is the Applicant willing to provide to OHA an organizational chart that includes the Community Advisory Council, and notes relationships between entities, including the CAC and the Board, how information flows between the bodies, the CAC and Board connection to various committees, and CAC representation on the board?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

4. Health Equity Assessment and Health Equity Plan

a. Is Applicant willing to develop and implement a Health Equity Plan according to OHA guidance, which includes a plan to provide cultural responsiveness and implicit bias education and training across the Applicant’s organization and Provider Network? See Sample Contract and Cultural Responsiveness Training Plan Guidance Document.

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

b. Is Applicant willing to include in its Health Equity Plan at least one initiative using HIT to support patient engagement?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

c. Is Applicant willing to adopt potential health equity plan changes, including requirements, focus areas and components, based on OHA plan review feedback and, when applicable, based on guidance provided by the Oregon Health Policy Board’s Health Equity Committee?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________
d. Is Applicant willing to designate a single point of accountability within the organization, who has budgetary decision-making authority and health equity expertise, for the development and implementation of the Health Equity Plan?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

__________________________

e. Is Applicant willing to faithfully execute the finalized Health Equity Plan?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

__________________________

f. Is Applicant willing to a) ask vendors for cultural and linguistic accessibility when discussing bringing on new HIT tools for patient engagement and b) when possible, seek out HIT tools for patient engagement that are culturally and linguistically accessible?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

__________________________

5. Traditional Health Workers (THW) Utilization and Integration

a. Is Applicant willing to develop and fully implement a Traditional Health Workers Integration and Utilization Plan?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

__________________________

b. Is Applicant willing to work in collaboration with the THW Commission to implement the Commission’s best practices for THW integration and utilization?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

__________________________

c. Is Applicant willing to fully implement the best practices developed in collaboration with the THW Commission?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

__________________________

d. Is Applicant willing to develop and implement a payment strategy for THWs that is informed by the recommendations from the Payment Model Committee of the THW Commission?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

__________________________
e. Is Applicant willing to designate an individual within the organization as a THW Liaison as of the Effective Date of the Contract?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

f. Is Applicant willing to engage THWs during the development of the CHA and CHP?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

6. Community Health Assessment and Community Health Improvement Plan

a. Is Applicant willing to partner with local public health authorities, non-profit Hospitals, any CCO that shares a portion of its Service Area, and any Tribes that are developing a CHA/CHP to develop shared CHA and CHP priorities?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

b. Is Applicant willing to align CHP priorities with at least two State Health Improvement Plan (SHIP) priorities and implement statewide SHIP strategies based on local need?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

c. Is Applicant willing to submit its Community Health Assessment and Community Health Improvement Plan to OHA?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

d. Is Applicant willing to develop and fully implement a community engagement plan?

☑ Yes ☐ No

If “no” please provide explanation:
F. Behavioral Health Attestations (Attachment 11)

1. Behavioral Health Benefit

a. Will Applicant report performance measures and implement Evidence-Based outcome measures, as developed by the OHA Metrics and Scoring Committee, and as specified in the Contract?
   
   Yes [ ] No [ ]
   If “no” please provide explanation: ________________________________

b. Will Applicant work collaboratively with OHA and its partners to implement all of the requirements in Exhibit M of the Contract?
   
   Yes [ ] No [ ]
   If “no” please provide explanation: ________________________________

c. Will Applicant be fully responsible for the Behavioral Health benefit for Members beginning in CY 2020?
   
   Yes [ ] No [ ]
   If “no” please provide explanation: ________________________________

d. Will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner? Fully integrated manner means that Applicant will not sub-capitate any Provider or entity for Behavioral Health services separately from physical health services nor will Applicant enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services.
   
   Yes [ ] No [ ]
   If “no” please provide explanation: ________________________________

e. Will Applicant report on the information and data specified in the Performance Expectations section as specified in the Contract and submit an annual report to OAH for review and approval?
   
   Yes [ ] No [ ]
   If “no” please provide explanation: ________________________________

f. Will Applicant have sufficient resources, including technological, financial, Provider and workforce, to integrate the Behavioral Health benefit with oral and physical health care benefits?
   
   Yes [ ] No [ ]
   If “no” please provide explanation: ________________________________
g. Will Applicant ensure the provision of cost-effective, comprehensive, person-centered, Culturally Responsive, and integrated Community-based Behavioral Health services for Members?
   ☑ Yes  ☐ No

   If “no” please provide explanation: ____________________________________________

h. Will Applicant provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally Responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care?
   ☑ Yes  ☐ No

   If “no” please provide explanation: ____________________________________________

i. Will Applicant follow Intensive Care Coordination standards as identified in OAR 410-141-3160/70?
   ☑ Yes  ☐ No

   If “no” please provide explanation: ____________________________________________

j. Will Applicant ensure Members have access to Referral and screening at multiple health system or health care entry points?
   ☑ Yes  ☐ No

   If “no” please provide explanation: ____________________________________________

k. Will Applicant use a standardized Assessment tool, to adapt the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member?
   ☑ Yes  ☐ No

   If “no” please provide explanation: ____________________________________________

l. Will Applicant work collaboratively to improve services for adult Members with SPMI as a priority population? Will Applicant make significant commitments and undertake significant efforts to continue to improve treatment and services so that adults with SPMI can live and prosper in integrated Community settings?
   ☑ Yes  ☐ No

   If “no” please provide explanation: ____________________________________________
m. Will Applicant ensure Members have timely access to all services under the Behavioral Health benefit in accordance with access to service standards as developed in Appendix C, the Administrative Rules Concept Document, under OHPB #17?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

n. Will Applicant have an adequate Provider Network to ensure Members have timely access to Behavioral Health services and effective treatment in accordance with the Delivery System and Provider Capacity section of the Contract?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

o. Will Applicant establish written policies and procedures for Prior Authorizations, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and be responsible for any inquiries or concerns and not delegate responsibility to Providers?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

p. Will Applicant establish written policies and procedures for the Behavioral Health benefit and provide the written policies and procedures to OHA by the beginning of CY 2020?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

q. Will Applicant require mental health and substance use disorder programs be licensed or certified by OHA to enter the Provider Network?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

r. Will Applicant require Providers to screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________
Will Applicant ensure Applicant’s staff and Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/)?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________

Will Applicant ensure Providers are trained in Trauma Informed approaches and provide regular periodic oversight and technical assistance to Providers?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________

Will Applicant require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACEs) and trauma in a Culturally Responsive and Trauma Informed framework and approach?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________

Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________

Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________

Will Applicant include OHA approved Behavioral Health homes (BHHs) in Applicant’s network as the BHHs qualify in Applicant’s Region?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________

Will Applicant assist Behavioral Health organizations within the delivery system to establish BHHs?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________
z. Will Applicant utilize BHHs in their network for Members to the greatest extent possible?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

aa. Will Applicant provide a full psychological evaluation and child psychiatric consultation for children being referred to the highest levels of care (day treatment, subacute or PRTS)?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

2. MOU with Community Mental Health Program (CMHP)

a. Will Applicant enter into a written memorandum of understanding (MOU) with the local Community Mental Health Program (CMHP) in Applicant’s Region by beginning of CY 2020, in accordance with ORS 414.153?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

b. Will Applicant develop a comprehensive Behavioral Health plan for Applicant’s Region in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, Peers, families, housing authorities, housing Providers, courts)?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

c. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the local Community Mental Health Program (CMHP) for the delivery of mental health services under ORS 430.630

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________
3. **Provisions of Covered Services – Behavioral Health**

a. Will Applicant provide services as necessary to achieve compliance with the mental health parity requirements of 42 CFR§ 438, subpart K and ensure that any quantitative treatment limitations (QTLs), or non-quantitative treatment limitations (NQTLs) placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i)?

- Yes  
- No

If “no” please provide explanation: ________________________________

b. Will Applicant assume accountability for Members that are civilly committed and are referred to and enter Oregon State Hospital; be financially responsible for the services for Members on waitlist for Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA; and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA?

- Yes  
- No

If “no” please provide explanation: ________________________________

c. Will Applicant reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health Provider, and reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical Provider?

- Yes  
- No

If “no” please provide explanation: ________________________________

d. Will Applicant ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards? Will Applicant remain responsible for coordinating Behavioral Health services with Non-Participating Providers and reimbursing for services?

- Yes  
- No

If “no” please provide explanation: ________________________________

e. Will Applicant ensure continuity of care throughout episodes of care and provide Intensive Care Coordination and general Care Coordination as specified in the Contract?

