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>
</tr>
</thead>
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<tr>
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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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<tr>
<td>✔️ Full County Coverage Exception Requests (Section 3.2) (Optional)</td>
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<tr>
<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 and interrelationships between the parent, Affiliates and the Applicant.</td>
</tr>
<tr>
<td>✔️ Attachment 6 – Subcontractor and Delegated Entities Report</td>
</tr>
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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 10 – Social Determinants of Health and Health Equity 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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<tr>
<td>✔️ Attachment 16 – Member Transition Plan</td>
</tr>
<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: Trillium Community Health Plan, Inc. (Trillium)

Address:
1800 Millrace Drive
Eugene, OR 97403

State of Incorporation: Oregon
Entity Type: DBC

Contact Name: Chris Ellertson, President & CEO
Phone: 503-213-5163
Email: christian.d.ellertson@healthnet.com

Oregon Business Registry Number: 341187-94

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](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](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/](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: [Signature] Title: CEO Date: 3/29/19

(Authorized to Bind Applicant)

State of Oregon

County of Washington

Signed and sworn to before me on 3/29/19 (date) by Chris Ebertson (Affiant's name).

Rebecca Majerus, Notary Public

My Commission Expires: 10/12/20
Attachment 4 - Disclosure Exemption Certificate

Chris Ellertson ("Representative"), representing [Trillium Community Health Plan, Inc.] ("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 [4/22/2019] (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. [x] 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

Exhibit A to Attachment 4

Applicant identifies the following information as exempt from public disclosure under the following designated exemption(s):

<table>
<thead>
<tr>
<th>Section Redacted</th>
<th>ORS or other Authority</th>
<th>Reason for Redaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment 6 - Key personnel resumes and Organizational Listing</td>
<td>ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47</td>
<td>1. Confidential and proprietary commercial information.</td>
</tr>
<tr>
<td>Attachment 8 - Value Based Payment Information, and VBP Excel Template</td>
<td>ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47</td>
<td>2. Confidential Financial and Payment Model Information.</td>
</tr>
<tr>
<td>Attachment 9 - DRAFT HIT Roadmap</td>
<td>ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47</td>
<td>3. Confidential and proprietary commercial information.</td>
</tr>
<tr>
<td>Attachment 12 - page 8 Narrative that discloses financial information.</td>
<td>ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47</td>
<td>5. Confidential Financial and Payment Model Information.</td>
</tr>
<tr>
<td>Attachment 3.2.e Reference, Page 2</td>
<td>ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47</td>
<td>6. Confidential Reference Information.</td>
</tr>
</tbody>
</table>
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 ☐

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: 1

   How many contracts did not meet those standards? Number: 0 If any, please explain.

   Response: Trillium has a single contract with the state since the inception of the CCO in 2012, with updated contractual agreements signed annually.

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 ☐ NO ☑

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

   Response:

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 ☑

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

   Response:
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: Trillium Community Health Plan, Inc. has satisfied all business requirements for the State of Oregon.

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: Please see the following page for a copy of our Pay Equity Certificate issued by the Department of Administrative Services.

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: Trillium Community Health Plan, Inc.

RFA: OHA-4690-19
Project Name: CCP 2.0 Request for Applications

Signature: [Signature]
Title: CEO
Date: 3/29/19

(Authorized to Bind Applicant)
Certificate of Completion

The State of Oregon, Other, Non State Employees, hereby certifies that

James Emanuel

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On 3/14/2019
REGISTRY NUMBER
34118794

REGISTRATION DATE
02/14/2006

BUSINESS NAME
TRILLIUM COMMUNITY HEALTH PLAN, INC.

BUSINESS ACTIVITY
OREGON HMO

MAILING ADDRESS
7700 FORSYTH BLVD
SAINT LOUIS MO 63105 USA

TYPE
DOMESTIC BUSINESS CORPORATION

PRIMARY PLACE OF BUSINESS
7700 FORSYTH BLVD
STE 800
SAINT LOUIS MO 63105 USA

JURISDICTION
OREGON

REGISTERED AGENT
329227 - C T CORPORATION SYSTEM

780 COMMERCIAL ST SE STE 100
SALEM OR 97301 USA

If the Registered Agent has changed, the new agent has consented to the appointment.

PRESIDENT
MARK MEYERS

7700 FORSYTH BLVD
SAINT LOUIS MO 63105 USA

SECRETARY
CHRISTIAN D ELLERTSON

7700 FORSYTH BLVD
SAINT LOUIS MO 63105 USA
I declare, under penalty of perjury, that this document does not fraudulently conceal, fraudulently obscure, fraudulently alter or otherwise misrepresent the identity of the person or any officers, directors, employees or agents of the corporation on behalf of which the person signs. 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**

**NAME**

KELLY LETTMANN

**TITLE**

POA

**DATE SIGNED**

01-08-2019
Articles of Incorporation
of
Trillium Community Health Plan, Inc.

Article I
The name of the Corporation is Trillium Community Health Plan, Inc.

Article II
The purposes for which this Corporation is organized are as follows:

(1) To provide services as a Health Care Service Contractor;

(2) To market group and individual health plans and related products and services to the general public; and

(3) To engage in any other lawful business.

Article III
The Corporation is authorized to issue 10,000 shares of Common Stock.

Article IV
Any action required or permitted by the Oregon Business Corporation Act to be taken at a shareholders meeting may be taken without a meeting if the action is taken, in accordance with the Oregon Business Corporation Act, by shareholders having not less than the minimum number of votes that would be necessary to take such action at a meeting at which all shareholders entitled to vote on the action were present and voted.

Article V
No director of the Corporation shall be personally liable to the Corporation or its shareholders for monetary damages for conduct as a director, provided that this Article shall not eliminate the liability of a director for any act or omission for which such elimination of liability is not permitted under the Oregon Business Corporation Act. No amendment to the Oregon Business Corporation Act that further limits the acts or omissions for which elimination of liability is permitted shall affect the liability of a director for any act or omission which occurs prior to the effective date of the amendment.

Article VI
The Corporation shall indemnify to the fullest extent not prohibited by law any current or former director of the Corporation who is made, or threatened to be made, a party to an action, suit or proceeding, whether civil, criminal, administrative, investigative or other (including an
action, suit or proceeding by or in the right of the Corporation), by reason of the fact that such person is or was a director, officer, employee or agent of the Corporation or a fiduciary within the meaning of the Employee Retirement Income Security Act of 1974 with respect to any employee benefit plan of the Corporation, or serves or served at the request of the Corporation as a director, officer, employee or agent, or as a fiduciary of an employee benefit plan, of another corporation, partnership, joint venture, trust or other enterprise. The Corporation shall pay for or reimburse the reasonable expenses incurred by any such current or former director in any such proceeding in advance of the final disposition of the proceeding if the person sets forth in writing (i) the person’s good faith belief that the person is entitled to indemnification under this Article and (ii) the person’s agreement to repay all advances if it is ultimately determined that the person is not entitled to indemnification under this Article. No amendment to this Article that limits the Corporation’s obligation to indemnify any person shall have any effect on such obligation for any act or omission that occurs prior to the later of the effective date of the amendment or the date notice of the amendment is given to the person. This Article shall not be deemed exclusive of any other provisions for indemnification or advancement of expenses of directors, officers, employees, agents and fiduciaries that may be included in any statute, bylaw, agreement, general or specific action of the Board of Directors, vote of shareholders or other document or arrangement.

Article VII

The street address and the mailing address of the initial registered office of the Corporation is 1800 Millrace Road, Eugene, Oregon 97403, and the name of its initial registered agent at that address is David Cole.

Article VIII

The name of the incorporator is Jason M. Brauser and the address of the incorporator is c/o Stoel Rives LLP, 900 SW Fifth Ave., Suite 2600, Portland, Oregon 97204.

Article IX

The mailing address for the Corporation for notices is 1800 Millrace Road Eugene, OR 97403.


[Signature]

Jason M. Brauser, Incorporator
Acknowledgment Letter

The document you submitted was recorded as shown below. Please review and verify the information listed for accuracy.

If you have any questions regarding this acknowledgement, contact the Secretary of State, Corporation Division at (503)986-2200. Please refer to the registration number listed above. A copy of the filed documentation may be ordered for a fee of $5.00. Submit your request to the address listed above or call (503)986-2317 with your Visa or MasterCard number.

Document
ARTICLES OF INCORPORATION

Filed On                      Jurisdiction
02/14/2006                    OREGON

Name
TRILLIUM COMMUNITY HEALTH PLAN, INC.

Registered Agent
DAVID COLE
1800 MILLRACE RD
EUGENE OR 97403
Acknowledgment Letter

The document you submitted was recorded as shown below. Please review and verify the information listed for accuracy.

Document
ARTICLES OF AMENDMENT

Filed On
07/10/2012

Jurisdiction
OREGON

Name
TRILLIUM COMMUNITY HEALTH PLAN, INC.

Principal Place of Business
1800 MILLRACE
EUGENE OR 97403

Registered Agent
DAVID COLE
1800 MILLRACE RD
EUGENE OR 97403

President
THOMAS KURT WUEST
1800 MILLRACE RD
EUGENE OR 97403

Secretary
TERRY WAYNE COPLIA
1800 MILLRACE RD
EUGENE OR 97403

THEJOH
ACK
07/10/2012
Articles of Amendment
to
Articles of Incorporation of
Trillium Community Health Plan, Inc.

1. The name of the corporation is Trillium Community Health Plan, Inc.

2. The following is added as Article X of the Articles of Incorporation of the corporation:

“ARTICLE X

Subject to applicable law, including without limitation ORS 60.181, the Oregon Insurance Code, and laws applicable to Oregon coordinated care organizations, if a majority of the outstanding shares of Common Stock approve, by a vote (whether taken at a meeting or by written consent) taken within 90 days after the end of a fiscal year of the Corporation, a distribution of the excess cash of the Corporation (which shall be an amount equal to (a) the Corporation’s net cash provided by its operating activities for the preceding fiscal year, less (b) net cash used in the Corporation’s operations for such fiscal year, less (c) reasonable reserves established in good faith by the Board of Directors), the Corporation shall distribute such excess cash to the holders of Common Stock promptly following such approval.”

5. The amendments to the Articles were adopted by the Board of Directors of the corporation on June 25, 2012.

6. There are 5,000 shares of the corporation’s Common Stock outstanding, 5,000 of which were entitled to vote on the amendments to the Articles. 5,000 shares of the corporation’s Common Stock voted to approve the amendment to the Articles and none voted against.

June 25, 2012

Trillium Community Health Plan, Inc.

By
Name
Title

The person to contact about this filing is Luis Garcia at (503) 294-9838.
Corporation/Limited Liability Company - Information Change

REGISTRY NUMBER: 34118794
ENTITY TYPE: ☑ DOMESTIC ☐ FOREIGN

In accordance with Oregon Revised Statute 192.410-192.490, 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.

1. NAME OF CORPORATION OR LIMITED LIABILITY COMPANY:

Trillium Community Health Plan, Inc.

2. BUSINESS ACTIVITY

Complete only the sections that you are updating.

6. ADDRESS WHERE THE DIVISION MAY MAIL NOTICES:

3. PRINCIPAL PLACE OF BUSINESS: (Street Address)

1800 Millrace Drive
Eugene, OR 97403

4. THE REGISTERED AGENT HAS BEEN CHANGED TO:

Christian D. Ellerton, Secretary
1800 Millrace Drive
Eugene, OR 97403

5. REGISTERED AGENT'S PUBLICLY AVAILABLE ADDRESS:

Must be an Oregon Street Address, which is identical to the registered agent's office.

7. THE NEW REGISTERED AGENT HAS CONSENTED TO THIS APPOINTMENT.

8. THE STREET ADDRESS OF THE NEW REGISTERED OFFICE AND THE BUSINESS ADDRESS OF THE REGISTERED AGENT ARE IDENTICAL.
The entity has been notified in writing of this change.

9. INDIVIDUAL WITH DIRECT KNOWLEDGE (Names and Addresses)
List the name and address of at least one individual who is a director, or controlling shareholder of the corporation (member or manager of the LLC) or an authorized representative with direct knowledge of the operations and business activities of the corporation or LLC.

Christian D. Ellerton, Secretary
1800 Millrace Drive
Eugene, OR 97403

10. NAME(S) AND ADDRESS(ES) OF CORPORATE OFFICERS OR LLC MEMBERS/MANAGERS
Corporations list the name and address of one President and one Secretary (ORS 60.787, ORS 65.787, ORS 62.455, ORS 554.315).
Limited Liability Companies list the name and addresses of the managers for a manager-managed limited liability company or the name and address of at least one member for a member-managed limited liability company (ORS 63.787). Please attach a separate sheet of paper if needed.
If making changes to this section, list all current names and addresses. This replaces what is currently on the record.

PRESIDENT OR OWNER(S) (MEMBERS): (Names and Addresses)

Mark Meyers
1800 Millrace Drive
Eugene, OR 97403

SECRETARY OR MANAGER(S): (Names and Addresses)

Christian D. Ellerton
1800 Millrace Drive
Eugene, OR 97403

11. EXECUTION: I declare as an authorized signer, under penalty of perjury, that this document does not fraudulently conceal, obscure, alter, or otherwise misrepresent the identity of any person including officers, directors, employees, members, managers or agents. 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: Christian D. Ellerton
TITLE: Secretary

CONTACT NAME: (To resolve questions with this filing)
Allan Patterson
PHONE NUMBER: (Include area code)
503-796-2976

FEES
No Processing Fee
Free copies are available at sos.oregon.gov/business using the Business Name Search program.

Information Change 12/17
ATTACHMENT 6 — GENERAL QUESTIONS

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Page limits for this General Questionnaire is nine pages, items that are excluded from the page limit will be noted in that requirement.

A. BACKGROUND INFORMATION ABOUT THE APPLICANT

1. QUESTIONS

In narrative form, provide an answer to each of the following questions.

Describe the Applicant’s Legal Entity status, and where domiciled.

Trillium Community Health Plan (Trillium), the Applicant, is a wholly-owned subsidiary of Agate Resources, Inc. (Agate), a for-profit corporation 100% owned by Centene Corporation (Centene), a for-profit corporation. Trillium is domiciled in Eugene, Oregon.

a. Describe Applicant’s Affiliates as relevant to the Contract.

Trillium’s Affiliates include subcontractors to support covered services and business functions including management services, vision and pharmacy services, nurse advice line, and disease management services as detailed in Att.6.D.1.a. Our affiliate, Health Net of Oregon (Health Net), operates a Medicare Advantage plan that will support dual eligible members in 2020 for any new counties that we may be awarded. We intent to expand Trillium’s Dual Eligible Special Needs Plan (D-SNP) product in 2021. See Att.6.A.1.g.

b. Is the Applicant invoking alternative dispute resolution with respect to any Provider (see OAR 410-141-3268)? If so, describe.

No. Trillium is not invoking alternative dispute resolution proceedings.

c. What is the address for the Applicant’s primary office and administration located within the proposed Service Area?

Trillium’s primary office and administration is 1800 Millrace Drive, Eugene, OR 97403, with a second location at 13221 SW 68th Parkway, Tigard, OR 97223.

d. What counties are included in this Service Area? Describe the arrangements the Applicant has made to coordinate with county governments and establish written agreements as required by ORS 414.153.

Trillium’s proposed Service Area includes Lane, Clackamas, Multnomah, and Washington, and partial in Linn and Douglas Counties. For ease of review, we refer to our proposed Service Area as the Lane Region (inclusive of Lane, and partial Linn and Douglas Counties) and the Tri-County Region (inclusive of Clackamas, Multnomah and Washington Counties). Trillium has Memorandums of Understanding (MOUs) with Lane, Linn, and Douglas Counties that set forth roles and responsibilities to coordinate services and efforts to meet the needs of the communities we serve and to achieve improved outcomes in compliance with the Sample Contract, ORS 414.153, and other State requirements. We have met with and provided a draft MOU for the CCO 2.0 program to Clackamas, Multnomah, and Washington Counties. Washington and Clackamas Counties have indicated a willingness and interest in jointly developing an MOU should Trillium be awarded a CCO 2.0 Contract (see Att.7.1.d and 7.12.c).

Liaisons to Support County Government Relationships. To develop, coordinate, and manage relationships with county governments, Trillium has designated points of contact including Behavioral Health (BH), Developmental Disability (DD), and Long Term Care (LTC) Liaisons. Coordination activities include regular meetings to collaboratively establish written agreements outlining division of responsibilities, payment and authorization processes, data sharing protocols for care coordination, and agreed-upon outcomes to ensure member access to behavioral health and public health services.

e. Prior history: (1) Is Applicant the Legal Entity that has a contract with OHA as a CCO as of January 1, 2019 (hereinafter called "Current CCO")? (2) If no to 1, is Applicant the Legal Entity that had a contract with OHA as a CCO prior to January 1, 2019? (3) If no to 1 and 2, is Applicant an Affiliate with or a Risk Assumming Entity of a CCO that has a current or prior history with OHA? (4) If no to 1, 2, and 3, what is Applicant’s history of bearing health care risk in Oregon?
Trillium (legal entity) holds contract #143121-14 with OHA as a CCO as of January 1, 2019.

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 • Oregon Educators Benefit Board • Adult Mental Health Initiative • Cover All Kids • Other (please describe)

Outside of our CCO experience, Trillium currently contracts with OHA for Cover All Kids.

g. Does the Applicant (or an Affiliate of Applicant) have experience as a Medicare Advantage contractor? Does the Applicant (or an Affiliate of Applicant) have a current contract with Medicare as a Medicare Advantage contractor? What is the Service Area for the Medicare Advantage plan?

Trillium has offered a D-SNP (H2174-001) in Lane County, Oregon since 2007. Our affiliate, Health Net, also has experience as a Medicare Advantage contractor, covering 14 counties in Oregon, including our entire proposed Service Area.

h. Does Applicant have a current Dual Special Needs Coordination of Benefits Agreement with OHA to serve Fully Dual Eligible Members?

Yes, Trillium has a current Dual Special Needs Coordination of Benefits Agreement with OHA.

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?

Yes, Trillium and our affiliate Health Net hold a current certificate of authority from the DCBS.

j. Does the Applicant (or an Affiliate of Applicant) hold a current contract effective January 1, 2019, with the Oregon Health Insurance Marketplace?

Neither Trillium nor Health Net hold a contract with the Oregon Health Insurance Marketplace.

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.

As a locally-based, community-rooted health plan, Trillium has over 20 years’ experience engaging and developing sustainable partnerships with community members, providers, and stakeholders to collaboratively address and improve health and disparities that exist amongst our members and the community.

Through the structure OHA has established and in collaboration with our Live Healthy Lane partners, we engage a diverse group of stakeholders to identify priorities through our Community Health Improvement Plan (CHP) including BH, oral health (OH), education, housing, business, economic development, early childhood, social services and non-emergent transportation (NEMT). Based on those priorities, we leverage our Community Advisory Councils (CACs) and Rural Advisory Council (RAC) to guide investments and initiatives in conjunction with the Clinical Advisory Panel (CAP). Our Chief Equity Officer and Community Relations team, in addition to our leadership team, are accountable for understanding the needs and resources of the community and engaging effective partners based on community direction. For example, to address the priority of food insecurity and cultural, socioeconomic, regional, and racial disparities in the prevalence of obesity and diabetes, we partnered with FOOD for Lane County to

DEMONSTRATED EXPERIENCE & CAPACITY

Driven through our governance structure, care coordination interactions, financial investments, trainings and learning collaboratives, and staff, we have:

• Created a Rural Advisory Committee (RAC) based upon identified membership needs
• Invested more than $13 million in the Lane Region in the last 5 years
• Distributed monthly population health Hot-Spotter Report to PH, BH, and OH providers
• Invested in SDOH-HE programs and tools through the Trillium Innovation Fund
• Provided free SDOH program evaluations to community partners
provide the Produce Plus program in targeted clinics and other locations, expanding community access to high quality fruits and vegetables. In 2018, we expanded our partnership to include Trillium’s VeggieRx program which integrates access to fresh fruits and vegetables with diabetes prevention education, including exercise and nutrition. Forty-four members participated in the initial pilot program and preliminary results indicate that members who used Trillium’s VeggieRx vouchers lost nearly twice as much weight on average compared to members that did not use the vouchers. Based on the lessons learned and successes in our current Service Area and as evidenced by our Community Engagement Plan (see Att. 10 RFA Community Engagement Plan Requirement Components and Att. 10 RFA Community Engagement Plan Required Tables), we have the experience and capacity to engage community members and providers. We look forward to developing similar relationships in the Tri-County Region to address and improve social determinants of health and health equity (SDOH-HE) and health disparities.

1. Identify and furnish résumés for the following key leadership personnel (by whatever titles designated): • Chief Executive Officer • Chief Financial Officer • Chief Medical Officer • Chief Information Officer • Chief Administrative or Operations Officer (résumés do not count toward page limit; each resume has a two page limit)

See Att. 6 Key Leadership Personnel Resumes.

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: • The Application generally, • Each Attachment to the RFA (separate contacts may be furnished for parts), • The Sample Contract generally, • Each Exhibit to the Sample Contract (separate contacts may be furnished for parts), • Rates and solvency, • Readiness Review (separate contacts may be furnished for parts), and • Membership and Enrollment

See Att. 6 RFA Contact List.

2. REQUIRED DOCUMENTS

<table>
<thead>
<tr>
<th>Background Narrative</th>
<th>Pages 1-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Résumés (excluded from pages limit)</td>
<td>Att. 6 Key Leadership Personnel Resumes</td>
</tr>
<tr>
<td>Contact list (excluded from pages limit)</td>
<td>Att. 6 RFA Contact List</td>
</tr>
</tbody>
</table>

B. CORPORATE ORGANIZATION AND STRUCTURE

1. QUESTIONS

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.

See Att. 6 Articles of Incorporation.

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

See Figure A. Organization Chart Listing. As of December 31, 2018, Trillium is 100% owned by Agate, which is 100% owned by Centene. No single individual has a controlling percentage over the organization.

c. Describe any licenses the corporation possesses.

Trillium is licensed by DCBS to transact insurance in the state of Oregon.

d. Describe any 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.

Trillium does not hold any administrative service or management contracts with other parties outside of Centene Management Company, LLC (CMC), as referenced in Att.6.C.

2. REQUIRED DOCUMENTS

<table>
<thead>
<tr>
<th>Articles of Incorporation (excluded from page limit)</th>
<th>Att. 6 Articles of Incorporation</th>
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</thead>
<tbody>
<tr>
<td>Narrative of Items b through d</td>
<td>Page 3</td>
</tr>
</tbody>
</table>
C. CORPORATE AFFILIATIONS, TRANSACTIONS, ARRANGEMENTS

1. QUESTIONS

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. Please see Att. 6 Organization Listing.

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.

Below outlines our parent and Affiliate expense arrangements for 2017 and 2018, respectively.

<table>
<thead>
<tr>
<th>Organization and Services Provided</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agate Resources, Inc. (Agate) (Data, claims processing, care management, care coordination, general management services)</td>
<td>$35,145,141</td>
<td>N/A</td>
</tr>
<tr>
<td>Centene Management Company, LLC (CMC) (Information systems, claims processing, fraud and abuse, third party liability services, provider data management, human resources support, finance services)</td>
<td>N/A</td>
<td>$55,219,616</td>
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<tr>
<td>Envolve PeopleCare, Inc. (Nurse advice line and outbound calling; select disease management services [2018 only*])</td>
<td>$96,599</td>
<td>$97,892</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$72,689*</td>
</tr>
<tr>
<td>Envolve Vision, Inc. (Vision services)</td>
<td>$214,668</td>
<td>$217,537</td>
</tr>
<tr>
<td>Bankers Reserve Life Insurance Company of Wisconsin (Reinsurance)</td>
<td>$1,707,062</td>
<td>$1,769,257</td>
</tr>
<tr>
<td>Envolve Pharmacy Solutions, Inc. (Pharmacy Benefit Management services)</td>
<td>N/A</td>
<td>$75,372,925</td>
</tr>
</tbody>
</table>

c. Describe Applicant’s demonstrated experience and capacity for: • Managing financial risk and establishing financial reserves • Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350.

Since 2012, Trillium has managed financial risk using methods including a sound provider network and risk sharing provisions within our provider contracts, appropriate medical and utilization management, stop loss reinsurance arrangements for catastrophic cases, and an investment portfolio that seeks preserve capital while maximizing total return and maintaining liquidity. We record non-medical expenses on an incurred basis at the amount of the ultimate anticipated liability, and estimate medical claims liability amounts in a manner adequate to cover obligations under moderately adverse conditions. Quarterly, two independent external actuaries review Trillium’s medical claims reserves for sufficiency. Our external auditor, KPMG, issues an annual audit report opining on the material accuracy of our financial statements. We have established and will continue to monitor on a quarterly basis our restricted reserves for compliance as required for an Oregon Department of Consumer & Business Services Licensed Insurer. Similarly, we review our net worth on a quarterly basis relative to the requirements set forth by OAR 410-141-3350 and ORS 750.045. *Trillium has a history of meeting requirements as our membership has grown and our capital and surplus level is well in excess of the benchmarks set forth by OAR 731.554 and the standard benchmark of 200% of the Authorized Control Level established by NAIC’s Risk Based Capital model for determining appropriate minimum capital and surplus levels.

2. REQUIRED DOCUMENTS

<table>
<thead>
<tr>
<th>Item a., an organization chart or listing (excluded from page limit)</th>
<th>Att. 6 Organization Listing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrative for Items b and c</td>
<td>Page 4</td>
</tr>
</tbody>
</table>
D. SUBCONTRACTS

1. INFORMATIONAL QUESTIONS

a. Please identify and describe any business functions the Contractor subcontracts or delegates to Affiliates.

Trillium subcontracts the following business functions to Affiliates: CMC (management services), Envolve PeopleCare (nurse advice line and select disease management services), Envolve Pharmacy Solutions (pharmacy benefit management), and Envolve Vision (vision services).

b. What are the major subcontracts Applicant expects to have? 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)

Trillium’s expected major subcontracts for our proposed CCO 2.0 Service Area are:

- **Dental**: Advantage Dental Services, Capitol Dental Services, ODS Community Dental, and Willamette Dental (Letters of Agreement (LOAs) for Tri-County Region with these Dental Care Organizations)
- **Interpretation Services**: Linguava Interpreters
- **Management Services**: CMC
- **NEMT**: Lane Transit District (Lane Region) and GridWorks, MTM, and LogistiCare (LOAs for Tri-County Region)
- **Nurse Advice Line**: Envolve PeopleCare
- **Pharmacy Benefit Management**: Envolve Pharmacy Solutions
- **Vision**: Envolve Vision
- **Select BH Services**: Lane County (Trillium Behavioral Health)

For a full list of subcontracts, see **Att. 6 Subcontractors and Delegated Entities Report**. For an example of subcontracted work performed, see **Att. 6 Subcontracted Work Example**.

**Monitoring Subcontractor Performance.** Through Trillium’s written agreements, subcontractors retain responsibility for fully complying with all applicable federal and State laws and regulations and all terms of the Sample Contract. Our comprehensive Third Party Oversight Program, and supporting policies and procedures, guide our subcontractor performance oversight approach, outlining procedures for training, risk assessments, monitoring, audits, and corrective action plans (CAPs). We monitor subcontractor performance through ongoing operational calls, either weekly or monthly. We also conduct formal Joint Operations Committee (JOC) meetings quarterly, with documented minutes routed to Trillium and subcontractor participants for review and approval. Subcontractors complete monitoring dashboards, which are reported to Trillium, and reviewed in JOC meetings. Prior to executing agreements, if the subcontractor is a new vendor to Trillium, a pre-service risk assessment is completed. We conduct annual audits to review each subcontractor, considering NCQA, CMS, Contract and agreement requirements. Audits include subcontractor-specific policy, procedure, and file reviews of delegated functions, such as customer service, quality, grievances, employee screening, and compliance functions. Subcontractor performance is reported to, and overseen by, the Quality Improvement Committee and Compliance Committee, each of which meets quarterly. If Trillium identifies a subcontractor issue through meetings, monitoring, or audits, or receives a report of non-compliance, sanction, or complaint from a regulatory agency, we promptly communicate the issue to the subcontractor for investigation and resolution. As appropriate, subcontractors are required to complete quality improvement plans and/or CAPs, and may be subject to penalties for non-compliance.

2. REQUIRED DOCUMENTS

| Narrative for Items a and b | Page 5 |
E. THIRD PARTY LIABILITY
1. INFORMATIONAL QUESTIONS

a. How will Applicant ensure the prompt identification of Members with TPL across its Provider and Subcontractor network?

We ensure prompt identification of members with TPL across our network through our proactive, comprehensive strategy and processes based on a Medicaid as a payer of last resort principle in line with federal and State requirements, including OHA TPL policies outlined in Exhibit B, Part 8, Sections 16 and 17 of the Sample Contract, as amended via RFA Addendum 7.

**PROMPT IDENTIFICATION OF TPL**

*Pre-payment Cost Avoidance.* Trillium determines when TPL may be primary before claims are paid through loading of TPL and Coordination of Benefit (COB) data received from submitted claims, through provider service interactions, uploaded TPL/COB documentation through our secure Provider Portal, self-reported through member interactions with staff, from OHA (RFA Sample Contract Exhibit B.16.p), and from leading TPL/COB vendors, who maintain updated information on other insurance nationwide. We bring all TPL/COB information together in our Unified Member View member eligibility system which is automatically linked to a member’s unique master member index. Unified Member View is integrated with our claims processing system, enabling efficient cost avoidance through claim suspension for members with TPL/COB, for claims submitted without required payment information from a primary payer. Monthly, our TPL/COB vendors review our member eligibility data against regularly updated, nationwide databases of insurance eligibility information to identify available TPL/COB coverage. The member level TPL/COB data we receive from our vendors is loaded into our system and validated by systematically matching member identifiers from these vendors with corresponding identifiers in Unified Member View. Trillium maintains records of our actions related to TPL recovery, making them available for OHA upon request.

*Post-payment Recovery.* We work closely with our TPL/COB and subrogation recovery vendors to identify and recover payments post-payment. We provide our vendors with a weekly claims detail report, including major medical, prescription drug and dental claims, so that they can determine if claims are related to TPL/COB for a member and recover the funds. Our vendors bill the primary carrier on our behalf for recovery from the third party payer. For cases related to subrogation, one of our leading vendors initiates steps for recoveries made through settlements.

**Sustainability & Transparency**

Subcontractors. In addition to working with our Providers, we incorporate our subcontractors in our cost avoidance processes. We have provisions in our subcontractor contracts requiring timely reporting of TPL/COB information from our subcontractors as outlined in Exhibit B, Part 8, Section 16 of the Sample Contract.

**Policies and Procedures.** We have a comprehensive TPL recovery (TPLR) policy in place for identifying TPL resources, allowing providers to request TPL information from members, reporting to OHA identified TPL, performing cost avoidance, adjusting encounters to reflect the amounts recovered from the primary payer, and recovering liability from the third party.

b. How will Applicant ensure the prompt identification of Members covered by Medicare across its Provider and Subcontractor network?

Trillium has signed a Coordination of Benefits Agreement (COBA) to participate in the automated claims crossover process administered by Medicare. Our Health Information System currently supports this process, as well as the CMS COBA Eligibility Record Layout format. We coordinate with the CMS Benefits Coordination & Recovery Center (BCRC) for Medicaid as the “payer of last resort.” When our claims system receives a claim from the BCRC, it identifies the member with Medicare as the primary payer, validates COB
identification information on the claim, and adjudicates the claim for remaining Trillium benefits using the COB segment in the claim for secondary payment information. We also use the TPL/COB identification approaches described in Att.6.E.1.a to identify members covered by Medicare across our provider and subcontractor network. In addition, one of our TPL/COB vendors is dedicated to performing TPL/COB identification activities for Medicare members. For the Medicare COB post-payment process, when our recovery partners find an overpayment, they pursue the refund with the providers directly, and direct the provider to bill Medicare for reimbursement.

2. REQUIRED DOCUMENTS

F. OVERSIGHT AND GOVERNANCE

1. INFORMATIONAL QUESTIONS

Please describe:

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.

Trillium operates under the oversight of the Trillium Governing Board (Board) which meets the requirements of a CCO “Governing Body” as defined by ORS 414.625. To support members in the Lane and Tri-County Regions, our Board will expand to feature two Regional Boards of Directors (BODs) for Lane and Tri-County, respectively.

Selection and Appointment. Our Board members will be drawn from our two Regional BODs and include community and county representatives, providers, stakeholders, and members of the community at large. See Att.7.A.1 for additional details. Any member of the Board or the Regional BOD may nominate an individual to fill a Board vacancy. The Board’s Executive Committee vets potential Board candidates, reviews qualifications and makes recommendations to the Board, which votes on the appointment of all new members. Annually, the Executive Committee evaluates the Board Composition for needed changes or additions.

Operation. The Board and Regional BODs will meet quarterly or frequently as needed. General meetings of the Board and the Regional BODs will be open to the public. The Board and the Regional BODs may meet in closed Executive Sessions to discuss confidential matters. The Board will participate in an annual strategic planning retreat. Key Committees will provide annual reports to the Board and Regional BODs each January that include proposed priorities. Staff support Board activities and provide the Board with the resources, data, and operational information needed to support decision-making, which is exercised locally by or under the Authority of the Board which is a foundational component of Trillium and Centene’s model. Pursuant to Trillium’s bylaws, certain decisions are subject to Centene approval.

b. Please describe Applicant’s key committees including each committee’s composition, reporting relationships and responsibilities, oversight responsibility, monitoring activities and other activities performed.

KEY COMMITTEES THAT REPORT TO THE BOARD:

Executive Committee. Composed of Board Members and management staff. Responsible for vetting candidates for Board vacancies, developing meeting agendas, and coordinating the work of the other key committees.

Compliance Committee. Composed of management staff accountable for Operations, Medical Management, Finance, and Compliance. Responsible for general oversight of compliance with statutory, regulatory, contract, and program compliance, including HIPAA.

Finance Committee. Composed of management staff and interested members of the Board including community representatives. Responsible for developing guidelines and policies to govern the local Financial Advisory Committees and performing other fiduciary oversight functions at the Governing Board level.

Health Equity Council. Composed of our Health Equity Officer (Council chair), health equity professionals and community stakeholders or representatives invested in equality in healthcare. Responsible for reviewing and
advising the Board on SDOH-HE spending priorities recommended by the CAC, ensuring organization adherence to our Health Equity Plan, and developing policies that promote the elimination of health disparities and the achievement of health equity for Oregon Health Plan (OHP) members and the community at large. The Diversity and Health Equity Committee reports to the Health Equity Council. 

**Quality Improvement Committee (QIC).** Composed of CCO providers representing BH, OH, and PH; representation from County BH authorities; and Quality Improvement (QI) management staff. Responsible for oversight of Trillium’s overall QI Program and activities.

**Tribal Advisory Council.** Composed of American Indian/Alaskan Native representatives and tribal providers. Responsible for advising the Board on tribal health, including staff training on cultural competency, healthcare disparities, and access to care.

**KEY COMMITTEES THAT REPORT TO THE REGIONAL BODs:**

**Compensation Committee.** Composed of providers representing primary care, BH and multiple specialties; County personnel; hospital system representative; Trillium senior leadership, and support staff. Responsible for reviewing current provider payment models, studying other models, and recommending possible changes.

**Financial Advisory Committee (FAC).** Composed of interested members of the Board and support staff. The FAC will also include two community members (not on the Regional BOD). Responsible for reviewing and commenting on proposed projects, procurements or programs referred by management, Executive Committee, or the Board, and review and providing input regarding Trillium’s work with the OHA rate setting process.

**Community Advisory Council (CAC).** Composed of representatives of the community and county government, with consumers making up a majority of the membership in accordance with ORS 414.625 and ORS 414.627. Responsible for advising and making recommendations to the Board and Regional BODs to ensure that the health and social needs of the consumers and the community are being addressed, and advising on the design and priorities of Trillium in achieving the Triple Aim. Additionally, Trillium has established a Rural Advisory Committee (RAC) for our Lane Region to solicit feedback for members living in rural communities.

**Clinical Advisory Panels (CAP).** Composed of a representative and proportional number of providers including PCPs, specialty, BH, OH, and allied health/expanded care providers; a hospitalist; community service organization; public health officer; post-acute or LTC providers; and Trillium support staff. Responsible for ensuring Regional BOD community provider advocacy and engagement in domains including service model design, QI, clinical outcomes, HIE, and engaging the larger healthcare community. The CAP recommends clinical policy guidelines and impact of alternative payment models to Regional BOD.
c. The composition, reporting responsibilities, oversight responsibility, and monitoring activities of Applicant’s CAC.

**Composition.** Our Regional BODs will each include a CAC. Our CACs include at-large and rural OHP members, as applicable; OHP members representing other community advisory groups and commissions; county representatives of Health & Human Services divisions linked to healthcare transformation (not subject to term limits) and other system partners; a community leader from outside the healthcare system; a representative with research and evaluation expertise; a representative with marketing/public relations/media expertise; and a representative appointed by the CAP (not subject to term limits). The need for additional advisory councils, like the RAC Trillium convenes in the Lane Region currently, will be evaluated as part of CCO 2.0 implementation.

**Reporting Relationships.** The CACs will report at least annually to the Board and the Regional BODs. CACs will have two representatives on each Regional BOD. The Chairperson of each RAC (or other committee created based on identified needs) will serve on the Regional BOD.

**Oversight/Monitoring Responsibilities.** The CAC has oversight and is responsible for advising and making recommendations to ensure responsiveness to health and social needs of the consumer and community; aid in achieving the goals of the Triple Aim with a focus on providing quality services accessible to all members. Duties of the CAC include, but are not limited to, identifying and advocating for preventive care, SDOH-HE, and Health-Related Services (HRS) practices for Trillium; overseeing a community health needs assessment; and adopting a CHP to serve as strategic guidance for Trillium to address health disparities and meet the health needs of their region.

2. REQUESTED DOCUMENTS

| Narrative for Items a, b and c | Page 7-9 |
Exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.
Exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.
RFA CONTACT LIST

Amanda Cobb, Director, Product Development & Management for Trillium Community Health Plan will serve as the main contact for RFA #4690-19. Please see the chart below identifying Amanda Cobb’s contact information including telephone number, and email address for each component of our RFA response.