- Yes  
- No

If “no” please provide explanation: ________________________________
4. Covered Services Component – Behavioral Health
   a. Will Applicant establish written policies and procedures for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114? Will the emergency response system provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions?
      ☑ Yes  ☐ No
      If “no” please provide explanation: _______________________________________
   
   b. Will Applicant ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute psychiatric care facility?
      ☑ Yes  ☐ No
      If “no” please provide explanation: _______________________________________
   
   c. Will Applicant establish written policies and procedures for a Quality Improvement plan for the emergency response system?
      ☑ Yes  ☐ No
      If “no” please provide explanation: _______________________________________
   
   d. Will Applicant collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in Community integrated settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons?
      ☑ Yes  ☐ No
      If “no” please provide explanation: _______________________________________
   
   e. Will Applicant work with Hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED? Will Applicant develop remediation plans with EDs with significant numbers of ED stays longer than 23 hour?
      ☑ Yes  ☐ No
      If “no” please provide explanation: _______________________________________
f. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an ED in a six-month period?
   - Yes
   - No
   If “no” please provide explanation: ________________________________

h. Will Applicant establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold?
   - Yes
   - No
   If “no” please provide explanation: ________________________________

i. Will Applicant assure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute, and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?
   - Yes
   - No
   If “no” please provide explanation: ________________________________

j. If Applicant identifies a Member, over age 18 with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder, is appropriate for Long Term Psychiatric Care (State Facility level of care), will Applicant request a LTPC determination from the OHA LTPC reviewer?
   - Yes
   - No
   If “no” please provide explanation: ________________________________
k. If Applicant identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site?  
☐ Yes  ☐ No  
If “no” please provide explanation: ________________________________

l. If Applicant identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site?  
☐ Yes  ☐ No  
If “no” please provide explanation: ________________________________

m. For the Member age 18 and over, will Applicant work with the Member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated Community-based setting possible consistent with Member choice?  
☐ Yes  ☐ No  
If “no” please provide explanation: ________________________________

n. Will Applicant authorize and reimburse Care Coordination services, in particular for Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed Community treatment programs? Will Applicant authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160-70?  
☐ Yes  ☐ No  
If “no” please provide explanation: ________________________________

o. Will Applicant ensure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?  
☐ Yes  ☐ No  
If “no” please provide explanation: ________________________________
Will Applicant provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC?

☐ Yes  ☐ No

If “no” please provide explanation: 

Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer bridger, or other Community provider prior to discharge, and that all such Warm Handoffs are documented?

☐ Yes  ☐ No

If “no” please provide explanation: 

Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870?

☐ Yes  ☐ No

If “no” please provide explanation: 

Will Applicant ensure all adult Members receive a follow-up visit with a Community Behavioral Health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital?

☐ Yes  ☐ No

If “no” please provide explanation: 

Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?

☐ Yes  ☐ No

If “no” please provide explanation: 

Will Applicant coordinate with system Community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated Community setting, Supported Housing to the extent possible, consistent with the individual’s treatment goals, clinical needs and the individual’s informed choice?

☐ Yes  ☐ No

If “no” please provide explanation: 

---
v. Will Applicant ensure coordination and appropriate Referral to Intensive Care Coordination to ensure that Member’s rights are met and there is post-discharge support? If Member is connected to ICC coordinator, will Applicant ensure coordination with this person as directed in OAR 410-141-3160-3170?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

w. Will Applicant work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals’ immediate need for housing and work with Acute Care Psychiatric Hospitals in the development of each individual’s housing assessment?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

x. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

y. Will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

z. Will Applicant coordinate services for each adult Member with SPMI who needs assistance with Covered or Non-covered Services?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

aa. Will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________
bb. Will Applicant provide Utilization Review and utilization management, for Members receiving Behavioral Health Services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such setting transition to the most integrated Community setting, Supported Housing to the extent possible, consistent with the individual’s treatment goals, clinical needs, and the individual’s informed choice?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

cc. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member’s diagnosis and needs?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

dd. Will Applicant ensure that Members with SPMI receive Intensive Care Coordination (ICC) support in finding appropriate housing and receive coordination in addressing Member’s housing needs?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

ee. Will Applicant ensure Members with SPMI are assessed to determine eligibility for ACT?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

ff. Will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

gg. Will Applicant ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________
hh. Will Applicant, when ten (10) or more of Applicant’s adult Members with SPMI in Applicant’s Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Applicant solutions, create additional capacity by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams?

☑ Yes ☐ No

If “no” please provide explanation:

If Applicant lacks qualified Providers to provide ACT services, will Applicant consult with OHA and develop a plan to develop additional qualified Providers? Will lack of capacity not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist? Will no individual on a waitlist for ACT services be without such services for more than 30 days?

☑ Yes ☐ No

If “no” please provide explanation:

ii. Will Applicant ensure all denials of ACT services for all adult Members with SPMI are: based on established, evidence-based medical necessity criteria; reviewed, recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate; and follow the Notice of Adverse Benefit Determination process for all denials as described in the Contract?

☑ Yes ☐ No

If “no” please provide explanation:

jj. Will Applicant be responsible for finding or creating a team to serve Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards?

☑ Yes ☐ No

If “no” please provide explanation:

kk. Will Applicant be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member’s participation?

☑ Yes ☐ No

If “no” please provide explanation:
ill. Will Applicant require that a Provider or care coordinator meets with the Member to discuss ACT services and provide information to support the Member in making an informed decision regarding participation? Will this include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member’s self-identified needs, and ways that ACT can enhance a Member’s care and support independent Community living?

☐ Yes  ☐ No
If “no” please provide explanation: 

mm. Will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC?

☐ Yes  ☐ No
If “no” please provide explanation: 

nn. Will Applicant report the number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month?

☐ Yes  ☐ No
If “no” please provide explanation: 

oo. Will Applicant ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative?

☐ Yes  ☐ No
If “no” please provide explanation: 

pp. Will Applicant document efforts to provide ACT to individuals who initially refuse ACT services, and document all efforts to accommodate their concerns?

☐ Yes  ☐ No
If “no” please provide explanation: 

qq. Will Applicant offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services?

☐ Yes  ☐ No
If “no” please provide explanation: 
rr. Will Applicant ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

ss. Will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI in accordance with OAR 309-091-0000 through 0050?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

tt. Will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295? (“Supported Employment Services” means the same as “Individual Placement and Support (IPS) Supported Employment Services” as defined in OAR 309-019-0225.)

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

uu. Will Applicant work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________

vv. Will Applicant work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting, Supported Housing to the extent possible, consistent with the individual’s treatment goals, clinical needs, and the individual’s informed choice?

☑ Yes    ☐ No

If “no” please provide explanation: __________________________________________
ww. Will Applicant provide Substance Use Disorder (SUD) services to Members, which include outpatient, intensive outpatient, medication assisted treatment including Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, and OAR Chapter 415 Divisions 20, and 50?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________________________

xx. Will Applicant comply with Substance Use Disorder (SUD) waiver program designed to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, upon approval by Centers for Medicare and Medicaid Services (CMS)?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________________________

yy. Will Applicant inform all Members using Culturally Responsive and linguistically appropriate means that Substance Use Disorder outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are Covered Services consistent with OAR 410-141-3300?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________________________

zz. Will Applicant participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________________________

5. **Children and Youth**

a. Will Applicant develop and implement cost-effective comprehensive, person-centered, individualized, and integrated Community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________________________

b. Will Applicant utilize evidence-based Behavioral Health interventions for the needs of children 0-5, and their caregivers, with indications of Adverse Childhood Experiences (ACEs) and high complexity?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________________________
c. Will Applicant provide Intensive Care Coordination (ICC) that is Family and youth-driven, strengths based and Culturally Responsive and linguistically appropriate and abide by ICC standards as set forth in Appendix C, Administrative Rules Concept under OHPB #24 and in accordance with the ICC section in the Contract? Will Applicant abide by ICC standards as forth in Appendix C, Administrative Rules Concept, under OHPB #24, and in accordance with the ICC section in the Contract?

☑ Yes   ☐ No

If “no” please provide explanation: 


d. Will Applicant provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and Family? Will Services alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder?

☑ Yes   ☐ No

If “no” please provide explanation: 


e. Will Applicant adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS) and/or Intensive Outpatient Services and Supports?

☑ Yes   ☐ No

If “no” please provide explanation: 


f. Will Applicant ensure the availability of service, supports or alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting?

☑ Yes   ☐ No

If “no” please provide explanation: 


g. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member’s diagnosis and needs?