<table>
<thead>
<tr>
<th>RFA Section</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Application</td>
<td></td>
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<tr>
<td>All RFA Attachments</td>
<td></td>
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<tr>
<td>Sample Contract</td>
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<tr>
<td>Exhibits to the Sample Contract</td>
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<td>Rates and Solvency</td>
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<td>Readiness Review</td>
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<td>Membership and Enrollment</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Contact Name:</strong> Amanda Cobb</td>
</tr>
<tr>
<td></td>
<td>Director, Product Development &amp; Management</td>
</tr>
<tr>
<td></td>
<td>Trillium Community Health Plan</td>
</tr>
<tr>
<td></td>
<td><strong>Phone Number:</strong> 541-799-3116</td>
</tr>
<tr>
<td></td>
<td><strong>Email Address:</strong> <a href="mailto:acobb@trilliumchp.com">acobb@trilliumchp.com</a></td>
</tr>
</tbody>
</table>
EXAMPLE OF SUBCONTRACTED WORK WITH DENTAL CARE ORGANIZATIONS
Below we provide an example of Trillium Community Health Plan (Trillium)’s subcontracted work performed by our subcontracted Dental Care Organizations (DCOs).

Subcontractor Oversight. Trillium maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Sample Contract. Aligned with CCO 2.0 goals, Trillium will continue to work collaboratively with all DCOs to expand access to oral health services, support the full integration of oral health (OH), physical health (PH), and behavioral health (BH), and improve OH outcomes for our members.

| DCO Names and Initial Contract Effective Dates | Advantage Dental Group, LLC: January 1, 2014  
|                                              | Capitol Dental Care: April 1, 2014  
|                                              | ODS Community Dental: April 1, 2014  
|                                              | Willamette Dental Group, PC: January 1, 2014  
|                                              | *For the CCO 2.0 program, we have letter of agreements (LOAs) in place with Advantage Dental Group, Capitol Dental Care, and Willamette Dental Group to support our proposed counties of Clackamas, Multnomah and Washington Counties (Tri-County Region). |
| Services Performed | Services include: Claims (Encounter Data), Provider Credentialing and Recredentialing, Dental Network Development and Management, Member and Provider Complaints, Appeals (does not do final appeal), and Customer Service |
| How Subcontracted Services Relate to the Sample Contract | • Ensuring members have access to all OH Covered Services within the scope of the member’s Benefit Package  
| | • Facilitating the exchange of patient information for care coordination for contracted PH, BH, and OH providers  
| | • Developing, implementing and participating in activities supporting a continuum of care that integrates BH, OH and PH interventions seamlessly and holistically  
| | • Ensuring choice of OH providers and access to an OH provider network that meets the needs of its members and potential members  
| | • Ensuring timely access to OH services in accordance with OAR 410-141-3220 |
| Key Highlights of Relationships | • Communication and Data Sharing. Trillium supplies DCOs with a monthly Hot-Spotter Report comprised of data on Trillium members assigned to each DCO’s panel including clinical information, Emergency Department (ED) utilization, health risk scores, which members would benefit from Care Coordination and, coming by 2020, members who are past due for OH screenings. We also require DCOs to share information, including claims data, complaint logs, preventive care services provided, and personalized dental care plans, for members that have complex conditions or higher ED usage.  
| | • Co-Located Services. We contract with co-located PH and OH clinics, such as the Lane County Community Health Center Delta Oaks Clinic and Springfield Family Physicians clinic that have Expanded Practice Dental Hygienists onsite to provide screenings, fluoride varnish and sealant applications, OH education, and Primary Dental Provider referrals.  
| | • OH Collaborative. Trillium launched an OH Collaborative in 2018, bringing together DCOs, OH providers, and schools, to expand school-based OH programs to all eligible elementary and middle schools in Lane County. Because of Trillium’s leadership, all eligible Lane County schools will have an OHA-certified OH program for the 2019-2020 school year.  
| | • Incentives for Improved Health and Cost Outcomes. We provided grant funding to Willamette Dental’s Chronic Condition Dental Management program that manages dental disease, using evidence-based treatment protocols, for Trillium members with high or extreme dental risk who also use tobacco or have diabetes. Program design features include: risk-based member identification and stratification; a virtual care team (using PH and BH provider information) to enable CC; a personalized care plan; use of embedded Care Advocates; and shared savings. In 2016, total average costs for members completing the
**TRILLIUM COMMUNITY HEALTH PLAN**  
**RESPONSE TO RFA OHA #4690-19 – CCO 2.0**  
**ATTACHMENT 6 – SUBCONTRACTED WORK EXAMPLE**

<table>
<thead>
<tr>
<th>Support of CCO 2.0 Goals</th>
<th>Trillium’s collaborative relationship with DCOs supports the achievement of the following CCO 2.0 goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Increasing integration of and access to PH, BH, and OH services</td>
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<tr>
<td></td>
<td>• Ensuring adequate capacity of OH services across the continuum of care</td>
</tr>
<tr>
<td></td>
<td>• Supporting EHR adoption across BH, OH and PH contracted providers</td>
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<tr>
<td></td>
<td>• Ensuring BH, OH and PH providers have access to HIE technology that enables sharing patient information for care coordination, including timely hospital event notifications</td>
</tr>
<tr>
<td></td>
<td>• Increasing provider access to comprehensive electronic patient data needed to support coordinated care and population health efforts</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Oversight/Monitoring</th>
<th><strong>Monitoring DCO Performance.</strong> Through Trillium’s written agreements, DCOs retain responsibility for fully complying with all applicable federal and State laws and regulations and all terms of the Sample Contract. We monitor DCO performance through ongoing operational calls, either weekly or monthly. We conduct annual audits to review each DCO, considering NCQA, CMS, Contract and agreement requirements. Audits include policy, procedure, and file reviews of delegated functions. DCO performance is reported to, and overseen by, the Quality Improvement Committee and Compliance Committee, each of which meets quarterly.</th>
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<tbody>
<tr>
<td></td>
<td>• <strong>Joint Operations Committee (JOC).</strong> Trillium conducts formal JOC meetings quarterly, with documented minutes routed to Trillium and DCO participants for review and approval. DCOs complete monitoring dashboards, which are reported to Trillium, and reviewed in JOC meetings.</td>
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<td></td>
<td>• <strong>Issue Resolution.</strong> If Trillium identifies a DCO issue through meetings, monitoring, or audits, or receives a report of non-compliance, sanction, or complaint from a regulatory agency, we promptly communicate the issue to the DCO for investigation and resolution. As appropriate, DCOs are required to complete quality improvement plans and/or CAPs, and may be subject to penalties for non-compliance.</td>
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<tr>
<td></td>
<td>• <strong>Network Adequacy.</strong> We contractually require DCOs to adhere to OH wait time to appointment requirements, monitor appointment availability, and report results to Trillium quarterly. Trillium will periodically evaluate reported full time equivalent availability of OH providers by conducting secret shopper calls and comparing the results against the DCO’s Delivery System Network assessments.</td>
</tr>
</tbody>
</table>

Program were reduced by $729.90 year over year while costs for the control group increased by $541.51.

- **Healthy Smiles-Partnership.** Trillium partnered with Capitol Dental Care and Advantage Dental to bring OH screening and prevention services to Cornerstone Community Housing complexes to improve OH.
- **Increased Access to Health Information Technology.** Trillium plans to collect data on electronic health record (EHR) use among OH providers through an annual survey process in conjunction with our DCOs. We will also enlist and promote the connection of DCOs to the health information exchange (HIE) technology for shared access to PH and BH information.
1. GOVERNANCE AND ORGANIZATIONAL RELATIONSHIPS

A. GOVERNANCE

This section will describe the Governance Structure, Community Advisory Council (CAC), and how the governance model will support a sustainable and successful organization that can deliver health care services within available resources, where success is defined through the triple aim. Please describe:

(1) The proposed Governance Structure, consistent with ORS 414.625.

Trillium Community Health Plan (Trillium) operates under the oversight of the Trillium Governing Board (Board) which meets the requirements of a CCO Governing Body as defined by ORS 414.625. Members of the Board will be drawn from two Regional Boards of Directors (Regional BODs) organized to support members in the Lane Region (Lane County and contiguous zip codes in Linn and Douglas Counties) and Tri-County Region (Clackamas, Multnomah, and Washington Counties). The Board will include: at least one representative of a Dental Care Organization (DCO); at least four representatives of the healthcare delivery system (two representatives from each Regional BOD); at least two healthcare providers in active practice including a physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care, and a mental health or chemical dependency treatment provider; at least one Traditional Health Worker (THW); four members of the community at large (two representatives from each Regional BOD); the Chairperson of each of our Regional Community and Rural Advisory Councils (CAC/RAC); the Chairperson of each Regional BOD; representatives from a housing authority, school district, and Public Health; and a representative from our Tribal Advisory Council (inclusive of American Indian and Alaskan Native representation) and our Health Equity Council.

(2) The proposed Community Advisory Council (CAC) in each of the proposed Service Areas and how the CAC was selected consistent with ORS 414.625.

Trillium will operate at least one CAC in the Lane Region and Tri-County Region of our proposed Service Area. Each CAC will include representatives of the community and county government, with consumers making up a majority of the membership, in accordance with ORS 414.625. The role of the CAC is to advise and make recommendations to ensure responsiveness to health and social needs of the consumer and community, including community funding recommendations, and aid in achieving the goals of the Triple Aim with a focus on providing quality services accessible to all members. Duties of the CAC include, but are not limited to: identifying and advocating for preventive care practices, influencing Social Determinants of Health and Health Equity (SDOH-HE) and other community funding, including global Health-Related Services (HRS); overseeing a Community Health Assessment (CHA) and adopting a Community Health Improvement Plan (CHP) to serve as strategic guidance for Trillium to address health disparities, support Health System Transformation, and meet the health needs of their region. The CACs will meet every three months, at a minimum. CAC meetings are open to the public. CAC Charters outline the duties of the councils. We have taken the additional step of establishing a RAC for our current Service Area to remain responsive to our members in rural communities. The need for additional advisory Councils, such as the RAC Trillium convenes in the Lane Region currently, will be evaluated as part of CCO 2.0 implementation. For CAC selection, each Regional BOD will establish a membership committee with representatives of the counties that their region serves. The committee will appoint

Attachment 7
CAC members based on recommendations from the Regional Board or Governing Board, county representatives, or self-nominated individuals.

(3) The relationship of the Governance Structure with the CAC, including how the Applicant will ensure transparency and accountability for the governing body’s consideration of recommendations from the CAC.

The Chairperson of each CAC will serve as representatives on the Board. Two CAC members will serve as representatives on each Regional BOD, which also has input directly into the Board. One of these representatives will be a consumer member of the CAC, and the other a non-consumer, community leader member of the CAC. These representatives are full voting members of the Board and Regional BOD and are responsible for ensuring two-way communication between the CAC and the Board, as well as assisting the Board in its work to communicate with the larger community. This integration ensures transparency, accountability, and results.

(4) 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.

Trillium’s governance structure is designed to reflect the needs of all of our members, including members with special health care needs such as those with severe and persistent mental illness (SPMI) and members receiving Long-Term Care (LTC) services. Our current Board includes two provider representatives from the behavioral health (BH) services system and one representative from the county Senior and Disability Services office. Our CAC includes a consumer representative who receives DHS-Medicaid funded LTC services as well as a consumer representative who identifies as living with SPMI. Our current Governing Board, key committees and subcommittees include 11 individuals who serve as representatives of the BH system and 4 representatives of the LTC system. Trillium will make efforts to ensure similar diverse representation across the Tri-County Regional BOD and CAC, including representation of members with SPMI and those receiving LTC services.

B. CLINICAL ADVISORY PANEL

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.

(1) 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.

Trillium has an established Clinical Advisory Panel (CAP) in our current Service Area and will establish a CAP in the Tri-County Region. The role of the CAP is to engage local providers to build networks of care that enhance outcomes consistent with the goals of the Triple Aim. The CAPs will meet no less than once per month with additional meetings held as needed. Each CAP is made up of a representative and proportional number of providers from across the region including PCPs, specialty providers, BH providers, oral health (OH) providers (including providers from Eugene Pediatric Associates, PeaceHealth, Springfield Family Physicians, and Lower Umpqua Hospital District), allied health/expanded care providers, hospitalists, community service organizations, public health, post-acute or LTC providers, and Trillium support staff. The CAPs will have two standing subcommittees, the Clinical Advisory Subcommittee and the ED Utilization Workgroup, who oversee clinical initiatives that promote best practices in the provision of guideline-based care and address the drivers of potentially preventable acute utilization. Current CAP focus areas include opiate management; integration of physical health (PH), BH, OH and SDOH-HE; high needs/high utilizer populations; and CCO metrics. Each CAP will report to their Regional BOD, which is overseen by the Board.
(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.

Trillium has a CAP for our current Service Area and will establish one in the Tri-County Region utilizing the governance and organizational structure described in Att.7.1.B.1 with focus areas tailored to the Region’s needs and local provider network input.

C. AGREEMENTS WITH TYPE B AREA AGENCIES ON AGING AND DHS LOCAL OFFICES FOR APD (APD)

While DHS Medicaid-funded LTC services are legislatively excluded in HB 3650 from CCO responsibility and will be paid for directly by the Department of Human Services, CCOs will still be responsible for providing physical and Behavioral Health services for individuals receiving DHS Medicaid-funded LTC services and will be responsible for coordinating with the DHS Medicaid-funded LTC system. To implement and formalize coordination and ensure relationships exist between CCOs and the local DHS Medicaid-funded LTC Providers, CCOs will be required to work with the local Type B AAA or DHS’ APD local office to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving DHS Medicaid-funded LTC services.

(1) Describe the Applicant’s current status in obtaining MOU(s) or contracts with Type B AAAs or DHS local APD office.

Trillium maintains a MOU with the Lane Council of Governments (LCOG) Senior and Disability Services (SDS) and Aging and People with Disabilities (APD) Districts 6 and 7 to ensure coordination of services for individuals in our current Service Area served by Trillium and the Type B Area Agency on Aging (AAA) and APD local offices. The MOU is effective through Dec. 31, 2019, and we have executed a new MOU for the CCO 2.0 Program. Trillium will continue to submit to the Oregon Health Authority (OHA) annual updates of MOU or sub-contractual arrangements with AAA or State APD district office(s) in accordance with the Sample Contract. See (2) below for our efforts to establish additional MOUs in the Tri-County Region and Linn County.

(2) If MOUs or contracts have not been executed, describe the Applicant’s efforts to do so and how the Applicant will obtain the MOU or contract.

Trillium has been in active discussions with the AAAs in our proposed Service Area to ensure we will have all required MOUs or contracts in place by Readiness Review. Based on our engagement activities to date in the Tri-County Region, Trillium has provided a draft MOU to Multnomah County Aging, Disability & Veterans Services Division, Washington County Developmental Disability Program and Clackamas County Mental Health/Developmental Disabilities with respect to the negotiation and development of a mutually agreeable MOU post CCO contract award and the continued collaboration between Trillium and the AAAs/APDs in the Tri-County region to further build, develop and enhance our strategic relationship for members receiving DHS Medicaid-funded LTC services. Our intent is to have an executed MOU in place for the Tri-County region by Readiness Review that includes Multnomah, Clackamas, Washington County AAAs and local APD offices. Trillium has also outreached to Linn County and will continue to outreach in efforts to develop relationships and execute an MOU. Lastly, recognizing the important role AAAs play in addressing the needs of older adults and individuals with disabilities, we have a LOA in place with the Oregon Wellness Network (OWN), the division of the Oregon Association of Area Agencies on Aging and Disabilities that serves as a network hub for the 17 AAAs across the State. Our LOA will enable us to leverage and access the broad continuum of OWN services for our LTC members including home delivered meals, caregiver support and evidence-based disease management programs, fall prevention services, diabetes prevention and chronic disease self-management education and transitions of care.

Attachment 7
D. AGREEMENTS WITH COMMUNITY PARTNERS RELATING TO BEHAVIORAL HEALTH SERVICES

To implement and formalize coordination, CCOs will be required to work with local mental health authorities and Community Mental Health Programs to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving mental health services.

(1) Describe the Applicant’s current status in obtaining MOU(s) or contract(s) with LMHAs and CMHPs throughout its proposed Service Area.

Trillium maintains MOUs with the LMHAs and CMHPs in Lane, Douglas, and Linn Counties that set forth roles and responsibilities to coordinate services and efforts to meet the BH needs of the communities we serve and to achieve improved outcomes in compliance with the Sample Contract, ORS 414.153, and other State requirements. The status of MOUs and contracts in our proposed Service Area is described in (2) below. We will continue to report on our agreements in accordance with the Sample Contract.

(2) If MOUs or contracts have not been executed, describe the Applicant’s efforts to do so and how the Applicant will obtain the MOU(s) or contract(s).

Trillium has met with LMHAs and CMHPs across our proposed Service Area to ensure we will have an MOU/contract in place prior to Readiness Review. In the Tri-County Region, we have met with the LMHAs in Multnomah, Clackamas, and Washington Counties and have provided draft MOUs for the CCO 2.0 program. Multnomah, Washington and Clackamas Counties have indicated a willingness and interest in jointly developing a MOU should Trillium be awarded a CCO 2.0 contract in these areas.

(3) Describe how the Applicant has established and will maintain relationships with social and support services in the Service Area, such as:

Our Community Engagement Plan and Governance structure are the foundation upon which our relationships are built. Through our partnerships with community organizations that are supported by MOUs, letters of support, or referral and data sharing agreements that formalize how we work together, we build member care plans and referral networks that are required to address SDOH-HE. We identify member SDOH-HE needs during Member Welcome Calls, the Initial Risk Screening (IRS), provider SDOH-HE assessments, and ongoing Care Coordination and predictive modeling/reporting. Our MemberConnections® Representatives (MCRs), Traditional Health Workers (THWs), Care Coordinators, and functional liaisons identify and maintain relationships with social and support services organizations and connect members to resources and supports, leveraging the Trillium Resource Exchange, our online, up-to-date, searchable community resource database. Below we outline key relationships with social and support services established in our current Service Area. Additional cross-sector relationships that we have established are demonstrated throughout Trillium’s Application. We will continue to establish and maintain relationships in the Tri-County Region through in-person engagement; invitations to participate in our CAC, subcommittees, and workgroups; and established channels of communication with our regional Care Coordination Teams.

• DHS Child Welfare and Self Sufficiency field offices in the Service Area

Through daily reporting from DHS that identifies children in the Child Welfare system, we conduct outreach to assure screening for developmental, BH, and PH assessments for children and youth in DHS custody are completed within OHA timelines, track the completion of appointments within targeted timelines, and assist families with addressing any barriers. DHS District 5 is represented on our current CAC. We will pursue a formalized agreement with DHS to continue our collaborative efforts to screen for children in DHS custody across our proposed Service Area.

• Oregon Youth Authority (OYA) and Juvenile Departments in the Service Area
To support referrals for services and appropriate BH interventions for youth following release, Lane County Youth Services participates on Trillium’s System of Care (SOC) Executive Committee, and Trillium is represented on the Juvenile Justice Advisory Committee. Through our Center for Family Development contract and the Phoenix Program, Trillium supports Youth Services’ provision of BH services to incarcerated youth. We will pursue a formalized agreement with the OYA and county Juvenile Departments in the Tri-County Region prior to CCO 2.0 Readiness Review. Additionally, Trillium has obtained Letters of Support (LOS) from the Native American Youth and Family Center (NAYA), Oregon Alliance for Children’s Programs, and Youth Villages in the Tri-County Region to support at-risk youth and young adults leaving the juvenile justice system.

- **Department of Corrections and local Community corrections and law enforcement, local court system, problem solving courts (drug courts/mental health courts) in the Service Area, including for individuals with mental illness and substance abuse disorders**

We participate in monthly Mental Health Summit meetings with Lane County employees, law enforcement, and community partners to help justice-involved individuals. Trillium is a partner in the Healthy Directions Coalition, which brings together police departments, Tribal organizations, family support organizations, and school districts to prevent underage drinking in coastal communities. We participate in the Mobile Rural Crisis Group to implement mobile crisis in Florence and other rural counties, and we provide BH crisis support through the Crisis Assistance Helping Out on the Streets (CAHOOTS) program, deployed by local police departments. We will participate in or convene as needed similar collaborative forums in the Tri-County Region, and offer relevant trainings to corrections and law enforcement stakeholders, such as Trauma-Informed Care (TIC), Mental Health First Aid (MHFA), and concepts of Recovery and Resiliency.

- **School districts, education service districts that may be involved with students having special needs, and higher education in the Service Area**

Trillium maintains provider agreements with Lane County School District 4J, the Springfield School district, and the Bethel Student Health Center to provide BH services, including drop-in crisis services. We also support the Reedsport School District in helping students and families access BH support services and resources. The District 4J superintendent serves on Trillium’s Board, and the 4J and Springfield School Districts are active in Trillium’s Innovators’ Collaborative. Trillium recently sponsored the Centene national program “No One Eats Alone Day” in the Bethel School District and the rural Siuslaw School District. We contract with the University of Oregon Health Center and Lane Community College to provide BH and counseling services, and we partner with the University of Oregon for our Family Check-Up Program. Our Care Coordinators work with school counselors and teachers to provide appropriate input and participation in Individual Education Plans and include on our interdisciplinary care teams based on member and family preference. We will continue to partner with schools and school-based programs in the Tri-County Region to support early identification of member needs and offer education and training to educators, school nurses, students, and parents on relevant topics such as bullying, opioid use and abuse, Trauma Informed Care and Mental Health First Aid. For example, we are in active conversations with the Boys and Girls Clubs of Portland Metropolitan Area to support the delivery of afterschool youth and family emotional health services.

- **Developmental disabilities programs**

Trillium works with Lane County Developmental Disabilities (which participates on the SOC Executive Committee and our CAC) for referrals to services and appropriate BH interventions for individuals with intellectual and developmental disabilities (I/DD). We contract with the Lane Independent Living Alliance.
(LILA) to support members with intellectual and other disabilities and will seek to enter into similar partnerships with Centers for Independent Living (CILs) in the Tri-County Region. Additionally, we will collaborate with the University Centers of Excellence in Developmental Disabilities (UCEDD) to offer provider training and participate in our governance committees to assist with development of approaches to address the needs of members with I/DD in our Service Area. Our plan is to work with UCEDD’s network of community partners, such as the Oregon Council of Developmental Disabilities, to ensure we meet the PH and BH need of individuals with I/DD.

**Tribes, tribal organizations, Urban Indian organizations, Indian Health Services and services provided for the benefit of Native Americans and Alaska Natives**

We work to connect members to health and social support services today in coordination with the Eugene Tribal Outreach Offices of the Tribes in our Service Area – including the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians (CLUTSI); the Coquille Tribe; and the Siletz Tribe. We are establishing additional relationships, including LOAs and participation in our Tribal Advisory Council, in our proposed Service Area with other Tribal Health Organizations including Cow Creek Band, the Native American Rehabilitation Association of the Northwest Indian Health Clinic, and the Portland Area IHS Office. We will establish a Tribal Liaison and Tribal Advisory Council to develop a culturally appropriate response tailored to the diverse resources, patterns of care, and needs of each Tribe. Through our prevention investments, we have supported parenting education to Native American families in a partnership with Lane Kids and the Relief Nursery. We support AI/AN access to IHS and Tribal 638 provider services, whether or not we have a contract.

**Housing organizations**

We engage in several partnerships to support housing needs, including training and Wraparound services through the Cornerstone Community Housing Community Health Worker program, housing and social supports for high-risk individuals through the Frequent User System Engagement (FUSE) initiative, medical respite for homeless members through the ShelterCare Recuperation program, support services and in-home healthcare as part of the Homes for Good program, and funding for a Housing First apartment community. We also participate in cross-sector housing-related workgroups, such as the Lane County Poverty and Homelessness Board. We are also establishing key housing partnerships in the Tri-County Region with organizations such as the Sequoia Mental Health Services/Tri-County Behavioral Health Association for which we have a letter of intent to partner.

**Community-based Family and Peer support organizations**

We contract with LILA to provide peer support and activities to improve self-sufficiency for those with aging and/or disability needs. Through the Trillium Innovation Fund, we provided funding for rural trauma-informed community health and peer support at Orchid Health, including $93,400 in 2018. We contract with the Oregon Family Support Network, Youth ERA, Centro Latino Americano, and Direction Service to provide Wraparound services, including family and youth peer supports, and with NAMI to provide education and support to families. Trillium provides community-based family support through our Prevention Program investments to improve mental health and reduce tobacco use and childhood obesity. The Family Check-Up intervention has helped over 500 families address parenting challenges and reduce risk factors for adverse childhood experiences. We have received LOAs from community-based family, peer support and Wraparound providers in the Tri-County Region such as Youth Villages and The Children’s Center. Additionally, we are in discussions with Acadia Healthcare/Allied Health Services to provide BH, SUD, PTSD and Trauma services, and Quest Center for Integrative Health to provide BH HIV, wellness care, and LGBTQ health services.

**Other social and support services important to communities served**
We convene the Lane County SOC Executive Council, a committee comprised of BH providers, youth and family, and public partners designed to make recommendations to improve the SOC for children and youth in the County. We are active in the SOC Advisory Committee, which provides recommendations to the Executive Council on policies, resources, financing, implementation, outcomes, and oversight, and in the SOC Wraparound Review Committee, which reviews Wraparound referrals for eligibility determination. In the Tri-County Region, we will adapt these processes and best practices and leverage existing county systems and processes in collaboration with local SOC and Wraparound stakeholders and providers, such as, Youth Villages and The Children’s Center.

2. MEMBER ENGAGEMENT AND ACTIVATION

Members should be actively engaged partners in the design and implementation of their treatment and care plans through ongoing consultations regarding cultural preferences and goals for health maintenance and improvement. Member choices should be reflected in the selection of their Providers and in the development of Treatment Plans while ensuring Member dignity and culture will be respected.

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.

Hired locally and trained in cultural competency and person-centered planning, Trillium’s Care Coordination Team (CC Team) and member-facing staff view each member and their family/support network as a partner in their health to increase self-management and health literacy – all in alignment with our Quality Management and Improvement (QMI) activities. We use Motivational Interviewing and our Strengths-Based Model to help members articulate goals and preferences to be incorporated into their care and treatment plans. We encourage member choice in selection of providers; educate on care options and self-management skills and available resources; support healthy behaviors through programs such as our Fluvention® flu prevention program and Start Smart for Your Baby® maternal health program; and engage peers and family supports to accelerate readiness to change. We encourage member engagement and personal responsibility through our member incentive program, MyHealthPays, where members can earn gift cards and other rewards for completing preventive/wellness care. Incentives align with CCO metrics and provider value-based payment models including colorectal cancer screening (COL), adolescent well care (AWV), and prenatal care. For CCO 2.0, we will incent member competition of the Initial Risk Screening (IRS). Members are also notified of needed preventive services and follow-up care through care gap alerts configured based on clinical-practice guidelines and accessible via our secure Member Portal and mobile application beginning 2020.

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

As outlined below, we will ensure a comprehensive communication program that meets members where they are. We engage all members in culturally and linguistically appropriate ways starting with a New Member Welcome Call and distribution of the Member Welcome Packet (mailed within 14 days of effective date of coverage). The welcome packet includes: the Member Handbook and access to our video member handbook (created in partnership with our CAC); member ID card and contact information; “to do” list for early engagement; reference guide to PH, BH, and OH benefits; an IRS with instructions to complete; how to access interpretation services and materials in other languages and formats; and other resources to promote ongoing engagement.
member engagement. We will work closely with our CAC (and CAC SDOH Workgroup), RAC, Health Equity Council, and Tribal Advisory Council to advise, inform, and evaluate our communication program in alignment with the CCO 2.0 program and QMI plan.

• **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;**

We encourage members to be active participants in their health and meet members where they are, clinically, culturally, linguistically, socially, and geographically. We evaluate social circumstances through incorporation of SDOH-HE data in our processes. For instance, our SDOH risk score helps our CC Team identify and target members at-risk for adverse health outcomes due to the social, economic, and environmental conditions they experience. Our Member Concierge team is trained in local resources, geography, health disparities, and cultures, and equipped to explain benefits, self-service programs (e.g. Health Library and MyStrength virtual mental health club) and incentives; assist with Primary Care Provider (PCP)/Primary Care Dental Provider selection and appointment and transportation scheduling; complete the IRS, demonstrate Member Portal navigation, and connect with care coordination services, as needed. Our MemberConnections® Representatives (MCRs), three of whom are certified Community Health Workers (CHWs), provide education, navigation, and resource linkages. In 2019, we are introducing member, provider and community access to the Trillium Resource Exchange, an online searchable database of vetted and regularly updated social, health, and wellness resources.

• **Engage Members in culturally and linguistically appropriate ways;**

We assess for and document each member’s primary and preferred language as part of our IRS process, systematically sharing this information across Trillium staff and Care Teams. We document other member preferences (e.g. beliefs, customs, values) as part of our care planning process to ensure cultural sensitivity. Members have access to the Linguava Language Line - our Oregon-based trusted partner for translation and interpretation services - for onsite and telephonic language translation services. Our 508-compliant website is available in 15 languages including Spanish. All member materials are available in English, Spanish, and other languages and formats, upon request. Our staff are trained on CLAS and follow all 15 CLAS standards, disability sensitivity, cultural competency and health care traditions, and People First Language, with emphasis on developing skills to communicate appropriately and address even the most unique linguistic, disability, and/or culturally-related needs.

• **Educate Members on how to navigate the coordinated care approach and ensure access to advocates including Peer wellness and other Traditional Health Worker resources;**

Health system navigation is a critical function of Trillium and inherent in job descriptions of all member-facing staff. Extending our staff’s reach and helping to meet the cultural and condition-specific needs of our members, we actively refer to, educate on, and engage with THWs. We support providers in their promotion and availability of THWs. We actively use Peer Support Specialists as a first point of contact for members following a BH hospitalization for mental/behavioral illness. We will keep staff, members, and providers apprised by facilitating access to the THW registry maintained by the OHA Office of Equity and Inclusion. Additional details on our approach to THW access and utilization can be found in Att.10.F.

• **Encourage Members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate;**

ENSURING ACCESS TO INTERPRETIVE SERVICES

We recently engaged a member who speaks partial Korean sign language, partial American Sign Language, and language developed by the member. We connected her to an interpreter that navigated these methods to facilitate communication with her and her family, Care Coordinator, and PCP.
Through community and county government partnerships, care coordination processes, member outreach and education and ongoing feedback from our CAC, Health Equity Council, and Tribal Advisory Council we equip members with the information, tools, and programs to navigate the health care landscape and make healthy lifestyle choices in a manner that is culturally and linguistically appropriate. We have systems in place to monitor and close care gaps and we measure member likelihood to engage through our Care Management (CM) Engagement score, which gives our CC Team insights to more effectively support each member and encourage member use through education, incentives, HRS, and CC activities. As mentioned above, our staff are trained in and follow CLAS standards. We invest in and promote evidence-based interventions to address identified needs of our community based on the CHA and CHP. As part of our investment in the Triple Aim, we have set aside $1.33 per member per month to fund wellness and prevention programs in Lane County for our current Service Area. For example, our Coordinated Approach to Child Health (CATCH) program in rural school districts in Lane County, is designed to promote better nutrition and increased physical activity. After the first year, more students reported eating fruits and vegetables, getting more exercise, and watching fewer hours of television. We will establish similar partnerships in the Tri-County Region (see Att. 10 RFA Community Engagement Plan Required Tables).

• Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities; and

All of our member materials are written in plain language at the sixth-grade reading level. For members with Limited English Proficiency (LEP) and low health literacy, Trillium provides spoken translation of all vital information, including member rights and responsibilities. We employ teach-back techniques to ensure understanding. We will include a written language block explaining that key documents contain important information and encouraging members to contact Customer Services for oral interpretation or for reading and explanation of the material for any member with LEP. Members will also be informed of their rights in the Member Handbook, available in alternative languages and formats (e.g. Braille, large print, audio) and given the opportunity to ask questions during the member welcome call.

• Meaningfully engage the CAC to monitor and measure patient engagement and activation.

The CAC provides a forum through which our members are able to provide input into Trillium’s programs and processes (described in Att.10.B.1.c). We use this forum to review member materials, appeal and grievance trends, and satisfaction surveys to make improvements. In 2018, the CAC’s Member Engagement Subcommittee presented an analysis of missed appointments to our Board which covered issues on poverty sensitivity and recommendations for improved engagement and availability of transportation assistance.

3. TRANSFORMING MODELS OF CARE

Transformation relies on ensuring that Members have access to high quality care: “right care, right place, right time”. This will be accomplished by the CCO through a Provider Network capable of meeting Health System Transformation (HST) objectives. The Applicant is transforming the health and health care delivery system in its Service Area and communities – taking into consideration the information developed in the Community health assessment – by building relationships that develop and strengthen network and Provider participation, and Community linkages with the Provider Network.

A. PATIENT-CENTERED PRIMARY CARE HOMES

Integral to transformation is the Patient-Centered Primary Care Home (PCPCH), as currently defined by Oregon’s statewide standards in OAR. These standards advance the Triple Aim goals of better health, better care, lower costs by focusing on effective wellness and prevention, coordination of care, active management and support of individuals with Special Health Care Needs, a patient and Family-centered approach to all
aspects of care, and an emphasis on whole-person care in order to address a patient’s physical, oral and Behavioral Health care needs.

(1) Describe Applicant’s PCPCH delivery system.

As described in the table below, over 90% of our current members are assigned to 60 certified PCPCHs, improved from 84% in 2017 and 51.3% in 2014. Most (50) are at the Tier 4 or 5 level.

| Number of PCPCH Providers / Assigned Members by Tier and Provider Type in Current Service Area |
|---------------------------------|-----|-----|-----|-----|-----|-----|-----|
| Provider Type                   | Tier 5 | Tier 4 | Tier 3 | Tier 2 | Tier 1 | Total |
| FP/GP/Int Med/Multisp          | 2 / 8,186 | 32 / 38,685 | 4 / 2,936 | 0 / 0 | 0 / 0 | 38 / 49,807 |
| Pediatrics                      | 0 / 0 | 5 / 9,388 | 1 / 786 | 0 / 0 | 0 / 0 | 6 / 10,174 |
| BH Home                         | 0 / 0 | 2 / 515 | 1 / 178 | 0 / 0 | 0 / 0 | 3 / 693 |
| FQHC/RHC                        | 3 / 573 | 6 / 18,449 | 4 / 841 | 0 / 0 | 0 / 0 | 13 / 19,863 |
| **Total**                       | 5 / 8,759 | 45 / 67,037 | 10 / 4,741 | 0 / 0 | 0 / 0 | 60 / 80,537 |

To date, we have outreached to 100% of PCPCHs in the Tri-County Region and have obtained 92 LOAs.

<table>
<thead>
<tr>
<th>Number of PCPCH Providers by Tier in Tri-County Region</th>
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<tbody>
<tr>
<td>Tier 5</td>
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We offer practice transformation technical assistance to providers below Tier 3 to help them move to a higher tier and provide financial incentives (described in Att.8.C.2) that increase as PCPCHs move to higher tiers. These incentives will be higher for providers in rural areas and providers serving members with high levels of social complexity. We contract with over 98% of the certified PCPCHs in our current Service Area and have prioritized outreach and contracting with certified PCPCHs in our proposed Service Area.

(2) Describe how the Applicant’s PCPCH delivery system will coordinate PCPCH Providers and services with DHS Medicaid-funded LTC Providers and services.

Under our current MOU with the Lane Council of Governments Senior and Disability Services, and under future MOUs across our proposed Service Area, each member receiving LTC services has/will have an interdisciplinary care team (IDT) that includes the member’s PCPCH and encourages participation of LTC providers and agencies, as appropriate. This gives the PCPCH access to the member’s individualized care plan (ICP) that includes relevant LTC service information and enables the PCPCH to help coordinate and integrate care. We further facilitate coordination through data sharing. For example, in addition to PreManage in our PCPCHs, AAAs and several LTC facilities have PreManage. Delivering information to our PCPCHs, we will expand our Hot-Spotter Report to include if members are receiving LTC services and any known LTC providers from the LTC report we receive from AAAs/APDs. As of March 13, 2019, over 81% of our LTC members receiving PH services were assigned to a Tier 4 or 5 PCPCH.

(3) Describe how the Applicant will encourage the use of Federally Qualified Health Centers (FQHC), Rural health clinics, migrant health clinics, school-based health clinics and other safety net providers that qualify as Patient-Centered Primary Care Homes.

Central to our Medicaid network strategy, Trillium contracts with all safety-net providers that qualify as PCPCHs in our current Service Area, and we have targeted all such providers in our proposed Service Area. These providers serve nearly one-quarter (24%) of our members today. For new members that do not make a PCP selection, our auto-assignment algorithm prioritizes higher tier PCPCHs that have openings, which often results in auto-assignments to safety-net providers.

B. OTHER MODELS OF PATIENT-CENTERED PRIMARY HEALTH CARE

(1) If the 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 provides 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.

Qualifying criteria for any model we introduce include coordinated, preventive, effective for members with special health care needs, patient and family-centered, and integrated. For example, our Intensive Community Care Management (ICCM) program serves high-cost complex members with five or more chronic PH conditions and at least one BH condition by providing intensive care management in a PCPCH setting. We will expand the program by targeting integrated PCPCHs ready and willing to participate in our current and proposed Service Area. Our network also includes BH Homes that provide coordinated and integrated care for persons with serious and persistent mental illness, (SPMI) and substance use disorders (SUD).

(2) Describe how the Applicant’s use of this model will achieve the goals of Health System Transformation.

The ICCM program meets the State’s goals of providing fully integrated care, including addressing SDOH-HE, linking payment to performance, and constraining cost growth. The ICCM primary care team assists the member in all levels of care and carries the diagnostic responsibility and treatment modalities forward. The team is also responsible for decreasing service barriers, including SDOH-HE, enlisting needed services and specialty care, and forming community and agency partnerships to ensure an integrated and full spectrum of care. ICCM performance metrics include: all current CCO metrics; ensuring that all ICCM team members use the same EHR; ensuring that assigned members have at least one dental visit and one PCP visit per year and receive a follow-up contact within 48 hours of an ED visit; and use of SDOH-HE Z-Codes. ICCM providers can earn back a monthly PMPM withhold by meeting savings targets and achieving performance metrics. This pay-for-performance arrangement meets the criteria for Level 2.C under the Health Care Payment Learning & Action Network’s (LAN’s) Alternative Payment Model Framework.

4. NETWORK ADEQUACY

Applicant’s network of Providers must be adequate to serve Members’ health care and service needs, meet access to care standards, including time and distance standards and wait time to appointment, and allow for appropriate choice for Members, and include Traditional Health Workers including Community Health Workers, Personal Health Navigators and certified, qualified interpreters.

A. EVALUATION QUESTIONS

(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.

TRILLIUM’S APPROACH TO ASSESSING PROVIDER NETWORK ADEQUACY

Trillium will assess network adequacy in accordance with Oregon Administrative Rules (OAR) 410-141-3220 and the factors in Exhibit G Section 1 of the Sample Contract. Accountable for assessing network adequacy is our Provider Network Management Team (Network Team), who will continue to analyze geographic access mapping results, Delivery System Network (DSN) reports, out-of-network utilization, Medical Management requests, results of subcontractors’ network adequacy assessments, and self-reported member data. Trillium’s Quality Improvement Committee (QIC), comprised of staff representing all functional areas of our health plan,
will review and develop actions to address any identified or projected gaps, and share results and actions with all functional areas, Trillium’s Health Equity Council, and the Board of Directors.

**Data Points Used to Inform the Assessment of Network Adequacy.** Trillium uses the following data points to inform our Network Adequacy Assessment:
- Member and provider locations
- The percentage of members with a provider within the acceptable number of miles and/or driving times, in minutes in accordance with OAR 410-141-3220;
- Wait-times to appointments in accordance with OAR 410-141-3220
- The number of providers accepting new members in our Service Area
- The ratio of provider-to-member availability in our Service Area; Member complaints about provider availability
- Provider complaints about specialist or bed availability
- Member Grievances and Appeals
- Member Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results
- The volume of out-of-network service utilization.

**Methodology for Network Adequacy Evaluation.** Using the collected data, Trillium’s Network Team calculates and compares adequacy measures against predefined standards established through contractual, State or federal requirements, and reports identified gaps to meeting network adequacy based on geography and/or provider type. In the absence of contract or regulatory standards, Trillium will use industry-accepted standards and guidelines, such as National Committee for Quality Assurance (NCQA) provider-to-member ratios. Trillium will collaborate with local THW collectives, such as the Oregon Community Health Worker Association and the THW Hub in Lane County in conjunction with Direct Service, PeaceHealth, and Kaiser Permanente to develop measures and standards for assessing the adequacy of our THW network. Trillium’s **2018 assessment of our Provider Network demonstrated 100% compliance with all network adequacy standards** in accordance with OAR 410-141-3220.

**Ensuring Network Adequacy across our Proposed Service Area.** Trillium has experience expanding our Provider Network as part of our response to rapid growth in membership during Medicaid expansion in 2014. To date, 16 of our affiliate plans have experience significantly expanding their networks as a result of entry in to new Service Areas. Not one of our affiliate plans have missed an implementation deadline or failed a readiness review. Trillium is deploying the same best practice approach to building strong Provider Networks as our affiliates. To date, we have contracts and LOAs with over 5,295 providers throughout our proposed Service Area, ensuring that Trillium meets Network Adequacy and Capacity standards across the Tri-County Region. We have obtained contracts and LOAs with approximately 830 primary care providers, 480 mental health providers, 65 SUD providers/ facilities, 640 dental providers, 220 vision providers, and 92 PCPCHs. Additionally, we have LOAs with four DCOs that are currently participating in Trillium’s contracted provider network, and three NEMT providers.

**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.**

Trillium will **establish and evaluate network provider capacity** in accordance with the factors in Exhibit B Part 4 Section 3.a.2 of the Sample Contract. We will use NCQA provider-to-member ratios to determine the minimum number of providers required to serve our members by provider type, for example, a ratio of 1 PCP
per 2,000 members. As part of ongoing monitoring, we will inquire about and document provider panel capacity upon contract execution and assess panel limit against actual and contracted membership. We will track providers with open or closed panels quarterly, note panel status in our online Provider Directory, and require providers to immediately call Trillium’s Provider Relations if their capacity changes. We will contractually require providers to maintain an open panel to be eligible for participation in any of Trillium’s VBP programs.

Data Points and Methodology Used to Inform Network Capacity Assessment and Evaluation.

Ensuring Capacity Meets Demand. The Network Team reviews utilization of services no less than quarterly using claims data. Additionally, the Network Team monitors access to services annually using member feedback such as CAHPS survey results, and provider appointment availability completed through call auditing.

Culturally Responsive and Linguistically Appropriate Care. To evaluate our network’s capacity to provide culturally responsive and linguistically appropriate care, Trillium will measure the following data points: volume of providers that speak languages other than English; volume of members that request interpretation; volume of member grievances related to linguistic concerns, and volume of providers that participate in cultural competency training. We will compare the volume of member translation requests and grievances received related to linguistic concerns to the availability of providers that speak other languages and availability of providers with cultural competency training.

Physical and Disability Accessibility. Trillium is supported by Centene’s Provider Accessibility Initiative to provide equal access to services and accessibility for our members with disabilities and will conduct an initial needs assessment of our Provider Network to measure accessibility and create a target list for outreach and education. To evaluate our network’s capacity to ensure physical accessibility, we will compare the volume of ADA compliant providers as indicated by data (e.g., appropriate wheelchair access and health exam tables) collected through site visits and outreach from our Provider Network team, against the volume of access-related member grievances about specific practitioners, groups and geographic areas. We use a predefined goal of member grievances concerning appointment access of less than 5.0 per 1,000 members.

(3) How does Applicant intend to remedy deficiencies in the capacity of its Provider Network?

In addition to all of the data points described above in Att.7.4.A.1 and Att.7.4.A.2, our QIC, together with appropriate functional areas and our Health Equity Council, use the results of our DSN and other internal assessments, to identify network gaps, prioritize deficiencies, and work to implement targeted or system-wide interventions in a timely manner. For example, Trillium will:

- Target a specific provider specialty or geographic area for focused recruitment efforts, including personal outreach and leveraging partnerships to encourage participation
- Identify sources of provider dissatisfaction or barriers to contracting and work collaboratively with providers to address these barriers
- Use provider contracting and value-based purchasing incentives to encourage network participation, open panels, and after-hours care
- Require subcontractors to monitor, report on, and ensure compliance by their downstream providers
- Promote the use of Telehealth services
- Charge the Health Equity Council with developing strategies specific to addressing the culturally and linguistic needs identified
- Approve out-of-network authorizations or Single Case Agreements (SCA) when a member needs services that are not available in our Service Area

CULTURALLY RESPONSIVE NETWORK

We will charge our newly formed, community represented Health Equity Council with developing and monitoring strategies to address cultural and linguistic deficiencies in the network.
(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 accordance with OAR 410-141-3220, Trillium ensures, monitors, and routinely measures wait time to appointment standards using the following methods and data points:

⊙ **Appointment Access Phone Survey.** To measure wait time to appointment for primary care, specialty care, and BH services, we use a subcontractor to conduct an annual Appointment Access phone survey of our Provider Network. *We collect the following data points:* wait times for routine primary care, specialist, and BH visits; wait times for primary care urgent visits, emergent appointments, and after-hours access; and BH wait times for urgent care, non-life threatening emergencies, and routine follow-up.

⊙ **Subcontractor Oversight.** We contractually require Dental Care Organizations (DCOs) to adhere to OH wait time to appointment requirements, monitor appointment availability, and report results to Trillium quarterly. We collect Non-Emergent Medical Transportation (NEMT) related grievances in our Grievance and Appeal log to identify trends in wait times to NEMT services.

⊙ **Member Feedback.** To monitor timely access through member experience, Trillium analyzes CAHPS survey results; member feedback about access to specific practitioners, groups and geographic areas; and complaints, grievance, and appeal data. *We collect the following data points:* percentage of members who report they obtained routine, urgent, and specialist care as soon as they needed/wanted it; volume of member complaints and grievances about access issues; and direct member feedback through the Community Advisory Council (CAC) and other forums.

⊙ **Provider Feedback.** To monitor timely access through provider experience, Trillium analyzes provider survey results, provider feedback, and provider complaints. *We will collect the following data points:* percentage of providers who report no specialists available to refer members to; percentage of providers who report no bed availability; and direct provider feedback through the CC and other forums.

⊙ **Staff Feedback.** All member and provider facing staff (e.g., Medical Management, Call Center, and nurse advice line staff) are encouraged to report any expressed concerns or identified access issue to the QIC, which will route the information to the appropriate functional area for intervention.

(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 Applicant’s prospective Members will be measured and periodically validated.

To ensure *availability of oral health (OH) providers*, Trillium contracts with four DCOs (Willamette Dental Group, Advantage Dental, Oregon Dental Services, and Capitol Dental Care) to maintain a geographically robust network of approximately 1,000 OH providers (including OH specialists such as endodontists) throughout our current and proposed Service Area. Our dental network also includes services provided within safety net providers such as school-based programs, FQHCs, and integrated clinics. We contractually require all DCOs to monitor and evaluate the adequacy and access of their OH network in accordance with OAR 410-141-3220 as described above in Att.4.a.1.

**Measuring and Validating Full Time Equivalent (FTE) Availability of Providers.** Trillium will require DCOs to submit the FTE availability of OH providers as part of the quarterly DSN assessment. We will periodically evaluate reported FTE availability of OH providers by conducting secret shopper calls and comparing the results against the DCO’s DSN assessments.

(6) Describe how Applicant will plan for fluctuations in Provider capacity, such as a Provider terminating a contract with the Applicant, to ensure that Members will not experience delays or barriers to accessing care. Trillium proactively accounts for capacity fluctuations by maximizing the volume of providers we recruit and retain in our network. Our network development strategies include extending agreements to newly
In response to Medicaid expansion, Trillium helped open five new primary care clinics: Brookside Clinic, Delta Oaks, Orchid Clinic, Centennial Clinic, and Oregon Integrated Health.

**Member Continuity of Care.** If a provider exits our network, we ensure seamless delivery of services by working with members to ensure they are referred and transitioned to a provider who meets the member’s needs, using efforts such as referring members to out-of-network providers as needed using SCAs. As part of our ongoing collaboration with DCOs, we will use Joint Operating Committees to identify and address any provider adequacy and capacity concerns within our OH Provider Network.

**B. REQUESTED DOCUMENTS**

**Completion of the DSN Provider Report (does not count towards page limitations)**

Please see [Att. 7 DSN Provider Capacity Report](#). In accordance with OHA’s “Answer 25” in Addendum #8 to Request for Application (RFA) OHA-4690-19 Trillium has not responded separately to the DSN narrative questions per OHA’s instruction that “the responses in Attachment 7 - 4.a.(1)-(6) will suffice”.

**5. GRIEVANCE & APPEALS**

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:

Trillium has a grievance and appeal (G&A) system in place to collect, analyze, integrate, and report G&A system data. Our cross-departmental Leadership Team reviews G&A system data monthly to identify trends and areas of concern, including whether timeliness standards are met; identify patterns related to specific issues, providers, or Trillium departments; and target any corrective actions. They forward data to the Quality Improvement Committee (QIC) for further analysis and action. The QIC reviews grievance system data quarterly to identify emerging trends and develop prompt improvement actions, such as policy, process, or other organizational improvements. The QIC also reviews appeals data quarterly to identify trends and develop improvements to address them, such as updating; clarifying specific utilization guidelines; or additional provider education. Trillium also collects G&A data for the OHA quarterly report that is utilized for process improvement.

a. **Access to care** (wait times, travel distance, and subcontracted activities such as Non-Emergent Medical Transportation).

b. **Network adequacy** (including sufficient number of specialists, oral health and Behavioral Health Providers).

**Access to Care and Network Adequacy.** We use grievance data to identify and implement plan-wide, departmental, or provider/subcontractor corrective action to address access to care (appointment availability, wait times, travel distance); network adequacy gaps; provider compliance issues; additional provider or staff training needed; fraud and abuse; and needed business process improvements. For example, if G&A staff
identify a trend in grievances related to appointment availability for a certain specialty, information is brought to the Quality Improvement (QI) Director for further analysis. Based on results, the appropriate course of action is pursued with the influencing department staff (e.g. Contracting or Provider Relations); evaluated and monitored by QI and G&A staff; and reported to the Leadership Team. Potential action may include contracting with additional specialists in the area, identifying telemedicine solutions, or outreach to current specialists to address and help support scheduling issues. When we determine a specific provider has met a G&A threshold relating to the provider’s office, Provider Relations and QI staff (as applicable) will conduct an additional provider office visit and forward the results to the Peer Review and Credentialing Committee.

c. Appropriate review of prior authorized services (consistent and appropriate application of Prior Authorization criteria and notification of Adverse Benefit Determinations down to the Subcontractor level).

We use appeal system data related to Prior Authorization (PA) determinations as a mechanism to monitor appropriate application of PA criteria and timeliness of notification of Adverse Benefit Determinations at the plan and subcontractor level. The QIC reviews appeals data (including data from subcontractors) related to PA denials, the number and percent of PAs overturned, and timeliness of notifications quarterly to identify, trend, and update UM policies and/or PA criteria, and develop and deliver appropriate provider and staff education.

6. COORDINATION, TRANSITION AND CARE MANAGEMENT

A. CARE COORDINATION:

(1) Describe how the Applicant will support the flow of information between providers, including DHS Medicaid-funded LTC care 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.

Trillium is committed to providing Care Coordination (CC) and technology solutions to support the secure, HIPAA compliant flow of information between providers and systems of care and minimize duplication of services. Our CC model is designed to be inclusive, engaging providers and agencies from across the system of care through interdisciplinary care teams (IDT), direct Care Coordinator outreach, and integrated case rounds. We facilitate the exchange of health information and use of timely and actionable member data through our role-based, secure web portals, provider Hot-Spotter Reports, and secure emails. A Member Health Record, available on our Provider Portal, provides actionable information in a manner and format that allows providers to view clinical history, individualized care plans (ICPs), and current interventions on their members. We will also offer our Community Partner Portal allowing authorized users, such as Medicare Advantage Plans, Oregon Department of Human Services (DHS), Type B AAAs and APD Districts offices, and other agencies to check member eligibility; submit documents; view risk and care alerts, and ICPs; and submit and view associated notes.

(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.

One of our roles as a current CCO is to support providers in delivering the best possible care to members and facilitate partnerships and linkages to allow for access to and coordination of community resources and prevention and self-management programs. We will utilize our current experience and proven approaches to work with providers to develop necessary partnerships – and maintain existing partnerships – throughout our Service Area. Key approaches include but are not limited to the following activities:
Use of our Innovators’ Collaborative, an integral part of our Trillium University educational program bringing together PH, BH, OH, and LTC providers and social service agencies; community organizations; school districts; THWs; and Advisory Council and Panel members (e.g. CAC, Tribal Advisory and CAP) to learn about social and support services and tools to coordinate across systems and sectors.

Use of provider collaboratives to share best practices on accessing community resources.

Promoting the awareness of and use of our Trillium Resource Exchange (available online to members and providers) that includes information on social and support services.

Use of case conferences and IDTs that bring providers and community partners together.

Use of MOUs and LOAs that facilitate data sharing and validation and coordination and communication among providers and community partners with the goal of promoting whole-person care.

(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.

To help providers communicate with and educate members regarding CC, we will add new tools to our website’s provider resource page such as:

- Tips and checklists of criteria for assuring effective member communication
- Instructions for referring a member for CC services
- A flyer, available in English, Spanish, and other languages and formats (e.g., Braille, large print, audio) upon request, that providers can give to members they wish to refer for CC. The flyer will ensure consistent messaging across providers by providing easy to understand and culturally appropriate information on the CC program, as well as Trillium contact information and instructions for how to reach the CC Team.
- Information on the availability and how to access interpreter services.

(4) Describe how the Applicant will work with Providers to implement uniform methods of identifying Members with multiple diagnoses and who are served with multiple healthcare and service systems.

Our technology solutions and decision support tools allow us to systematically identify members with multiple diagnoses who are being served by multiple providers and systems of care and to share this 360-degree view of the member with our provider partners. We have successfully worked with providers and incorporated their input on the type of actionable information and data they need to identify and provide effective care for complex members. For example, with input from our provider partners, we developed and implemented our Hot-Spotter Report with targeted data on high risk-members assigned to a provider’s panel with member-level information provided electronically to PH, BH, and DCO providers (who distribute to the OH providers) monthly. We also participate in the PreManage Collaborative to support efforts to implement uniform and standardized methods for identifying members for CC using PreManage tools and applications.

(5) Describe how Applicant will implement an intensive Care Coordination and planning model in collaboration with 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 these Members.

Since the inception of the CCO program, we have implemented several integrated models that support a whole-person approach for complex and specialized populations. For example, our innovative Intensive Community Care Management (ICCM) program, developed in partnership with Springfield Family Physician and the Center for Family Development, serves members who have five or more chronic PH conditions and at least one BH condition. The ICCM program provides CC services in a PCPCH setting. We will utilize lessons learned and best practices implementing programs such as ICCM to implement additional ICC and
planning models throughout our proposed Service Area. We will promote the delivery of ICC services with our PCPCHs through training on person-centered care planning, use of IDTs, and the provision of actionable data and analytics.

**Intellectual and/or Developmental Disabilities (I/DD).** We identify PCPCHs that offer evidence-based integration models to support access to integrated services for individuals with I/DD that can effectively be treated in primary care settings. For example, Springfield Family Physicians in Lane County offers integrated services with expertise and training in serving I/DD and complex patient populations and OHSU clinics serving I/DD patients are part of our network. Our CC Team is trained in Person Centered Thinking and works with the member’s County Services Coordinators and Brokerage Personal Agents as an integral participant in the IDT. We also contract with LILA to provide assessments, activities, and programs to gain skills for independent living and socialization for our members. As a best practice, we will look to enter into agreements with CILs in our expansion counties. Additionally, we will collaborate with the University Centers of Excellence in Developmental Disabilities (UCEDD) to offer provider training and participate in our governance committees to assist with development of approaches to address the needs of members with I/DD in our Service Area. Our plan is to work with UCEDD’s network of community partners, such as the Oregon Council of Developmental Disabilities, to ensure we meet the PH and BH need of individuals with I/DD.

**6) Describe how the 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) SPA and Members receiving DHS Medicaid-funded LTC services, given the exclusion of DHS Medicaid-funded LTC services from Global Budgets.**

We work closely with a variety of stakeholders, including OHA, State agencies, and other State funded or operated entities, including local CMHPs, DHS, AAAs, APD offices, PCPs, PCPCHs, BH and LTC providers to ensure coordination and integration of care and services for members with SPMI receiving home and community-based services (HCBS) and members receiving DHS Medicaid-funded LTC services. As described in Att.11, our CC program is designed to coordinate across systems and disciplines, covered and non-covered services. SPMI and LTC eligible members are enrolled in ICC with a Care Coordinator serving as the member’s primary point of contact, working with the member and his/her IDT to develop and monitor the ICP; providing educational resources; connecting to vocational rehab and supportive employment; making appropriate care and service connections regardless of payer source; and providing ongoing coordination of State Plan personal care and other HCBS and LTC services, including coordination with the member’s AAA or APD case manager.

**7) Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, including the use of Traditional Health Workers, especially for Members with intensive Care Coordination needs, and those experiencing health disparities.**

**Strategies.** We train all new CC hires in Trauma Informed Care (TIC) and Person-Centered Thinking and offer provider trainings on evidence-based strategies such as TIC and Mental Health First Aid. We support Project ECHO’s Psychiatric and Addictions Case Consultation module, a free resource to educate providers on prescribing Medication Assisted Treatment (MAT) and offer remote specialty consultation and work effectively and triage with our Assertive Community Treatment (ACT) partners at Laurel Hill and South Lane Mental Health to serve members with SPMI. We promote the Nurse-Family Partnership Home Visiting Program for our new moms and support providers in adhering to clinical guidelines and assisting members in meeting their self-management goals through programs such as our Diabetes Disease Management Program.
Use of THWs. THWs are embedded into Trillium’s delivery system to extend the reach of our CC Team in addressing holistic needs. For example, Peer Support Specialists, Peer Recovery Specialists and other THWs work to decrease barriers to services, enlist auxiliary services and specialty care, and coordinate partnerships with agencies. In addition, members referred to housing assistance partners, such as Cornerstone Community Housing, meet with a Community Health Worker (CHW)/Peer who walks the member through the process and connects them to Wraparound services. Trillium employs five MemberConnections® Representatives (MCRs) as part of our Care Team, three of whom are certified CHWs, providing education, navigation, and resource linkages. Care Coordinators refer members to these MCRs based on member need and use shared documentation and calendar functions to ensure seamless coordination. Trillium plans to expand the role of MCRs to provide acute hospital discharge and follow-up assistance for members who have a high risk of readmission, based on our success with peer-lead mental health hospitalization follow-up. MCRs receive evidence-based training to address SDOH-E, increase health literacy, and meet the cultural and linguistic needs of our members facing disparities.

(8) 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.

(a) 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.

We ensure all members have a Primary Care Provider (PCP) within 30 days of enrollment. Our first objective is to support members in choosing a PCP. For members that do not choose a PCP, we assign based on previous PCP, geography, and cultural or language preferences, prioritizing auto-assignments to higher tier PCPCHs. Once enrolled, we educate members about their benefits and how to access services by mailing our Member Welcome Packet within 14 days and completing a member Welcome Call within 30 days. During the Welcome Call, we offer to help select a PCP, schedule a PCP appointment and arrange transportation as needed. We prioritize Welcome Call outreach by using enrollment data to identify members who may qualify for Intensive Care Coordination (ICC) or may require urgent access, such as pregnant members or members with SPMI. Trillium will complete an Initial Risk Screening (IRS) for all newly enrolled or transitioned members within 30 days of enrollment or within 10 days of receiving a referral. We include the IRS in the Welcome Packet but try to complete during the Welcome Call. If we are unsuccessful reaching a member by phone, we will send a letter explaining the importance of and how to complete the IRS: in-person or telephonically; electronically via the Member Portal, or by mail. For hard to reach members, we will leverage our MCRs, providers, and community partners to help complete the IRS. As part of our no-wrong door approach, Customer Service Representatives identify whether the IRS has been completed when a member calls, and if not, attempt to complete the IRS. The IRS is intended to identify immediate clinical or social needs as well identify members for referral to CC. If the IRS reveals the need for urgent services, we will coordinate these services for the member in a timely fashion.

(b) Describe how the 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.

In addition to ensuring that all Trillium members have a medical home that meets their needs, we provide PCPs with training and website links to evidence-based, culturally appropriate tools and resources (including onsite and telephonic language translations services) with the expectation that they will perform age-appropriate health screenings in the language of the member’s choosing. Tools and resources include, for example: EPSDT-related screens; the Adverse Childhood Experience (ACE) Questionnaire; the Screening, Brief Intervention, and Referral to Treatment (SBIRT) screen; pregnancy and postpartum BH screens; and screens for SDOH-HE, including PRAPARE. Through the Trillium Innovation Fund, we are piloting Simple Screens tablets in five
We provide intensive support for those discharged back to the community at high risk for readmission. For

(9) 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.

(a) Describe the 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, skilled 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.

Transition of Care (TOC). Our CC Model supports members transitioning from one care setting to another with a goal of assuring the member receives needed supports to live in the most integrated community setting possible. Trillium’s transition-oriented CC is designed to minimize issues that can occur during transitions, such as declining health, hospital admission or readmission, transcription errors, medication errors and missed follow-up appointments. We employ our evidence-based TOC protocols including the following key processes and activities:

- Establish a single point of contact for transition activities, e.g. the member’s Trillium Care Coordinator, a Trillium Transitions Coordinator, or the AAA or APD case manager
- Notify providers, including the member’s PCP/BH providers, IDT including AAA/APD case manager (if member receiving LTC services) of transition, and engage in planning
- Assess current and post-transition needs and goals and update the member’s ICP in collaboration with the member, the member’s PCP, facility, and chosen circle of support
- Communicate regularly and coordinate with the member, the member’s family/caregiver, the member’s IDT, facility discharge planners, and providers, as appropriate
- Assess and evaluate risk of hospital admission or need for alternative level of care to guide the necessary intensity and urgency of follow up care post discharge
- Develop a transition plan addressing PH, BH, LTC, SDOH-HE, and other needs with the IDT including making referrals for waiver service eligibility, as appropriate
- Provide discharge planning services upon admission, that includes making arrangements and authorizing services for a safe placement, such as housing, residential care, DME, hospice/palliative care, home-and community-based services (HCBS), and BH services (e.g. 7-day follow-up or intensive outpatient)
- Provide assistance with addressing SDOH-HE such as assistance with locating affordable housing, household supplies, and follow-up contacts to ensure services are provided
- Authorize and/or arrange for post-transfer services; facilitate authorizations, appointments, and transportation, and secure necessary equipment or supplies
- Educate the member/caregiver on needed post-transition care and follow up, including education on early symptom recognition to avoid admissions
- Conduct medication reconciliation and address medication needs

Our approach considers needs related to barriers and the member’s social context on par with clinical needs, and we provide intensive support for those discharged back to the community at high risk for readmission. For
members identified as moderate or high risk, we contact the member within three days after discharge to confirm appointments, transportation, and in-home services. Post-discharge interventions generally last 30 days and are followed up by continued CC visits every other month when a person is in complex CM or ICC services to ensure the member understands signs and symptoms to monitor, keeps follow-up appointments, understands any changes in medications, and has needed social services and supports.

(b) Describe the 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.

Any time members receiving LTC services anticipate or experience a transition, our Transitions Team actively engages with the member’s AAA or APD Transition and Diversion team to re-assess the member’s need, develop a transition of care plan, and update the member’s ICP to help the member remain in the most integrated community setting possible. We will have MOUs with all Type B AAAs and APD local field offices in our Service Area prior to Readiness Review that delineate how we coordinate and communicate to promote and monitor TOC, including data exchange; regular IDT meetings; a single ICP, and joint caregiver support and training on red flags. We also have an agreement in place with the Oregon Wellness Network, LLC (representing AAAs across the State) to assist with providing non-medical transition of care activities for members receiving DHS-funded LTC services in our proposed Service Area.

(c) Describe the 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.

Tracking Member Transitions. We utilize our Combination Report, which includes census and PreManage data to identify and track transitions. We receive real-time Admission, Transfer, Discharge (ADT) data that provides our CC Team and providers with real time notification when a member is admitted to and discharged from inpatient or emergency care. To deliver information closer to the point of care, we will integrate data and systems with partnering hospitals and providers as well as AAAs and APD case managers to design population-specific cohorts and daily driver reports as part of our CC programs, such as ED diversion for high utilizers, opioid abuse and region-specific initiatives.

Member and Family Engagement. Members experiencing a transition are engaged at the point of care, with transition planning initiated at admission and the CC and/or TOC Team coordinating with the member, family/caregiver and facility staff to identify and address transition needs and goals and understand discharge instructions. Engagement and activation are integral to promoting personal responsibility, behavior change and meaningful participation in the CC and TOC process. We use Motivational Interviewing and our Strengths-Based Model to help members articulate goals and preferences; teach self-management skills; and educate members and families on red flags, which are indications that their condition is worsening, and medication side effects, and how to respond. We refer to and involve THWs, such as peers and other supports, to help engage members and promote culturally responsive care. We will provide members/caregivers with our Personal Health Record booklet and Caregiver Journal to track information such as medications, diagnoses, post-discharge care needed, provider contact information, and questions or concerns to discuss with the provider.

(10) Individual care plans: As required by ORS 414.625, the Applicant will use individualized care plans to address the supportive and therapeutic needs of Members with intensive Care Coordination needs, including Members with severe and persistent mental illness receiving home and Community-based services covered under the State’s 1915(i) State Plan Amendment. Care plans will reflect Member or Family/caregiver preferences and goals to ensure engagement and satisfaction.
(a) **Describe the 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 severe and persistent mental illness receiving home and Community-based services covered under the State’s 1915(i) SPA.**

In alignment with our core value of *whole-person care*, the development of the ICP is *person-centered, trauma-informed, recovery-oriented and strengths-based*. Our standards and procedures include an assessment of the member’s personal goals and short- and long-term health needs and preferences, including those related to PH, BH, OH, and LTC services, and social needs, to drive ICP development. The ICP is reflective of member-identified goals and preferences, provider choices, and selected action steps to take in achieving goals. We often find that SDOH-HE becomes a priority over addressing health needs, for example, electricity for refrigerator to store insulin, or air conditioning for asthmatics. ICPs are developed with the member, appointed representatives, and circles of support, with direct input from providers and agencies involved in each member’s care through the IDT. As described in greater detail in Att.11.E, for members with SPMI, the ICP includes the full range of covered and non-covered services, such as Supportive Housing and peer support services, ensuring services are in place prior to the member’s transition. Our person-centered planning strategies ensure services, supports and interventions (including Supported Housing) are consistent with each member’s identified preferences, treatment goals, clinical and social needs and informed choice. As part of the care planning process, Care Coordinators assist the member with identifying strategies for accomplishing their goals and help them move them toward engagement, treatment, and recovery.

(b) **Describe the 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.**

As described in Att.11.3, our CC program includes a *universal screening process* to identify high-risk/high needs members (inclusive of members receiving DHS Medicaid-funded LTC services) who are eligible for ICC services. An *Initial Risk Screening* (IRS) is initially completed as part of the Welcome Call. Members with urgent or ongoing needs or determined to be eligible for ICC are triaged to the CC Team for further assessment. As triggered by the IRS, we complete a *comprehensive assessment* to effectively match members with appropriate services (e.g. ACT, Wraparound Services, waiver services etc.). Depending on the identified needs of the individual, the CC Team may also complete additional supplemental screenings such as the PHQ-9, Columbia Suicide Risk Assessment, and Edinburgh Depression Screen. We use findings from the universal screenings and assessments coupled with other information on critical risk factors that trigger ICC to match members with appropriate services and level of CC, including referrals to ICC.

(c) **Describe how the 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**

We will have MOUs with all Type B AAAs and APD local field offices in our Service Area prior to Readiness Review that delineate how we will work together to provide integrated and coordinated care across the entire continuum of services and settings for members receiving Medicaid-funded LTC services. Trillium utilizes relevant referral, risk assessment, and screening information from AAAs and APD offices coupled with subsequent assessments (as appropriate) and information from external sources, such as ADT data and LTC providers, to form the basis for the development of the member’s ICP. We communicate and coordinate with AAAs and APDs via regularly scheduled joint case conferences; participation in IDT at the individual member level; and technology solutions such as PreManage and our Community Partner Portal.
(d) **Describe how the 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.**

We have established policies, processes, and systems in place to track all required assessments and re-assessments, supported by the reporting functionality available through TruCare, our integrated care management system. Care Coordinators reassess high-needs members at least semi-annually or upon a significant change in condition or status, such as an inpatient admission or ED visit identified through PreManage, or a change in housing status as identified during ongoing member outreach. As part of our process, Care Coordinators systematically (via reporting) and personally (via in-person and telephonic outreach and IDT engagement) monitor progress toward ICP goals. Care Coordinators are all trained in person-centered thinking and ask the member if their goals and preferences have changed and update the ICP at each interaction, as appropriate. Care Coordinators work with the member and their IDT to revise the ICP to include progress with existing goals, interventions or authorized services, as appropriate.

(e) **Describe how individualized care plans will be jointly shared and coordinated with relevant staff from Type B AAA and APD with and DHS Medicaid-funded LTC Providers and Medicare Advantage plans serving Fully Dual Eligible Members.**

As a CCO 2.0 enhancement, we will offer our role-based Community Partner Portal to provide access to a single and jointly shared care plan available to authorized users across the system of care. The Portal allows for the sharing of clinical information including completion and submission of assessments across community partners and agencies, including AAAs and APDs, LTC providers and Medicare Advantage plans. Authorized users can check member eligibility, submit documents, view care alerts, and view and contribute to a member’s ICP.

(II) **Describe the Applicant’s plan for coordinating care for Member oral health needs, prevention and wellness as well as facilitating appropriate Referrals to oral health services.**

**Educating and Assisting Members.** Upon enrollment, we educate members about their dental benefits and assigned Dental Care Organization (DCO). We review information during Welcome Calls and offer to help schedule dental appointments. We provide ongoing OH education, including the periodicity schedule for children, through our member webpage and newsletter, and link to the DCO provider directories on our website. **Partnering with DCOs.** We partner with DCOs to outreach to and educate members about OH, including screenings, in alignment with the EPDST Periodicity Schedule. We send reminder postcards and conduct targeted outreach calls to assist members with scheduling appointments. We also share our monthly Hot-Spotter Report with DCOs, which will be amended to identify members due or past due for OH screenings. Using the clinical data and health risk scores provided in these reports, DCOs identify and outreach to members to ensure appropriate engagement. For members in CC, we assess oral health needs during the care planning process and the Care Coordinator works with the DCO to schedule dental appointments. **Facilitating Provider Referrals.** Appropriate referral to and integration with OH is part of provider orientation and training. PCPCHs, PH, and BH providers can locate DCO contact information for making an OH referral by referencing the member’s ID Card or the Hot-Spotter Report. We are also working to develop referral forms for use by PH, BH, and OH providers and will provide cross training to improve the ease of referring members across provider types. Trillium also educates our network providers regarding OH integration through Learning Collaboratives held throughout the year and by promoting the State’s OH training programs.
(12) Describe Applicant’s plan for coordinating Referrals from oral health to physical health or Behavioral Health care.

Trillium sends our monthly Hot-Spotter Report to the DCOs and our PCP/PCPCH/BH providers to facilitate CC, communication, and referrals across providers. We are also working to develop a referral form for use by OH providers to improve the ease of referring members to PH and BH providers. We monitor our DCOs’ referral processes, procedures, and performance to PH and BH care providers to ensure that members receive timely, high-quality, integrated care. Issues are addressed by our Subcontractor Oversight Program at quarterly Joint Operating Committee meetings where subcontractor performance is assessed, and corrective action is taken, if needed. We also use these and other community forums to educate providers across the delivery system and identify programs and opportunities for referral, such as OH providers education members on tobacco cessation and impact of SUD on oral health and referring members with identified needs to CC.

B. CARE INTEGRATION

(1) ORAL HEALTH

(a) Describe the Applicant’s plan for ensuring delivery of oral health services is coordinated among systems of physical, oral, and Behavioral Health care.

(b) Describe Applicant’s plan for ensuring that preventive oral health services are easily accessible by Members to reduce the need for urgent or emergency oral health services.

Trillium promotes full integration and access to OH services through several mechanisms:

**Communication/ Data Sharing.** We supply PH and BH providers and DCOs with a monthly Hot-Spotter Report comprised of data on members assigned to each provider’s or DCO’s panel including clinical information, ED utilization, health risk scores, members that may benefit from CC, and, coming in 2020, members who are past due for OH screenings. Providers and DCOs use the report to prioritize member outreach and engagement and to drive interventions. We also require DCOs to share information, including claims/complaint data, preventive care services provided, and dental care plans, for members that have complex conditions or higher ED usage.

**Provider Education and Training.** In addition to our Provider Manual and newsletter, we sponsor ongoing Learning Collaboratives for providers, school-based OH programs, dentists, and community organizations to promote OH integration and the State’s OH training programs.

**Co-Located Services.** We contract with co-located PH/OH clinics, such as the Lane County Community Health Centers Delta Oaks Clinic and Springfield Family Physicians clinic that have expanded their practices to include Dental Hygienists onsite to provide screenings, fluoride varnish and sealant applications, OH education, and Primary Dental Provider referrals. In 2020, Trillium will promote greater integration by linking PCPCH and DCO member assignments. For example, members assigned to a PCPCH that has co-located OH services will be automatically assigned to the DCO providing those co-located services. We will work with our DCOs to implement this strategy with a goal of applying it to 80% of our members by the end of 2020. As described in Att. 8, we will also provide performance-related bonus payments to PCPs that offer integrated OH services. Meeting members where they are, we also provide OH screening at low income housing such as Cornerstone Community Housing and will offer this across our proposed CCO 2.0 Service Area.

**Robust Provider Networks.** Trillium maintains a robust and adequate network through four contracted DCOs. We contractually require DCOs to meet OAR OH access standards, regularly assess network adequacy, and
monitor member access through the grievance and appeals, quality metrics, and satisfaction survey results. We monitor DCO performance at quarterly Joint Operating Committee meetings and take corrective action as needed. For 2020, we will increase DCO accountability for access-related performance metrics such as: percent of members with a dental visit; sealant utilization; ED utilization; and network adequacy. Like the PCPCH model, the DCO contracts will include a tiered incentive model that rewards DCOs with larger incentive payments for higher performance.

Collaborating with Schools. Trillium launched an OH Collaborative in 2018, bringing together OH providers, schools, and DCOs to expand school-based OH programs to all eligible elementary and middle schools in Lane County. At the beginning of 2018, 23 Lane County schools eligible for OHA’s School Fluoride and School Dental Sealant Programs were unserved – the worst rate in the State – leaving 12,000 eligible children without free, school-based preventive OH. Because of Trillium’s leadership, all eligible Lane County schools will have an OHA-certified OH program for the 2019-2020 school year. For CCO 2.0, we will identify any school districts in the Tri-County Region without 100 percent coverage to support expansion of school-based coverage.

(2) HOSPITAL AND SPECIALTY SERVICES

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 Patient-Centered Primary Care Homes. Describe how the Applicant’s agreements with its Hospital and specialty care Providers will address:

We are committed to maintaining full compliance with all State access requirements across our Service Area. We use OHA-approved hospital and specialty provider contracts containing all required provisions. Our Provider Manual describes the roles of PCPCHs, specialty providers, and hospitals and are incorporated by reference into our provider contracts.

(a) Coordination with a Member’s Patient-Centered Primary Care Home or Primary Care Provider

Our hospital and specialty service contracts require timely PCPCH coordination using electronic health information in accordance with Trillium’s policies and procedures (P&Ps).