☑ Yes   ☐ No

If “no” please provide explanation: 


h. If Applicant identifies a Member is appropriate for LTPC Referral, will Applicant request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and Under, available on the Contract Reports Web Site?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

i. Will Applicant arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

j. Will Applicant coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA? For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), will Applicant also coordinate with such Member’s parent or legal guardian?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

k. Will Applicant ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the eligibility and timeline criteria in the Contract?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

l. Will Applicant have funding and resources to implement, to fidelity, Wraparound Services?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

m. Will Applicant enroll all eligible youth in Wraparound and place no youth on a waitlist?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

Yes ☐ No ☑

If “no” please provide explanation: ________________________________

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o. Will Applicant establish and maintain a functional System of Care in its Service Area in accordance with the Best Practice Guide located at [https://www.pdx.edu/ccf/best-practice-guide](https://www.pdx.edu/ccf/best-practice-guide) including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and Family voice representation to be 51 percent?

Yes ☑ No ☐

If “no” please provide explanation: ________________________________

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p. Will Applicant have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council?

Yes ☑ No ☐

If “no” please provide explanation: ________________________________

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q. By end of CY 2020, will Applicant have written Charters and new Member handbooks for Practice Level Work group, Advisory Council and Executive Council?

Yes ☑ No ☐

If “no” please provide explanation: ________________________________

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G. Cost and Financial Attestations (Attachment 12)

1. Rates

Does Applicant accept the CY 2020 Rate Methodology appended to Attachment 12?

Yes ☑ No ☐

If “no” please provide explanation: ________________________________

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2. Evaluate CCO performance to inform CCO-specific profit margin

a. Does Applicant agree to performance and efficiency evaluation being used to set profit margins in CCO capitation rates?

Yes ☑ No ☐

If “no” please provide explanation: ________________________________
b. Does Applicant agree to accept the CCO 2.0 capitation rate methodology as described in the Oregon CY20 Procurement Rate Methodology document and also accept the performance evaluation methodology and its use in setting CCO-specific profit margins?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

__________________________________________________________________

c. Does Applicant agree to report additional data as needed to inform the performance evaluation process, including data on utilization of Health-Related Services?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

__________________________________________________________________

d. Is Applicant willing to have OHA use efficiency analysis to support managed care efficiency adjustments that may result in adjustments to the base data used in capitation rate development to further incentivize reductions in Waste in the system?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

__________________________________________________________________

3. Qualified Directed Payments to Providers

a. Is Applicant willing to make OHA-directed payments to certain Hospitals within five Business Days after receipt of a monthly report prepared and distributed by OHA?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

__________________________________________________________________

b. Is Applicant willing to report to OHA promptly if it determines payments to Hospitals will be significantly delayed?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

__________________________________________________________________

c. Is Applicant willing to exclude the portion of OHA-directed payments for provider tax repayment when negotiating alternative or Value-Based Payment reimbursement arrangements?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

__________________________________________________________________
d. Is Applicant willing to provide input and feedback to OHA on the selection of measures of quality and value for OHA-directed payments to Providers?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

4. Quality Pool Operations and Reporting

a. Does Applicant agree to having a portion of capitation withheld from monthly Capitation Payment and awarded to the Applicant based on performance on metrics based on the Quality Incentive Pool program?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

b. Does Applicant agree to report to OHA separately on expenditures incurred based on Quality Pool revenue earned?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

c. Does Applicant agree to report on the methodology it uses to distribute Quality Pool earnings to Providers, including SDOH-HE partners and public health partners?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

d. Does Applicant have a plan to evaluate contributions made by SDOH-HE and public health partners toward the achievement of Quality Pool metrics?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

5. Transparency in Pharmacy Benefit Management Contracts

a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 5. If not, please answer parts b-f of this question.

☐ Yes ☑ No

If “no” please provide explanation: See attached.
b. Will Applicant use a pharmacy benefit manager that will provide pharmacy cost passthrough at 100% and pass back 100% of rebates received to Applicant?
   ☑ Yes   ☐ No
   If “no” please provide explanation: ________________________________

c. Will Applicant separately report to OHA any and all administrative fees paid to its PBM?
   ☑ Yes   ☐ No
   If “no” please provide explanation: ________________________________

d. Will Applicant require reporting from PBM that provides paid amounts for pharmacy costs at a claim level?
   ☑ Yes   ☐ No
   If “no” please provide explanation: ________________________________

e. Will Applicant obtain market check and audits of their PBMs by a third party on an annual basis, and share the results of the market check with the OHA?
   ☑ Yes   ☐ No
   If “no” please provide explanation: ________________________________

f. Will Applicant require its PBM to remain competitive with enforceable contract terms and conditions driven by the findings of the annual market check and report auditing?
   ☑ Yes   ☐ No
   If “no” please provide explanation: ________________________________

6. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria
   a. Will Applicant partner with OHA on the goal of increasing the alignment of CCO preferred drug lists (PDL) with the Fee-For-Service PDL set every year by OHA?
      ☑ Yes   ☐ No
      If “no” please provide explanation: ________________________________

   b. Will Applicant align its PDL in any and all categories of drugs as recommended by the P&T committee and as required by OHA?
      ☑ Yes   ☐ No
      If “no” please provide explanation: ________________________________
c. Will Applicant post online in a publicly accessible manner the Applicant’s specific PDL with coverage and Prior Authorization criteria in a format designated by OHA and update the posting concurrently or before any changes to the PDL or coverage/PA criteria become effective?

☑ Yes  ☐ No

If “no” please provide explanation: _______________________________________

7. Financial Reporting Tools and Requirements

a. Is Applicant willing to partake of all financial, legal and technological requirements of the National Association of Insurance Commissioners (NAIC) in whatever capacity necessary to file its financial information with OHA under NAIC standards?

☑ Yes  ☐ No

If “no” please provide explanation: _______________________________________

b. Will Applicant report its required financial information to OHA on the NAIC’s Health Quarterly and Annual Statement blank (“Orange Blank”) through the NAIC website as described in this RFA, under NAIC standards and instructions?

☑ Yes  ☐ No

If “no” please provide explanation: _______________________________________

c. Will Applicant report its financial information to OHA using Statutory Accounting Principles (SAP), subject to possible exemption from SAP for 2020 as described in this RFA?

☑ Yes  ☐ No

If “no” please provide explanation: _______________________________________

d. Will Applicant file the financial reports described in this RFA, including Contract Exhibit L and supplemental schedules with the instructions referenced in this RFA?

☑ Yes  ☐ No

If “no” please provide explanation: _______________________________________

e. Is Applicant willing to resubmit its pro forma financial statements for three years starting in 2020, modified to reflect the Enrollment expected assuming other CCOs that may operate in Applicant’s Service Area?

☑ Yes  ☐ No

If “no” please provide explanation: _______________________________________
f. Does Applicant commit to preparing and filing a Risk Based Capital (RBC) report each year based on NAIC requirements and instructions?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________________________


g. Is Applicant willing to submit quarterly financial reports including a quarterly estimation of RBC levels to ensure financial protections are in place during the year?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________________________


h. Is Applicant willing to have its RBC threshold evaluated quarterly using a proxy calculation?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________________________


i. If Applicant’s estimated RBC falls below the minimum required percentage based on the quarterly estimation, is Applicant willing to submit a year-to-date financial filing and full RBC evaluation?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________________________


8. Accountability to Oregon’s Sustainable Growth Targets

a. Does Applicant commit to achieving a sustainable growth in expenditures each calendar year (normalized by membership) that matches or is below the Oregon 1115 Medicaid demonstration project waiver growth target of 3.4%?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________________________


b. Does Applicant similarly commit to making a good faith effort towards achievement of future modifications to the growth target in the waiver?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________________________


c. Does Applicant agree that OHA may publicly report on CCO performance relative to the sustainable growth rate targets (normalized for differences in membership)?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________________________
d. Does Applicant agree that OHA may institute a Corrective Action Plan, that may include financial penalties, if a CCO does not achieve the expenditure growth targets based on the current 1115 Medicaid waiver?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________

9. Potential Establishment of Program-wide Reinsurance Program in Future Years
a. Will Applicant participate in any program-wide reinsurance program that is established in years after 2020 consistent with statutory and regulatory provisions that are enacted?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________

b. Will Applicant use private reinsurance contracts on only an annual basis so as to ensure ability to participate in state-run program if one is launched at the start of a calendar year?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________

c. Does Applicant agree that implementation of program-wide reinsurance program will reduce capitation rates in years implemented as a result of claims being paid through reinsurance instead of with capitation funds?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________

10. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk
a. Is Applicant willing to have its financial solvency risk measured by Risk Based Capital (RBC) starting in 2021?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________

b. Is Applicant willing to achieve a calculated RBC threshold of 200% by end of Q3 of 2021 and thereafter to maintain a minimum RBC threshold of 200%?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________
c. Is Applicant willing to report to OHA promptly if it determines that its calculated RBC value is or is expected to be below 200%?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________


d. Is Applicant willing to report to OHA promptly if it determines that its actual financial performance departs materially from the pro forma financial statements submitted with this Application?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________

e. Will Applicant maintain the required restricted reserve account per Contract?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________

11. Encounter Data Validation Study

a. Is Applicant willing to perform regular chart reviews and audits of its encounter claims to ensure the Encounter Data accurately reflects the services provided?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________

b. Is Applicant willing to engage in activities to improve the quality and accuracy of Encounter Data submissions?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________

H. Member Transition Plan (Attachment 16)

1. Is Applicant willing to faithfully execute its Member Transition Plan as described in Attachment 16?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________
5. Transparency in Pharmacy Benefit Management Contracts
5.a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 6. If not, please answer parts b-f of this question. No.

Based on its most recent analysis, Advanced Health's current contracted rates are superior to those offered through the Oregon Prescription Drug Program. However, if that situation changes, Advanced Health would certainly consider moving to the Oregon program, as it desires to provide the least costly comparable alternative. See Attachment 12, Question D.4.
Attachment 14 — Assurances

Applicant Name:  Western Oregon Advanced Health, LLC abn Advanced Health

Authorizing Signature:  

Printed Name: Benjamin J. Messner

Instructions: Assurances focus on the Applicant’s compliance with federal Medicaid law and related Oregon rules. For each assurance, Applicant will check “yes,” or “no.” A “yes” answer is normal, and an explanation will be furnished if Applicant’s response is “no”. Applicant must respond to all assurances. If an assurance has more than one question and Applicant’s answer is “no” to any question, check “no” and provide an explanation. These assurances must be signed by a representative of Applicant.

Each assurance is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. **Emergency and Urgent Care Services.** Will Applicant have written policies and procedures, and oversight and monitoring systems to ensure that emergency and urgent services are available for all Members on a 24-hour, 7-days-a-week basis? Will Applicant 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)

   ☑ Yes  ☐ No

   If “no” please provide explanation: ____________________________________________________________

2. **Continuity of Care.** Will Applicant implement 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? Will Applicant follow Intensive Care Coordination (ICC)/ENCC standards and Care Coordination standards, including transition meetings, as directed in OAR 410-141-3170? Will Applicant 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]

   ☑ Yes  ☐ No

   If “no” please provide explanation: ____________________________________________________________

3. Will Applicant implement 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? Will Applicants 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? Will Applicants document all monitoring and Corrective Action activities? Will 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]

   ☑ Yes  ☐ No

   If “no” please provide explanation: ____________________________________________________________
4. Will Applicant have an ongoing quality performance improvement program for the services it furnishes to its Members? Will the program 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 OAR 410-141-0200]

☑ Yes ☐ No

If “no” please provide explanation: 

5. Will Applicant make Coordinated Care Services accessible to enrolled Members? Will Applicant not discriminate between Members and non-Members as it relates to benefits to which they are both entitled including reassessment or additional screening as needed to identify exceptional needs in accordance with OAR 410-141-3160 through 410-141-3170? Will Applicant 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]

☑ Yes ☐ No

If “no” please provide explanation: 

6. Will Applicant 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 B “Sample Contract”? Will Applicant 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]

☑ Yes ☐ No

If “no” please provide explanation: 

7. Will Applicant develop and distribute OHA-approved informational materials to Potential Members that meet the language and alternative format requirements of Potential Members? Will Applicant 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]

☑ Yes ☐ No

If “no” please provide explanation: 

Attachment 14 - Assurances
8. Will Applicant have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant provided in the Member handbook or via health education, about the availability of intensive Care Coordination for Members who are aged, blind and/or disabled, or are part of a prioritized population, and appropriate use of emergency facilities and urgent care? Will 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]

☑ Yes  ☐ No

If “no” please provide explanation:  ____________________________________________

9. Will Applicant 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 Appendix B, Core Contract? Will Applicant 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]

☑ Yes  ☐ No

If “no” please provide explanation:  ____________________________________________

10. Will Applicant provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled; Members with high health needs or multiple chronic conditions; Members receiving Medicaid-funded long-term care or long-term services and supports or receiving Home and Community-Based Services (HCBS) under the state’s 1915(i), 1915(j), or 1915(k) State Plan Amendments or the 1915(c) HCBS waivers, or Behavioral Health priority populations in accordance with OAR 410-141-3170? Will Applicant ensure that Prioritized Populations, who sometimes have difficulty with engagement, are fully informed of the benefits of Care Coordination? Will Applicant ensure that their organization will be Trauma Informed by January 1, 2020? Will Applicant utilize evidence-based outcome measures? Will Applicant ensure that Members who meet criteria for ENCC receive contact and service delivery as required in OAR 410-141-3170? Will Applicant 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]

☑ Yes  ☐ No

If “no” please provide explanation:  ____________________________________________
11. Will Applicant maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant and its Providers or Subcontractors will not hold Members responsible for debt incurred by the Applicant or by Providers if the entity becomes insolvent? Will Applicant 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]

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________

12. Will Applicant 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? Has Applicant 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? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant 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]

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________

13. Will Applicant maintain an efficient and accurate system for capturing Encounter Data, timely reporting the Encounter Data to OHA, and regularly validating the accuracy, truthfulness and completeness of 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? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant 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]

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________

14. Will Applicant 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? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant 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]

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________
15. Assurances of Compliance with Medicaid Regulations

Item 15 of this Attachment 14 has ten assurances of Compliance with Medicaid Regulations. These Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to be eligible to contract as a CCO. For purposes of this section and the federal Medicaid regulations in 42 CFR Part 438, a CCO falls within the definition of a “managed care organization” in 42 CFR 438.2. This section asks the Applicant to provide a brief narrative of how the Applicant meets each applicable Assurance. The Applicant must provide supporting materials available to the OHA upon request.

Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15:

b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.
c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.
d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.
g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.
h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.
i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.
j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.
15. Assurances of Compliance with Medicaid Regulations

15. Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15: BACKGROUND: Advanced Health has established written policies and procedures (P&P) relating to each of the Medicaid Assurances. Each P&P is based on: (1) Medicaid regulations and interpretative guidance, (2) Oregon statutes, administrative rules, and interpretative guidance, and (3) contractual obligations of the CCO Contract. Each set of P&P must conform to these requirements, and each contains a reference chart that connects the requirements of each of these sources to the specific P&P and harmonizes nomenclature as needed. Advanced Health assigns each set of approved P&P to a specific department head, who is accountable for (A) ensuring that the actual practice of his or her department, as well as inter-departmental activities, comply with the P&P on an ongoing basis; (B) proposing and implementing updates as obligations and practices change; and (C) seeking continual improvement of these based on lean tools and principles.

15.a. Medicaid Assurance #1 – 42 CFR § 438.206 Availability of services. Advanced Health's P&P relating to Provider Network complies with the requirements of this Regulation. Attachment 7 to the Application describes the depth and breadth of Advanced Health's Provider Network (delivery network), which is sufficient to meet expected needs of Members (enrollees). Advanced Health has implemented a system for assigning Members to Providers that takes into account, among other matters, Member preferences and special needs, women's health needs, and the geography of its rural, sparsely populated area. Under Advanced Health's P&P, no Network Provider may refuse to accept new Members. Each Network Provider has entered into a written agreement that meets the requirements of this Regulation, including matters relating to timely access, providing services in a Culturally Responsive manner and oversight by Advanced Health. When Members must be served by out-of-network Providers, Advanced Health enters into written agreements with these Providers which ensure that Members receive the care they need on the same terms as with in-network Providers. Advanced Health's Chief Medical Officer is accountable for the obligations imposed by this Regulation.

15.b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services. Advanced Health's P&P relating to Provider Network complies with the requirements of this Regulation. Attachment 7 to the Application
describes the depth and breadth of Advanced Health's Provider Network (delivery network), which is sufficient with respect to preventive, primary and specialty care Providers, and number, mix and geographic distribution of Providers, to meet expected needs. While certain specialties are not currently represented, Advanced Health has established relationships with out-of-network Providers to meet these needs. Advanced Health has attested that it is willing to provide copies of all of its Provider and Subcontractor agreements in unredacted form to OHA. Advanced Health's Chief Medical Officer is accountable for the obligations imposed by this Regulation.