(b) Processes for PCPCH or Primary Care Provider to refer for Hospital admission or specialty services and coordination of care.

The PCPCH or PCP is responsible for providing member referrals for medically necessary specialty services and for arranging prior authorization (PA) as appropriate for elective hospital inpatient, residential treatment facility, home health, and other services in advance. Referrals and PA requests may be submitted by fax or through our secure Provider Portal.

(c) Performance expectations for communication and medical records sharing for Hospital and specialty treatments, at the time of Hospital admission or discharge, for after-hospital follow up appointments.

Our hospital and specialty service contracts require providers to (a) share member medical records with other Trillium network providers in accordance with Trillium’s P&Ps; (b) permit Trillium, Trillium’s designated representative, OHA, or applicable State and federal regulatory agencies to inspect such records; and (c) provide copies of such records to Trillium upon request. These requirements support our concurrent review and discharge planning processes for planned or unplanned hospital admissions and support our post-discharge CC activities, including referrals for follow-up appointments with primary and specialty care providers.

(d) A plan for achieving successful transitions of care for Members, with the PCPCH or Primary Care Provider and the Member in central treatment planning roles.

In addition to requiring PCPCH coordination, hospitals are contractually required to provide comprehensive transitional care, including appropriate follow-up care, when members enter or leave the hospital in accordance with Trillium’s P&Ps, including, for example, our Continuity and Coordination of Medical Care and CC P&Ps.
C. DHS MDAID-FUNDED LONG TERM CARE SERVICES

CCOs will be responsible for the provision of health services to Members receiving DHS Medicaid-funded LTC services provided under the DHS-reimbursed LTC program. DHS Medicaid-funded LTC services include, but are not limited to, in-home supports/services, Adult Foster Care, Residential Care Facilities, Assisted Living Facilities, DHS Medicaid-funded LTC Nursing Facility state plan, State Plan Personal Care for APD, Adult Day Services, Contract Nursing Program, administrative examinations and reports, non-medical transportation (except in some areas where contracted to transportation brokerages) and PACE state plan (including Medicare benefits).

(1) Describe how the Applicant will:

(a) Effectively provide health services to Members receiving DHS Medicaid-funded LTC services whether served in their own home, 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;

We are committed to ensuring that members receiving DHS Medicaid-funded LTC services have access to the full continuum of services provided under the CCO 2.0 Global Budget. We support the provision of healthcare services for members receiving Medicaid-funded LTC services by:

- Ensuring every LTC member has access to a medical home (PCP or PCPCH) of their choosing that is most closely aligned with their integrated and self-determined care needs.
- Ensuring that, regardless of setting, members and providers have access to the support and services required to effectively meet member-determined goals as identified in the member’s person-centered care plan, including quality of life goals.
- Supporting the communication and linkages between the member’s medical home and any other care or service needs required along the continuum, including LTC. This includes a 360 degree view and access for authorized users to member-level health information through our Provider, Member, and Community Partner Portals and PreManage tools.
- Ensuring our LTC members have access to Interdisciplinary Care Teams (IDTs) that provide multidisciplinary support for collaboration across the care continuum. IDTs include the member and the member’s circle of support, member’s PCP, Care Coordinator, AAA or APD case manager, and LTC providers involved in the member’s service delivery.
- Promoting prevention to optimize health and wellness, recovery, and resiliency; prevent functional decline; and support individuals in the most integrated community setting.
- Grounding all relationships and interactions with providers, members and partners in our culturally and linguistically responsive, person-centered, and trauma-informed values.
- Providing technology-driven solutions to provide actionable information. For example, we provide the member’s Type B Area AAA or APD case manager our Hot-Spotter Report that includes member-level information on PH and BH utilization and care gaps.
- Employing a dedicated LTC Liaison to support coordination across Trillium and the LTC delivery system and adherence to the MOUs with the AAAs and APD local field offices.

Role of Type B AAA and APD offices. As described above in Att.7.1.c, since 2012, we have had a MOU in place with the Lane Council of Governments (LCOG), Senior and Disability Services (SDS), and APD Districts 6 and 7 field offices. Through the MOU, Trillium works with SDS to identify members enrolled in our CCO and receiving LTC services; share assessment information; establish IDTs to coordinate care and develop individualized care plans for high-needs mutual members; develop coordinated transitional care practices that incorporate cross-system education, timely information sharing, minimal cross-system duplication of effort, and...
effective deployment of cross-system resources to ensure whole-person care. Our proposed MOUs we are discussing in Multnomah, Clackamas and Washington, Linn and Douglas Counties provide in more detail the roles and responsibilities of the AAAs and APD offices.

**Use best practices applicable to individuals in DHS Medicaid-funded LTC settings including best practices related to Care Coordination and transitions of care:**

We put the member at the center of all CC and transition of care activities. We facilitate collaboration and coordination between the member and their Care Coordinator; family and chosen circle of support; and the member’s IDT across all settings of care, including DHS-funded LTC settings. We utilize relevant referral, risk assessment and screening information from AAAs and APD offices coupled with subsequent assessments (as appropriate) and information from external sources, such as ADT data and LTC providers, to form the basis for the development of the member’s ICP. We communicate and coordinate with AAAs and APDs via regularly scheduled joint case conferences; participation in IDT at the individual member level; and technology solutions such as PreManage and our Community Partner Portal. Any time members receiving LTC services anticipate or experience a transition, our Transitions Care Team will engage with the member’s AAA or APD Transition and Diversion team, as appropriate, to re-assess the member’s need, develop a transition of care plan and update the member’s ICP to help member remain in the most integrated community setting possible. We also have an agreement in place with the Oregon Wellness Network, LLC (representing AAAs across the State) to assist with providing non-medical transition of care activities for members receiving DHS-funded LTC services in our proposed Service Area.

(2) **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 for coordination of care:**

(a) Co-Location: co-location of staff such as Type B AAA and APD case managers in healthcare settings or co-locating Behavioral Health specialists in health or other care settings where Members live or spend time.

(b) Team approaches: Care Coordination positions jointly funded by the DHS Medicaid-funded LTC and health systems, or team approaches such as a multi-disciplinary care team including DHS Medicaid-funded LTC representation.

(c) 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).

(d) Clinician/Home-Based Programs: increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform Assessments, plan treatments, and provide interventions to the person in their home, Community-based or Nursing Facility setting.

**Co-location.** We have several efforts well under way to support the adoption of clinical integration models that support a whole-person approach to service delivery for complex populations, including individuals that are receiving LTC services. For example, we are working with Springfield Family Physicians and the Center for Family Development to implement an Intensive Community Care Management (ICCM) Program to meet the needs of high-cost complex members, including members that are receiving DHS-funded LTC services. Eligible members are assigned an ICCM Primary Care Team who assists the member in all levels of care; addresses barriers to care, including SDOH-HE, and coordinates with specialty care and other agencies and providers, including AAAs/APDs/LTC providers for those members that are also receiving LTC. As another mechanism to coordinate across systems of care, a TBH Older Adult Behavioral

**Integration of Care**
Health Specialist is embedded in Lane County SDS. The co-location of this specialist with AAA case managers is a best practice and OHA priority. Trillium’s close relationship with Lane County has enabled this Specialist to be an integral part of our CC Team, and the Specialist is able to leverage both systems to meet the needs of the members. As we develop and strengthen relationships with AAA partners in the Tri-County Region, we will collaborate to replicate this best practice.

Team Approaches. The use of IDTs that work together to maximize resources and collaborate across systems to provide a seamless, nonduplicative, and integrated experience for our members receiving LTC services is an integral component of our CC Model. We routinely identify other Care Coordinators, such as AAA case managers, that are supporting our members as part of the initial risk screening or re-assessment processes. We also use information received from AAAs/APDs that identifies members enrolled in our CCO and are receiving DHS-funded LTC services. We document this in TruCare, our care management system and initiate a process to coordinate with the other entity to avoid duplication of services. Members receiving LTC services have access to an IDT (and choice of who attends) to support the delivery of services that addresses the PH, BH, functional, and social needs of the individual. This team-based care is structured to improve the integration of covered and non-covered services.

Clinician/Home-Based Programs

Supporting Members at Home. We will seek out contracting opportunities with providers and vendors in our Service Area to provide home visits, primary care services and management of chronic conditions, and care gap closure for members that require in-home assistance at the member’s setting/residence. We will work with AAAs and APDs to develop a mechanism to share data, such as the use of our Community Partner Portal, and refer members that they believe could benefit from home visits from mid-level practitioners who can provide interventions in the member’s home or residential setting.

Remote Monitoring Program. As discussed previously in Att.7, Trillium is collaborating with the AAAs and APD local offices on the development and implementation of coordinated transitional care practices across systems of care for CCO LTC members. As part of these efforts, we will assess the feasibility of offering our remote monitoring program using passive sensors that monitor everyday living activities, such as eating, sleeping and movement around the home. For members who choose to participate, the system gathers information to establish individual patterns and alerts the plan and authorized caregivers to disruptions in patterns to enable early intervention and avoid costly transitions in care. If this solution is deployed, information on changes in activity will be sent to the member’s primary Care Coordinator and, as appropriate, the AAA or APD case manager, to provide timely and actionable information about the member’s health needs. Our Arizona affiliate’s pilot resulted in a statistically significant decrease in overall per member per month costs, driven by a significant decrease in hospitalizations in the pilot group compared to the control group.

Compassionate Connections Home-Based Palliative Care Program. We will evaluate partnerships with providers and vendors to develop Home-Based Palliative Care Program options. Palliative care aims to improve the quality of life of members and their families facing life-threatening illness. Properly caring for complex populations requires us to assess their co-morbid conditions and address end of life planning. Our affiliate health plans have worked extensively in this space, with a program called Compassionate Connections. This in-home palliative care program targets individuals meeting the criteria for these services and uses an algorithm to pinpoint members that would benefit from palliative care services. In our affiliate health plans, we collaborate with all parties to assess members that may benefit from in-home palliation. A palliative care team will conduct home visits and coordinate with the member’s care team (inclusive of member’s PCP and AAA/APD case manager) to ensure appropriate care.
Other Innovations. Informal caregivers taking care of members with functional or cognitive limitations often lack support which can lead to caregiver burnout and may decrease the members' quality of life and ability to remain in their home. To support caregivers and supplement caregiver support programs provided by AAAs, Trillium will offer Caregiving Collaborations®, a formal caregiver support program designed to help our members remain in the home as long as possible, by providing encouragement, information, and tools for informal caregivers. Through Caregiving Collaborations®, we will offer the following tools:

- **Caregiver Resource Center**: Offers information about early symptoms, exacerbation identification, managing illnesses, and balancing needs, as well as tools, tips, and links to community-based resources.
- **Caregiver Journal**: Enables caregivers to write about stressors, strategies they use to manage stress and how effective they are, and other aspects of their caregiving journey.
- **Caregiver Collaborations® Application**: (pending successful pilot results from Trillium’s affiliate health plan): Enhances the caregiver's ability to connect with a Care Manager and other care team members using group chats and bi-directional video and file sharing.

D. UTILIZATION MANAGEMENT

Describe how the Applicant will perform the following UM 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 disability and developmental disabilities, adults who have serious mental illness and children who have serious emotional disturbance.

TRILLIUM’S UTILIZATION MANAGEMENT (UM) APPROACH

Our UM program is founded on the mission of optimizing health status, sense of well-being, productivity, and access to quality healthcare, while managing cost trends, for all members. UM decisions take into account individual member circumstances, management of chronic and co-occurring conditions, level of member engagement, and member utilization trends. These activities are supported by our team-based approach, leveraging internal and external experts from CC, our DCOs, DHS for LTC and waiver services, and community-based agencies such as AAAs. Through this coordinated effort, we integrate PH, BH, OH, LTC, and SDOH-HE needs to arrange services that are evidence-based, tailored for managing different conditions and delivered in the right setting, by the right provider, at the right time, in compliance with all OHA Contract requirements, as well as with the Mental Health Parity and Addiction Equity Act (MHPEA).

**1. How will the authorization process differ for acute and ambulatory levels of care; and**

**Prior Authorization (PA) Process across Levels of Care.** PA is only required for those procedures and services for which quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review, such as non-emergent inpatient admissions, BH inpatient admissions, inpatient detoxification, Residential Treatment, all out-of-network services, certain outpatient services, DME and specialty injectable medications, as clearly described on the PA list. PA is never required for emergency services or urgent care services. Authorizations for services are processed through TruCare, our integrated health management platform that supports consistency among UM staff. UM staff can also generate reminder and referral flags, such as to the member’s Care Coordinator or for discharge planning. These prompts enhance early identification of needs and facilitate collaboration across teams.

**Acute Care Services.** PA requests for inpatient services are subject to a 24-hour PA turnaround time. Facilities submit demographic and clinical information via fax, Provider Portal, or the provider’s EHR which is reviewed for medical necessity and appropriateness of care. ADT feeds enhance our review, early identification and collaboration processes. Upon notice of an ADT, our UM and CC staff contact the member and/or their PCP or BH provider to facilitate the most appropriate level of care and follow up in real time. Members with special
healthcare needs, including SPMI or serious emotional disturbance (SED) or those receiving waiver or I/DD services, are quickly identified by CC staff for appropriate outreach to other providers or agencies involved in their care. Recognizing these and other contributing factors, Trillium uses McKesson’s InterQual guidelines to determine medical necessity and appropriateness of acute care. We also use the Subacute/SNF guidelines to assist in determining medical necessity for subacute or nursing facility care for members with catastrophic conditions or special healthcare needs.

**Ambulatory Services.** Trillium does not require referrals to specialty care for in-network consults or BH outpatient care for the first 25 visits, removing barriers to care. Providers submit PA requests through fax or portal, with a 14 day turn-around-time for routine requests or 72 hours for urgent requests. For outpatient service requests, we use the Oregon Prioritized Listing of Health Services (Prioritized List) and OARs to determine medical necessity and appropriateness. When the Prioritized List and OARs do not speak to a condition or treatment, clinical staff utilize local and corporate policies and procedures reflective of local provider input. For members with special healthcare needs, UM staff collaborate with CC to understand additional needs or circumstances to be considered in PA decisions.

**Staff Expertise.** We train all UM staff to appropriately apply decision criteria and recognize members with special healthcare needs for additional consideration and collaboration. Staff receive specialized training based on their area of focus and experience, including both PH and BH inpatient and outpatient, making each staff an expert in their subject matter. In addition, we provide UM staff with disease/condition-specific Quick Reference Guides (QRGs) that include an overview of the condition, indicators, evidence-based treatment, insights to action for the UM, references to relevant evidence and experts, and a list of other resources related to the condition. UM staff use these QRGs as a resource and a double check to ensure timely, effective, and evidence-based UM interventions.

**Identifying Inappropriate Utilization.** We identify patterns of over, under and inappropriate utilization by monitoring and analyzing claims and authorization data to identify opportunities for improvement (e.g. education, clinical intervention), assess internal compliance, and assess provider compliance with our UM guidelines, including clinical practice guidelines. With oversight from the Chief Medical Officer, staff review and analyze transactional (e.g. ADT feeds) and trended (e.g. no PCP visit in 6 months for members with special healthcare needs and 12 months for all members, 3 ED visits in 30 days, readmissions) UM data reports daily, weekly, monthly, quarterly, annually and ad hoc. We monitor and analyze data at aggregate and detail levels by member, provider, specialty and type of service, diagnosis, cohort (e.g. members with SUD or SPMI), place of service, region and services authorized versus services received. Performance is compared to average network performance or national benchmarks to identify issues and data is presented to the UM and Quality Improvement Committees for further review and recommended action. Benchmarking can be adjusted to account for members with special healthcare needs, such as expected utilization for a child with SED compared to the general child population. We also continually identify potential under/over utilization through staff contact with members and providers during care planning and other telephonic interactions. Care Coordinators are specifically trained to recognize and address the added challenges for members with special healthcare needs, such as ensuring preventive visits for members with I/DD or SPMI. Our network management staff may also identify trends as part of their ongoing review or network performance and drill down reports that may reflect inappropriate utilization.

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**ED DIVERSION**

Trillium observed a significant decrease in ED utilization since the implementation of our ED Diversion Case Management program from 59.07 in January 2018 to 47.08 per 1,000 members in November 2018.
Addressing Inappropriate Utilization. Once identified, we address inappropriate utilization at both the population and individual level, and both the provider and member level. For example, CC staff reach out directly to members and engage in appropriate services and we alert providers to member care gaps to support their own outreach efforts.

7. ACCOUNTABILITY

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of Health System Transformation. CCOs will be held accountable for their performance on outcomes, quality, health equity and efficiency measures identified by OHA through a public process in collaboration with culturally diverse stakeholders.

During the development of CCO 2.0, OHA committed to shared accountability for Health System Transformation across the state. This included a commitment to Members, Providers, and to CCOs that performance expectations would be clear and that the monitoring and enforcement of those requirements would be applied consistently, transparently and equitably.

Accountability for the performance of Contract requirements is critical to the success of Health System Transformation. The quality outcomes of CCO performance are publicly measured and reported through both the State performance and core metrics and CCO incentive metrics. In addition to public accountability for quality, health equity and efficiency, Successful Applicants will remain accountable for the performance of Contract requirements. This includes accountability for the performance of subcontracted and delegated activities, the oversight and monitoring of subcontracted entities, and the timely and complete submission of reporting deliverables.

CCO 2.0 Accountability Standards include:

- Standardized requirements for Contract deliverables including formatting, structure, timeliness, completeness, and accuracy
- A clear relationship between performance issues and contract enforcement mechanisms
- An escalation process for resolving performance issues
- Consistent and fair application of contract enforcement mechanisms
- Prioritizing the resolution of performance issues which impact Member access and care
- Efforts to improve the clarity and consistency of OHA guidance to CCOs on issues where misinterpretation or ambiguity may exist

Accountability, transparency, and quality improvement are core tenets of our commitment to OHA and Health System Transformation. Our quality program is built on the Triple Aim and Quadruple Aim - better health, better member and provider care and experience and lower costs. We have reviewed CCO 2.0 Accountability Standards and all contract and reporting requirements described in the Sample Contract and have the experience, capacity, and infrastructure to fully comply and help meet OHA’s commitment to accountability.

a. Describe any quality measurement and reporting systems that the Applicant has in place or will implement in Year 1.

Our established quality measurement and reporting systems are a key differentiator, designed to position our members, providers, and State partners to realize transformation and quality goals. Trillium’s health information technology supporting our Quality Management and Improvement Program (QMI) Program allow key personnel the necessary access and ability to manage and report data required to support the measurement aspects of QMI activities.

Measurement and Reporting Systems. Through our Centelligence® health informatics platform, we integrate data from internal and external sources to produce actionable information: care gap and wellness alerts, key
performance indicator (KPI) dashboards, provider clinical profiling analyses, population level risk stratifications, and over 12,000 unique operational and State compliance reports. Supporting measurement and reporting, Centelligence solutions include:

- **Centelligence Predictive Analytics**: examines large data sets daily, providing a comprehensive array of targeted clinical reports. This includes the computation and interpretation of a member’s clinical data, delivering actionable insights for quality, population health, enhanced drug safety, and quality of care.

- **Centelligence Enterprise Quality Platform**: NCQA-certified software system used to monitor, profile, and report on the treatment of specific episodes, care quality, and care delivery patterns. The platform integrates claims and member, provider, and supplemental data into a single repository to convert raw data into statistically meaningful information and enable an integrated clinical and financial view of care delivery to identify cost drivers, help guide best practices, and manage variances to improve performance.

- **Interperta (available in 2020)**: analytics engine that delivers population and single member analytic precision medicine capabilities on a **daily basis**; certified by NCQA for HEDIS 2018, selected as one of two NCQA Measure Certification℠ HEDIS® 2019 national beta testers, and certified for the Integrated Healthcare Association for provider incentive metrics.

**b. Will the 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)?**

**External Measurement and Reporting.** CCO metrics, CAHPS, HEDIS, NCQA Health Plan Accreditation, and Star Ratings are tools Trillium monitors to support accountability, transparency, consistency, and common, comparable measures. For example, Trillium calculates and analyzes HEDIS rates utilizing our NCQA-certified HEDIS engine. HEDIS rates, analysis, and progress are reported to our local Quality Improvement Committee and appropriate subcommittees at least annually. HEDIS rates are audited by an NCQA-certified auditor and submitted to NCQA and CMS as appropriate. Trillium participates in External Quality Review (EQR) and Information Systems Capabilities Assessment (ISCA) annually. Trillium is also pursuing NCQA Health Plan Accreditation for 2020.

**c. Explain the Applicant’s internal quality standards or performance expectations to which Providers and Subcontractors are held.**

**Provider Expectations.** We hold our network to quality standards that align with OHA priority measures and fall within the provider’s span of influence. The QMI program monitors quality indicators such as provider-specific grievances/appeals and patient safety data, including quality of care issues and adverse events, to identify trends and performance opportunities. Quality indicators are assessed throughout the year using systematic analysis. Each year, PCPs are given a performance report card that shares data at the individual provider level. Providers are graded on their performance using metrics specific to their practice. Finally, we expect providers to meet or exceed all policy requirements, including access standards, credentialing, billing, clinical practice guidelines, and other clinical and administrative P&Ps, as outlined in the Provider Manual and up-to-date reference materials. Performance issues with providers are prioritized and enforced according to P&Ps and failure to comply could result in a Corrective Action Plan (CAP).

**Vendor Oversight.** Vendors are held to the same contract standards as Trillium providers. The Vendor Oversight Team (VOT) is responsible for the development, implementation and monitoring of our delegation program. The VOT leads regular Joint Oversight Committee meetings with business owners and delegates to review performance metrics, discuss program updates, and address performance concerns. The VOT
coordinates with Trillium business areas to assess delegate performance against established standards and requirements annually, including audits of contracted services. Quality Improvement Plans (QIPs) are requested from delegates demonstrating substandard performance. If performance issues are not resolved by the implementation of the QIP, a CAP may be required. The VOT maintains responsibility for the implementation and monitoring of QIPs and CAPs resulting from oversight recommendations.

d. Describe the mechanisms that the Applicant has for sharing performance information with Providers and contractors for Quality Improvement.

Sharing Performance Outcomes. Trillium has existing systems in place to push data to our stakeholders, including members, providers and the State. External-facing tools include:

- PCP and Pediatric Health Care Collaboratives are comprised of providers and provider office staff representing 80% of our Medicaid members. These collaboratives are designed to engage providers in the region and provide input and feedback to Trillium on CCO technical specifications, performance reports and best practices for meeting quality goals.
- Web-based portals including our Provider Portal, Member Portal, and Community Portal, delivering clinical information, care gaps and health alerts, and performance dashboards.
- Market driven Multi-Payor Portal designed to simplify the flow of care gap information between the plan and providers. This portal allows for alerts to be pushed to providers together with medical records attached when necessary to support care gap closure with a simple web interface. Trillium also pushes notifications of hospital and SNF discharges that serves as a “call to action”.
- Hot-Spotter Reports securely emailed to providers monthly for assigned member panel, including over 40 data elements to support population health management, such as ED and inpatient visits, BH risk, last PCP visit, dental visits, indicators for conditions (e.g. SPMI, opioid use), and social determinants of health (e.g. homelessness or illiteracy).
- Value-Based Payment (VBP) Total Cost Reporting is available to large provider groups as part of VBP agreements, highlighting provider performance toward VBP measures
- PreManage allows real time ADT feeds that can be shared with providers and CC staff for more timely intervention and support with care transitions.

8. FRAUD, WASTE AND ABUSE COMPLIANCE

a. Please describe how Applicant currently engages in activities designed to prevent and detect Fraud, Waste and Abuse.

Trillium maintains a Contractor Fraud, Waste and Abuse (FWA) Prevention Handbook, an Enterprise FWA Prevention Handbook outlining FWA policies and procedures, and a compliance plan that fully complies with State and federal requirements, as well as Contract requirements, including those in Exhibit B, Part 9. We use multiple approaches to prevent and detect FWA. Our claims processing system verifies provider participation, member eligibility, benefit determination, and duplicate submissions prior to payment. We contract with subcontractors to screen for billing discrepancies on a pre-payment basis through a predictive modeling tool. The National Correct Coding Institute and clinical validation edits are also applied to every claim at the time of adjudication to ensure provider-coding accuracy. We pull 1.5% of all claims data monthly for service verification audits, which request members to confirm services provided, provider name, date of service, and amount paid. Audited members who believe they did not receive the service are asked to call Customer Services, who refer suspected FWA to Centene’s Special Investigation Unit, who monitors claims to identify anomalies in billing patterns. Our Quality Department verifies services by reviewing the accuracy, timeliness,
and completeness of the claims data against the provider’s medical record documentation. Providers may be put on pre-payment reviews, as warranted.

b. Please describe how Applicant intends to monitor and audit its Provider Network, Subcontractors, and delegated entities for potential Fraud, Waste and Abuse activities.

Through provider and subcontractor agreements, we require our providers and subcontractors to follow all applicable State, federal, and contractual requirements and outline FWA responsibilities and obligations. Centene’s Internal Audit Department completes periodic audits of processed claims to validate timely claims authorization, processing, and payment, referring suspicious claims to SIU for investigation. A certified coder pulls 100 claims randomly each quarter for provider offices for which we have EHR access. Trillium plans to implement a BH provider auditing program in 2019 which will focus on quality of care but may expose FWA issues. Trillium requires subcontractors to complete annual compliance and code of conduct training, including FWA. We audit local subcontractors with delegated functions and Centene audits national subcontractors, requiring proof of FWA policy and annual FWA plan. Audits can result in corrective action plans or penalties.

9. QUALITY IMPROVEMENT PROGRAM

Oregon will continue to develop and maintain a Transformation and Quality Strategy to assess and improve the quality of CCO services and to ensure compliance with established standards. CCO accountability measures and related incentives will be core elements of the state’s Quality Strategy. Oregon will continue its robust monitoring of CCO system performance and will continue to assure that established standards for quality assessment and improvement are met.

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.

QUALITY MANAGEMENT AND IMPROVEMENT (QMI) PROGRAM

Trillium is committed to the provision of a well-designed and well-implemented QMI program and structure. Our program aligns with and supports the *Triple Aim and Quadruple Aim* - better health, better member and provider care and experience and lower costs in accordance with Exhibit B of the Sample Contract and as outlined in our Transformation and Quality Strategy (TQS), Program Description, Annual Work Plans, and Annual Program Evaluations. Ultimate accountability for the QMI and TQS lies with our Board with operational oversight delegated to the Quality Improvement Committee (QIC).

Health System Transformation Activities. Examples of best practices, innovations, and successful interventions supporting member outcomes are included below.

- **Annual Fluvention® Campaign**: Program with proven results that helps educate families, communities, and organizations to increase the overall influenza vaccination rate.
- **Quit Tobacco in Pregnancy (QTiP)**: Incentives for pregnant women to quit smoking.
- **Start Smart for Your Baby®**: Incentives, education and tools for pregnant women and new moms providing customized support and care for a healthy pregnancy and baby.
- **Adolescent Well-Care (AWC) Visits and Colorectal Cancer (COL) Screenings Incentives**: Improving point of service member engagement through gift cards distributed by providers.
- **Diabetes Prevention Program**: Program for individuals with prediabetes and high risk of diabetes that motivates them to improve their health through skills training and resources.
Super Saturdays: Partnership with pediatric providers to encourage adolescent members to get an annual physical using incentives and provider engagement.

Healthy Smiles: Partnership with Capitol Dental Care and Advantage Dental to embed dental care at Cornerstone Community Housing to improve oral health (OH).

OH Collaborative: Bringing school-based screenings to 100% of Lane County school districts. Combined with our continuous efforts to improve data collection, we have had year-over-year improvement in outcomes. For example, COL screening improved by 3.2% from 2016 to 2017 and the AWC visit rate of 47.4% increased by 8.2% points, exceeding the goal of 42.20%.

Engagement. Our member engagement and activation strategy uses a three-pronged data focused approach to identify, engage and improve outcomes:

1. Support providers with data at the point of care to close care gaps.
2. Use data to identify members with over or under-utilization, understand barriers to appropriate care, and implement individual and systematic interventions.
3. Use and share data to promote coordination and collaboration across the system of care.

HEALTH AND WELLNESS CURRENT PROGRAMS AND EXPERIENCE

Outreach Strategies. Outreach strategies include established processes such as birthday cards and Health Report Cards to educate on member incentives and remind members and families of preventive screenings and services due and how to contact us for assistance with appointments. We track care gaps and conduct phone outreach to non-compliant members to help them schedule appointments. A THW may also conduct a home visit for at-risk members. We interface directly with members/families at health fairs and workshops.

Written Materials. We provide written information on recommended preventive services and how to contact Trillium for assistance with appointments in the Member Handbook, Member Portal, and mailings, such as back-to-school flyers reminding members and parents to access recommended screenings and immunizations during any PCP visit. All written member information is developed with consideration for member language and literacy capabilities, meeting State and federal requirements for reading level and language and format availability.

Healthy Pathways. Trillium is committed to serving as role models for our members and our community, offering Healthy Pathways, an employee workplace wellness program that promotes a healthier lifestyle and personal accountability through health risk assessment, biometric screening, health coaching, a built-in incentives program, education, and mobile and online support services. Staff can earn extra incentives (e.g. gift cards, activity trackers) by completing personal health challenges to track activities and healthy habits.

Provider Partnerships. We encourage and support provider efforts to improve preventive and follow-up care utilization through interactive technology, care gap reports, Hot-Spotter Reports and alerts via the Provider Portal. Our CCO performance dashboard facilitates sharing best practices, brochures, coding sheets and quick reference guides. We also host monthly Adult & Pediatric Healthcare Collaboratives; meetings to foster a CCO/provider partnership focused on improvement opportunities for Health System Transformation.

Care Coordination (CC). Member individualized care plans include preventive care services and activities to promote member behavior change aimed at improving health and wellness. For example, Motivational Interviewing and the Strengths-Based Model help members articulate goals and preferences; teaching self-management skills; and engaging peers and other THW. CC staff also assist members with scheduling appointments and arranging for appropriate accommodations such as transportation and interpreter services.
**Community Partnerships.** Contributing to the health and wellness of our members are community organizations we partner with to provide integrated care and service. For example:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Nature of Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOOD for Lane County</td>
<td>Members who participate in the Diabetes Prevention Program receive vouchers for fruits and vegetables that can be used at FOOD for Lane County farms locations.</td>
</tr>
<tr>
<td>Lane County WIC</td>
<td>Trillium WIC participants are eligible for a supplemental food benefit, receive breast feeding support, attend nutrition education classes in a group setting or online, and receive information on and referrals to other health and social services programs.</td>
</tr>
<tr>
<td>Lane County Public Health</td>
<td><strong>Reduce Tobacco Use</strong>: Quit Tobacco in Pregnancy (QTip), Good Behavior Game, Life Skill Clinics, Provider Training. <strong>Reduce Childhood Obesity</strong>: NAP-SACC, CATCH Mental Health Promotion: Triple P, Family Check Up, Community based parenting education</td>
</tr>
<tr>
<td>Cornerstone Community Housing</td>
<td>Healthy Homes Program partnership - innovative strategy to promote housing access, retention, and stabilization through 5 Pillars: Health and Wellness, Food and Nutrition, Youth Development, Adult Learning, and Community Building</td>
</tr>
</tbody>
</table>

**Demonstrated Outcomes.** As a result of these and other efforts, we have seen a 5.2 percentage point improvement in the Child Immunization Status (CIS) rate, 7.7 percentage increase in the Developmental Screening rate, and a 5.5 percentage increase in the Controlling Hypertension rate over the past 3 years.

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.**

**EVALUATION AND OVERSIGHT**

**Local Experience.** Through our interoperable, standards-based health information technology (HIT), Trillium securely collects, stores, and analyzes demographic and clinical data from multiple internal and external sources. For example, subcontractor data (e.g. pharmacy), OHA’s MMIS, PreManage, and provider EHRs, as further detailed in Att.9.c. Data is used by our QMI program to evaluate care and services, make system improvements, and reward high performance.

**National Expertise.** Trillium benefits from the resources and expertise of our parent company, Centene Corporation, in support of our QMI activities. Examples of Centene’s support include research, design, production and printing of member and provider materials for national QI interventions. In addition, QMI staff frequently exchange best practices with peers at our affiliate plans via regular conference calls. This allows us to continually refine and improve our approaches based on collective lessons learned.

**Provider Incentives.** Provider incentives include P4P quality incentives for closing CCO metric care gaps, non-financial incentives such as the potential for streamlined prior authorization for high performers, and value-based payment (VBP) agreements based on member outcomes.

**Dedicated QMI Program Staff Resources.** Trillium’s QMI Program is infused throughout all operations across the organization; however, key positions are accountable for leading and supporting these efforts. Our local QMI department staffing model includes our Chief Medical Officer (CMO) and supporting Medical Directors, Senior Quality Improvement (QI) Director; QI Director (Management) who oversees the NCQA Coordinator, HEDIS Team (10 FTE), Appeals & Grievance Team (5 FTE), QI Audit Team (8 FTE), and Project Coordinator; QI Director (Improvement) who oversees the QI Coordinator, QI Specialists and Analysts (6 FTE); Project

**TIMELY SUBMISSION OF OHA METRICS**

Trillium has a history of supporting and submitting OHA metrics timely and accurately, including state quality metrics, CMS core metrics, and CCO incentive metrics. Under the 2017 Incentive Metric, Trillium achieved the benchmark or improvement target in 14 of 17 metrics and was the top performer in Controlling Hypertension and Diabetes HbA1c Poor Control measures.
Coordinator; and Program Analyst. QMI staff provide oversight to ensure quality coordinated healthcare is provided and goals and objectives of the TQS and QMI program are met.

**Established Policies and Procedures (P&Ps).** Trillium P&Ps ensure compliance with State, Federal, NCQA, and Contract requirements, and accountability for quality across all Trillium functions. Our quality P&Ps clearly define roles, functions, and responsibilities for all QMI activities, providing for regular quality reporting to Trillium’s committees, management, and providers, and dissemination of information to members and key stakeholders. Trillium’s P&Ps promote continuous QI processes, including systematic data collection, analysis, evaluation, ongoing monitoring, and reporting of performance and results. They outline procedures for remedial action for deficiencies, timelines for correction, and assign a specific staff person to be responsible for ensuring compliance and follow-up.

**Capacity to Collect Data.** In line with our unwavering commitment to quality, Centene has made a $41 million investment in supporting a modular, cloud-based, and enterprise-wide quality analytics platform. With improved integration and enhanced performance management, this quality platform will allow for daily data updates and integrated risk gap visualization. Using the most current CCO Accountability Measure and NCQA HEDIS technical specifications, and consistent with Trillium’s Rapid Cycle Plan Do Study Act (PDSA) improvement methodologies, our quality analytics will enable Trillium to use more real-time data to track HEDIS and HEDIS-like measures, evaluate intervention effectiveness, and make evidence-informed decisions about whether to modify or discontinue interventions, where necessary. Please see Att.7.7.a for a description of our current and future HIT to support quality measures and reporting.

**Using Quality Metrics to Improve Quality and Service Delivery.** Based on satisfaction survey results, CCO quality metrics, grievance and appeals data, and utilization trends, we design, develop, and implement QI initiatives that are monitored and evaluated by dedicated quality staff. Initiatives and outcomes are reported up through the QIC with direct input from our advisory committees. Results are used to inform our annual quality work plan and TQS and drive provider performance through VBP and member compliance through MyHealthPays incentives.

**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 Authorization.**

**COMPREHENSIVE SYSTEM TO FACILITATE COORDINATION**

Trillium uses our integrated health management platform, TruCare, to house a single, comprehensive member record supporting all CC and UM collaboration and functions. This tool allows a member-centric view for all team members to review assessments, referrals and prior authorizations (PA), service utilization, and program participation, while also assessing and addressing current and future needs. As per written policy, all contacts with the member, provider, or member representative are documented in TruCare.

**Coordination across the Delivery System.** Critical elements of the member record are available securely to our network providers and authorized representatives via our secure, role-based Web Portals, allowing them similar access to a comprehensive, holistic view of the member.

**P&Ps to Ensure Continuity of Care.** Our established continuity of care processes and proposed Continuity Coordinator, described further in Att.16, ensure consistent, unduplicated, seamless care for all new or transitioning members, in full compliance with OHA requirements. Our approach includes the use of varied data sources to proactively identify new or transitioning members who may need assistance. We systematically identify those with potential risk factors who may require individualized assistance to support the transition. We then outreach to providers, facilitate service authorizations as needed, and provide coordination and other hands on support in a timely manner. Going forward, we support reinstatement of the statewide Member Transition of Care workgroup, which facilitates collaboration among CCOs, OHA, and other integration partners.
10. MEDICARE/MEDICAID ALIGNMENT

a. Is Applicant under Enrollment and/or Marketing sanction by CMS? If so, please describe?
   Trillium is not under Enrollment and/or Marketing sanctions by CMS.

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?
   Trillium has operated a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) in Lane County since January 1, 2007 and as of March 2019, the Trillium Advantage Dual HMO SNP (contract number H2174) has 2,484 members. Our affiliate, Health Net, operates a Medicare Advantage HMO plan (contract number H6815) and a PPO plan (contract number H5439) covering our entire proposed Service Area. We intend to expand our D-SNP product in 2021 to cover any additional counties that we may be awarded through this Application.

11. SERVICE AREA AND CAPACITY (not counted towards overall page limit)

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 the 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.

TRILLIUM’S SERVICE AREA AND CAPACITY

Demonstrated CCO Experience. As a locally-based, community-rooted organization, Trillium has been serving OHP members for over 20 years. Throughout our tenure, we have honed our approach to partnering and engaging with providers, stakeholders, and the community to provide high-quality, integrated, member-centered healthcare in our Service Area. Since the inception of the CCO program in 2012, Trillium has served members in Lane County and certain contiguous zip codes in Linn and Benton Counties. In 2015, Trillium expanded our Service Area to include members in Reedsport – located in Western Douglas County and a contiguous zip code in Coos County. Trillium has brought demonstrated success to our current Service Area, building programs, systems, and partnerships to improve the health and wellness of our local communities. Our approach to serving our communities emphasizes integrated physical, behavioral, and oral health integration, innovative prevention efforts that address the social determinants of health and promote health equity, and transparent working relationships with county governments and community organizations, including the LTC delivery system, to support Care Coordination and whole-person care.