15.c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care. Advanced Health's P&Ps on PCP Assignments, Care Coordination and Specialist Referrals comply with this Regulation. Advanced Health has implemented a system for assigning Members (enrollees) to Primary Care Providers which ensures that each Member has an ongoing source of primary care. Primary Care Providers are the primary source of coordination of each Member's care, including oral, physical, and Behavioral Health. Attachments 7 and 11 describe the program of Care Coordination for Members with Special Health Care Needs, which results in identification of such Members, assessment of the Special Health Care Needs of such Members, the development and oversight of treatment plans and direct access to specialists as needed. Advanced Health's Senior ICC/ENCC Executive is accountable for the obligations imposed by this Regulation.

15.d. Medicaid Assurance #4 – 42 CFR § 428.210 Coverage and authorization of services. Advanced Health's set of P&Ps relating to Covered Services and Authorizations comply with this Regulation. They (A) harmonize the definitions of Medically Appropriate and medically necessary; (B) ensure that Covered Services are provided in a manner that complies with this Regulation; and (C) prohibit the arbitrary denial or reduction of the amount, duration, or scope of a Covered Service because of the diagnosis, type of illness or condition of the Member (beneficiary). Advanced Health's P&P relating to Prior Authorizations (initial and continuing; standard and expedited), including the time frames for such authorizations, comply with this Regulation. All Subcontractors and Providers are required to comply with these sets of P&P. Advanced Health's P&P relating to Notices of Adverse Benefit Determination (notices of adverse action) comply with this Regulation. No utilization or other arrangements create an incentive to deny, limit, or discontinue Medically Appropriate (medically necessary) services. Advanced Health's Chief Medical Officer is accountable for the obligations imposed by this Regulation.

15.e. Medicaid Assurance #5 – 42 CFR § 438.214 Provider selection. Advanced Health's P&P on Provider Network complies with this Regulation and ensures that Advanced Health does not discriminate against particular Providers,
both in- and out-of-network. Its P&P relating to Credentialing of Providers complies with this Regulation, providing documented processes for credentialing and re-credentialing of Providers across oral health, physical health and Behavioral Health services. Advanced Health's Chief Medical Officer is accountable for the obligations imposed by this Regulation.

15.f. Medicaid Assurance #6 – 42 CFR § 438.224 Confidentiality. Advanced Health's set of P&P relating to HIPAA and Privacy requires the organization to comply with all federal and State privacy rules, in terms of the use and disclosure of all individually identifiable health information. Advanced Health's Chief Privacy Officer is accountable for the obligations imposed by this Regulation and must work closely with Advanced Health's Chief Information Officer in carrying out these responsibilities.

15.g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems. Advanced Health's P&P on Grievances and Appeals complies with the provisions of this Regulation and Subpart F of 42 CFR Part 438. Advanced Health works hard to ensure that Members are aware of their rights with respect to Grievances and Appeals and are encouraged to express their views. Advanced Health works closely with Subcontractors to ensure that the Grievance and Appeals system works seamlessly across the Provider Network. Advanced Health's Senior Quality and Program Executive is accountable for the obligations imposed by this Regulation.

15.h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation. Advanced Health's P&P on Provider and Subcontractor Arrangements requires that Advanced Health (A) evaluate each potential Subcontractor's capacity and ability to perform the requested services; (B) assess each potential Subcontractor's willingness to enter into Advanced Health's standard Subcontractor agreement without changes that would adversely affect Advanced Health's ability to meet its obligations; (C) have a written agreement in place with each Subcontractor prior to any performance it, which agreement which sets forth, among other things, the performance required and a process for Corrective Action and possible termination for nonperformance; and (D) engage in a meaningful evaluation of the performance of each Subcontractor not less often than annually. Attachment 6 to the Application describes an example of oversight. Advanced Health's Chief Operating Officer is accountable for the obligations imposed by this Regulation.

15.i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines. Advanced Health's P&P on Clinical Practice Guideline Selection and Dissemination comply with this Regulation and ensure that appropriate Practice Guidelines are adopted, updated regularly, and disseminated across the Provider Network. Advanced Health works closely with Network Providers and Subcontractors to
ensure that Advanced Health's Practice Guidelines are applied consistently across the network. Advanced Health's Chief Medical Officer is accountable for the obligations imposed by this Regulation.

15.j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems. Advanced Health's set of P&P on Health Information Technology (HIT) complies with this Regulation, requiring that the system of HIT maintained by Advanced Health can (A) collect data with respect to Members (enrollees) and services requested and provided; (B) produce, transmit, and record data accurately, completely and in accordance with all privacy laws; and (C) retain such data in a format readily available for review by federal and State authorities. Advanced Health works closely with Network Providers and Subcontractors to ensure that Advanced Health's HIT works smoothly as the Advanced Health HIT interacts with systems at these organizations. Advanced Health's Chief Information Officer is accountable for the obligations imposed by this Regulation.
Attachment 15 — Representations

Applicant Name: Western Oregon Advanced Health, LLC abn Advanced Health

Authorizing Signature: 
Printed Name: Benjamin J. Messner

Instructions: For each representation, Applicant will check “yes,” or “no.” On representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all representations.

These representations must be signed by a representative of Applicant.

Each representation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. Will Applicant have an administrative or management contract with a contractor to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program?
   □ Yes  □ No
   Explanation: See attached.

2. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the systems or information technology to operate the CCO program for Applicant?
   □ Yes  □ No
   Explanation: See attached.

3. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the claims administration, processing and/or adjudication functions?
   □ Yes  □ No
   Explanation: See attached.

4. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Enrollment, Disenrollment and membership functions?
   □ Yes  □ No
   Explanation: See attached.
5. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the credentialing functions?

☐ Yes  □ No

Explanation: See attached.

6. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the utilization operations management?

☐ Yes  □ No

Explanation: See attached.

7. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Quality Improvement operations?

☐ Yes  □ No

Explanation: See attached.

8. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of its call center operations?

□ Yes  ☐ No

Explanation: See attached.

9. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the financial services?

□ Yes  ☐ No

Explanation: See attached.
10. Will Applicant have an administrative or management contract with a contractor to delegate all or a portion of other services that are not listed?
   ■ Yes    ■ No
   Explanation: See attached.

11. Will 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, other than as disclosed in response to representation 1-10 above?
   ■ Yes    ■ No
   Explanation: See attached.

12. Other than VBP arrangements with Providers, will Applicant sub-capitate any portion of its Capitation Payments to a risk-accepting entity (RAE) or to another health plan of any kind?
   ■ Yes    ■ No
   Explanation: See attached.

13. Does Applicant have a 2019 CCO contract? Is Applicant a risk-accepting entity or Affiliate of a 2019 CCO? Does Applicant a management services agreement with a 2019 CCO? Is Applicant under common management with a 2019 CCO?
   ■ Yes    ■ No
   Explanation: See attached.
ADVANCED HEALTH
REPRESENTATIONS
Attachment 15

1. Will Applicant have an administrative or management contract with a contractor to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program? **No.**
With one exception, discussed below, Advanced Health directly hires, supervises, and as necessary, terminates, its own employees/staff. Advanced Health has its own employee manual and is ultimately responsible for the proper oversight of its employees. Pursuant to an administrative services agreement with an Affiliate (as defined in the RFA) of Advanced Health, DOCS Management Services, LLC, the latter provides administrative assistance to Advanced Health with respect to hiring (including workforce development), supervision, and other ongoing human resources matters, including payroll reporting and tax compliance. The Chief Executive Officer (CEO) position is a concurrent employment arrangement with Advanced Health and two of its Affiliates and the individual occupying the CEO position is designated by Advanced Health's 60% equity owner, Southwest Oregon IPA, Inc. The Advanced Health Board of Directors conducts an annual evaluation of the CEO's performance, and this effort is typically led by the Executive Committee of the Board of Directors. Recognizing the potential difficulties of this arrangement, if at any time Advanced Health Board of Directors becomes concerned with the performance of the Advanced Health CEO, a written agreement among Advanced Health and the Affiliates is in place to ensure that Advanced Health's concerns are promptly addressed. In addition, Advanced Health will engage an unrelated third party to assist it in evaluating the contractual performance of any Affiliate, which will necessarily address concurrently employed staff.

2. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the systems or information technology to operate the CCO program for Applicant? **Yes.**
Advanced Health's Chief Information Officer is responsible for Advanced Health's performance of information technology functions, including accomplishment of the HIT Roadmap goals and timelines. Pursuant to an administrative services agreement with an Affiliate of Advanced Health, DOCS Management Services, LLC, the latter provides information technology services and equipment (including software) to support Advanced Health's efforts in this business function.

3. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the claims administration, processing and/or adjudication functions? **Yes.**
Advanced Health's Chief Operations Officer (COO) is responsible for Advanced Health's performance in claims administration, processing and adjudication. Pursuant to an administrative services agreement with an Affiliate of Advanced Health's...
Health, DOCS Management Services, LLC, the latter provides administrative services and equipment (including software) to support Advanced Health's efforts in this business function. The COO's responsibility for claims management is currently held by the CEO, pending the vacancy in the COO position being filled.

4. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Enrollment, Disenrollment and membership functions? Yes.

Advanced Health's COO is responsible for Advanced Health's performance in Enrollment, Disenrollment, and membership functions. Pursuant to an administrative services agreement with an Affiliate of Advanced Health, DOCS Management Services, LLC, the latter provides administrative services and equipment (including software) to support Advanced Health's efforts in this business function. The COO's responsibility for Enrollment, Disenrollment and membership functions is currently held by the CEO, pending the vacancy in the COO position being filled.

5. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the credentialing functions? No.

Advanced Health's Chief Medical Officer is responsible for Advanced Health's performance in credentialing. Advanced Health conducts some of the required credentialing activities directly. For other credentialing activities, Advanced Health will enter into Privileged Provider Subcontracts that will require certain Privileged Providers, with appropriate Advanced Health oversight and coordination, to carry out all of the obligations associated with credentialing Providers that are associated with the Privileged Provider. If the Privileged Provider does not perform adequately, that privilege will be withdrawn. Advanced Health answered "no" to this question because it considers credentialing to be an essential part of healthcare services, not part of an administrative services or management arrangement.

6. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the utilization operations management? No.

Advanced Health's Chief Medical Officer is responsible for Advanced Health's performance in utilization management. Advanced Health conducts some utilization activities directly. In other cases, Advanced Health will enter into Privileged Provider Subcontracts that require certain Privileged Providers, with appropriate Advanced Health oversight and coordination, to engage in certain utilization management activities with respect to Providers that are associated with the Privileged Provider. If the Privileged Provider does not perform adequately, that privilege will be withdrawn. Advanced Health answered "no" to this question because it considers utilization management to be an essential part of healthcare services, not part of an administrative services or management arrangement.
7. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Quality Improvement operations. **No.**
Advanced Health's Executive Program Director is responsible for Advanced Health's performance in Quality Improvement activities. Advanced Health conducts many Quality Improvement activities directly. In some cases, Advanced Health will enter into Privileged Provider Subcontracts that require certain Privileged Providers, with appropriate Advanced Health oversight and coordination, to engage in certain Quality Improvement activities with Providers that are associated with the Privileged Provider. If a Privileged Provider does not perform adequately, that privilege will be withdrawn. Advanced Health answered "no" to this question because it considers Quality Improvement to be an essential part of healthcare services, not part of an administrative services or management arrangement.

8. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of its call center operations? **Yes.**
Advanced Health's COO is responsible for Advanced Health's performance in call center operations. Pursuant to an administrative services agreement with an Affiliate of Advanced Health, and DOCS Management Services, LLC, the latter provides administrative services and equipment (including software) to support Advanced Health's efforts in this business function. The COO's responsibility for call center operations is currently held by the CEO, pending the vacancy in the COO position being filled.

9. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the financial services? **Yes.**
Advanced Health's Chief Financial Officer is responsible for Advanced Health's performance in the financial services function. Pursuant to an administrative services agreement with an Affiliate of Advanced Health, DOCS Management Services, LLC, the latter provides administrative services and equipment (including software) to support Advanced Health's efforts in this business function.

10. Will Applicant have an administrative or management contract with a contractor to delegate all or a portion of other services that are not listed? **Yes.**
Pursuant to an administrative services agreement between an Affiliate of Advanced Health, DOCS Management Services, LLC, the latter provides administrative services and equipment (including software) to support Advanced Health as it may request in any other business functions that do not involve the direct provision of healthcare services. These are expected to include Customer Service, contract management, document management and retention, and similar services. Advanced Health will enter into supplemental services / statements of work agreements as more (or fewer) services are required.
11. Will Applicant have contracts with related entities, contractors and Subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract, other than as disclosed in response to representation 1-10 above? Yes.
Advanced Health interprets the adjective "related" to apply to entities, contractors, and Subcontractors, but has not found a formal definition of "related." It is assumed that this means connected by ownership of equity interests in amounts less than would constitute Control. Advanced Health anticipates entering into Privileged Provider Subcontracts with the following Subcontractors: (A) Southwest Oregon IPA, Inc., an Affiliate of Advanced Health, to provide physical health and integrated Behavioral Health services; (B) Advantage Dental, a 10% equity owner of Advanced Health, to provide oral healthcare services; and (C) Coos Health and Wellness, which is a division of Coos County and a 10% equity owner of Advanced Health, to provide certain specialty Behavioral Healthcare services. Advanced Health is likely to have standard Network Provider contracts with certain other Providers to provide healthcare services, and some of these Providers could potentially be indirectly related to Advanced Health by reason of ownership of equity interests in certain Advanced Health equity owners.

12. Other than VBP arrangements with Providers, will Applicant sub-capitiate any portion of its Capitation Payments to a risk-accepting entity (RAE) or to another health plan of any kind? Yes.
In Year 1 of the CCO 2.0 contract period, Advanced Health's primary dental Provider (Advantage Dental, which is an equity owner of Advanced Health) will be paid on a per-member-per-month basis. The contract will meet the criteria for LAN Category 4N. As detailed in Attachment 8, this contract will be transitioned to LAN Category 4A in Year 2 of the contract period. In Years 1 and 2 of the contract period, Advanced Health's primary non-emergent transportation Provider (Bay Cities Brokerage, formerly known as Bay Cities Ambulance) will be paid on a per-member-per-month basis. The contract will meet the criteria for LAN Category 4N. As detailed in Attachment 8, this contract will be transitioned to LAN Category 4A in Year 3 of the contract period. Southwest Oregon IPA, Inc., an Affiliate of Advanced Health (SWOIPA), will be a risk bearing entity that will be paid on a sub-capitated basis. SWOIPA will be contractually obligated to assist Advanced Health in its efforts to implement VBP arrangements, as described in Attachment 8.

13. Does Applicant have a 2019 CCO contract? Is Applicant a risk-accepting entity or Affiliate of a 2019 CCO? Does Applicant have a management services agreement with a 2019 CCO? Is Applicant under common management with a 2019 CCO? Yes and No.
YES: Advanced Health has a 2019 CCO contract. NO: Advanced Health is the current CCO. Is not a risk-accepting entity or Affiliate of a 2019 CCO. It does not have a management services agreement with a 2019 CCO. It is not under common management with a 2019 CCO.
Policy and Purpose

Advanced Health recognizes that a change in health care coverage and Providers is a potentially disruptive experience for Incoming and Outgoing Members. It is Advanced Health's policy to do its utmost to ensure that such Members experience a seamless transition when they are changing CCOs during Open Enrollment periods (or otherwise) with minimal and ideally no disruptions of care. Transitions of Care must be accomplished safely, and in an orderly and timely manner, for each affected Member, their Representatives, and their Providers. To those ends, Advanced Health has adopted, and will update as appropriate to ensure compliance with federal Law, State Law and contractual requirements, this Member Transition Plan to implement Transitions of Care for affected Members in order to maximize and maintain Continued Access to Care.

Definitions

A. **Continued Access to Care**: Access to Medically Appropriate Covered Services and Care Coordination during a Member's Transition of Care.

B. **CCO**: A Coordinated Care Organization that has or had a contract with OHA.

C. **CCO Contract**: The Oregon Health Plan Amended and Restated Health Plan Services Contract Coordinated Care Organization Contract between Advanced Health and OHA, as it may be amended from time to time.

D. **Incoming Member**: A Transitioning Member who will become a Member covered by Advanced Health.

E. **Member**: A person who is Enrolled with Advanced Health or another CCO, including Enrolled dependents, and is entitled to receive Covered Services.

F. **Member Transition Plan (the "Plan")**: Advanced Health's plan for a safe and orderly Transition of Care with respect to Members transferring to a Receiving CCO or from a Transferring CCO.

G. **OHA**: Oregon Health Authority.

H. **Policy**: Advanced Health's Transition of Care Policy.

I. **Prior Authorized Care**: Covered Services authorized by the Transferring CCO at the time that the Member Enrolls in a Receiving CCO.

J. **Procedure**: Advanced Health's Transition of Care Procedure.

K. **Receiving CCO**: The CCO with whom a Member is Enrolled immediately after the Member's Disenrollment from a Transferring CCO.
L. Transferring CCO: The CCO from whom a Member Disenrolls to then Enroll in a Receiving CCO.

M. Transition of Care: Transition of a Member from Advanced Health to a Receiving CCO or from a Transferring CCO to Advanced Health. (Note: the use of the defined term "Transition of Care" differs from the use of that term by the Centers for Medicare and Medicaid Services when referring to a transition from one care setting to another.)

N. Transition of Care Coordinator (TCC): An Advanced Health staff member with responsibility for Transition of Care for a Transitioning Member.

O. Transition of Care Manager: The person that Advanced Health designates to implement and monitor compliance with the Policy, the Procedure, and this Plan.

P. Transition of Care Period: The longer of the following periods after the effective date of an Incoming Member's Enrollment with Advanced Health: (a) 30 days for physical and oral health and 60 days for Behavioral Health or until the Incoming Member's new primary care Provider reviews the Member's treatment plan, whichever comes first; and (b) 90 days for Fully Dual Eligible Members.

Q. Transitioning Member: A person eligible for Covered Services who is experiencing a Transition of Care. A Transitioning Member may be an "Incoming Member" or an "Outgoing Member." [Discuss: culturally appropriate language / LGBTQ nomenclature.]

R. Outgoing Member: A Transitioning Member who will no longer be covered by Advanced Health and will be covered by another CCO or other arrangement approved by OHA.

(All terms not defined in this Plan have the meanings assigned to them in the CCO Contract.)

Transition of Care

1. In General. Advanced Health recognizes that it may be, for various Transitioning Members, a Transferring CCO or a Receiving CCO, and it must be prepared to facilitate the Transition of Care in either situation.

(a) Advanced Health will coordinate with OHA and CCOs to identify Transitioning Members as early as possible in the Transition of Care process. [Discuss: identification of Transitioning Members.]

(b) Advanced Health [has adopted] the Policy and the Procedure. A senior staff member in each department of Advanced Health potentially involved in Transitions of Care (e.g., Care Coordination, Data Analytics, and Claims), who will be appointed by the manager of such department, will have responsibility for ensuring that each department's activities are aligned
with the Policy, Procedure and this Plan to support successful Transitions of Care.

(c) The Transition of Care Manager will have the following responsibilities:

(i) Ensuring that the Member Handbook, website, and navigators provide accurate and accessible information to Members regarding their rights and responsibilities with respect to Transitions of Care;

(ii) Developing necessary and appropriate correspondence and forms (paper and electronic) and other documents to implement Transitions of Care;

(iii) Coordinating with each staff member in the various departments described in Section 1(a);

(iv) Coordinating with OHA and other CCOs with respect to procedures for prompt identification of Members who will experience a Transition of Care;

(v) Ongoing outreach to other CCOs to establish relationships and procedures to facilitate safe, orderly and timely Transitions of Care, and in particular, strategies for identifying departments at other CCOs that are responsible for Transitions of Care so that Advanced Health can build relationships and lines of communication between key staff members of each CCO, leading to established procedures that help eliminate delays or interruptions in care;

(vi) Exploring opportunities to improve the timeliness, orderliness and safety of Transitions of Care, including by working with other CCOs to explore jointly developing technological solutions that will facilitate data sharing and standardizing the organization and format of data that CCOs exchange in a Transition of Care;

(vii) Analyzing instances of Transitions of Care to evaluate Advanced Health's performance in this arena, developing strategies for continual improvements, and reporting and recommending changes to management;

(viii) Assigning Transitioning Members to Transitional Care Coordinators; and

(ix) Taking such further actions as directed by management to implement the Policy, the Procedure and this Plan.

(d) As appropriate, Advanced Health will enter into Memoranda of Understanding with other CCOs to standardize procedures that will facilitate data sharing and validation, sharing Member Prior Authorization history, Provider matching and assignment, Continued Access to Care, and customer support, all with the goal of successful Transitions of Care for Transitioning Members. Advanced Health will provide such Memoranda to OHA.
(c) Advanced Health remains responsible for providing Covered Services for a Transitioning Member until the effective date of the Member's Disenrollment from Advanced Health.

(f) Advanced Health will update this Plan, and the Policies and Procedures that inform it, in response to changes in applicable federal Law, State Law, and contractual requirements.

2. Advanced Health as the Transferring CCO (Transferring Members to a Receiving CCO). This Section applies to situations in which Advanced Health is the Transferring CCO, i.e., a Member (the "Outgoing Member") will no longer have coverage with Advanced Health and will have coverage from another CCO or other arrangement approved by OHA.

(a) When Advanced Health identifies an Outgoing Member, the Transition Care Manager will assign the Outgoing Member to a Transition of Care Coordinator (TCC).

(b) The TCC will send the Outgoing Member a written communication introducing him-or herself, notifying the Outgoing Member of the steps that Advanced Health takes to provide Continued Access to Care to the Outgoing Member, and informing such Outgoing Member that the Member or any of his or her Providers or Member Representatives may contact Advanced Health to learn more about the services that Advanced Health provides to facilitate the Transition of Care. The TCC will be aware of high-need Outgoing Members and be available to perform Warm Handoff activities for these Outgoing Members and other Outgoing Members who may need special supports. For Members with limited English proficiency who are under the care of a Provider who speaks the Member's native language, the services of healthcare translators will be provided to the Member and his or her Representatives.

(c) The TCC will be available to communicate with Outgoing Members assigned to the TCC, along with their Providers and Member Representatives, about how Advanced Health facilitates Continued Access to Care during a Transition of Care. For Members who are mid-course in the required processes of establishing eligibility for bariatric or gender reassignment surgery, Advanced Health will facilitate Continued Access to Care until those eligibility requirements have been met, prior to effecting the actual Transition of Care for the Outgoing Member.

(d) Advanced Health will comply with requests from [Discuss: OHA or each Receiving CCO, or both] for complete historical utilization data and records with respect to an Outgoing Member within 21 calendar days of the effective date of a Member's enrollment with the Receiving CCO. [Discuss: timing coordination/no timely notice]
(i) The TCC will confirm the Receiving CCO and connect with that CCO to begin the Transition of Care process;
(ii) The TCC will submit a request to Advanced Health's Analytics Department, which then performs a data extraction of Advanced Health's records relating to the Outgoing Member and confers with Providers and Subcontractors to obtain all applicable information located in those entities' systems.
(iii) Advanced Health will provide all data as permitted by HIPAA and in a HIPAA compliant format to facilitate each Transition of Care. [Discuss: privacy and security procedures]
(iv) The historical utilization data and records with respect to an Outgoing Member include, at a minimum:
(A) Current Prior Authorizations and pre-existing orders;
(B) Prior Authorizations for any services rendered in the last 24 months;
(C) Current Behavioral Health services that Advanced Health provides to the Member;
(D) A list of all active prescriptions;
(E) Current ICD-10 diagnosis;
(F) All records relating to high-needs Care Coordination;
(G) Any additional medical or financial records as necessary to maximize and maintain the Outgoing Member's continuity of care;
(H) Such other records as required by federal Law, State Law, or contractual obligations.
(c) The TCC will then accomplish the following activities:
(i) Reviewing the Outgoing Member's records to confirm and identifying for the Receiving CCO whether the Member is chronically ill, high risk, hospitalized, or pregnant and within the last four weeks of pregnancy, has any other needs that require high-level coordination, or falls within any of the following categories:
(A) Prioritized Populations;
(B) A medically fragile child;
(C) A member of a Breast and Cervical Cancer Treatment program;
(D) A Member receiving CareAssist assistance due to HIV/AIDS;
(E) A Member receiving services for end-stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services;
(F) A Member discharged from the Oregon State Hospital or Medicaid funded residential Behavioral Health Programs in the last 12 calendar months;
(G) A Member participating in Oregon's CMS Approved 1915(k) and 1915(c) programs for individuals who have met institutional level of care requirements in order to access Home and Community Based Services; or

(H) A Member who, in the absence of continued access to services, may suffer serious detriment to his or her health or be at risk of hospitalization or institutionalization;

(ii) Coordinate care with the Receiving CCO for the Outgoing Member, including by identifying the Outgoing Member's Primary Care Providers and Behavioral Health Providers and any specialty Providers;

(iii) Prioritize Care Coordination with the Receiving CCO if the TCC identifies that the Member falls within any of the categories set forth in Section 2(e)(i);

(iv) Coordinate with the Receiving CCO to (A) facilitate and schedule medically necessary appointments for care and services for dates of service after the Member will cease to be Enrolled with Advanced Health and (B) confirm that the Receiving CCO is aware of Prior Authorized Care and the Member's needs with respect to prescription medications, medical Case Management Services, and NEMT;

(v) Facilitate Advanced Health's continuation of Covered Services to the Outgoing Member in a course of treatment for which a change in Providers may be harmful until the treatment is concluded or an appropriate transfer of care is arranged; and

(vi) Complete such other activities as are required by federal Law, State Law, or contractual obligation.