Leveraging local and national experience, robust technology systems, best practices and innovations, and grounded in community engagement, Trillium is fully equipped and excited about the opportunity to provide best-in-class services and value to residents of our existing and proposed Service Area. Recognizing the importance of partnerships and stakeholder engagement in implementing a successful CCO, we are actively building and strengthening relationships across our proposed Service Area to ensure we will have the capacity to deliver integrated and coordinated services to our members in each region in support of CCO 2.0 transformational goals. Our proposed CCO 2.0 Service Area includes the entirety of Lane, Clackamas, Multnomah, and Washington Counties and certain contiguous zip codes in Linn (97446) and Douglas (97424, 97436, 97441, 97467, 97473, and 97493) Counties. Based upon our understanding of patterns of care, and new requirements of the CCO 2.0 program, Trillium determined that the members we have served in two contiguous zip codes in Benton County would best be served by a CCO that is serving the entire county.

Trillium’s Community Engagement Plan is the foundation upon which our relationships with community organizations are built. Through our partnerships with organizations that are supported by MOUs, letters of support, or referral and data sharing agreements that formalize our connections, we build on these community-based relationships through our member supports. We identify members’ needs during Member Welcome Calls, and our MemberConnections® Representatives (MCRs), Traditional Health Workers (THWs), Care...
SINCE THE CCO PROGRAM BEGAN, TRILLIUM HAS:

- Invested more than $13 million in Lane County to open five new clinics to ensure all members have access to primary care.
- Set aside $1.33 per member per month (PMPM) to fund programs that prevent chronic disease and help Trillium members live healthier lives.
- Reinvested nearly all of our Quality Pool incentive funds (92%) back to providers.
- Through the Frequent User System Engagement (FUSE) initiative in partnership with Lane County and ShelterCare, reduced healthcare costs decreased by 53%, ED use by 26%, and inpatient stays by 55% for enrolled individuals.

DETERMINING OUR CCO 2.0 SERVICE AREA

In determining our proposed Service Area for the CCO 2.0 Program, Trillium considered not only our experience serving and working with members, providers, and community-based organizations in these areas, but also the Community Health Assessments (CHAs) and Community Health Improvement Plans (CHPs) in place for each of these counties. We are also seeking opportunities to participate in the existing CHA and CHP process for each county in our proposed Service Area. Trillium recognizes that each of these counties has unique populations and healthcare needs.

Understanding Community Needs through CHP and CHA Engagement.

- **Lane and Linn Counties.** Through our experience serving members in Lane County and a contiguous zip code in Linn County, we understand the importance of addressing regional priorities such as tobacco use, homelessness, early childhood health, and access to affordable housing. We are an active partner in LiveHealthy Lane, a collaborative effort with Lane County, the 100% Health Community Coalition, United Way of Lane County, PeaceHealth, and other cross-sector community partners, to develop the local CHA and CHP.

- **Douglas County.** Through our experience serving members in Reedsport, we know the importance of addressing healthcare and environmental factors that cause high rates of obesity, diabetes, and asthma, such as physical activity, access to healthy foods, and tobacco cessation and prevention. For the CCO 2.0 Program, we are building upon our existing partnerships to address these issues. For example, after our Rural Advisory Council (RAC) highlighted inadequate access to nutrient-dense food as a challenge faced by Reedsport residents, we partnered with Project Blessing to provide holiday meals. In December 2018, Trillium and Project Blessing provided ingredients that allowed 683 individuals to make three holiday meals. We are also planning to expand our partnership with the Oregon Food Bank to increase access to healthy foods across our proposed Service Area, including Douglas County.

- **Multnomah, Clackamas, and Washington Counties.** Individuals located in the Tri-County Region experience challenges such as rising housing costs; racial and ethnic disparities in employment,
homeownership, child welfare, and education; and increases in high-risk behaviors among teens such as binge drinking, lack of fruit and vegetable consumption, and sexually transmitted infection. Based on conversations we have had with organizations that address these issues and SDOH-HE in the Tri-County Region, we know that many organizations are excited to engage with CCOs for the first time to address these key community priorities. For example, we have letters of support (LOS) with Home Forward, the Multnomah Housing Authority; Washington County Housing Services, and Innovative Housing Inc. to develop innovative solutions to addressing housing in the Portland area. We will develop and lead a pilot program with the Washington County Housing Services to develop integrated housing and permanent supportive housing services approach and model that we will replicate across our proposed Service Area. We look forward to collaborating with county governments, community-based organizations, providers, and other stakeholders to adapt and evolve innovations and best practices learned from serving our existing Service Area to these new regions.

**Our Infrastructure and Successful Model for Expansion.** Trillium brings to the CCO 2.0 Program a wealth of experience learned from our time providing coordinated, integrated, community-centric care to our existing Service Area. Through this experience, we have built an established infrastructure that prepares us for continued growth and expansion under the CCO 2.0 Program. We have effectively scaled our staffing model, office locations, provider network, and other operational areas as our membership has grown, in particular following expansion of the State’s Medicaid program and our expansion into the Reedsport area in 2015. Since 2012, Trillium has invested *more than $13 million in Lane County to open five new clinics* to ensure all members have access to primary care, to expand prevention services targeted at reducing tobacco use and obesity, and to further integrate and enhance community behavioral health services. In expanding our Service Area for CCO 2.0 to additional counties, Trillium will improve member access to integrated, community-oriented care while supporting member choice.

**Supporting Behavioral Health Access and Integration.** Trillium prides ourselves on the relationships we have established with counties, providers, and support services in our current Service Area that support access to integrated and coordinated physical, behavioral, oral health and DHS-funded LTC services that is seamless to the member. Through our longstanding relationship with Lane County Health & Human Services and Trillium Behavioral Health, supported by our integrated technology platforms and experienced clinical and BH experts, we have developed a robust approach to Care Coordination and member engagement. Trillium is excited to continue developing relationships with counties and BH providers throughout our entire proposed Service Area to create solutions tailored to the needs of each member and community.

**Governance.** We maintain a clearly defined governance structure to support engagement, accountability, and compliance. Our CACs for Lane County and Reedsport, RAC, and CAP bolster our efforts to engage members, providers, and other stakeholders to ensure we understand the healthcare and social services landscape, needs, and challenges in our proposed Service Area. To ensure we continue operating an effective, regionally-focused governance structure as we expand our Service Area, we propose establishing a Regional Board of Directors (BOD) in Clackamas, Multnomah, and Washington Counties (Tri-County Region) and a Regional BOD for Lane County and certain contiguous zip codes in Linn and Benton Counties (Lane County Region). Under this structure, both Regional BODs would report to the Trillium Governing Board, comprised of representatives from Regional BODs and other CCO committees, to support the provision of regionally-focused innovations and solutions while maintaining a common oversight structure that facilitates sharing of knowledge and best practices. Each Regional BOD would include a CAC (and/or RAC), CAP, Compensation Committee, and other local committees as appropriate. We will continually assess opportunities to enhance our governance structure.
to address unmet needs across our proposed Service Area. This structure will offer local control, stakeholder engagement, and consistent delivery of superior healthcare services to all of our CCO members. Additional information on Trillium’s governance structure can be found in our responses to Att.6.F.1 and Att.7.1.

Building and Maintaining Relationships. We maintain close working relationships with the counties in our current Service Area. Trillium is an integrated partner with Trillium Behavioral Health (TBH), a subset of Lane County, and shares systems, resources, and locations that enable us to provide a seamless experience for our members, regardless of where they obtain their care. Trillium has maintained a comprehensive administrative services agreement (ASA) with Lane County since 2012 that guides our extensive collaborative efforts. We actively participate in the Lane County H&HS Policy and Advisory Boards to better understand the issues faced by our members, providers, and the community. Lane County also has representation on our Board, CAC, CAP, RAC, Senior Management Team, and Quality Assurance Committee. We work closely with the Douglas Public Health Network (DPHN) to best support our Reedsport members and have provider agreements with the Linn County Department of Health Services to provide physical and behavioral health services, as described in the following sections regarding our partial county Service Area.

Local Community Development Team Supporting Network Development and Community Partnerships. We plan to leverage our positive working relationships and governance structure in our existing Service Area as a model to provide integrated and coordinated physical, behavioral, and oral health services to members in our proposed expanded Service Area. In preparation for the CCO 2.0 Program, Trillium is supported by Centene’s Community Development Team, which is comprised of industry experts in Medicaid managed care, network development and hospital partnerships, primary care, mental health, substance use, LTC, SDOH-HE, and safety net providers, tribal health and local governments and community partners. This team has boots on the ground in each county today, meeting in person and establishing formal channels of communication to identify issues, solicit needs and desired solutions, and build sustainable relationships to jointly partner and solution now and in the future.

b. Does Applicant propose a Service Area to cover less than a full County in any County? If so, please describe how:

(1) Serving less than the full county will allow the Applicant to achieve the transformational goals of CCO 2.0 (as described in this RFA) more effectively than county-wide coverage in the following areas:
   • Community engagement, governance, and accountability;
   • Behavioral Health integration and access;
   • Social Determinants of Health and Health Equity;
   • Value-Based Payments and cost containment; and
   • Financial viability;

(2) Serving less than the full county provides greater benefit to OHP Members, Providers, and the Community than serving the full county;

PRESERVING MEMBER CHOICE AND CONTINUITY IN PARTIAL COUNTY

Partial County Exception. Trillium is proposing less than a full county to preserve member choice and continuity for members and providers. We are not pursuing the full counties in these areas, as our primary objective is to follow existing practice patterns and preserve the member and provider relationships established...
through our current Service Area. Our greatest ability to achieve the transformational goals of CCO 2.0 and each of the areas described, is to follow current practice patterns and leverage the current community committee structure (e.g. Rural Advisory Council established in Reedsport), BH providers and integration strategies, links to community-based agencies and social services, VBP arrangements with providers, and cost and quality controls in place or planned to ensure financial viability.

**Historical Service Area.** Since the inception of the CCO program in 2012, Trillium has served members in Lane County and zip codes 97448 and 97456 in Benton County and 97446 in Linn County. In 2015, Trillium expanded our Service Area to include members in Reedsport – located in Western Douglas County (97424, 97436, 97441, 97467, 97473 and 97493) and a contiguous zip code in Coos County (97449) – through a competitive application process.

**Application for Partial County Service Area.** It would be Trillium’s desire to maintain member choice, honor current practice patterns, and preserve continuity in all of our contiguous zip codes. Based on current outreach, Trillium cannot guarantee with confidence our ability to secure MOUs with all of the required entities in Benton County by Readiness Review. In response we are limiting our Application to the partial counties of Linn and Douglas.

**Honoring Patterns of Care.** By continuing to serve members in the contiguous areas in Linn and Douglas Counties for the CCO 2.0 program, Trillium aims to ensure continuity of care and preserve and support existing patterns of care for each community we serve, understanding that members, providers, and other available resources may not always be defined by county boundaries. For example, through detailed analysis of our membership in these areas, we know that our members in Linn County frequently access care in Lane County. Specifically, from 2016-2018, approximately 80% of claims for members in these areas originated in Lane County. Due to coastal patterns of care, many members in Reedsport travel north into Lane County to obtain care, particularly for BH services. For example, since 2016, more Reedsport members received BH services in Lane County than in any other county, including Douglas or Coos. Trillium also found that more Linn members received BH services in Lane County than in any other county. From 2016 to 2018, approximately 78% of BH claims for Linn County members originated in Lane County.

(3) The exception request is not designed to minimize financial risk and does not create adverse selection, e.g. by red-lining high-risk areas.

Trillium’s request to continue serving the contiguous zip codes outlined above in Douglas and Linn Counties is based solely on current practice patterns and maintaining continuity of care for our members and providers and is in no way designed to minimize financial risk or create adverse selection.

**Sustainability & Transparency**

Trillium reserves the right to set the maximum number of Members an Applicant may contract to serve and define the area(s) an Applicant may serve based upon OHA’s evaluation of the Applicant’s ability to serve Members, including dually eligible Members, OHA’s needs and the needs of its Members. OHA may require an Applicant to accept OHA’s additional Service Area request(s) as a condition of receiving an award or a Notice to Proceed as OHA and its Members’ needs warrant. Applicants must apply for Service Area on a county-wide basis. An Applicant that requests to cover less than a full County will be required to provide additional information and its reasoning for the request in its Application. OHA will consider requests during Application evaluation. These Applicant requests and subsequent OHA responses do not limit OHA in any way from requiring additional changes to an Applicant’s proposed Service Area based on OHA’s needs and the needs of its Members. Applicants should submit this information in an Excel document according to naming conventions identified elsewhere in this RFA.
## SERVICE AREA TABLE

<table>
<thead>
<tr>
<th>County (List each desired County separately)</th>
<th>Maximum Number of Members-Capacity Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clackamas County</td>
<td>82,800</td>
</tr>
<tr>
<td>Douglas County (97424, 97436, 97441, 97467, 97473 and 97493)</td>
<td>2,700</td>
</tr>
<tr>
<td>Lane County</td>
<td>117,750</td>
</tr>
<tr>
<td>Linn County (97446)</td>
<td>1,025</td>
</tr>
<tr>
<td>Multnomah County</td>
<td>318,600</td>
</tr>
<tr>
<td>Washington County</td>
<td>151,200</td>
</tr>
</tbody>
</table>

In some areas the patterns of care may be such that Members seek care in an adjoining county. Applicant may choose to contract with Providers located outside the Service Area covered to ensure sufficient access to care for Members. The Service Area places no restriction on the location or distribution of an Applicant’s Provider Network. The Applicant will receive rates for each county. If a prospective Applicant has no Provider Panels, the Applicant must submit information that supports their ability to provide coverage for those Members in the Service Area(s) they are applying. In determining Service Area(s) Applicants must consider the allowable driving distance and time to Primary Care Physicians (PCP) and any other Provider type outlined in contract or OAR 410-141-3220.12.

### 12. STANDARDS RELATED TO PROVIDER PARTICIPATION

#### A. STANDARD #1 - PROVISION OF COORDINATED CARE SERVICES

The Applicant has the ability to deliver or arrange for all the Coordinated Care Services that are Medically Necessary and reimbursable.

In the context of the Applicant’s Community health assessment and approach for providing integrated and coordinated care, to assess whether the Applicant has the ability to deliver services, the delivery system network data must be submitted in the required formats and evaluated. Based upon the 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, describe Applicant’s comprehensive and integrated care management network and delivery system network serving Medicaid and dually eligible Members for the following categories of services or types of service Providers that has agreed to provide those services or items to Members, whether employed by the Applicant or under subcontract with the Applicant:

- Acute Inpatient Hospital Psychiatric Care
- Addiction treatment
- Ambulance and emergency Medical Transportation
- Assertive Community Treatment
- Community Health Workers
- Community prevention services
- Dialysis services
- Family Planning Services
- Federally Qualified Health Centers
- Health Care Interpreters (qualified/certified)
- Health education, health promotion, health literacy
- Home health
- Hospice
- Hospital
- Imaging
- Intensive Case Management
- Mental health Providers
- Navigators
- Non-Emergent Medical Transportation
- Oral health Providers
- Palliative care
- Patient-Centered Primary Care Homes
- Peer specialists
- Pharmacies and durable medical Providers
- Rural health centers
- School-based health centers
- Specialty Physicians
• Substance use disorder treatment Providers
• Supported Employment
• Tertiary Hospital services
• Traditional Health Workers
• Tribal and Urban Indian Health Services
• Urgent care center
• Women’s health services
• Others not listed but included in the Applicant’s integrated and coordinated service delivery network

INSTRUCTIONS: Submit the information in about each Provider or facility following the file extract specifications in the DSN Provider Capacity Report Protocol for all Provider or facility types in Applicant’s Provider Network. Providers or facilities must be currently contracted to provide or have signed letters of intent to enter into a contractual agreement to serve Applicant’s prospective members after award. The DSN Provider Report does not count toward overall page limits.

Note: As part of the Readiness Review process, Applicants will need to provide signature pages and credentialing details for Physician and Provider contracts that the OHA reviewers select based upon the OHA DSN Provider Report and Facility tables that are a part of the initial Application submission.

Serving the integrated healthcare needs of Medicaid members since 2012, Trillium has established a comprehensive and adequate network and system of care to serve all covered populations in our current Service Area, and we are actively building an adequate network for the Tri-County Region.

Local Partnerships. Key partners in delivering coordinated and integrated services include, for example, County Behavioral Health, County Public Health, Area Agencies on Aging and Aging (AAA) and Aging and Physical Disability (APD) local offices, first responders (e.g. law enforcement), social service providers and agencies, transportation vendors, Dental Care Organizations (DCOs), Tribal organizations, and our delivery network, including physicians, physician extenders, hospitals, facilities, and Traditional Health Workers (THWs). Trillium supports providers such as FQHCs in providing health education (e.g., nutritional counseling sessions, lactation consultations), health promotion (e.g., group diabetes classes), health literacy services, and community prevention services (e.g., dental and medical screenings).

Robust Provider Network. A list of providers in our network is included in Attachment 7 DSN Provider Capacity Report. To further demonstrate our commitment to the depth and adequacy of our delivery network and ability to integrate and coordinate:

- Trillium has invested $6.3 million since the start of the CCO Program on expanding access for OHP members. For example:
  - We provided funding to help open five new primary care clinics in Lane County: Brookside, Delta Oaks, Orchid Clinic, Centennial Clinic, and Oregon Integrated Health.
  - To swiftly address the provider shortage challenge created by Medicaid expansion and increase member access to care, Trillium offered additional payments to providers for accepting new OHP patients, provided consulting services to improve work flow, and awarded grants to increase space in existing clinics to accept additional patients.

“Together we are tangibly improving the health of Trillium members and, by doing so, making Lane County better.”
- Oliver Alexander, Co-Director
Orchid Health Oakridge Clinic

- 98% of certified PCPCHs in our current Service Area participate with Trillium and we will continue to outreach to secure 100% across our proposed Service Area.
- Over 90% of current Trillium members are assigned to a certified PCPCH, including over 88% assigned to a Tier 3 or higher provider (as of February 1, 2019).
- Fewer than 5% of PCPs in our current Service Area are out-of-network providers.

Attachment 7
Trillium supports a **culturally sensitive network**, for example, working with the Nuestras Familias (Our Families) project to establish a culturally specific and responsive wraparound program for Spanish speaking families.

Trillium partnered in the three-year **Trillium Innovation Project (TIP) to improve integration** with start-up funding through Lane County and ongoing funding from Trillium:

- Eight TIP program sites committed to providing integrated care to approximately 17,000 of our members and collaborating through monthly Learning Collaborative and quarterly workshops
- Four primary care medical homes integrating Behavioral Health (BH)
- Four BH clinics integrating Physical Health (PH)

We continuously work to **expand access to Oral Health (OH)**, working with Cornerstone Community Housing to bring OH screening and prevention for children to their family housing complexes and establishing an OH Collaborative with our Dental Care Organizations (DCOs) to provide school-based screenings to 100% of Lane County school districts.

To ensure the quality of OH services, we have **incorporated quality metrics into our DCO contracts**, for example, use of PreManage and other Health Information Exchange (HIE), after-hours access, quality and utilization standards, school-based models, and non-traditional/innovative programs.

Trillium initiated a contract in 2014 with Lane Transit District for **transportation benefits** that includes mileage reimbursement, bus passes, taxi rides, and wheelchair or stretcher vans.

Since 2012, Trillium has been committed to partnering with providers to achieve our shared goals of improving member health outcomes and healthcare quality including **distribution of incentive metric quality pool funds**. Since 2013, Trillium has shared 92% of our incentive payments with the provider community as quality bonus payments, totaling $65.7 million.

Trillium was rated **above the CCO 2018 average for CAHPS** composites “Getting Needed Care” and “Getting Care Quickly” for both Adults (83% and 94% respectively) and Children (83% and 90% respectively).

See Standard 2 below describing how we have expanded capability and capacity of our network to serve members with special healthcare needs.

### Delivering Integrated and Coordinated Services to Meet Community Need

Driven by our **vision**, “Working together to create a caring community where all people can live a healthier life”, **values**, “Compassion, Equity, Inclusion, and Collaboration”, and the **needs of our community**, Trillium has multiple forums to collect initial and ongoing community input. Based on our Community Health Assessment (CHA), we identified two strategic issues we have worked to build our Care Coordination (CC) and delivery system network around.

- **How can we promote access to economic and social opportunities to live a healthy life?**
- **How can we promote healthy behaviors and engage the community in healthy living?**

### Delivering Whole-Person Care

Working closely with our Community Advisory Council (CAC), Rural Advisory Council (RAC), and Clinical Advisory Panel (CAP), we continue to expand the breadth and depth of our holistic CC and delivery care network in alignment with our CHA. Ensuring every member is connected to needed whole-person care is our team of Care Coordinators and MemberConnections® Representatives (MCRs) supported by IDTs who link members to care and services, leveraging screenings and assessments, data mining and predictive modeling, and internal and external referrals to identify PH, BH, LTC, and social needs and disparities and determine appropriate levels, frequency, and intensity of service. For example:

- Utilizing the **Regional Health Equity Coalition** model to address SDOH-HE through a collaborative project with the CHP partners known as the Lane Equity Coalition (LEC).
Expanding the existing Double Up Food Bucks program, developed in collaboration with Lane County, into rural communities and partnering with our local food bank on three programs: Screen and Intervene, Produce Plus and Veggie Rx. These programs identify food insecurity and provide access to no-cost fresh fruits and vegetables to Trillium members.

Working with Lane County HHS to implement the Frequent Users System Engagement (FUSE) project to assist homeless members who experience high utilization of health, social and government services. The positive results of the FUSE program have resulted in additional Trillium investment to expand the project.

Coordinating with Cornerstone Community Housing Healthy Homes to assist our members living in their supportive housing units to navigate and engage in the healthcare system.

Funding and partnering with Lane County Public Health to administer and monitor a variety of prevention programs aimed at improving the health and well-being of Trillium members. For example, we provided training funds for 50 tobacco treatment specialists and one trainer serving as Tobacco Cessation Counselors across the county.

Employing five MCRs hired from within the community and serving as Community Health Workers. MCRs assist Trillium members one-on-one with understanding and navigating their health, health benefits and services and other community resources, such as transportation, food, shelter, or other health or social programs.

Supporting these efforts today and in the future is our monthly Innovators’ Collaborative, which brings together physicians, BH providers, DCOs, community-based organizations and CAC/RAC members to improve communication across systems and processes.

Comprehensive and Quality Network. Trillium is committed to improving the health of the community one individual at a time through a robust and engaged network of highly skilled practitioners and providers focused on treating the whole person. Our approach to network management integrates and unifies PH, BH, OH and social needs, matching our provider network to the needs of our members, including members with special healthcare needs. Our ongoing efforts and activities include:

- Soliciting feedback from our CAC, RAC, and CAP and expanding our community reach to add a Tribal Advisory Council and Health Equity Council.
- Soliciting feedback from our Care Coordinators; providers, including THWs; and community-based organizations who work directly with our members to understand their needs and any network gaps.
- Working with provider associations, member advocacy groups, and other stakeholders to identify and address member needs and referral patterns.
- Providing practice transformation support through training and technical assistance to build provider capacity to provide whole person care and serve members with complex needs.
- Tracking and trending satisfaction survey data, complaints, grievances, and appeals to identify and address issues, breaking out by member type and/or condition.

Ensuring provider network adequacy entails much more than just counting the number of providers signing contracts. Trillium’s approach recognizes the cultural (language, ethnicity, disability), social (geography, poverty, education), and complex health needs of the population and measuring the quality of the network in serving members with special healthcare needs.

B. STANDARD #2 – PROVIDERS FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS

In the context of the Applicant’s Community health assessment and approach for providing integrated and coordinated care, Applicant shall ensure those Members who have Special Health Care Needs such as those who are aged, blind, disabled, or who have high health care needs, multiple chronic conditions, mental illness or substance use disorder or who are children/youths placed in a substitute care setting by Children, Adults and
Families (CAF) and the Oregon Youth Authority (OYA) (or children receiving adoption assistance from CAF), or any Member receiving DHS-funded Medicaid LTC or home and Community-based services, have access to Primary Care and Referral Providers with expertise to treat the full range of medical, oral health, and Behavioral Health and Substance Use Disorders experienced by these Members.

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 populations and children/youths in substitute care or Members who have high health care needs, multiple chronic conditions, mental illness or substance use disorder. In narrative form, describe their qualifications and sub-specialties to provide Coordinated Care Services to these Members.

**Providers with Specialized Skills or Subspecialties.** Based on the list of providers and facilities in our DSN report submitted as part of Standard #1, coupled with our direct experience serving complex members in our current Service Area and active engagement with the provider community in our proposed Service Area, we have identified a comprehensive network of providers with the specialties, sub-specialties, trainings, and focus areas to effectively serve the holistic needs and conditions of members with special health care needs as described.

**Narrative Description.** Driving integrated, whole person care, our integrated PCPCH network includes 50 Tier 4 and 5 clinics. In support of our primary care clinics, we have contracts and LOAs with a referral network of over 5,000 providers with primary specialties that serve members with special healthcare needs, such as psychiatry and neurology, behavioral pediatrics, child and adolescent psychology, addiction counseling, pain medicine, occupational therapy, geriatric medicine, and hospice and palliative medicine. This also includes BH providers that specialize in both mental health and SUD to better understand the correlation between mental illness and addiction and internal medicine providers with experience treating members with multiple chronic conditions. Over 5,000 providers have indicated ADA access, ensuring physical access for our members with disabilities. Our facility network includes over 100 facilities specializing in members with special health care needs, including nursing facilities and psychiatric and SUD residential treatment facilities. Ten providers in the State have Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) training, of which 40% are on our DSN. Other common subspecialties include palliative medicine, geriatrics, and pediatric subspecialties ranging from behavioral pediatrics and neurodevelopmental disabilities to endocrinology and nephrology. All of these special skills and subspecialties are available in our network to support team-based care, led by the member’s PCP with support from Trillium’s Care Coordinator to foster coordinated, integrated care. For complex members, the assigned PCP may also be a specialist who has agreed to serve as PCP and has the capacity to deliver coordinated care. Our Care Coordinator will also pull in expertise from the community to help identify providers, educate and support PCPs, and provide input into care planning, such as Community Developmental Disabilities Programs, AAAs, Veterans Services, Tribal organizations and member advocacy groups and provider associations, such as Latino Network, Mental Health & Addiction Association of Oregon, and the Oregon Medical Association.

**Building Network Capacity.** Through our local and national experience, we understand what it takes to continually build a network to meet the challenges and needs of members with special healthcare needs. Based upon the State’s goals, our experience under the current Contract, and our national Medicaid experience and expertise, our key focus areas for building network capacity for members with special healthcare needs include:

**BH Adequacy and Integration with PH.** We are committed to integrating and unifying BH and PH, and we recognize that achieving this goal requires innovative delivery system approaches. Accordingly, we have supported the following activities:
Co-location and deep integration with Trillium and Trillium Behavioral Health.

Intensive Community Care Management (ICCM) is a partnership with the Center for Family Development and Springfield Family Physicians to provide intensive community care management in a PCPCH setting, which we plan to expand based on best practices.

Promoting Project ECHO’s Psychiatric and Addictions Case Consultation module, a free resource to educate providers on prescribing MAT and offer remote specialty consultation.

Through our Choice Team and our Serious and Persistent Mental Illness (SPMI) Care Coordinator we effectively work and triage with our Assertive Community Treatment (ACT) partners at Laurel Hill and South Lane Mental Health to serve members with SPMI.

We attend the MH Summit to triage our SPMI population in the criminal justice system and the Acute Care Council to triage issues pertaining to barriers to service and care gaps.

**Substance Use Disorder (SUD).** With the national opioid crisis and impact of SUD on health and wellness, we support our network to deliver and refer to appropriate SUD services through:

- Leveraging the national experience and best practices of our parent company, Trillium is implementing Centene’s OpiEnd program which supports providers in their efforts to prevent opioid use and misuse. Ongoing resources to prevent, identify and treat opiate misuse/overuse will include a Pain and SUD Playbook for staff and providers; a Provider Opioid Toolkit that will contain the CDC Guideline for Prescribing Opioids for Chronic Pain; assessment tools and checklists to identify and treat opioid use; and tapering tools to help providers taper patients responsibly and safely within requirements.
- SBIRT training to help PCPs screen, educate and refer for SUD treatment and service.
- Employing a master’s level Certified Alcohol/Drug Counselor (CADC) who has served as our Health Equity Officer since 2012.
- More than doubling our Medication Assisted Treatment (MAT) waivered prescribers in the last two years from less than 10 to over 30, as identified on the SAMHSA Registry.

**Integrating with Oral Health.** In addition to bringing OH to our members, such as schools and housing units, we identify and address needed dental services while complex members are in the hospital and reimburse for “practice visits” for members with developmental disabilities to address fears, answer questions and identify barriers before the actual appointment takes place.

**Aged, Blind and Disabled (ABD).** We will collaborate with providers to creatively invest in initiatives to close gaps, expand services, and improve quality for ABD members. For example, we will launch our Provider Accessibility Initiative in Oregon to help providers meet minimum federal and State disability access standards, including provider education about access requirements and available tools to assist with compliance and enforcement, and a needs assessment of our provider network to measure accessibility and target areas for improvement.

**Child Welfare.** Trillium works closely with foster care youth and child-serving agencies such as Oregon Community Programs, Looking Glass and The Child Center. We attend monthly meetings with our Wraparound Providers at Direction Services and Central Latino Americano and have a presence on the SOC Advisory Council. We offer a team of experts and provide education on benefits and issues affecting children in care, including trauma informed care.

**Children with Special Health Care Needs.** We work with parents, providers, and advocates, such as the Child Development and Rehabilitation Center (CDRC) and 90by30 project to end child abuse, to identify practice patterns and build out PCPCHs and Health Homes that specialize in children. We will also identify providers who offer evidence-informed BH services, such as Multisystemic Therapy and Functional Family Therapy, and
where providers don’t exist, identify providers willing to be trained to bring evidence-based treatments to their communities.

**Complex Social Needs.** We have specialized programs to support members with complex social needs, such as members experiencing homelessness. For example, Trillium collaborates with PeaceHealth and ShelterCare to provide medical respite for homeless members post discharge.

**C. STANDARD #3 – PUBLICLY FUNDED PUBLIC HEALTH AND COMMUNITY MENTAL HEALTH SERVICES**

Under ORS 414.153, Applicants must execute agreements with publicly funded Providers for authorization of and payment for point-of-contact services (i.e. immunizations, sexually transmitted diseases and other communicable diseases) and for cooperation with the local mental health authorities unless cause can be demonstrated that such an agreement is not feasible. Submit the following table in an Excel format, detailing Applicant’s involvement with publicly funded health care and service programs. Include those publicly funded health care and service programs with which you have subcontracts. Table does not count toward overall page limits.

Please see **Att. 7 Publicly Funded Programs** for a listing in an excel format of Trillium’s involvement with publicly funded public health and community mental health services.

**PUBLICLY FUNDED HEALTH CARE AND SERVICE PROGRAMS TABLE**

<table>
<thead>
<tr>
<th>Publicly Funded Health Care and Service Programs Table Name of publicly funded program</th>
<th>Type of public program (i.e. County Mental Health Department)</th>
<th>County in which program provides service</th>
<th>Specialty/ Sub-Specialty Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other formatting conventions that must be followed are: all requested data on Applicant’s Provider Network must be submitted in the exact format found in the DSN Provider Capacity Report Protocol (Standard #1).

**(I) Describe how Applicant has involved publicly funded providers in the development of its integrated and coordinated Application.**

Trillium is an integrated partner with Trillium Behavioral Health (TBH), a subset of Lane County, and shares systems, resources, and locations that enable us to provide a seamless experience for our members, regardless of where they obtain their care. We work closely with the County to manage services in accordance with ORS 414.153 and maintain ongoing dialogue to ensure we provide coordinated, integrated care to our members. We participate in numerous Lane County Health & Human Services Policy and Advisory Boards, including the Poverty and Homelessness Board, the Mental Health Advisory/Local Alcohol and Drug Planning Committee, and the Mental Health Summit, among others, to better understand the issues faced by our members, providers, and the community. Lane County is represented on our Board, CAC, CAP, RAC, Senior Management Team, Diversity & Health Equity Committee, and Quality Assurance Committee. We also work with the Douglas Public Health Network (DPHN) to best support our Reedsport members, and our Health Equity Officer has served on the DPHN Board since 2017.

**A Collaborative Application.** As a result of this partnership, Trillium’s Application reflects the expertise and perspectives of our Lane County counterparts. Through TBH, Lane County representatives were actively involved in strategy development and review of Trillium’s Application. In particular, these individuals were integral in helping us refine concepts and innovative practices related to our BH response in Att. 11. TBH also serves on workgroups to discuss strategies for meeting CCO 2.0 requirements and supporting Oregon Health
Policy Board CCO 2.0 policy recommendations. In addition, we created and executed a robust plan for presenting initiatives and innovations proposed in our application to our Board of Directors, governance committees, and other local committees and organizations. **Att. 7 Publicly Funded Programs** describes our agreements with publicly funded providers, including counties and other providers and non-profit organizations that receive public funding. Trillium will report to OHA on our agreements for publicly funded healthcare and service programs annually, in accordance with Exhibit G of the Sample Contract.

**2) Describe the agreements 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.**

Trillium has MOUs with the LMHAs in Lane, Linn, and Douglas Counties that set forth roles and responsibilities to coordinate services and efforts to meet the BH needs of the communities we serve and to achieve improved mental health outcomes. In accordance with ORS 414.153(4), the agreements outline the BH safety net authorization and payment method with respect to individuals entering or transitioning from Oregon State Hospital or residential care, Care Coordination (CC) for residential services and supports, community-based specialized services, and specialized services to reduce recidivism of individuals with mental illness in the criminal justice system. The agreements also identify joint performance outcomes, including client engagement, Emergency Department (ED) and State Hospital utilization, criminal justice involvement, and out-of-home placements for children.

**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.**

Trillium has begun engaging with each of the counties and publicly funded providers in our proposed Service Area to build transparent relationships and it is our intent to have agreements in place by Readiness Review and prior to CCO 2.0 Contract execution as required by ORS 414.153(4). In the Tri-County Region, we have met with the LMHAs in Multnomah, Clackamas, and Washington Counties and have provided draft MOUs for the CCO 2.0 program.

**D. STANDARD #4 – SERVICES FOR THE AMERICAN INDIAN/ALASKA NATIVE POPULATION (AI/AN)**

**1) Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population.**

Trillium has over 850 members who identify as AI/AN in our current Service Area. We work to connect members to health and social support services in coordination with the Eugene Tribal Outreach Offices of the Tribes in our Service Area – including the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians (CLUTSI); the Coquille Tribe; and the Siletz Tribe. We are also formalizing our relationship through a LOA with Coquille Community Health Center. We are establishing additional relationships, including LOAs and participation in our Tribal Advisory Council, in our proposed Service Area with other Tribal Health Organizations including Cow Creek Band, the Native American Rehabilitation Association of the Northwest Indian Health Clinic, and the Portland Area IHS Office. In our meetings to date, our AI/AN contacts have stated that Trillium is the only CCO to reach out to them to discuss partnerships. Our Tribal Liaison will work closely with the Tribal leaders and IHS and Tribal 638 providers to support bi-directional education and training and recruit local staff and THWs, including Tribal Community Health Representatives (CHR)s, to deliver culturally responsive services. We are also excited to establish a Tribal Advisory Council composed of Tribal representatives and providers to advise the Trillium Board on Tribal health including healthcare traditions, disparities, access, and member engagement. Through our national relationships, we have direct experience...
adapting programs and services for AI/AN populations, such as adaptation of Trauma-Focused Cognitive Behavioral Therapy for AI/AN members and collaborating with Tribes in other markets (including CA, NE, NM, and WA) and the National Indian Health Board to identify solutions to build upon the healthcare services delivered to AI/AN members.

E. STANDARD #5 – INDIAN HEALTH SERVICES (IHS) AND TRIBAL 638 FACILITIES

(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.

Trillium has no IHS or Tribal 638 Contracts in our current Service Area (Lane Region) but will continue outreach and collaboration activities in an effort to secure Contracts in our proposed Service Area.

(2) Please describe your experience working with Indian Health Services and Tribal 638 facilities.

• Include your Referral process when the 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 facility that is not a Participating Provider.

To increase access to services, ensure continuity, and honor current patterns of care, we support AI/AN access to IHS and Tribal 638 provider services, whether or not we have a Contract. Our claims and administrative systems are configured to ensure unrestricted access by systematically identifying and providing for payment to any IHS and Tribal 638 providers without prior authorization (PA). This includes configuring our PBM’s point of sale system to ensure pharmacy benefits delivered at IHS and Tribal 638 providers are exempt from the preferred drug list. AI/AN members are educated on their ability to self-refer to IHS and Tribal 638 providers through the Member Handbook, website and targeted outreach. Likewise, IHS and Tribal 638 providers will be informed of their ability to be paid for Medicaid services provided to AI/AN members without PA through outreach and information clearly articulated on our website. Referrals that originate from a non-participating IHS or Tribal 638 to another IHS or Tribal 638 will also be exempt from PA requirements. Trillium will track reimbursement and utilization data related to IHS and Tribal 638 providers and proactively follow up to resolve any identified concerns related to PA or claims payment.

F. STANDARD #6 – PHARMACY SERVICES AND MEDICATION MANAGEMENT

(1) Describe Applicant’s experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs.

Since 2012, Trillium has provided prescription drug coverage to our members to ensure that covered medications are safe, medically necessary and clinically appropriate, provided in a cost-effective manner, and successfully managed in the context of funded Condition/Treatment Pairs. Trillium covers medications that treat covered conditions on the Prioritized List. When we receive the OHA-revised Prioritized List, our Pharmacy and Therapeutics (P&T) Committee reviews drugs associated with the Prioritized List of Treatment Pairs to determine which drugs should be removed from and added to our formulary. Once the P&T revises the formulary, we notify our affiliated Pharmacy Benefit Manager (PBM), Envolve Pharmacy, to update the claims adjudication coding to remove and add drugs to conform to the updated formulary.