(f) Advanced Health will maintain financial responsibility for all Members who are hospitalized prior to the date of the Member's Disenrollment through the date of discharge and for patients receiving post-Hospital extended care benefits after termination of Advanced Health's CCO Contract to the extent Advanced Health is responsible under the CCO Contract.

3. **Advanced Health as Receiving CCO (Receiving Members from a Transferring CCO).** This Section applies in circumstances in which Advanced Health is the Receiving CCO, i.e., another CCO is transferring a Member (the "Incoming Member") to Advanced Health.

(a) When Advanced Health identifies an Incoming Member, the Transition Care Manager will assign the Transitioning Member to a Transition Care Coordinator ("TCC").

(b) The TCC will send the Incoming Member a written communication (1) notifying the Incoming Member of the steps that Advanced Health takes to provide Continued Access to Care to the Incoming Member;
(2) requesting that the Member contact Advanced Health to begin the Transition of Care process; and (3) informing the Incoming Member that the Incoming Member or any of the Member's Providers or Representatives may contact Advanced Health to learn more about the services that Advanced Health provides to facilitate the Transition of Care.

(c) The TCC will be available to communicate with Incoming Members assigned to the TCC, along with their Providers and Member Representatives, about how Advanced Health facilitates Continued Access to Care during a Transition of Care. The TCC will be aware of high-need Incoming Members and be available to perform Warm Handoff activities for these Incoming Members and other Incoming Members who may need special supports.

(d) The TCC will contact the Transferring CCO to request that the Transferring CCO send Advanced Health the Incoming Member's complete historical utilization data and records and coordinate with Advanced Health in identifying whether the Member falls within any of the categories set forth in Section 2(e)(i);

(i) The TCC will coordinate with Advanced Health's analytics department to input all information and records received from the Transferring CCO into Advanced Health's system; and

(ii) The TCC will review the records received from the Transferring CCO and any other information received from the Incoming Member to determine the Providers who were providing the Incoming Member with Covered Services before the Member transferred to Advanced Health and what types of Providers Advanced Health should engage to provide the Member with Continued Access to Care during the Transition Period.

(e) Advanced Health provides Continued Access to Care, without delay, to a Member during the Member's Transition of Care Period. During the Transition of Care Period, [Discuss: specific required activities, subject to CCO contract development and negotiation]:

(i) Advanced Health provides the Member access to Covered Services consistent with the access that the Member had under the Transferring CCO;

(ii) If a Member can be Enrolled with the Member's Provider under the Transferring CCO, then Advanced Health Enrolls the Member with that Provider; in all other cases, Advanced Health promptly refers the Member to appropriate Providers pursuant to Advanced Health's Member assignment system, including primary care and specialty Providers as identified by the TCC;
(iii) The TCC coordinates care with the Transferring CCO and prioritizes Continued Access to Care to the Member when the TCC identifies that the Member falls within any of the categories set forth in Section 2(e)(i);

(iv) The TCC coordinates with the Transferring CCO to facilitate and schedule Medically Appropriate appointments for care and services for dates of service after the Member Enrolls with Advanced Health;

(v) Advanced Health covers all Prior Authorized Care and, where appropriate, permits the Member to retain the Member's previous Provider, unless and until:
   (A) The minimum or authorized prescribed course of treatment is completed; or
   (B) A reviewing Provider develops an Evidence-Based, medically appropriate care plan pursuant to which the treatment is no longer Medically Necessary; provided that, for specialty care, Advanced Health will have a qualified Provider review any treatment plan.
   (C) Notwithstanding subsections (A) and (B) above, Advanced Health continues the entire course of treatment with the Member's previous Provider as described in the following service-specific continuity of care period situations:
      (1.) Prenatal and postpartum care;
      (2.) Transplant services through the first-year post-transplant;
      (3.) Radiation or chemotherapy services for the current course of treatment; and
      (4.) Prescriptions with a defined minimum course of treatment that exceeds the Transition of Care Period.

(f) The TCC monitors the Transition of Care to identify issues that may arise during the Transition of Care process. The TCC is available to communicate with Members and their Representatives and Providers about how Advanced Health facilitates Continued Access to Care during a Member's Transition in Care.

(g) Advanced Health is not responsible for payment of the following services for an Incoming Member before the end of the Transition of Care Period:
   (i) Health-Related Services (as defined in OAR 410-141-3150); or
   (ii) Inpatient hospitalization or post-Hospital extended care, for which any predecessor CCO, including the Transferring CCO, was responsible under its contract with the OHA.

(h) Advanced Health remains responsible for Care Coordination and discharge planning activities in conjunction with others as described in OAR 410-141-3160 and OAR 410-141-3170.
(i) Advanced Health obtains written documentation as necessary for Transition of Care from the following:
   (i) OHA’s Division of Medical Assistance Programs’ clinical services for Members transferring from FFS;
   (ii) Other CCOs as needed; and
   (iii) Previous Providers, with Incoming Member consent, when necessary.

(j) During the Transition of Care Period, Advanced Health does not delay service authorization if written documentation of prior authorization is not available in a timely manner. [Discuss: procedures to ensure patient safety and orderliness of authorization/care]

(k) Advanced Health follows all service authorization protocols outlined in OAR 410-141-3225 and gives the Member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. Each such notices meets the requirements of 42 CFR §438.404 and OAR 410-141-3240.

4. **Termination or Non-Renewal of CCO Contract.** If the CCO Contract will be terminated or not renewed, then this Section applies.

   (a) Advanced Health will follow the processes set forth in Section 2 and cooperate with OHA to safely, orderly, and timely accomplish the Transition of Care of Members to coverage under new arrangements authorized by the OHA (whether a Receiving CCO, Open Card, or other arrangement).

   (b) The Transition of Care Manager will be responsible for coordinating Advanced Health staff (and coordinating, as applicable with Network Providers and Subcontractors) to ensure completion of Advanced Health’s obligations under its transition plan, and such responsibilities will include the coordination of Advanced Health staff to accomplish all Transitions of Care successfully. The Transition of Care Manager will designate a staff member in the Care Coordination department who will be primarily responsible for these duties, and he or she will report regularly to the Transition of Care Manager on the Transition of Care of Members. The Transition of Care Manager will make the designated staff member available to OHA for consultation and coordination discussions.

   (c) Advanced Health will ensure that both it, and as necessary and appropriate, its Providers and Subcontractors who are providing care to Members, cooperate with OHA in the following ways:
      (i) forwarding, at the request of and in the manner directed by OHA and in compliance with all privacy rules, all records relating to Members, including but not limited high needs care coordination records, copies of medical, behavioral, oral health and case care management records, Member files, and any other pertinent information as OHA requests;
(ii) facilitating and scheduling Medically Necessary arrangements or appointments for care and services, including arrangements for appointments with Network Providers for dates of service after the Contract termination date for the period during which Advanced Health is responsible for the care of the Members;

(iii) identifying chronically ill, high risk, hospitalized and pregnant Members in their last four months of pregnancy, as well as other populations requiring special assistance in the Transition of Care;

(iv) continuing to provide Continued Access to Care until appropriate transfer can be arranged for those Members in a course of treatment for which a change of Providers could be harmful; and

(v) conferring with OHA’s designated representatives in determining what further cooperation and coordination is necessary and appropriate for effective Transition of Care for Members.

(d) Advanced Health will provide the records to OHA in a usable form, and at no expense to OHA or any Member, using a file format and dates for transfer specified by OHA. [Discuss: mechanisms to transfer data.] Advanced Health will include in the records the following information, at a minimum: [Discuss: connect to CCO Contract for specific information required, such as numbers and status of grievances in process; numbers and status of hospital authorizations in process, listed by hospital; daily hospital logs; prior authorizations; approved health related services; approved program exceptions; medical cost ratio data; information on outstanding payments for medical care rendered to Members.]