Co-Morbidity Rule. In accordance with OAR 410-141-0480 (8), Trillium will cover medications that meet the co-morbidity rule, which allows treatment of non-funding conditions if treatment of the non-funded condition will ameliorate or positively impact the funded condition. Trillium has included in its formulary some medications that are covered under the co-morbidity rule. For example, treatment of allergies is not above the line on the Prioritized List; however, untreated allergies can exacerbate asthma symptoms. Trillium has allergy medications that are on the formulary for members who have an asthma co-occurring condition. Members
and/or their providers submit a prior authorization (PA) request for a non-formulary medication for a non-funded condition with documentation that demonstrates the non-formulary medication will improve a funded condition. Through the PA process, Trillium will make a determination on whether a medication will be covered. If the medication is approved, a PA override is entered into the adjudication system to allow the drug to pay. If denied, the member and/or the provider can exercise their appeals rights.

**PDL.** While we have successfully provided our own drug and formulary benefit that follows the Prioritized List, Trillium is prepared to work with OHA to move towards a single PDL.

(2) **Specifically describe the Applicant’s:**

- **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.**

Trillium uses our PA process to process formulary exception requests to allow members to receive non-formulary, but medically necessary medications, as indicated. We develop evidence-based clinical criteria and associated point of service (POS) edits to determine medical necessity for all drugs requiring PA. We will also continue to post any changes to PA criteria and edits, policies, and program changes on our website at least 30 days in advance of any changes and will directly contact providers with members impacted by these changes. PA requests are accepted via secure e-mail, phone, fax, or online through a secure portal to ensure the medical necessity of prescribed medications, promote preferred medication utilization, and support appropriate utilization consistent with OHA’s Sample Contract. We will continue to process PA requests within 24 hours of receipt, authorize three-day emergency supplies for pending determinations until finalized, and ensure continuity of care for new members through automatic approvals based on claims history. Our claims system enables us to adjudicate PA required medications without the practitioner submitting a PA based on Smart PAs built into our claims adjudication system, thus preventing delays in dispensing a full medication supply and reducing administrative efforts by pharmacists and prescribers. Members who meet any of the following conditions will have access to non-PDL or formulary medications: allergy, contraindications, drug-to-drug interactions, unacceptable or toxic side effects to medications in the drug class, therapeutic failure, age-specific indication, a unique indication of a non-preferred drug, clinically unacceptable risk with a change in therapy, or medical co-morbidity or other medical complication that precludes the use of a preferred agent.

- **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.**

Trillium’s formulary has been developed with local input through our P&T Committee, evidence-based practices, the national experience of our PBM, and OHA and NCQA guidance. Our formulary includes FDA approved drug products for each therapeutic class and at least one item in each therapeutic class of over-the-counter (OTC) medications at all times. Trillium’s P&T Committee will continue to monitor each therapeutic class of drugs at least annually per NCQA guidelines, reviewing current literature on drug efficacy and making changes to the formulary (to the extent permissible by OHA) to ensure there is a preferred drug for each therapeutic class and an OTC alternative. Preferred drugs and OTC medications generally do not require a PA, which eases pharmacy and provider burden. PA is required on some preferred drugs when the medication requires a focused review to make sure the drug is clinically appropriate based upon multiple factors including guidance from evidence-based research and the compendia.

- **Development of clinically appropriate utilization controls.**

Utilization controls include PA, step therapy, and drug utilization review (DUR) based on evidence-based practices and clinical guidelines. For example, prospective DUR includes POS clinical edits and alerts using the
Medi-Span® clinical database coupled with provider and pharmacy education and retrospective DUR includes Non-Adherence, Therapeutic Care Gaps, Therapeutic Duplication, Interaction and Contraindication, and Cost Reduction Opportunity report monitoring to identify opportunities for intervention and improvement.

- **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.**

**Accountability.** Formulary revisions are managed through our P&T Committee, composed of our Chief Medical Office, Pharmacy Director, and local physicians and pharmacists. Our local P&T Committee best understands the needs of our members; therefore, we do not delegate formulary and clinical criteria development to our PBM. At least annually, and more frequently when new drugs are introduced to the market, the P&T Committee reviews the clinical criteria to ensure it meets evidence-based practices. We review our decisions with our PBM to leverage their national expertise. This additional review provides a quality check to ensure we have accounted for all evidence-based sources. Even with this review, we keep our criteria locally-driven. We will also seek and incorporate guidance provided by the Oregon P&T based on OHA approval.

**Review Process.** Trillium has established policies and procedures to review and develop new clinical criteria. We develop new criteria as drugs are identified with significant potential for inappropriate use and utilization management should be considered in the form of PA, including:

- When an agent is released or has new indications for conditions with alternative treatment options
- When an agent has safety warnings that significantly limit use
- When there is a change in State and/or Federal regulations that either limits or opens up coverage of an agent

Drafted criteria take into consideration FDA approved indications, evidence-based national guidelines, standards of practice, coverage under OHP, alternative treatment options and PDL agents. Once drafted, criteria for specialty medications are reviewed by two specialists in the same field of practice and reviewed by a panel of pharmacists. Current criteria are reviewed at least annually and may be reviewed more frequently under the following circumstances:

- Changes in clinical practice guidelines/standards.
- Changes in OHP coverage; covered conditions and guidelines per the Prioritized Lists.
- New agents are released which fall under the same therapeutic class as existing criteria.

After the P&T Committee reviews and approves recommendations for new and updated criteria they are sent to Envolve Pharmacy to revise the POS adjudication system, where applicable.

(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.**

**Adequate Network.** Trillium currently contracts with every Medicaid-participating pharmacy in our Service Area. To ensure compliance, we perform a network adequacy analysis any time a pharmacy closes or is removed from our network. If a gap is identified, we conduct targeted outreach to pharmacies to close the gap. In the past year, no pharmacies left our network.

**Communication.** We communicate formulary choices, changes to formularies, PA request process, and clinical criteria to our network using three methods:

- A minimum of a quarterly update to providers via Trillium’s Provider Relations communications and Compliance Department
Website resources: machine readable formulary and criteria, one year of historical updates, instructions on “how to file a non-formulary drug request”, and a chart of commonly requested prior authorized drugs and their alternatives (updated quarterly)

Mailings directly to affected members and their prescribers

(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.

POS System. Trillium’s affiliated PBM, Envolve Pharmacy, has provided services for nearly 20 years and has the system platforms and data interfaces in place for all aspects of our pharmacy program including accurate POS claims processing and payment, administration of drug coverage according to a plan or State formulary, member eligibility processing, PA and drug utilization review. The POS claims system adjudicates pharmacy claims in real-time and more than 99.9% of POS claims are processed electronically, with an average response time of less than a second, after which a message is sent to the pharmacy confirming acceptance or denial of the submitted claim. The POS system also edits each claim before adjudicating to ensure the National Drug Code (NDC) and dispensed units are appropriate for the drugs entered into the system, and capturing all relevant clinical and historical data elements for all claims paid.

Third Party Liability (TPL). We will continue to maintain comprehensive TPL information in our claims adjudication system that is continually refreshed to ensure we have the most up-to-date files available. Our primary source of TPL information comes from the eligibility file, which we maintain on the member eligibility record to ensure proper claims adjudication. We have processes in place to monitor paid and rejected claims to ensure claims processing and Coordination of Benefits (COB) accuracy. When we identify a claim for which Trillium is the secondary payer, it triggers an alert that notifies the pharmacy to submit to the claim to the primary carrier and to bill Medicaid as the secondary payer. This message indicates that the member has dual coverage and that payment must be coordinated with the primary payer through COB.

(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.

Trillium will continue to process pharmacy PAs within 24 hours, leveraging our PBM’s POS claims system and fully staffed in-house PA team. Prescribers can submit PA requests 24/7 via facsimile, via our web portal (CoverMyMeds) and by phone during regular business hours.

(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.
- The dispensing fees associated with each category or type of prescription (for example: generic, brand name, mail order, retail choice 90, specialty).
- 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.

Our PBM’s contractual arrangements are not currently provided to Trillium. Trillium will have access to this information with the implementation of the new transparent pricing contract on May 1, 2019 and will provide the requested information to OHA at that time.
(7) Describe Applicant’s ability to engage and utilize 340B enrolled Providers and pharmacies as a part of the CCO including:

• Whether Applicant is currently working with FQHCs and Hospitals; and if so,
• 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
• How the Applicant is evaluating the impact of these adjunctive programs whether they are generating positive outcomes.

Trillium contracts with two organizations for 340B drug pricing: OHSU for hemophilia products and Acaria Pharmacy for direct acting agents for Hepatitis C and HIV/AIDs treatments. On May 1, 2019, Trillium will move to OHA’s FFS 340B reimbursement methodology described in the Pharmaceutical Administrative Rule Book 410-121-0155, which means that outpatient 340B pharmacies will be paid at their acquisition cost plus a dispensing fee. Under this arrangement, 340B providers/pharmacies will have no spread; therefore, we will not be monitoring adjunctive programs. We will work with OSHU to develop pricing transparency. If not, we will coordinate with other CCOs to work with OSHU on its adjunctive programs. We will not evaluate adjunctive programs for 340B covered entities with transparent pricing because there isn’t a “spread” funding mechanism for those programs. For those that have spread arrangements, we will coordinate with other CCOs to evaluate the impact of adjunctive programs.

(8) Describe Applicant’s ability and intent to use Medication Therapy Management (MTM) as part of a Patient-Centered Primary Care Home.

Trillium will offer Envolve Pharmacy’s MTM program to all eligible members, including those assigned to PCPCHs, to help them use their medications safely and effectively. MTM includes comprehensive medication reviews between pharmacists and high-risk members. During each conversation, pharmacists discuss medication related problems with members and help resolve them. The types of problems we will typically identify include: non-adherence – all chronic medications, gaps in care, therapeutic duplications, opportunities to reduce cost, drug-age contraindications, drug-drug interactions, drug-Inferred disease interactions, de-prescribing opportunities, opioid misuse and other dangerous drug cocktails. Our MTM program will help identify missing therapies and high-risk medications. This allows pharmacists to address and resolve pharmacotherapy issues and engage our PCPCHs in medication management. As a part of the program, pharmacists will provide individualized educational resources based upon the member’s specific care plan goals and needs. Providing customized assessments, care plans, and educational materials will empower our members to be their own advocate. After the pharmacist develops the care plan, we will contact members and their PCPCH for any needed follow up. If a member is non-adherent to therapy, pregnant, or elderly, assessments will occur every 90 days, or more frequently if their adherence issues persist.

(9) Describe Applicant’s ability to utilize E-prescribing and its interface with Electronic Medical Records (EMR).

Through our partnership with Surescripts, we fully support the exchange of a HIPAA-compliant, secure online transactions that allows prescribers who use e-prescribing software that integrates with the member’s EHR to submit real-time requests for patient-specific medication history, eligibility information, and benefit coverage so that prescribers can easily identify medications on the formulary and alternatives for medications that require PA. Our e-prescribing is a process that provides prescribers secure access to prescription benefit information and patient prescription history and allows them to electronically route prescriptions to members’ pharmacies of choice. This process supports the increasing demand for interoperability and value-based care in the pharmaceutical industry.
(10) Describe Applicant’s capacity to publish formulary and Prior Authorization criteria on a public website in a format usable by Providers and Members.
Trillium will continue to publish our formulary and PA criteria on our website in its current format that is usable by providers and members.

G. STANDARD #7 – HOSPITAL SERVICES (RECOMMENDED LIMIT 4 PAGES)

(1) Describe how the 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.
• Indicate what services, if any, cannot be provided locally and what arrangements have been made to accommodate Members who require those services.
• Describe any contractual arrangements with out-of-state hospitals.
• Describe Applicant’s system for monitoring equal access of Members to Referral Inpatient and outpatient Hospital services.

Comprehensive Hospital Network. Trillium maintains a comprehensive provider network to serve the diverse clinical and cultural needs of our members timely and appropriately, including in and out of area hospitals and facilities. Our contract provisions include non-discrimination clauses and require providers to work within the scope of their license. We monitor timeliness through our network adequacy reporting and utilization data. We evaluate amount, duration and scope during the UM process and should we identify any trends or indications of services being limited for our members as compared to others within the same Service Area, or discriminated against in any way, we refer information to our QIC for review and appropriate action.

Out of Area Hospital Services. Trillium is currently contracted with all hospitals in our current Service Area and in active conversations with all hospitals in our proposed Service Area and will continue to contract with any willing provider of outpatient services. While Trillium’s in-area hospitals provide most of the care and service needs of our membership today, there are highly specialized needs, for example organ transplants, that may require out of area referral. In an emergency, members are always instructed to go to the nearest hospital, regardless of network status. For planned admissions, members may be referred outside of the network or Service Area, as their condition requires, which we arrange through a single case agreement.

Out of State Hospital Access. Trillium does not hold direct contracts but has contractual access to out-of-state hospitals, including Lucile Packard and PeaceHealth, through reciprocity agreements. We may also leverage hospital contracts held by our affiliate plans across the country, including in the contiguous states of Washington and California, and use Centene’s national relationships with hospital systems to encourage local contracts.

Monitoring for Equal Access. Trillium’s quality program, in conjunction with Provider Network Management (PNM), monitors and evaluates access and availability of services. To assess equal access to hospital services, we review grievance and appeals data and look for trends in utilization data that indicate disparities or unequal access. Upon identification of access issues, UM refers to PNM for investigation and outreach. If UM identifies trends in a contracted facility not taking our members, we report that information to the QIC for review and appropriate action.

(2) Describe how the 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 Rooms, and urgent care/walk-in clinics, other than their Primary Care home.
• Procedures for improving appropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics.
**Engaging and Educating.** Trillium’s first goal is to connect members to a Primary Care home that meets their clinical, cultural and geographic needs. Recognizing that members have needs outside of regular office hours or that cannot wait for an appointment, Trillium educates all members on how to use emergency and urgent care services through the following:

- New member orientation and training, including a Welcome Call and Welcome Packet
- Targeted mailings, texts, phone and CC outreach to promote appropriate access, wellness and chronic condition management based on care gaps or inappropriate ED use, including 1:1 outreach to high utilizing members to assess and address barriers
- Referral to CC or Intensive CC for at risk members
- Referral to a Traditional Health Worker (TWH) for members unreachable by phone
- Member resources, web page, materials and notifications, including the Member Handbook, Newsletters and educational campaigns
- Knowledgeable Customer Services and nurse advice line staff who can appropriately educate and refer members to appropriate care at each member contact
- Member Concierge staff who outreach to members most in need of comprehensive, anticipatory service and provide administrative and education assistance

**Tracking and Monitoring.** Tracking of inappropriate use of services is a joint function of QMI, UM, CC and Provider Departments, supported by proactive technologies.

**Utilization Reports.** UM and CC look at trends in data through the following reports:

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot Spotter</td>
<td>Over 40 data elements that support population health management, such as ED and inpatient visits, BH risk, last PCP visit, dental visits, indicators for conditions (e.g. SPMI, opioid use), and social determinants (e.g. homelessness)</td>
<td>Monthly</td>
</tr>
<tr>
<td>Inappropriate ED Utilization</td>
<td>Identifies number of preventable ED visits, categorized by diagnosis, gender, and age group</td>
<td>Monthly</td>
</tr>
<tr>
<td>High ED Utilizer</td>
<td>Identifies member age, gender, location, and number of annual ED visits</td>
<td>Weekly</td>
</tr>
<tr>
<td>CC Prioritization</td>
<td>Identified members for CC outreach</td>
<td>Daily</td>
</tr>
<tr>
<td>Care Transitions</td>
<td>Tracks 7-day and 30-day readmissions by month and year-to-date</td>
<td>Monthly</td>
</tr>
<tr>
<td>UM Reporting</td>
<td>Over and underutilization, including ED and PCP</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

**Real Time Data.** ADT feeds support real time notification of ED visits. Upon notice, our Care Coordinators contact the member and/or their PCP or BH provider to facilitate the most appropriate level of care and follow up. We also use PreManage/Emergency Department Information Exchange (EDIE) to identify complex needs of high-risk patients in real-time, allowing providers to see visit and CC information from any ED a patient has visited instantly upon patient registration. We will use population-specific cohorts and daily driver reports as part of our outreach and CC programs, such as ED diversion for high utilizers, opioid abuse, and programs for BH-related ED visits.

**ED Diversion.** Our ED program targets members with three or more ED visits over the last 30 days. A dedicated ED Team outreaches to targeted members and follows-up with a letter and promotional materials to redirect members to appropriate alternate care. Our nurse advice line helps members navigate their medical circumstances and guides level of care decisions, such as going to the ED or urgent care or the need for ambulance services. Members may also be referred to their Care Coordinator for continued follow-up or enrollment in CC. Assistance is available 24/7 to help members identify the appropriate care setting. Our dedicated ED Utilization Workgroup focuses on process improvement, including community organizations, hospital, and BH providers in developing and implementing improvements.

**Interdisciplinary Care Team (IDT).** Trillium CC staff participates in weekly IDT meetings where physical and BH challenges are identified and appropriate coordination of supports are determined. CC contacts members
identified on hospital readmission and ED reports. IDTs are completed for members with high ED and hospital readmission visits, as well as behavior health needs, to ensure a collaborative and holistic approach is taken for each member.

**Leveraging Technology.** Our Transitions of Care (TOC) planning and readmission reduction activities begin immediately upon notice of admission. We currently receive notice through PreManage or the prior authorization process. When a member is admitted to an acute facility, we use our readmission risk stratification tool to determine the member’s level of risk for readmission and match them with the appropriate TOC support. We use PreManage to proactively send reports to our providers and to Dental Care Organizations for individuals who are using the ED for oral healthcare. Ambulance first responders also have access to PreManage and participate in the Lane County ED High Utilizers Community Collaborative. Trillium will our robust data analytics system to flag providers that have a high readmission rate and then look at potential root causes, such as provider capacity or after-hours availability.

**Describe how the Applicant will monitor and adjudicate claims for Provider Preventable Conditions based on Medicare guidelines for the following:**

- **Adverse Events; and**
- **Hospital Acquired Conditions (HACs).**

**Provider Preventable Conditions (PPCs).** Trillium protects our members and program integrity by monitoring and prohibiting payments for PPCs, including adverse events and certain Hospital-Acquired Conditions (HACs). Our contracts prohibit, or reduce payments, to providers for services associated with PPCs, in full compliance with federal and Oregon law. Contracts further prohibit providers from billing or charging us or members for these services. We monitor compliance through identification of potential and/or actual quality of care (QOC) events and PPCs using claims-based reporting and QOC reports. Our claims system is also configured to deny or reduce payment of PPCs in accordance with the contract. Our QMI department monitors and tracks occurrences of PPCs for trends in type, location, and provider, and investigates further and/or requests a corrective action plan as indicated, with input and oversight from QIC.

**Adverse Events.** As described above, hospitals are not permitted to receive or retain reimbursement for inpatient or outpatient services related to adverse events and members are held harmless for any related services. Providers are required to populate Present on Admission (POA) indicator on all acute care inpatient hospital claims for adverse events, as applicable.

**Hospital-Acquired Conditions (HACs).** Providers are required to identify HACs using specified admission indicators on claim forms allowing Trillium to process claims accordingly, track and report events. Our claims system is designed to deny claims with indications of HACs identified by the State, such as hospital-acquired pressure ulcers and infections. Trillium will comply with any future additions the State makes to its list of non-reimbursable HACs. Recoupment efforts will be made in cases involving “never events” as identified through claim and provider trending, member reported complaints, claims analysis and audit functions performed consistently via our payment integrity efforts and when fraud or abuse is identified.

**Describe the Applicant’s Hospital readmission policy, and how it will enforce and monitor this policy.**

**Hospital Readmissions.** Trillium promotes more clinically effective, cost efficient and improved healthcare through appropriate and safe hospital discharge of patients. For readmissions within 30 days of discharge that are determined to be inappropriate or preventable based on defined clinical review guidelines, including, but not limited to, a prior premature discharge from the same hospital or a failure to have proper and adequate discharge planning, we deny payment or reimbursement. Certain readmissions are excluded from a 30-day readmission review, including, but not limited to, planned readmissions for repetitive or staged treatments and transfers from out-of-network to in-network facilities. We conduct a pre-payment clinical review for all hospital
claims submitted for a member readmission within 30 days of a discharge from the same hospital or a related hospital. If medical records for both the original and subsequent readmission are not received, the second claim is denied. Trillium vigilantly monitors claim submissions to minimize the need for post-payment adjustments but may conduct a post-payment review as indicated. If the claim is determined to be inappropriate payment recovery is pursued.

(5) Please describe innovative strategies that could be employed to decrease unnecessary Hospital utilization. **Hospital Utilization.** Key components of activities that drive positive results include timely identification; member engagement, activation and personal responsibility; removing access barriers; and provider engagement, which frame the following current and future strategies:

**High Touch Care Coordination (CC).** We actively engage members and families/caregivers while still in the hospital to ensure access to needed services and support and promote self-management and health literacy and arrange for appropriate follow up care upon discharge. **Frequent User System Engagement (FUSE).** Trillium collaborates with PeaceHealth and ShelterCare to provide medical respite for homeless members in need of post-discharge care when leaving inpatient setting. *A 2017 analysis of the program found that inpatient rates were 85% lower during ShelterCare stays, and 40% lower post-ShelterCare stays.*

**Potentially Preventable Readmission (PPR) Score.** Our Centelligence health informatics platform allows us to analyze claims data to identify readmission risk. Our CC Team utilizes the PPR score to prioritize and design appropriate outreach and interventions. The PPR score updates daily as the member’s status changes. Provider staff analyze trends in claims data on ED utilization and readmissions at a population level, and work with providers to compare their performance to benchmarks and understand and address low performance.

**Transitions of Care (TOC).** Trillium’s dedicated Transitions Team focuses on prevention, continuity and coordination. The Transitions Team identifies and engages high risk members upon admission and deploys interventions (e.g. medication reconciliation, symptom identification and management, social/ community resource referrals) to address barriers known to contribute to readmission.

(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.

Trillium provides multi-disciplinary high touch, high engagement and coordination services for 2,469 members dually eligible for Medicaid and Medicare. Whether a member is in our affiliated D-SNP, Medicare Advantage plan, unaffiliated plan, or fee-for-service Medicare, we work with the member and other stakeholders to help identify and address barriers to care, and ensure members appropriately access care primary care under their Medicare benefit. This could include, Interdisciplinary Care Teams, coordinating with other providers, AAA/APD case managers or other affiliated plans through use of shared data, telephonic or in-person meetings. Members enrolled in our CCO and affiliated Medicare plan are assigned a single Care Coordinator who facilitates a single assessment and individualized care plan that spans all services. We are committed to coordinating with all Medicare entities that support our Medicaid members.
This information is exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.
Attachment 8 - Value-Based Payment Questionnaire

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Page limits for this Value-Based Payment Questionnaire is 15 pages. Items that are excluded from the page limit will be noted in that requirement.

A. Value-Based Payment (VBP) Requirements

VBP Minimum Threshold

CCOs must begin CCO 2.0 – January 2020 – with at least 20% of their projected annual payments to their Providers in 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. OHA will assess adherence retrospectively. The denominator in this calculation is the total dollars paid (claims and non-claims-based payments) for medical, behavioral, oral, prescription drugs and other health services. Administrative expenses, profit margin, and other non-service-related expenditures are excluded from the calculation.

Expanding VBP Beyond Primary Care to Other Care Delivery Areas

CCOs must develop new, or expanded from an existing contract, VBPs in care delivery areas which include Hospital care, maternity care, children’s health care, Behavioral Health care, and oral health care. The term “expanded from an existing contract” includes, but is not limited to, an expansion of a CCO’s existing contract such that more Providers or Members are included in the arrangement, or higher-level VBP components are included. Required VBPs in care delivery areas must fall within LAN Category 2C (Pay for Performance) or higher through the duration of the CCO 2.0 period.

Before the Contract is signed, successful Applicants will receive final specifications of care delivery area VBPs, including required reporting metrics, from OHA.

2020 VBP requirements are included in the Core Contract. CCOs must implement care delivery area VBPs according to the following schedule after 2020:

- By 2021, CCO shall implement two new or expanded VBPs. The two new or expanded VBPs must be in two of the listed care delivery areas, and one of the areas must be either Hospital care or maternity care. A CCO may design new VBPs in both Hospital care and maternity care. A VBP may encompass two care delivery areas; e.g. a hospital maternity care VBP that met specifications for both care delivery areas could count for both hospital care and maternity care delivery areas.
- By 2022, CCO shall implement a new VBP in one more care delivery area. By the end of 2022, new VBPs in both Hospital care and maternity care must be in place.
- By 2023 and 2024, CCO shall implement one new VBP each year in each of the remaining care delivery areas. By the end of 2024, new or expanded VBPs in all five care delivery areas must be implemented.

CCO VBP targets that achieve 70% VBP by 2024

CCOs must annually increase the level of payments that are value-based through the duration of the CCO 2.0 period. CCOs must meet minimum annual thresholds, according to the following schedule:

- For services provided in 2021, no less than 35% of the CCO’s payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;
- For services provided in 2022, no less than 50% of the CCO’s payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;
- For services provided in 2023, no less than 60% of the CCO’s payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher; and it is expected that, beginning 2023, no less than 20% of the CCO’s payments to Providers must fall within LAN Category 3B (Shared

Attachment 8
Savings and Downside Risk) or higher. Payments that fall within LAN Category 3B or higher will qualify for the overall VBP target of 60% because LAN Category 3B is higher than LAN Category 2C; and

- For services provided in 2024, no less than 70% of the CCO’s payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher and it is expected that beginning 2024, no less than 25% of the CCO’s payments to Providers fall within LAN Category 3B (Shared Savings and Downside Risk) or higher, also qualifying for the overall VBP target of 70% per statement above.

Patient-Centered Primary Care Home (PCPCH) VBP requirements

CCOs must provide per-Member-per-month (PMPM) payments to their PCPCH clinics as a supplement to any other payments made to PCPCHs, such as fee-for-service or VBPs. CCOs must also vary the PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs. The PMPMs must be appropriate, increase each year over the five-year contract and, although OHA is not defining a specific minimum dollar amount, the payments should be sufficient to aid in the development of infrastructure and operations needed to maintain or advance PCPCH tier level.

The PCPCH PMPM payment counts for this requirement at a LAN Category 2A level. Unless combined with a LAN category 2C or higher, it does not count toward the CCO VBP minimum threshold for 2020 or CCO VBP annual targets, which require a LAN Category 2C (Pay for Performance) or higher.

Risk adjustment within VBP arrangements

OHA may require CCOs to use risk adjustment models that consider social complexity within their VBP arrangements in later years (2022-2024).

b. VBP Reporting

CCO VBP Data Reporting for 2020 is specified in this RFA, below, and the Core Contract. Awarded Successful Applicants must report their VBP data and other details for future years as described below.

**CCO Data Reporting: 2020**

CCOs must comply with the following reporting requirements in Year 1:

1. Describe the specific quality metrics from the HPQMC Aligned Measures Menu, or HPQMC Core Measure Set, if developed in future years, that will be used, including the established benchmarks that will be used for performance-based payments to Providers and other relevant details; and/or

   a. If the aligned measure set does not include appropriate metric/s for planned VBP, Applicants may request approval from OHA to use other metrics. Preference will be given to those metrics defined by the National Quality Forum (NQF).

   b. Should OHA contract with one or more other CCOs serving Members in the same geographical area, the CCO shall participate in workgroups to select performance measures to be incorporated into each CCO’s value-based purchasing Provider contracts for common Provider types and specialties. CCOs will be informed in advance of the Provider types and specialties under consideration for performance measures. Each CCO shall incorporate all selected measures into its Participating Provider contracts.

2. By September 30, 2020, CCOs must submit payment arrangement data via APAC’s Appendices G and H. Please see APAC Reporting Guide for additional information.

3. Report PCPCH VBP details including:

   a. Payment differential and/or range across the PCPCH tier levels during year CY 1 (2020);

   b. Payment differential and/or range by PCPCH tier levels over CY 2 (2021) through CY5 (2024); and

   c. Rationale for approach (including factors used to determine the rate such as Rural/Urban, social complexity).

4. By Spring/Summer, CCO’s executive leadership team must engage in interviews with OHA to:

   a. Describe how the first year of activities and VBP arrangements compare to that which was reported in the Application, including detailed information about VBP arrangements and LAN categories;
b. Discuss the outcome of the CCO’s plan for mitigating adverse effects of VBPs and compare/describe any modifications to that which was reported in the Application; and
c. Report implementation plans for the two care delivery areas that will start in 2021; and
d. Any additional requested information on VBP development and implementation.

Data Reporting: 2021
1. In the first quarter of 2021, CCOs must submit Year 1 VBP Data Template, which includes summary data stratified by LAN categories that describes 2020 payment arrangements. Although the CCO will likely be unable to report exactly all adjudicated payments made for 2020, OHA will require the reporting of fee-for-service payments that are associated with a VBP in order to assess the CCO’s preliminary progress towards meeting the VBP targets. This will function as a rolled-up version of APAC’s Appendix G (before Appendix G data are available) and will allow for more timely monitoring of the CCO’s progress towards achieving the VBP targets. This report will also serve as a comparison for what the Applicant initially submitted. Note: Data submitted to Appendix G and H, which allows for a nine-month lag after the reported time period, will be the official assessment of a CCO’s VBP target achievement.
2. By September 30, CCOs must submit VBP data via APAC’s Appendix G and H for the previous calendar year.
3. Report PCPCH VBP details including:
   a. Payment differential and/or range across the PCPCH tier levels during year CY 2020;
   b. Payment differential and/or range by PCPCH tier levels over CY 2021 through CY 2024; and
   c. Rationale for approach (including factors used to determine the rate such as Rural/Urban, social complexity).

Data Reporting: 2022-2024
1. By September 30, CCOs must submit VBP data via APAC’s Appendix G and H for the previous calendar year.
2. Report PCPCH VBP details including:
   a. Payment differential and/or range across the PCPCH tier levels during year CY 1 (2020);
   b. Payment differential and/or range by PCPCH tier levels over CY 2 (2021) through CY 5 (2024); and
   c. Rationale for approach (including factors used to determine the rate such as Rural, Urban, or social complexity).
3. By May of each year, CCO’s executive leadership team must meet formally with OHA to:
   a. Describe the previous year of VBP arrangements;
   b. Discuss the outcome of the CCO’s plan for mitigating adverse effects of VBPs on populations with complex care needs or at risk for health disparities, and compare and describe any modifications to the plan;
   c. Report outcomes of the care delivery areas implemented in the previous year; and
   d. Report implementation plans for the upcoming new care delivery areas.
4. Report complete Encounter Data with contract amounts and additional detail for VBP arrangements.
C. VBP QUESTIONS

For all questions below, describe VBP data using The Health Care Payment Learning and Action Network (LAN) categories and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations

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.

Please see Att. 8 RFA VBP Data Template.

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.

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

APPROACH TO GROWING PCPCH INVESTMENTS

Trillium Community Health Plan (Trillium) maintains a network of 60 Patient Centered Primary Care Homes (PCPCHs), representing 98% of all PCPCHs practicing in our current Service Area. Our PCPCH network is comprised of a variety of safety-net, pediatric, and other primary care providers (PCPs) with the vast majority (over 83%) meeting Tier 4 or 5 requirements. Additionally we have contracts or LOAs in place with 92 PCPCHs in the Tri-County area that embrace a whole-person, patient and family-centered approach that promotes integration of our members’ physical, oral, and behavioral health (BH) care needs, ensuring that our members have access to a robust network of PCPCHs in our current and proposed Service Areas. To incentivize PCPCHs to move to higher Tier levels and reward improvements in various preventive services and chronic condition management metrics, today Trillium provides pre-member-per-month (PMPM) payments to Tier 4 and 5 PCPCHs. In accordance with CCO 2.0 requirements, Trillium will provide PMPM payments to all PCPCHs and vary the PMPM payments such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs.

Rationale for Approach. Trillium will take a provider-centric approach when developing PCPCH payments to appropriately account for a variety of factors related to a provider’s geographic location and panel makeup. For
example, we are cognizant of the unique challenges rural providers face, and understand that geographic barriers may significantly impact access to and delivery of services. To support the infrastructure necessary for PCPCHs to continue serving rural members, we will offer PCPCHs located in rural areas a percentage increase over the baseline Tier-level PMPM. Similarly, we will offer PCPCHs who serve members with high levels of medical or social complexity, for example PCPCHs that serve a high volume of members with Serious and Persistent Mental Illness (SPMI), a percentage increase over the baseline Tier-level PMPM. Additionally, we will work with PCPCHs to develop a methodology for determining how social determinant of health (SDOH) data can be used to determine an appropriate differential PMPM amount based on the social complexity of PCPCH membership. By reimbursing an enhanced PMPM to PCPCHs whose panels include a high level of medically or socially complex members, we are helping to offset the additional expense often related to caring for such members, thereby reducing the unintended consequence of a provider selectively building their membership panels with members who demonstrate lower levels of complexity.

In support of their continued commitment to improving quality of care, Trillium will work with PCPCHs to identify additional factors for increased reimbursement. For example, Trillium will explore paying pediatric PCPCHs who participate in an Oregon Pediatric Improvement Partnership (OPIP)-sponsored quality improvement project an additional percentage increase over the baseline PMPM.

### 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 health care 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 patient that are “fired” from Providers.**

### TRILLIUM’S PLAN FOR MITIGATING ADVERSE VBP EFFECTS

A central component of Trillium’s VBP strategy is to develop patient-centric and integrated care models that address the unique challenges faced by different cohorts of Medicaid populations. We are committed to developing VBP models that help to solve for, not exacerbate, health inequities and health disparities, and that do not disadvantage any member population. Based on Trillium’s and our affiliate health plans’ experience, we believe that programs tailored at the provider level that account for panel acuity, consider prevalence of social and medical complexity, and prevent providers from manipulating their panel composition in an effort to bolster performance reduces the likelihood of adverse impacts resulting from our VBP models.

Trillium staff regularly engage providers, members, and community stakeholders through our Community Advisory Council (CAC), Rural Advisory Council (RAC), Clinical Advisory Panel (CAP), Community Health Needs Assessment (CHA), and Community Health Improvement Plan (CHP), to better understand the health inequities and disparities our members face, identify community needs and design VBP models intended to help solve for such considerations.

Additionally, for CCO 2.0, we are adding a Health Equity Council, chaired by our Health Equity Officer, to review and advise the Governing Board on social determinants of health and health equity (SDOH-HE) spending. Through our initial risk screening, we collect and stratify member demographic data in alignment with Race, Ethnicity, Language, and Disability (REAL+D) requirements, as well as information on member’s social circumstances related to key SDOH-HE areas (e.g., food, housing, safety, employment, etc.). Additionally, Trillium requires providers participating in VBP models such as our innovative Intensive Community Care Management (ICCM), described in more detail under Att.8.C.5 below, to track ICD-10 Z-codes that capture
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 health care, Behavioral Health care, and oral health care; 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.

DESCRIPTION OF VBP ARRANGEMENTS TO BE DEVELOPED IN YEAR ONE AND
IMPLEMENTED IN YEAR TWO

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.)

TRILLIUM’S EXPERIENCE REWARDING PROVIDERS FOR PERFORMANCE
For the last 20 years, Trillium has been committed to partnering with our provider partners who achieve our
mutual goals of improving member health outcomes and health care quality. We have continuously rewarded
providers for their contributions in support of achieving these goals through the distribution of incentive metric
quality pool funds. Since 2013, Trillium has shared 92% of our incentive payments with the provider
community as quality bonus payments. In 2016, for example, our provider community contributed to Trillium
achieving scores in the top quartile of all 16 CCOs for the following measures:

⚠️ Assessments for children entering foster care (4th place, improved 23.2% over 2015, overall rate 83.3%)
⚠️ Controlling high blood pressure (3rd place, overall rate 69.7%)
Screening to determine mental and physical development of children 0-3 years of age (3rd place, overall rate 73.6%)

Diabetes care (1st place, overall rate 22.2%)

Member satisfaction with healthcare providers (2nd place, overall rate 88.3%)

In 2017, Trillium improved outcomes in 14 quality incentive measures compared to our 2016 performance. Additionally, in 2017, Trillium was the highest performing CCO for the following measures: controlling hypertension (1st place, overall rate 71.8%), and diabetes care (1st place, overall rate 18.7%).

Under the CCO 2.0 Contract, Trillium will embed CCO Incentive measures in VBP arrangements to promote alignment with OHA’s objectives and improve quality outcomes among members.

**Plan for Achieving OHA’s VBP Goals.** Trillium will leverage our existing provider partnerships and our experience rewarding our provider community for their performance against CCO quality metrics as the foundation for achieving OHA’s CCO 2.0 VBP targets. The service types on which we will focus our VBP efforts include hospital care, maternity care, children’s health care, BH care, and oral health (OH) care in alignment with OHA’s defined care delivery areas. We will offer a portfolio of VBP arrangements that include a broad range of HCP-LAN categories to ensure we have an arrangement in place that aligns with every provider’s capabilities, with a focus on HCP-LAN Category 2.C and 3.B.

**Our approach to achieving 70% VBP spend attributable to a HCP-LAN Category 2.C or higher by the end of 2024 includes:**

- Designing a broad portfolio of VBP arrangements which emphasize integrated, member-centric care to addresses unique needs of different Medicaid populations
- Offering VBP models that meet providers where they are today and provide meaningful support and infrastructure that take them to where they want to go
- Continuing to move providers along our VBP continuum by evaluating capabilities to identify additional providers for participation in one of Trillium’s HCP-LAN Category 2.C or higher VBP arrangements
Trillium will ensure that, by 2024, no less than 70% of Trillium’s payments to providers will be in the form of a VBP and fall within a HCP-LAN Category 2.C, and no less than 25% of payments to providers will fall within HCP-LAN Category 3.B or higher. We will comply with all OHA requirements, including submission of the Year 1 VBP Reporting Template, submission of payment arrangement data via APAC’s Appendices G and H, submission of PCPCH VBP details, and engaging in annual meetings with OHA to discuss VBP arrangements. The table below lists VBP programs that Trillium will implement each year over the course of the CCO 2.0 Contract, indicates if the VBP program is new or expanded, and identifies the corresponding HCP LAN category, and the care delivery area. We provide additional details for each VBP Program listed in the table below in our below response to Att.8.C.5.

Below, we detail our VBP plan that includes the strategies Trillium will employ in advance of go live and during each Contract Year through 2024.

**Strategies to be Employed Prior to Operational Start Date.**

**Provider Engagement Model to Support Providers along VBP Continuum.** A foundational component of Trillium’s VBP strategy is to employ a Provider Engagement Model that ensure providers receive the appropriate level of staff support for maximizing their VBP program success. We understand that to move an entire network’s performance toward higher quality, health plans must engage all providers in VBP arrangements and support them to improve over time and progress along the continuum of VBP arrangements. Trillium is currently exploring the integration of Prometheus Analytics logic, if deemed appropriate, into our Centelligence® Health Informatics Platform to analyze episodes of medical care and to potentially augment our value-based payment models, evaluate provider performance, identify care variations, and improve network efficiency. We currently use a range of similar tools to identify and act on inefficiencies in care delivery. Before integration, we will conduct a thorough investigation to ensure that our care managers, members and providers get the best experience from combining these tools. Disseminating actionable information from Prometheus Analytics to providers also has potential to increase providers’ capacity to excel in VBP arrangements and conduct
population health management. Subject to further guidance from OHA, Trillium will partner with OHA as we incorporate the cost and quality information from Prometheus Analytics into our existing dashboards for and arrangements with our provider network.

**Staff to Support Provider Performance Management.** To ensure providers engage in our VBP programs and successfully move along the continuum, Trillium will dedicate staff responsible for delivering proactive education and support for providers to improve performance on quality measures, control costs, and ensure continued access for our members. Our team will facilitate the successful participation of providers in our VBP models, including PCPCHs, BH providers and specialists, through analytic expertise and experience in financial analysis, quality and HEDIS reporting, and risk sharing agreements to their work educating providers.

**Critical Elements of Success.** Through our experience collaborating with providers to achieve improved quality and cost-containment outcomes, Trillium has identified many of the critical elements of success needed to support successful practice transformation through VBP participation:

- **Flexibility.** Through flexible payment models and timing, providers need accommodations for their varying levels of financial stability, data system sophistication, and current placement on the VBP continuum.

- **Communication.** Trillium offers providers on committees, including our CAP and HEC, the opportunity to review and provide input into the design of our VBP programs, with our Compensation Committee providing final recommendations to Trillium’s Governing Board. This illustrates our commitment to delivering transparent and collaborative communication with providers regarding future VBP strategies. Additionally, we will develop our Online Provider Resource Center, which will include a well-organized, searchable compendium of best practice documentation, training and educational materials, and tools to help providers manage the clinical, operational, and technology aspects of their practices.

- **Actionable Analytics, Reports and Information Tools.** Trillium gives all contracted providers access to timely and actionable analytics as further described in our response to Att. 9.D.2.B. Additionally, we will generate shadow reports for all contracted providers, through which providers’ prior gain/risk share performance and other factors will be evaluated to determine which VBP Level and arrangement best match their capabilities.

In addition to our Provider Engagement Model, Trillium will implement a number of initiatives to solidify our VBP programs prior to the Contract start date. Such efforts, many of which are already underway, include:

- **Developing a variety of VBP arrangements** that align with OHA’s goals and framework for the duration of the CCO 2.0 contract period, and account for the needs and challenges unique to small-volume providers, PCPs, hospitals and health systems, and specialists including BH providers. Based on the success of our affiliates serving similar Medicaid populations, Trillium will execute a thoughtful VBP strategy designed to maximize broad-based adoption of VBP models.

- **Developing a formalized Transition Strategy,** through which Trillium will assess providers’ continuum advancement readiness on an ongoing basis.
  - Our Transition Strategy will include offering a variety of flexible VBP programs, supporting providers at every step to ensure success, and over time attributing more members to more advanced and successful providers.
  - We will continually evaluate providers’ readiness for the next step in their practice evolution. Annually, we will perform comprehensive network assessments to determine advancement readiness and deliver a tailored program of practice transformation tools to accomplish quality goals, improve care coordination and health care outcomes, and engage members in making good health care choices.
Using our affiliates’ experience as the framework, our Transition Strategy will include a comprehensive provider education and support program to ensure our network of providers benefit, professionally and financially, from advancement along our VBP continuum.

- **Introducing our provider network** to the structure and mechanics of Trillium’s VBP arrangements.
- **Continuing to actively negotiate innovative VBP arrangements** designed to meet target thresholds with key providers throughout our Service Areas.

**STRATEGIES TO ACHIEVE YEAR 1 VBP GOALS**

Trillium will achieve at least 20% of payments aligned with an HCP-LAN Category 2.C or higher VBP arrangement during Contract Year 1 through the efforts and programs described below.

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*Exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.*
STRATEGIES TO ACHIEVE CONTRACT YEAR 2 VBP GOALS
Trillium will achieve at least 35% of payments aligned with an HCP-LAN Category 2.C or higher VBP arrangement during Contract Year 2 through the efforts and programs described below.

Exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.
STRATEGIES TO ACHIEVE CONTRACT YEAR 3 VBP GOALS
Trillium will achieve at least 50% of payments aligned with an HCP-LAN Category 2.C or higher VBP arrangement during Contract Year 3 through the efforts and programs described below.

Exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.

STRATEGIES TO ACHIEVE CONTRACT YEAR 4 VBP GOALS
Trillium will achieve at least 60% of payments aligned with an HCP-LAN Category 2.C or higher VBP arrangement, and at least 20% of payments aligned with an HCP-LAN Category 3.B or higher during Contract Year 4 through the efforts and programs described below.

Exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.
STRATEGIES TO ACHIEVE CONTRACT YEAR 5 VBP GOALS
Trillium will achieve at least 70% of payments aligned with an HCP-LAN Category 2.C or higher VBP arrangement, and at least 25% of payments aligned with an HCP-LAN Category 3.B or higher during Contract Year 5 through the efforts and programs described below.

Trillium has embraced the Triple Aim as a yardstick for measuring successful healthcare delivery transformation within our portfolio of VBP programs. We firmly believe that delivering on the Triple Aim (Enhanced patient experience, improving population health, and reducing costs) requires provider engagement, a sustainable work life balance, and viable and satisfactory business models for providers (the fourth aim). Our experience reveals that VBP objective setting requires a flexible programmatic approach rooted in provider engagement. Trillium will evaluate the effectiveness of each of our VBP programs on a quarterly basis to ensure alignment with OHA’s goals as well as with the Triple Aim.

**D. VBP REFERENCE DOCUMENTS**

<table>
<thead>
<tr>
<th>Reference Document</th>
<th>Description</th>
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<tbody>
<tr>
<td>OHA’s Value-Based Payment Roadmap for Coordinated Care Organizations</td>
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<tr>
<td>OHA’s Value-Based Payment Categorization Guidance for Coordinated Care Organizations</td>
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<tr>
<td>Health Care Payment Learning and Action Network’s (LAN’s) “Alternative Payment Model Framework White Paper Refreshed 2017”</td>
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<tr>
<td>LAN-APM Framework</td>
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<td>RFA VBP Data Template</td>
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<td>Year 1 VBP Data Template</td>
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<tr>
<td>APAC Reporting Guide</td>
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<tr>
<td>Health Plan Quality Metrics Committee 2019 Aligned Measures Set</td>
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</table>

Exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.
• Oregon Health Authority Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide
This information is exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.
ATTACHMENT 9 —HEALTH INFORMATION TECHNOLOGY

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Page limit for this Health Information Technology Questionnaire is 43 pages, items that are excluded from the page limit will be noted in that requirement.

INTRODUCTION

As CCOs set out to deliver coordinated care that meets the Triple Aim, having the right health information technology (HIT) is crucial. This attachment is intended to gather information from Applicants on their HIT capabilities and plans for HIT to meet OHA’s requirements. The responses included in this questionnaire will be used for both the RFA and for compliance and monitoring as follows:

RFA HIT Questionnaire: Responses will be used to evaluate whether Applicants meet minimum criteria as part of the RFA evaluation. In particular, Applicants will:

- Attest that they have or will have certain HIT capabilities as described in this document.
- Provide supporting detail about how they meet, or plan to meet each requirement, as well as projected plans for HIT activities related to the requirement, including milestones throughout the course of the 5 year contract. Supporting detail should include milestones and timelines for these activities. Please note: OHA will review supporting detail for completeness and applicability to the component, and will reject attestations that are not supported by complete, applicable detail. For example, a response in component 2 that does not address Behavioral Health Providers will not be considered complete.
- Certify or attest that they will meet monitoring and reporting requirements.

Draft HIT Roadmap: For Successful Applicants, responses will form the basis of a CCO’s draft “HIT Roadmap”. The draft HIT Roadmap will be subject to further OHA review during Readiness Review (see RFA, Section 5.6), which may include an interview and/or demonstration to show the CCO meets expectations and that future plans are credible. OHA may request further detail and negotiate milestones and targets, leading to an approved HIT Roadmap by December 31, 2019.

- Due to the critical nature of HIT to support CCO obligations, failure to complete an approved HIT Roadmap may delay completion of Readiness Review.

Contract, Monitoring and Reporting - Approved HIT Roadmap: CCOs will be required to maintain an approved HIT Roadmap, comply with the provisions of their Roadmap, provide an annual HIT Roadmap Update, and participate in an annual interview, including:

- An annual attestation that the CCO made progress on their roadmap, and provide supporting information on progress made, including any changes to the HIT Roadmap.
- Discuss the CCO’s annual HIT Roadmap update.

Discussion of the HIT Roadmap update also be part of the annual VBP interview in addition to the annual HIT Roadmap interview. Each annual HIT Roadmap update must be approved by OHA. Due to the critical nature of HIT to support CCO obligations, CCOs must continue to make progress on their HIT roadmaps to remain in good standing with OHA. OHA may offer technical assistance and reserves the right to require Corrective Action or other consequences including remedies authorized under the Contract (see Appendix B, Sample Contract, Exhibit D, Section 9).

Other HIT-related deliverables under the Contract:

- Annual attestation and reporting on progress on activities in the HIT Roadmap.
- Annual reporting on EHR adoption and HIE access and use information for CCO’s physical, behavioral, and oral health Providers. Information will be reported to OHA in the form of:

Performance Expectations (see Appendix B, Sample Contract, Exhibit M) including:

- proportion of contracted physical, behavioral and oral health Providers who have adopted EHRs (including those with any EHR, Certified EHR, and 2015 Certified EHR);
TRILLIUM COMMUNITY HEALTH PLAN
RESPONSE TO RFA OHA #4690-19 – CCO 2.0
ATTACHMENT 9 – HEALTH INFORMATION TECHNOLOGY

- proportion of contracted physical, behavioral and oral health Providers who have access to HIE and proportion using HIE for Care Coordination; and
- proportion of contracted physical, behavioral and oral health Providers’ who have access to, and proportion using, Hospital event notification; and
- EHR product and HIE tool(s) in use by each contracted Provider, in a format agreed to by OHA and the CCO during the draft HIT Roadmap review process.

- Signed HIT Commons Memorandum of Understanding (MOU) and annual payment of HIT Commons assessments
- Transformation Quality Strategy (TQS) – OHA encourages CCOs to reflect the HIT components of the transformation and quality initiatives in their TQS work plan and reporting (see Appendix B, Sample Contract, Exhibit B). HIT components will not be stand-alone requirements for TQS, but OHA would like to understand where HIT plays an important role in the transformation and quality work underway. OHA’s requirements are not intended to cause a proliferation of HIT systems. CCOs should have a good understanding of the HIT in place in their communities – with their network Providers and Hospitals – and incorporate Community partners in their HIT efforts. CCOs are encouraged to collaborate and leverage regional or statewide initiatives, where appropriate, as part of their HIT strategies. Further, OHA is supporting statewide HIT efforts that CCOs should consider leveraging. OHA can provide technical assistance related to HIT available to CCOs.

A. HIT PARTNERSHIP

The HIT Commons is a shared public/private partnership designed to accelerate and advance HIT adoption and use across the state by coordinating, standardizing, governing, and supporting statewide HIT efforts. It is an independent body co-sponsored by OHA and the Oregon Health Leadership Council. The HIT Commons is meant to leverage and build on the success of collaborative HIT efforts to date, in particular the Emergency Department Information Exchange (EDIE) governance model. For more information, see HIT Commons website: http://www.orhealthleadershipcouncil.org/hit-commons/.

Contractors will be expected to participate in the HIT Commons beginning 2020, including all of the following: maintaining an active, signed HIT Commons MOU (see 2020 HIT Commons MOU) and adhering to its terms, paying annual HIT Commons assessments (see http://www.orhealthleadershipcouncil.org/wp-content/uploads/2018/12/2019-HIT-Commons-Assessments.pdf), and serving, if elected, on the HIT Commons Governance Board or one of its subcommittees.

OHA’s HIT Advisory Group (HITAG) meets at least once a quarter and is an opportunity for CCOs to come together and share HIT best practices and advise OHA on its HIT efforts. All CCOs are invited to appoint a representative to HITAG. All CCOs will be required to send a representative to attend an annual HITAG meeting, regardless of whether that CCO has chosen to appoint a regular representative to HITAG. See the HITAG website for more information, including charter and current membership: https://www.oregon.gov/oha/HPA/OHIT/Pages/HITAG.aspx. Contractors will be required to participate in HITAG at least once annually.

1. INFORMATIONAL QUESTION

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

FULLY PREPARED TO SIGN HIT COMMONS MOU

Trillium Community Health Plan (Trillium) will sign the 2020 HIT Commons MOU and does not expect challenges or obstacles in fulfilling MOU terms throughout the entirety of the Contract. We will draw upon our experiences to partner with CCOs and the OHA in support of the MOU, through:

△ Partnerships and Collaboration. We will leverage our community-based, collaborative approach and partnerships to fulfill the terms of the MOU. For example, for the last six years our Manager of Data,
Analytics and Reporting has worked in collaboration with other CCOs and OHA in the Health Information Technology Advisory Group (HITAG) to provide constructive feedback on CCO needs in order to advance HIT in Oregon. Additionally, our Chief Medical Officer (CMO) serves on the Jefferson Regional Health Alliance where we partner to create collaborative HIT solutions across multiple counties.

**Continual Advancement of our Local HIT Strategy.** We are committed to adopting and promoting HIT tools across all provider types as part of our local HIT strategy, such as advancement of the Emergency Department Information Exchange (EDIE) and PreManage adoption. For example, our CEO and CMO actively participate in the Oregon Health Leadership Council (OHLC) where Trillium collaborates with other CCOs to develop best practices and use cases for HIT tools, such as EDIE/PreManage, to improve the quality of care and the flow of health information across providers and systems of care.

**Leveraging Best Practices and Lessons Learned from Affiliate Health Plans.** We also leverage the experience of our parent, Centene Corporation (Centene), and the best practices of our affiliate health plans. We participate in a monthly forum with our affiliates to pose questions, share best practices, and address current HIT issues. These forums offer a platform to learn about local, State, and national Health Information Exchange (HIE) trends, standards for clinical data exchange, and strategies for provider adoption of HIT tools.

We are committed to advancing HIT across Oregon if the opportunity presents itself and would be honored to serve on the HIT Commons Governance Board and advance HIT in Oregon.

**B. SUPPORT FOR EHR ADOPTION**

Electronic Health Records (EHRs) are foundational to continued healthcare transformation allowing Providers to better participate in Care Coordination, contribute clinical data for population health efforts, and engage in Value-Based Payment arrangements. The new CCO Contracts will build on current CCOs’ success in increasing EHR adoption rates for physical health Providers by increasing attention to EHR adoption by behavioral and oral health Providers. OHA does not require Providers to use any particular EHR product. Choosing an EHR product is a business decision for the Provider.

OHA expects CCO activities to lead to overall improvements in rates of EHR adoption. CCOs will set their own targets, choose where to focus their efforts, and decide how best to remove barriers to EHR adoption based on the needs in their communities. OHA expects that CCOs will set targets keeping in mind their Provider Networks. CCOs with more dispersed Provider Networks that may include many smaller Providers (who may face greater barriers to EHR adoption) may set more modest targets.

Please refer to the following link for information on related state programs:

**Medicaid EHR Incentive Program:** [https://www.oregon.gov/oha/HPA/OHIT/Pages/Programs.aspx](https://www.oregon.gov/oha/HPA/OHIT/Pages/Programs.aspx)

**1. EVALUATION QUESTIONS**

For each evaluation question, include information on Applicant’s current operations, what Applicant intends to arrange by the Contract Effective Date, and Applicant’s future plans. When answering the evaluation questions, please include in a narrative as well as a roadmap that includes activities, milestones and timelines.

Trillium currently has or will have by the dates documented below, all HIT capabilities discussed in this section, Attachment 9.B, and we will support all requirements in Oregon Health Policy Board (OHPB) Policy Recommendation #33 in addition to requirements outlined in the Sample Contract.

**SUPPORTING EHR ADOPTION AMONG ALL PROVIDER TYPES**

We support all providers in both adopting and meaningfully using EHRs. We will leverage our *Provider Partnership Management Team* to meet with providers to continually foster the use of EHRs and HIE while allowing for the varying capabilities of providers. We meet providers where they are, technologically, and encourage providers to use EHRs and HIE for data submission, quality metrics, and care gap closures so that providers connect and stay connected with us and share in the ongoing cost savings. For providers who have not
yet adopted EHR technology, we offer online member health records accessible via secure web portals for providers and care teams, as well as for members, enabling our no wrong door approach. See below: 

*Figure 9 Available Provider Supports and HIT Solutions Strategy*

**HIT Solutions**
- Health Information Exchange (HIE)
- Collective Medical PreManage / EDIE
- Multi-Payer Market Driven Portal (Care Gaps)
- Trillium Supplied Hot Spotter Reports
- Trillium Provider Portal and Community Partner Portal

**Provider Supports**
- Monthly Innovators’ Collaborative
- Provider Focused Communications
- Provider Engagement Visits and Contact
- Provider VBP Incentives
- HIT Liaison Support

**HIT Roadmap.** Per RFA Addendum 5, Question & Answers 87 and 88, and Addendum 8, Question & Answer 36, please see *Att. 9 Draft HIT Roadmap*, which summarizes in graphical and tabular format the activities, milestones, and timelines we discuss in Attachment 9, including activities in our existing Service Area as well as our proposed Service Area. We look forward to collaborating with OHA to refine our plans in alignment with OHA’s goals for CCO 2.0. Our HIT Roadmap will guide our activities to address EHR and HIE adoption and usage rates, as well as information supports for our VBP initiatives among PH, BH and OH providers. We continue to advance EHR adoption activities among PH providers by collecting data, incentivizing, identifying, and engaging providers as discussed above. We will identify PH provider champions within our provider community who can help share best practices and lessons learned, in order to provide transparent and accessible information to the provider community on HIT.

**a. How will Applicant support increased rates of EHR adoption among contracted physical health Providers?**

**Current Operations.** We invest in HIT to support increased rates of EHR adoption for PH providers through activities such as:

- Introducing web-based clinical tools including member care gap reports, Emergency Department (ED) and disease management alerts, online health records and shared care plans, and member panel rosters with summary clinical indicators.
Encouraging the adoption of EHRs among providers, which has allowed us to capitalize on an increasing amount of resulting HIE using a variety of State and local collaboratives, provider partnerships, and technology suppliers.

Implementing connectivity to EDIE/PreManage and integrated Admission, Transfer, Discharge (ADT) data feeds into our workflow and successfully promoted adoption among our providers. EDIE/PreManage alerts our providers to events related to Trillium members and displays utilization and ED activity for their Trillium member panel.

Increasing data sharing with providers through our Hot-Spotter Report (Hot-Spinner), a regularly updated report of all members with risk scores, total cost of care, as well as other data elements related to behavioral health (BH) and Social Determinants of Health and Health Equity (SDOH-HE) and Long-Term Care (LTC) information. This data sharing allows providers to reduce duplicative services and be alerted to and address issues a member may be facing in between visits.

Establishing our Innovators Collaboratives, a monthly forum bringing together Physical Health (PH), BH, Oral Health (OH), social service, and community-based organizations, as well as local school districts, Traditional Health Workers (THWs), Community Advisory Committee (CAC), and Rural Advisory Committee (RAC) members to learn about and share experiences on HIT topics.

As a result of these efforts, we have seen improvements in Care Coordination as well as improved CCO metric outcomes and HEDIS scores. For example, in 2017 (most recent reporting year), we surpassed 16 of our 18 CCO Incentive Metric targets. Additionally, Trillium has been able to lower costs due to reductions in duplicative tests, by alerting providers to address health issues before they become major and costly conditions. Based on experiences like this, we know that the key to accelerating adoption and meaningful use of technology solutions is to offer providers the ability to receive actionable information, displayed in a manner the provider needs (e.g. at the point of care), while also supporting automated workflows that relieve costly administrative burdens for providers. Our EHR and HIE initiatives not only incentivize providers to connect with us, but are also focused on improving meaningful use with targeted initiatives such as:

- Increasing the adoption of EDIE/PreManage
- Promoting Care Coordination and sharing of health information among members of the interdisciplinary care team through expanding the adoption and use of HIE
- Tracking and monitoring the use of EHRs by providers
- Support providers in the adoption of Value-Based Payment (VBP) arrangements

By Contract Effective Date. We will implement the following:

Enhanced Policies and Procedures. We are enhancing our policies and procedures related to EHR/HIE usage data collection among all provider types. Our HIT Liaisons will coordinate our HIT supports for Care Coordination, quality, provider HIE/EHR engagement and reporting, and VBP initiatives. HIT Liaisons will educate providers on the benefits of EHRs and HIE, and will develop, implement, and analyze the annual EHR/HIE survey. Our annual EHR/HIE survey will allow us to meet all of OHA’s monitoring and reporting requirements across all provider types and will inform how we engage providers and promote the use of EHRs.

Setting Targets to Promote Interoperability. Knowledge gained from provider engagement and from EHR data collection activities will be the foundation on which we will set EHR adoption targets annually for all provider types. By Contract effective date, we will set EHR adoption targets for all provider types around both increasing the number of providers using EHRs and increasing providers’ meaningful use of EHRs. In addition to setting targets around OHA HIT requirements, we will begin to incorporate CCO 2.0 recommendations, including patient access to electronic health information. After targets are set, our team will develop a plan for increasing adoption based on provider engagement insights from the previous year. This same process of
gleaning insights, led by our HIT Liaisons, will be replicated annually and in turn inform the strategy for the engagement of each provider type (PH, BH, and OH).

**Future Plans.** We will work with all provider types through an ongoing process of:

- **Assessing connectivity capability** of providers and their EHR investments
- **Mobilizing teams to conduct outreach** and support providers in ways that reflect the assessment to reach EHR adoption goals
- **Monitoring and reporting the progress** toward EHR adoption goals

This process will allow us to better understand and address barriers to adoption and to implement tailored strategies that address obstacles experienced by providers. Trillium will continue to support all of our providers with varying HIT needs.

For example, we will support PH providers in EHR adoption and utilization by:

- **Incentivizing Providers.** We will incent providers to adopt EHRs by encouraging advancement through the patient-centered primary care home (PCPCH) tiers, which require providers to adopt EHRs as they progress along the continuum and coordinating our EHR/HIE promotion efforts with our VBP strategy.
- **Collecting Data.** We use face-to-face site visits, phone calls, Public Use Files, and provider surveys to collect provider EHR information. This information will be entered into our Provider Data Management System (PDM) where the data can be used for annual reporting to OHA (e.g. data around EHR adoption, vendor, and technology needs).
- **Identifying Providers.** We will identify providers’ use of EHRs during routine provider contact (e.g. service inquiries, site visits) and provider training sessions, where we engage them to ensure they are aware of HIT resources available to them. We will continue to use existing data we receive to identify EHR use (e.g. through analyzing data sent from our Pharmacy Benefit Manager (PBM), which contains information on use of e-prescribing, etc.). Monitoring e-prescribing allows us to identify prescribers using traditional paper or fax prescriptions and to help them move along the technology continuum.
- **Engaging Providers.** We will tailor our communication efforts based on whether providers are using an EHR, and the level of HIE they are using to inform how we engage providers with education, tools and resources to encourage meaningful EHR/HIE use.

**Educational Tools.** Our **Provider Partnership Management Team** will engage providers through the use of site visits and will regularly host monthly Innovator Collaboratives, where topics like best practices for Certified EHRs can be shared with provider groups. We will tailor communication to providers using Provider Email Alerts powered by our email notification service. For example, our Provider Email Alerts will contain HIT topics such as the most recent developments in EHRs and HIE (including new guidance from OHA as well as HHS), how to choose an EHR if the provider does not yet use one, the importance of EHRs and HIE in enabling providers to take on VBP arrangements, and the necessity of EHRs to progress along the PCPCH continuum.

**Web Resources.** Providers will also have access to our **Provider Resource Center** available on our provider website, which will include a well-organized, searchable compendium of best practice documentation and tools to help providers with HIT challenges. To promote the Provider Resource Center, we will include information in provider welcome packets we issue to our newly contracted providers in our proposed Service Area. We will also make initial provider visits within 30 days of contracting with new providers and inform them of our EHR and HIE resources. Finally, we will send cursory information with web links via email to our providers so that they can understand available what tools we are making available to them.

**Setting Targets to Promote Interoperability.** To date, our data collection efforts on providers’ EHR adoption have demonstrated high adoption rates among PH providers in our current Service Area. Through this process, we found that the biggest barrier to increased use of EHR technology was identifying meaningful use cases. We have taken that feedback to go beyond adoption incentives and increase our focus on new use cases for
both EHR use and HIE connectivity. Our provider engagement efforts and tools will be continuously refined to respond to provider pain points and identified barriers to adoption.

**b. How will Applicant support increased rates of EHR adoption among contracted Behavioral Health Providers?**

**Current operations.** Trillium supports Behavioral Health provider EHR adoption by:

- **Collecting Data on Provider EHR Use.** In the past year, we conducted surveys on EHR and EDIE/PreManage use with our contracted BH providers. We found that as of 2018, over 80% of BH agencies in our current Service Area use EHRs. We will continue to collect data around BH provider EHR use, as we do today for PH providers to inform our efforts and strategies to increase adoption.

- **Identifying and Engaging Providers.** PH and BH operations are integrated at Trillium, so identification and engagement of BH providers are aligned to that of our PH providers.

- **Supplying data to BH Providers.** We provide BH providers with our Hot-Spotter Report in a data format that providers can load into their HIT to assist in care coordination and stratification. We also make our Provider Portal available to our BH providers, allowing secure access to member administrative, clinical, and demographic data.

**By Contract Effective Date.** We will implement the following:

- **Enhancing Policies and Procedures.** We are currently enhancing our policies, procedures and tools for EHR/HIE data collection with the goal to coordinate processes and support the flow of information among all provider types, including BH.

- **Setting Targets to Promote Interoperability.** Targets will be set in the same manner across all provider types. Knowledge gained from provider engagement and from EHR data collection activities for BH providers will be the foundation on which we will set EHR adoption targets annually for BH providers. After BH targets are set, we will develop a plan for increasing BH adoption based on insights from the previous year.

- **Future Plans.** Our HIT Roadmap will guide our activities to address provider EHR adoption rates among BH providers. We will utilize a similar EHR strategy for BH providers as we do for PH providers. Upon Contract start date, we will continue to advance EHR adoption activities among BH providers by collecting data, identifying providers, and engaging providers. Throughout our proposed Service Area, we will coordinate our data collection and provider engagement efforts with the Local Mental Health Authority (LMHA) in each respective county. We will also identify BH provider champions to help share best practices and lessons learned.

**c. How will Applicant support increased rates of EHR adoption among contracted oral health Providers?**

**Current Operations.** We work with our four Dental Care Organizations (DCOs) to monitor EHR/HIE adoption by their contracted OH providers (and have Letters of Agreement in place for Clackamas, Multnomah and Washington (Tri-County Region). Trillium maintains a strong partnership with our DCO partners that enables us to support OH providers in a similar manner through:

- **Collecting Data.** We collect data on EHR and HIE adoption and barriers to adoption which enables us to respond with appropriate provider engagement activities.

- **Identifying and Engaging OH Providers.** We share our Hot-Spotter Report with all DCOs. This information acts as an added incentive to facilitate EHR adoption, as this data capitalizes on their own EHR investment.

**By Contract Effective Date.** We will use the same flexible approach to support EHR adoption among OH providers as we do for PH and BH providers.

- **Enhancing Policies and Procedures.** We are currently defining and enhancing policies, procedures and tools for enhanced data collection to establish a coordinated process among all provider types.

- **Setting Targets for EHR Adoption and Meaningful Use.** Targets will be set in the same manner across all provider types. Knowledge gained from provider engagement and from EHR data collection activities for OH
providers will be the foundation on which we will set EHR adoption targets annually for OH providers. After OH targets are set, we will develop a plan for increasing OH adoption based on insights from the previous year. **Future Plans.** Our HIT Roadmap will guide our activities to address provider EHR adoption rates among OH providers. We will utilize a similar EHR strategy for OH providers as we do for PH and BH providers. Upon the Contract start date, we will continue to advance EHR adoption activities among OH providers by incentivizing providers, collecting data, identifying providers, and engaging providers. We will continue to pay higher reimbursement rates to DCOs who support OH providers to use EHRs. We will also identify OH provider champions to help share best practices and lessons learned.

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?

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?

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?

**IDENTIFYING BARRIERS TO EHR ADOPTION FOR ALL PROVIDERS**

We are leader in EHR adoption among our network providers (as compared to other CCOs). As such, we are prepared to assist providers in identifying and overcoming barriers to EHR adoption. To understand baseline EHR adoption in our proposed Service Area, we will deploy an annual EHR adoption survey. Sent to all provider types (PH, BH, OH), this annual survey will allow us to gather data on EHR utilization and barriers faced to help guide our Quality Improvement Committee to define and implement tailored strategies for action. Through our HIT Liaisons and Provider Partnership Management Team, we will ensure support for providers and continue to push toward transformation through HIT innovation. **Initiatives and Incentives to Support Adoption.** Through experience, we have found that a critical success factor to overcoming EHR adoption barriers involves:

- **Encouraging Adoption by Acclimating Providers to Online Clinical Data Use.** By offering providers free access to our online clinical applications (e.g., web portals), providers can demonstrably see the value of EHRs (e.g., care gaps, online patient rosters, medication history, care plans, etc.). This spurs provider interest in obtaining their own EHR for their entire patient panel, and over time, clinical data from additional sources can be obtained via connectivity initiatives, further demonstrating value to providers.

- **Encouraging Adoption through Information Sharing.** By expanding information sharing (e.g. Hot-Spotter Report), our team can have more productive dialogue with providers about promoting EHR adoption and overcoming barriers.

- **Continually Enhancing Our Strategy.** Through an annual cycle of provider engagement and feedback, barriers can be more quickly identified to guide the refinement of planned EHR activities.

**Barriers to EHR Adoption.** The table below illustrates the key considerations we have encountered with our current Provider Network, based on our surveys and meetings to date:

<table>
<thead>
<tr>
<th>Barriers to EHR Adoption</th>
<th>Plans to Address Barriers to EHR Adoption</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of additional, compelling, and impactful EHR use cases germane to specific communities</td>
<td>We plan to add additional BH and OH providers to Collaboratives to establish and normalize EHR use cases and best practices. We have already started this process with invitations sent to several BH and DCO organizations in our Lane County High ED Utilizer Community Collaborative.</td>
<td>PH, BH, OH</td>
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**HELPING PROVIDERS OVERCOMING HIT BARRIERS**

To help BH providers effectively use PreManage, Trillium identified Eugene Pediatrics as a provider champion. We organized a session where Eugene Pediatrics was able to share with other providers their challenges and successes with implementing PreManage.
2. INFORMATIONAL QUESTIONS

a. What assistance you would like from OHA in collecting and reporting EHR use and setting targets for increased use?

Trillium’s HIT Liaisons will be collecting data on EHR use among all provider types by deploying surveys and through provider engagement activities. We recognize OHA’s experience in HIT data collection throughout Oregon and we suggest that OHA share lessons learned from these experiences with CCOs (e.g. to maximize survey response rates). We also recommend that OHA consider facilitating a centralized reporting structure where all CCOs and providers can report on their EHR adoption for better information sharing and strategic HIT planning purposes.

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.

We are currently enhancing policies, procedures and tools to collect OHA required data, including EHR vendor data, through an annual survey that will assess of barriers to EHR use. In addition to surveys, we plan to collect data through face-to-face site visits, phone calls, Public Use Files, our Clinical Advisory Panel, the OHA Office of Health Information Technology, MOUs with Local Mental Health Authorities, AAAs/ADPs, other State and county agreements, relationships with providers, HITAG, and HIT Commons. Over the course of the Contract, we will analyze the survey outcomes with the appropriate partners in order to:

- Report EHR for PH, BH, and OH providers
- Identify strategies to increase EHR adoption for the following year
- Set EHR adoption targets for the following year

Utilizing these data sources will be instrumental to setting appropriate EHR adoption targets for all provider types in our proposed Service Area.
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.

Collecting data and setting targets will be done in coordination with and concurrently among all provider types. We plan to collect data on EHR use among BH providers through an annual survey process and through additional data sources (e.g., Public Use Files, Local Mental Health Authorities, etc.). These activities will inform how we set targets for BH providers.

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.

Collecting data and setting targets will be done in coordination with and concurrently among all provider types. We plan to collect data on EHR use among OH providers through an annual survey process in conjunction with our DCOs, and through additional data sources (e.g., Public Use Files, our Clinical Advisory Panel, etc.) to inform how we set targets for OH providers.

TQS Alignment. As encouraged by OHA, we align our HIT activities with our Transformation Quality Strategy (TQS), and our above described activities for PH, BH and OH EHR Usage reporting are aligned with Component 5a: Reporting on EHR Measures in our 2019 TQS.

C. SUPPORT FOR HEALTH INFORMATION EXCHANGE (HIE)

In this document, HIE refers to the activity of sharing health information electronically (not a specific HIE tool or organization). Tools for health information exchange (HIE), are foundational to continued healthcare transformation, allowing Providers to better participate in Care Coordination, contribute clinical data for population health efforts, and engage in Value-Based Payment arrangements. The new CCO Contracts will build on current CCOs’ success in increasing HIE access for physical health Providers by increasing attention to HIT access by behavioral and oral health Providers. OHA does not require Providers to use any particular HIE option or tool. Choosing an HIE option or tool is a business decision for the Provider.

CCOs must work to increase the number of physical, behavioral, and oral health Providers with access to HIE that supports Care Coordination. This could include exchanging care summaries, electronic Referrals, and other sharing that supports Care Coordination. Supporting the exchange of clinical information between physical, behavioral, and oral health is fundamental to the coordinated care model but can be challenging, especially given restrictions around sharing substance use treatment data. CCOs may elect to focus on supporting HIE for specific use cases or users, such as electronic Referrals, or shared care plans for high-need patients. CCO support for access to HIE for Care Coordination could include such things as: providing a rubric to help Providers assess their HIE needs and select HIE tools, providing TA to Providers in selecting HIE tools, hosting a collaborative to bring Providers together to talk about their experiences with HIE tools, providing financial incentives for adoption of HIE tools, or paying for subscriptions to HIE tools.

In addition, CCOs must ensure their contracted Providers have access to timely Hospital event notifications. Hospital event notifications are electronic messages that notify a Provider or CCO that their patient or Member has been admitted to, discharged from, or transferred within a Hospital or Emergency Department. Unlike claims data, admit, discharge, and transfer data can be made available in near-real time. “Timeliness” refers to near-real time availability. CCOs must also use Hospital event notification tool(s) to inform their own Care Coordination and population health management activities. CCOs have the option to use, and provide Providers access to, Hospital event notifications via the subscription to the statewide EDIE/PreManage tool, or any other tool or resource that ensures contracted Providers have access to timely Hospital event notifications. OHA expects CCO activities to lead to overall improvements in HIE access and, ultimately, HIE use. CCOs will set their own targets, choose where to focus their efforts, and decide how best to remove barriers to HIE access and use based on the needs in their communities. OHA expects that CCOs will set targets keeping in mind their...
Provider Networks. CCOs with more dispersed Provider Networks that may include many smaller Providers (who may face greater barriers to HIE access) may set more modest targets. Please refer to the following links for information on related state programs:

- HIE Onboarding Program: https://www.oregon.gov/oha/HPA/OHIT/Pages/HIE-onboarding.aspx

1. EVALUATION QUESTIONS (RECOMMENDED PAGE LIMIT 8 PAGES)

For each evaluation question, include information on Applicant’s current operations, what Applicant intends to arrange by the Contract Effective Date, and Applicant’s future plans. When answering the evaluation questions, please include a narrative as well as a roadmap that includes activities, milestones and timelines.

Trillium currently has or will have by the dates documented below, all HIT capabilities discussed in this section, Attachment 9.C, and we will support all requirements in Oregon Health Policy Board (OHPB) Policy Recommendation #33 in addition to requirements outlined in the Sample Contract.

CURRENT OPERATIONS TO INCREASE HIE FOR CARE COORDINATION

Although HIE access needs vary across provider types, provider size and location, our strategy to increase HIE access follows a consistent approach. We continually:

1) **Identify** use case opportunities to meaningfully impact Care Coordination with providers through Collaboratives (e.g. our Lane County ED High Utilizers Community Collaborative), data collection coordinated with our VBP strategy, and through the distribution of clinical data to our PH, BH, and OH providers (e.g. our Hot-Spotter Report).
2) **Assess** connectivity capabilities of providers and their EHR investments.
3) **Mobilize** our providers with outreach and support to power new HIE enabled use cases.
4) **Monitor** the usage of HIE initiatives which we do today through surveys and data collection.

**HIT Designed for HIE Applications.** Our HIT (supplied to us by our parent Centene) supports over 14 million members nationwide, including over seven million beneficiaries in coordinated care and managed Medicaid programs. We interface with HIE organizations, hospitals, and other providers through the clinical data exchange component of our HIT. For example, we currently receive and distribute Admission, Discharge and Transfer (ADT) data and our HIT also supports HHS Office of National Coordinator (ONC), standards-based data interchanges, including Health Level Seven (HL7), Fast Health Care Interoperability Resources (FHIR), Continuity of Care Document (CCD) exchange, and other standardized health information transactions.

**Mobilizing Trillium’s EHR/HIE Strategy.** Our EHR/HIE and data collection activities are directed by our HIT Liaisons, who coordinate our strategic HIT supports for Care Coordination, quality, provider EHR/HIE engagement & reporting, and VBP initiatives. Trillium’s EHR/HIE initiatives will continue to follow our **Identify, Assess, Mobilize and Monitor** framework, and we continually update our inventory of EHRs and HIE uses by our PH, BH, and OH providers (the latter through our relationship with our four DCOs). Please see **Att. 9 Draft HIT Roadmap**, for a timeline and summary of activities discussed in this Attachment 9, including the HIE and Hospital Event Notification components of our Draft HIT Roadmap.

**a. How will 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.

INCREASING HIE FOR CARE COORDINATION

**Current Operations.** The informatics heart of our enterprise HIT is our Centelligence® analytics platform. Centelligence integrates member demographics, and PH, BH, SDOH-HE, pharmacy claims, lab test results, health screenings and assessments; to produce utilization data, care gaps and predictive health risk scores. Each month we share key...
insights from this data via our Hot-Spotter Report (Hot-Spotter) which we securely transmit to our PH, BH, and OH providers to inform care coordination and population health activities. The Hot-Spotter is a list of all members with prospective relative risk scores, ED and inpatient visits, total cost of care, and indicators for conditions such as severe and persistent mental illness (SPMI), as well as several other data elements related to BH and SDOH-HE, including visit history for mental health and our prospective BH Risk score (based on member demographics and BH conditions in the past year). We send the Hot-Spotter to PCPs and DCOs for their assigned members, and to BH providers for members who were last seen for BH outpatient services. By providing PH, BH, and OH utilization and contact information, along with our Care Coordinator information, the Hot-Spotter enables cross disciplinary Care Coordination. Our secure Centelligence-powered Provider Portal also supports access to HIE. For example, the Member Health Record feature allows providers to view clinical history on their members, view claims, lab results, individualized care plans (ICPs), eligibility history, and completed assessments.

By Contract Effective Date. We will orient providers in our proposed Service Area as a part of our onsite provider orientations and webinars for new providers. Our education and training for new providers entails a detailed review of Hot-Spotter contents, how to use the report, and implementation and testing for electronic transmission.

Future Plans. We will implement the following:

△ **New Data Elements to Hot-Spotter Report.** In 2019, we are including information on members without annual office visits as well as the expansion of the SDOH-HE data elements we currently report in the Hot-Spotter (based on ICD-10 “Z” diagnoses claim codes). We are also planning to incorporate SDOH-HE in our risk scoring and population health stratification and will offer this information in the Hot-Spotter. We will also include most recent dental visit information, aligning with our 2019 Transformation Quality Strategy (TQS) Component 1a. Access: Utilization of OH Services.

△ **Incorporate SDOH-HE Data into Initial Risk Screening (IRS).** We have also included SDOH-HE into our IRS, which we will incorporate into our population health risk stratification.

△ **Offer Our Community-Based Portal.** In 2020, we will offer our role-based Community Partner Portal to authorized provider users across the system of care, for access to shared member care information to support care coordination activities and non-duplication of services. Users can check member eligibility for covered services, submit documents, view care alerts, a member’s Individualized Care Plan, and submit and view associated notes.

**ENGAGING PROVIDERS WITH BI-DIRECTIONAL HIE FOR CARE GAP**

Current Operations. In June 2018 Trillium teamed up with a market driven Portland based technology company offering a **Multi-Payer Market-Driven Portal** to enable online access for our PH providers to Hierarchical Condition Category (HCC) and HEDIS care gaps in support of our MA program. Every two weeks, we send care gap information from our HIT to the Multi-Payer Market-Driven Portal’s cloud platform for each member in every provider’s assigned member panel. Our providers can then access their respective dashboards, visualize their care gap closure status across members, and close these gaps electronically.
Figure 9 Multi-Payer Market-Driven Portal

Using the Multi-Payer Portal, our PH providers can review care gaps, and close out gaps with Trillium by electronically attaching substantiating documentation.

In this example, the provider needs to review a patient's chronic condition.

The Multi-Payer Market-Driven Portal has been popular with providers, since they can access data from multiple payers in one location. In our first six months of offering the system, PCPs representing 95% of Trillium’s CCO assigned membership accessed the portal. On 2/1/2019, we began a clinical quality program with our Medicare providers, incenting them to access the Portal and close care gaps. The result: we’ve seen a 275% increase in our providers’ use of the Multi-Payer Market-Driven Portal as measured by the care gaps they are accessing and closing.

By Contract Effective Date. We are currently in the process of expanding our use of the Multi-Payer Market-Driven Portal to support our OHP program, including support for enabling providers to monitor and close any care gaps directly related to OHA’s 2019 CCO Incentive Measures. In addition to our current Service Area, we will implement this solution for providers in our proposed Service Area, many of whom already use this Multi-Payer Market-Driven Portal.

Future Plans. In 2020, we are augmenting our predictive risk identification capabilities through our partnership with Interpreta, Inc., an informatics firm focused on delivering population and single member care gaps on a daily basis, allowing our providers to prioritize care gaps, including those gaps comprising the OHA’s 2019 CCO Incentive Measures. We will make Interpreta care gap information available through the Multi-Payer Market-Driven Portal, available daily in near real-time to our providers.

COORDINATING CARE THROUGH SHARED INFORMATION

Current Operations. Today, all Oregon hospitals have access to the Collective Medical EDIE service, and Trillium uses and promotes use of Collective Medical’s PreManage, with all our providers. Using PreManage, our PH providers are alerted to hospital events related to their Trillium members, and receive aggregate utilization, as well as discharge and ED activity for their Trillium member panel. Our Quality Improvement (QI) Team hosts monthly meetings with our key providers to discuss best practices, including the use of PreManage.

Facilitating Provider PreManage Use through Collaboration. In 2018 Trillium and the OHLC, along with community health providers launched the Lane County ED High Utilizers Community Collaborative. PCPs in this Collaborative serve over 60% of our CCO members, and we continue to invite additional providers, including BH, OH, and other providers. The goals of this Collaborative include identifying responsibilities and processes for Care Coordination, reduction in unnecessary ED utilization, and improved care transition through use of PreManage.
Trillium’s Role. Through the Lane County ED High Utilizers Community Collaborative, we are facilitating agreement on ways that Collaborative participants communicate with each other via PreManage, for example: developing agreement on what is entered in PreManage care plans (i.e. care history, care guidelines). Our Data Analytics Team helped the Collaborative identify a target population by preparing analyses based on PreManage Medicaid data and stratifying our members utilizing the ED. After reviewing the information, the Collaborative identified members with 7-12 ED visits in the past 6 to 12 months. The Collaborative will focus on this shared patient cohort to jointly learn how to use PreManage to enhance communication and decrease ED utilization.

Other Collaboratives. The Lane County ED High Utilizers Community Collaborative is modeled after other workgroups across Oregon that have succeeded in lowering ED utilization rates, and in fact Trillium, through our Medicare Advantage program, has been actively engaged in the Portland Metro Area Collaborative, and has recently been invited to join the Southern Oregon Collaborative. While all of these initiatives vary in their population focus (e.g. low-income homeless population in Portland), they all feature the advanced use of information-based workflows using HIE through PreManage.

By Contract Effective Date. As we have in our current Service Area, we will enlist additional PH providers throughout our proposed Service Area to utilize PreManage. We have already begun planning for this expansion with our partner, Collective Medical. In addition, throughout our proposed Service Area, we will engage in efforts similar to the Collaboratives described above. The relatively high penetration rate of PreManage usage throughout Oregon should afford a seamless rollout. As we are in our current Service Area, we will be fully engaged with our proposed Service Area and providers who have demonstrated similar collaborative efforts or advanced application of EDIE/PreManage.

INCORPORATING LANE COUNTY EMERGENCY MEDICAL SERVICES (EMS)

Current Operations. Today, we work with the Fire Chief in Eugene/Springfield, who shares data on Trillium members receiving EMS to better understand and target cohorts of high ED utilizers. In 2019, we plan to use this information to configure notification rules in PreManage and refine targeted interventions for members who need EMS. We are also in the process of enabling EMS access to PreManage, to allow EMS to participate in member care plans and medical history.

Future Plans. During 2019 and 2020, we will seek to expand the number and type of PH participants in the Collaborative for our proposed Service Area, including additional local Fire/EMS Departments.

ACCESSING EHRS FOR CARE COORDINATION

Current Operations. Authorized Trillium Care, Utilization, and Quality Management staff access the EHRs of twenty of our largest hospital and PCP groups and clinics in a fully HIPAA compliant manner. On the PCP side alone, our staff have authorized access to EHR data for approximately 50% of Trillium membership. We use this EHR access to support concurrent review, discharge planning, HEDIS data collection, care gap closures, and clinical quality improvement, as well as support of grievance and appeal processes. Information from the EHRs is incorporated in TruCare, our care management system.

By Contract Effective Date. For our proposed Service Area, we will seek to engage similar arrangements with key hospitals and clinics, via our HIPAA compliant administrative processes.

Future Plans. Over the course of the Contract, and with the cooperation of providers, we will transition the manner in which we access EHRs today from direct online access to HL7 and FHIR based data access via a Community Based HIE. This approach allows for incorporation of EHR data (including care plans based on CCDs), directly into our HIT for enhanced workflows, reporting, and Care Coordination. Our affiliates use our HIT in other state Medicaid plans to use CCDs for member transitions from one CCO to another. We are currently assessing alternative strategies, and will begin implementation in 2020, informed by both HITAG and
HIT Commons. We are also assessing the collection of SDOH-HE data from provider EHR systems through an HIE, including the receipt of SDOH-HE data (e.g., for identification of homeless populations and indications of food insecurity via clinical codes and text search).

**ACCESSING HEALTH INFORMATION VIA SECURE WEB PORTAL**

**Current Operations.** We also offer all of our PH providers’ access to Trillium’s secure web-based Provider Portal, enabling an alternative ‘no wrong door’ approach for health information sharing. The health information available in our Provider Portal is sourced from the same Centelligence analytics platform that powers our other health sharing applications (e.g. the Multi-Payer Market-Driven Portal) and includes online member level clinical and demographic data such as PH, BH, and prescription drug utilization, care gaps, health risks, ICP, and more.

**Future Plans.** In early 2019, Trillium partnered with Simple Screens, Inc., an Oregon based company that integrates PH, BH, OH, and social screening questionnaires, including the widely adopted Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) assessment, to identify patient concerns and share this information across organizations. Screening data is housed in Simple Screen’s HIPAA compliant enterprise scale cloud technology, and is accessible by authorized PH, BH, and OH providers as well as CCOs and other community health stakeholders, via a secure web portal or HL7 interface to the provider’s EHR. During 2019, we are piloting Simple Screens to promote the application of SDOH-HE screenings with several of our key PH and BH providers, who currently serve over 25% of our OHP members in our current Service Area. We plan to integrate the SDOH-HE data collected via the Simple Screens mobile system into TruCare, our Enterprise Data Warehouse (EDW), and Centelligence to support population health analytics and Care Coordination. Results of this pilot will inform our efforts to refine potential rollout activities throughout our proposed Service Area, in support of our 2019 Transformation Quality Strategy (TQS) Component 5d: Patient Engagement.

**b. How will 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.**

**EMPOWERING BH PROVIDERS WITH KEY HEALTH RISK INDICATORS**

**Current Operations.** We send the Hot-Spotter every month to our BH providers for members who were last seen for BH outpatient services. We also send a customized version of the Hot-Spotter to Lane County’s Type B Area Agency on Aging (AAA).

**By Contract Effective Date.** Similar to our approach for PH providers, and as we have done in our current Service Area, we will orient, train and implement Hot-Spotter distribution to our BH providers as well as the LMHAs in our proposed Service Area.

**Future Plans.** We are planning the incorporation of new data elements to be contained within the Hot-Spotter for all our providers receiving the Hot-Spotter. We are planning to include information on members without annual office visits as well as the expansion of the SDOH-HE data elements.

**COORDINATING CARE THROUGH SHARED INFORMATION**

**Current Operations.** In 2018, we contacted our network BH providers to determine if they were using PreManage, what barriers they had, and if help was needed. We arranged for PreManage classes for BH providers, and today approximately 35% of our network BH providers (who serve 60% of our Medicaid members recently treated at a mental health clinic) have PreManage access. We have also used the “lessons learned” from a key PH provider (Eugene Pediatrics) to help orient our BH providers. Two of our key BH partners, Lane County Trillium Behavioral Health and Options Counseling and Family Services are members of the Collaborative.
By Contract Effective Date. As we did in our current Service Area, we will enlist additional BH providers in our proposed Service Area to be on boarded to PreManage. We have already begun planning for this expansion with our partner, CMT. In addition, for any additional counties that we are awarded through this RFA, we will engage in efforts similar to the Collaborative above.

Future Plans. During 2019 and 2020, as part of an annual surveying process (similar to our 2018 initiative) we will seek to expand the number of BH participants using PreManage and participating in the Lane County High ED Utilizer Community Collaborative.

HIE IN SUPPORT OF BEHAVIORAL HEALTH HOME PROGRAM

Current Operations. Trillium, together with Lane County Health and Human Services, issued an RFP in 2018 for our Intensive Community Care Management (ICCM) program. ICCM focuses on members who have five chronic illnesses and at least one BH diagnosis. We are working with one of our Behavioral Health Homes and Center for Family Development (CFD), to deliver integrated PH, BH, and OH services provided onsite and with a multidisciplinary team to provide holistic care to our ICCM members. A critical requirement of the ICCM program is that providers maintain member demographic information (including accurate phone and address information), SDOH-HE, and other timely quality improvement data in their HIT and securely share that data with Trillium. We developed a secure data interface with CFD for the regular exchange of this ICCM program Information, helping to support our 2019 Transformation Quality Strategy (TQS) Component 6: ICCM Referrals for OH Care and Component 10: Quality Metrics related to Members with Special Health Care Needs.

Future Plans. During 2019, we are measuring the health and cost outcomes of our ICCM program, to inform our refinement/expansion of ICCM in our proposed Service Area. We will be fully supportive of programs such as ICCM in other counties that have demonstrated improved care and coordination to high-needs members.

SUPPORTING SDOH-HE INITIATIVES THROUGH DATA SHARING

Current Operations. The Frequent User System Engagement (FUSE) program is a partnership with Lane County, Laurel Hill Center who supplies our members with Assertive Community Treatment (ACT) services, and ShelterCare: a Eugene based agency supporting the homeless. FUSE is supported by housing navigators and community partners (including Trillium) who engage qualifying people to find a home and address unmet social and health needs, including BH needs and services for members with SPMI, which are very often at the core of FUSE program participant conditions and needs. Using our Centelligence analytics, we produce a FUSE Potential Enrollee List which we send to Lane County quarterly to identify Trillium members who are candidates for the FUSE program, helping to support our 2019 Transformation Quality Strategy (TQS) Component 11: FUSE Engagement. The County contacts these members for engagement and invitation to participate.

Future Plans. We will engage with additional counties in the Tri-County Region to support programs like FUSE (i.e. transitional housing providers such as Washington County Housing Services).

ACCESSING HEALTH INFORMATION VIA SECURE WEB PORTAL

Current Operations. We offer all of our BH providers’ access to Trillium’s secure web-based Provider Portal, enabling an alternative ‘no wrong door’ approach for health information sharing, and further facilitating care coordination.

Future Plans. In 2020, we will offer our role-based Community Partner Portal to provide authorized users across the system of care, including providers of Mental Health Rehabilitative Services, Personal Care Services and Habilitation Services, access to shared member care information. Users can check member eligibility for covered services, submit documents, view care alerts, view a member’s ICP, and submit and view notes.
c. How will 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.

**EMPOWERING OH PROVIDERS WITH KEY HEALTH RISK INDICATORS**

**Current Operations.** Today we send the monthly Hot-Spotter to our OH providers via our DCOs for their assigned members.

**Best Practice Use of Hot-Spotter Data at Willamette.** In 2015, Trillium awarded a Transformation Grant to Willamette Dental Group DCO (Willamette) to provide Care Coordination services for members with diabetes and OH issues. Willamette configured their HIT data warehouse to receive our Hot-Spotter data directly into their system, which enabled the integration of Hot-Spotter data with their own EHR data from across their dental offices. Willamette was able to use this integrated data to:

- Confirm whether an OH patient had diabetes based on the availability of PH data, and
- Identify members that may have diabetes and contact the member for a dental checkup.

With our guidance, Willamette then expanded their warehouse analytics (using the imported Hot-Spotter data) to identify members with other significant medical, ED, or BH utilization, but with no recent OH visits, to drive outbound calls to the member for a dental checkup and close care gaps.

**EHR Integration.** As another example of how we do and will integrated increased access to HIE for Care Coordination, Willamette also recently developed a data interface into their EHR so that the Hot-Spotter data we send can be electronically loaded and indexed to the appropriate member record in the EHR, enabling the practicing dentist to be alerted to germane PH, BH, or SDOH-HE issues the patient may have while in the dentist’s office.

**By Contract Effective Date.** As we have done in our existing Service Area, we will orient, train and implement Hot-Spotter distribution to our DCOs and OH providers in our proposed Service Area. We will use our experience with Willamette as a best practice approach to guide our efforts across DCOs. As our DCO’s are state-wide organizations, and Trillium has a long-standing positive relationship with all four of our DCO’s in our proposed Service Area, the ability to coordinate, expand, and continue to advance the OH of our members should be relatively seamless and positively received.

**Future Plans.** We intend to incorporate additional data elements in our Hot-Spotter Report, such as information on members without annual office visits. In addition, through our DCO EHR survey activity (already underway), we will target the most prevalent systems in use for potential Hot-Spotter interfaces (sharing the lessons learned by Willamette). We will also enlist and promote the connection of DCOs to the HIE for shared access to PH and BH information.

**Simple Screens.** As another mechanism to increase access to HIE to support Care Coordination and whole person care, we are piloting Simple Screens Inc.’s cloud-based technology to allow HIPAA compliant access by authorized PH, BH, and OH providers to screening results, including SDOH-HE information.

**ELECTRONIC REFERRAL PILOT FOR PH/BH/OH PROVIDERS**

**Future Plans.** We will pilot a secure, cloud based electronic referral tool (E-Referral tool). The E-Referral tool will facilitate closed loop referrals, enabling “referred from” and “referred to” providers to be aware of the outcomes and results of any referral. We will be piloting an E-Referral tool with an engaged provider. And based on successful pilot results, we will implement the E-Referral tool with other PH, BH, and/or OH providers.

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d. How will 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.
Current Operations. We currently promote the use of PreManage’s Hospital Event Notifications among Primary Care Providers (PCPs) and most of our high volume providers are using PreManage. We are also driving PreManage usage as part of our Collaborative. In addition, we also issue notifications of hospital and Skilled Nursing Facility (SNF) admissions and discharges to providers using the Multi-Payer Market-Driven Portal discussed above.

By Contract Effective Date. Our HIT Liaisons will work with our internal departments, and in coordination with HIT Commons, to develop web-based resources to assist providers in their choice of Oregon programs to increase use of Hospital Event Notification services. Our Provider Resource Center will also have information on ways in which we can assist providers to connect to CMT for Hospital Event Notifications, and guidance on OHA’s HIE Onboarding Program for connectivity for ADT services.

Future Plans. Throughout the Contract period, our HIT Liaisons will host HIE forums in every county we operate as a CCO and share feedback with HIT Commons. For our larger provider groups and health systems, we will offer discussion and demonstration of our own example of ADT integration into TruCare using Collective Medical.

e. How will 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.

Current Operations. Approximately 35% of our BH network providers (representing 60% of our BH utilizing members) have access to Hospital Event Notifications via EDIE and PreManage.

By Contract Effective Date. Our HIT Liaisons will work with our internal departments to develop resources to assist providers in increasing use of Hospital Event Notification services. In addition, as we did in 2018, in 2019 we will contact our BH providers in our proposed Service Area to generate interest in obtaining Hospital Event Notifications via the PreManage service, and (as we did in 2018), facilitate training on PreManage.

Future Plans. Throughout the Contract, we will host forums for BH providers and Local Mental Health Authorities (LMHAs), using results to inform decisions and recommendations we make to HIT Commons and HITAG.

f. How will 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.

Current Operations. In conjunction with our DCOs, we recently surveyed our OH providers for EHR/HIE use. Today, all dental offices (100%) that are a part of our DCO Willamette’s network have access to Hospital Event Notifications via PreManage. Our Advantage Dental DCO operates the Advance Dental Information Network (ADIN), and Advantage Dental is planning on connecting ADIN to a Community Based HIE in Contract year 2020, with access to ADT data for Hospital Event Notifications and potentially other applications. With regards to Capitol Dental DCO, 43% of Lane County dental clinics have access to HIE functionality. We have also begun surveying with our four DCOs (that also cover the Tri-County Region) HIE usage throughout our proposed Service Area.

By Contract Effective Date. With the continued cooperation of our DCOs, we will undertake the same activities for our OH providers as with our PH and BH providers, including extending invitations to key OH providers to join our Lane County and other Collaboratives. We will also work with the two DCOs in our network who do not yet have a plan to support receipt of Hospital Event Notification data, to formulate a detailed strategy for our HIT Roadmap.

Future Plans. Throughout the Contract, our HIT Liaisons will facilitate forums and collaboratives for OH providers through our DCO partners, and use the results to inform decisions and recommendations we make to both HIT Commons and HITAG.
g. How will 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.

INTEGRATING TIMELY HOSPITAL EVENT NOTIFICATIONS

Current Operations. Working with Collective Medical in 2018, we configured our HL7 standards-based HIT to receive ADT Hospital Event Notification data directly into TruCare, our care management system, to automatically drive efficient workflows. We currently support two use cases which capitalize on this integration: Inpatient Admission and Discharge Notifications.

Inpatient Admission Notification. Today, when our HIT receives an Inpatient (IP) Admission event notification, that ADT transaction from the hospital is electronically loaded into TruCare where a series of workflow tasks are automatically generated. When TruCare receives the IP Admission notification, the system creates a pre-populated IP authorization “shell” review request (item 1 in Figure 9.C.B), and places that review request shell into a specific work queue for the appropriate team of utilization management (UM) reviewers to process and complete (item 2). The next available UM reviewer then takes the “review task” from the queue for processing (item 3). This streamlined process relieves administrative burden on our hospitals and maintains data integrity by removing reliance on manual data entry.

IP Discharge Notification. Also, when our HIT receives an ADT transaction indicating an IP Discharge, TruCare automatically updates the member’s IP authorization record with the discharge date and builds a task in a UM work queue for follow-up.

By Contract Effective Date. In 2019, we are introducing new integrated workflows similar to above, in support of ED Hospital Event Notifications, again using an automated feed of real time ADT transactions. When our HIT receives an ED admission ADT transaction, TruCare will automatically build a task for appropriate UM follow-up.

PATIENT COHORT WORKFLOWS

By Contract Effective Date. Our Care Coordination Team is currently designing specific workflows for members with complex conditions, members with frequent readmissions, and members with Serious and Persistent Mental Illness (SPMI). These workflows include notification criteria which in turn are defined by patient cohorts (e.g. “SPMI”, “members with two or more ED readmissions in the last six months”), trigger events (e.g. “ED admission”), and notification rules (e.g. who is to be notified should there be a trigger event). We will use this information for appropriate interventions and for systemic care improvement. For example, we will monitor our HIT and Hospital Event Notification data (both in aggregate and by cohorts) and will work with providers to develop a remediation plan if an ED has many stays longer than 23 hours.

2. INFORMATIONAL QUESTIONS (RECOMMENDED PAGE LIMIT 2 PAGES)

a. What assistance you would like from OHA in collecting and reporting on HIE use and setting targets for increased use?

Participants in OHA HIE Onboarding Program. As another benchmark and tool for CCOs to track HIE use with their provider networks, Trillium believes it would be useful if OHA could share with CCOs lists of
providers participating in OHA’s HIE Onboarding program. We recommend that OHA’s data be lists at the TIN and/or NPI level to enable CCOs to match this information to their own network data.

**Developing HIE Usage Profiles across Oregon.** We suggest that OHA, in its role as co-sponsor of HIT Commons, request from the Reliance eHealth Collaborative, as well as from Collective Medical, HIE usage data across all counties of the State, thus allowing OHA to report to HIT Commons and participating CCOs usage by regions to help inform pragmatic HIE usage baselines (e.g. for rural vs. suburban vs. urban) and corresponding realistic targets.

**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.**

Our HIT Liaisons will issue an annual online provider survey to collect information on EHR/HIE use, including use of EDIE/Pre-Manage, our Hot-Spotter Report, use of the Multi-Payer Market-Driven Portal for care gap closure, participation status in a State based HIE network, and/or other HIE use. Several of our affiliated Medicaid health plans have used this strategy successfully and we will use this as best practice for Oregon. The survey will inform what specific type(s) of HIE the provider uses, which we will in turn report to OHA.

**Quantitative Measures.** To trend and report actual HIE usage to OHA, through our partner, Collective Medical, we will continue to receive HIE and Hospital Event Notification usage data (by provider) on three quantitative rubrics: a) login activity to PreManage, b) frequency of transmission of patient rosters to Collective Medical, and c) update of care plan content for patient records. We currently receive similar utilization statistics by provider from our Multi-Payer Market-Driven Portal technology partner, including logins, care gap access and closure activity. Finally, we directly control the electronic distribution of the Hot-Spotter, and will report to OHA the number of providers we send the Hot-Spotter to, as well as provider receipt acknowledgements.

**Providers Participating in EHR Incentive Programs.** One set of Public Use Files that we use to identify providers ready to participate in more advanced HIE use cases are CMS’ Annual Eligible Professional Recipients of Medicare Promoting Interoperability Program Payments data. We match this CMS data to our Delivery System Network (DSN) files at the NPI level, to help us determine which of our practitioners has received EHR payments through CMS, allowing us to trend this network match over time, as well as identify prospective practitioners who may be willing to connect with us for HIE applications. The number of our providers receiving CMS payments for the Medicare PI program is small (approximately 5% of our network practitioners in our current Service Area), so we also use data from OHA’s Medicaid EHR Incentive Program (also known as Medicaid Promoting Interoperability Program). Approximately 15% of the “Eligible Professionals” (individual practitioner providers) of our network providers in our current Service Area have received CMS or OHA incentive payments, and virtually all of our hospital providers have received these payments.

**Setting Targets.** Each year, our HIT Liaisons will incorporate information from our surveys and usage data, additional OHA information, input from HIT Commons, as well as our own Centene HIE Department, which tracks HIE usage across 32 states. Our HIT Liaisons will then formulate annual HIE targets, including percent of PH providers using HIE and target HIE utilization, and present these targets and supporting rationale to Trillium’s Clinical Advisory Panel for endorsement to our CEO and reporting to OHA via our Annual HIT Roadmap update.

**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.**

We will follow the procedures as previously noted above for our BH providers in collaboration with each of the Local Mental Health Authorities in our proposed Service Area.

**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.**
We will follow the procedures as previously noted above for our Oral Health providers. Our HIT Liaisons will also work collaboratively with our DCO partners to collect data.

D. HEALTH IT FOR VBP AND POPULATION HEALTH MANAGEMENT

CCOs will scale their VBP arrangements rapidly over the course of 5 years and will spread VBP arrangements to different care settings. CCOs will rely on HIT to support these arrangements including administering payments under VBP arrangements, supporting Providers with data needed to manage their VBP arrangements, and managing population health effectively through insight into Member characteristics, utilization and risk. OHA expects that CCOs will have the HIT needed to support increased expectations for VBP arrangements as well as support for population health management. OHA will support CCOs’ use of risk adjustment models that consider social and medical complexity within their VBP arrangements and plans to provide CCOs with technical assistance and collaborative learning opportunities.

VBP AND POPULATION HEALTH HIT CAPABILITIES AND EXPERIENCE

Trillium combines our over 20 years (seven years as a CCO) of local experience in Oregon with the national best practices of our affiliate health plans and best in class HIT tools of our parent company to support VBP arrangements and adoption. Trillium was a founding partner of the non-profit research organization Health Policy Research Northwest (HPRN), which from 2007 to 2012 conducted population health analysis in areas such as SDOH-HE, OH, and specialty care. Our local and national expertise is backed by an interoperable and scalable HIT system and our suite of integrated HIT includes our Centelligence health informatics platform and payment/financial software to support VBP arrangements and population health management. In alignment with OHPB policy recommendation #34, we will leverage our unique blend of local and national expertise combined with our information technology infrastructure to support our VBP arrangements, including the ability to risk stratify populations and manage population health efforts, manage VBP arrangements with contracted providers, and support contracted providers so they can effectively participate in VBP arrangements. Trillium attests that we will have by the dates documented below, all HIT capabilities discussed in this section, Att. 9.D.

1. INFORMATIONAL QUESTIONS: (RECOMMENDED PAGE LIMIT 3 PAGES)

a. If Applicant will need technical assistance or guidance from OHA on HIT for VBP, please describe what is needed and when.

TECHNICAL ASSISTANCE AND GUIDANCE FROM OHA ON HIT FOR VBP

Centelligence includes advanced analytical applications and reporting tools that enable us to support our proposed VBP program, as described in our response to Att. 8 Value Based Payment Questionnaire. However, we recognize that technology is always evolving and as such, we are committed to engaging in collaborative efforts related to data aggregation, electronic clinical quality measures, and other VBP data needs. We will share our best practices and recommendations with OHA, other CCOs, and community partners through existing partnerships such as the HIT Commons and HITAG. To reduce and prevent provider administrative burden, including issues caused by a proliferation of HIT systems, we outline below the areas where we would like to partner with OHA to receive guidance and technical assistance for HIT for VBP:

△ Partnership on how we can incorporate cost and quality information from Prometheus Analytics into our existing dashboards for and arrangements with our provider network. We were pleased to be granted access to Altarum’s descriptions of the logic underlying the Prometheus Analytics tool through this RFA process. We are currently reviewing the parameters with our analytics and clinical experts with the intention to integrate this logic, if appropriate, into our Centelligence population health informatics engine to: analyze episodes of care and potentially augment our VBP models; evaluate provider performance; identify care variations, and improve network efficiency. Disseminating actionable information from Prometheus Analytics to providers also has potential to increase providers’ capacity to excel in VBP
arrangements and conduct population health management. We are requesting guidance from the OHA before the Contract Start Date on how we can partner together to achieve this.

To address SDOH-E, we welcome the opportunity to partner with OHS on how we can best incentivize and encourage population of ICD-10 Z codes on claims and provide education to the provider community. We understand that the OHA intends to explore incentivizing collection of member-level data starting in CY2020 to inform risk adjustment beginning in 2022. Collecting Z codes on claims is one way to support collection of member-level data that captures social complexity which will support CCOs in use of risk adjustment models that consider social complexity in VBP arrangements. We are requesting guidance from OHA before the Contract Start Date on how we can partner together to achieve this.

b. What plans do you have for collecting and aggregate data on SDOH&HE, that may be self-reported or come from providers rather than be found in claims? Can you match demographic and SDOH&HE-related data with claims data?

Initial Risk Screening (IRS). Our IRS tool includes multiple questions designed to measure a member’s social circumstances related to key SDOH-HE areas (e.g., food, housing, safety, employment, etc.). For example, our IRS includes the following type of SDOH-HE assessment questions: “Within the past 12 months, did you worry that your food would run out before you got money to buy more?” Our IRS also incorporates demographic data in alignment with Race, Ethnicity, Language, and Disability (REAL+D) requirements. Assessment data, including the IRS and Comprehensive Assessment, are captured in TruCare. Our Care Coordinators will use the assessment results to assist members in getting needed social supports and resources, through the use of our Trillium Resource Exchange, which is our online database of community resources, also accessible by members, providers, and other Trillium staff. We are also currently piloting health kiosk technology at our affiliate health plans, and pending successful pilot results, will consider a pilot based on successful results. Health kiosks are an additional online venue for members to complete an IRS. Members can also complete the IRS via the secure Member Portal or through their Trillium Member Mobile App, which we will offer as part of CCO 2.0.

PROVIDERS

Shared Health Screenings via Secure Cloud Technology. We are partnering with Simple Screens, an Oregon-based technology company that integrates SDOH-HE screening questionnaires, including the widely adopted PRAPARE tool used by providers in Oregon. We are piloting Simple Screens to promote the application of SDOH-HE screenings with several of our key PH and BH providers, who currently serve over 25% of our OHP members in our current Service Area. We plan to integrate the SDOH-HE data collected via the Simple Screens mobile system into TruCare, and our EDW to support population health analytics and Care Coordination activities and interventions.

Provider EHRs. Trillium is also exploring collection of SDOH-HE data from provider EHR systems through a Community Based HIE network. For example, SDOH-HE indicators can be identified using clinical codes and text search on factors such as food insecurity and homelessness.

Social Service Providers and Community Organizations. We will be offering our interactive Trillium Resource Exchange to connect members/families to community-based services to address SDOH-HE. The Trillium Resource Exchange will provide easy identification of and referral to community resources and social services. Through closed loop referral tracking and coordination with community organizations, Trillium staff will be able to track, trend, and report on members’ SDOH-HE needs and utilization of services across Oregon. Referral tracking data for community resources will be aggregated and tracked within the Trillium Resource Exchange, which includes reporting functions to support population management.

Matching Demographic and SDOH-HE Data with Claims Data. We have the capability today to match demographic and SDOH-HE data with claims data. Our HIT includes our Unified Member View (UMV) system, which validates, integrates, manages, transmits, and reports on all levels of member demographic
Information, including those received via the OHA 834 Enrollment transaction file. UMV employs a master data management approach to collecting, matching, quality-assuring, storing and distributing member data. Our UMV and TruCare systems are integrated, which enables us to match member data in UMV with SDOH-HE data housed in TruCare to create a comprehensive member profile. Demographic and SDOH-HE data are integrated with our EDW which aggregates data for population health analysis. Housing all information from multiple sources, including our claims processing system, our Centelligence EDW allows us to match and aggregate demographic and SDOH-HE data with claims data to generate robust population health analytics and reporting from a single data repository. Data captured in the EDW is available in near real-time, enabling the best possible timeliness and integrity in reporting.

c. What are some key insights for population management that you can currently produce from your data and analysis?

Centelligence electronically receives, integrates, and continually analyzes data including PH, BH, OH, pharmacy, and vision claims; lab test results; assessments and authorizations; member demographics and eligibility; and provider demographics. Centelligence also includes a comprehensive family of integrated decision support and software tools, including our Enterprise Quality Platform, Key Performance Indicator (KPI) Dashboards, and Clinical Risk Grouping software. In addition, Centelligence features proprietary predictive modeling and care gap/health risk identification tools to anticipate, identify, monitor, and address issues and improvement opportunities. Centelligence enables us to generate the following population insight, including but not limited to:

- Population health risk category (healthy, chronic, complex)
- Indicators for SPMI
- Future risk (Prospective risk scores)
- SDOH-HE (ICD-10 Z codes such as Z55-Z65)
- ED and inpatient visits
- Potentially avoidable ED visits

2. EVALUATION QUESTIONS (RECOMMENDED PAGE LIMIT 15 PAGES)

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.

In recognition of OHPB recommendation #34, providers under a VBP arrangement require current, targeted, and actionable information to help manage financial risk and improve care. We have the HIT needed to support VBP arrangements by the start of Year 1 and will be introducing additional HIT as we administer new and expanded VBP arrangements under CCO 2.0. Our powerful suite of analytic and reporting tools allows us to calculate cost and quality metrics at the provider, clinic, provider-group, and CCO-level and succeed in our VBP arrangements. Our EDW and Centelligence platform support systematic data collection, indicator measurement, risk stratification, and drill-down and dashboard reporting to drive action, transparency, accountability, and continuous improvement of our quality measures and other performance metrics. Centelligence features our Enterprise Quality Platform to support calculation of quality metrics and Clinical Risk Grouping software that allows us to further analyze claims data for our population, including inpatient utilization and identification of Potentially Preventable Events (PPEs). We are able to monitor PPE rates among our providers, inform identification of likely factors leading to PPEs in our population, and develop VBP arrangements designed to impact PPE rates. Centelligence also powers our Provider Analytics tool for
providers, which allows several ways for providers to engage with VBP data, including data visualizations, data tables, drill-down capabilities, and exportable reports. Provider Analytics will be made available to providers as part of our Interactive Performance Dashboard tools.

**HIT to Make Payments Consistent with VBP Models.** Our provider agreements will specify VBP schedules, including quality and outcome thresholds required for providers to earn incentive payments. Based on the provider agreements, our HIT calculates a portion of the provider’s total potential payment (e.g., bonus, payment withhold) tied to the provider’s performance on cost and quality performance measures as calculated by our payment/financial software. Our HIT bundles encounters into episodes of care which enables us to make value-based bundle payments for providers treating patients with specific medical conditions. We will make incentive payments quarterly, and providers in VBPs can opt to receive paper or electronic payments. For electronic payments, we offer the free, widely used, multi-payer PaySpan system. We also conduct routine validation of payments, by systematically comparing performance measure results and processed claim details against projected incentive reimbursement, promoting accurate payment, in alignment with realized quality of care and other performance outcomes.

**HIT to Administer Initial VBP Arrangements.** We will report to OHA how we used HIT to administer VBP arrangements in place at the start of the year and will provide to OHA supporting detail about our implementation approach. We recognize that VBP-readiness is a journey and we will work at an individual provider level to assess current capabilities and provide a path to success in VBP contracting and implementation. Our readiness and implementation process starts with a qualitative discussion with providers about their objectives, capabilities, key challenges and vision. We then look to set of quantitative internal and external benchmarks to evaluate their strengths and opportunities. Finally, we collaboratively work with providers to identify the best-fit model for implementation and develop “Shadow Reports” (a pro-forma evaluation of provider performance in the identified model) to discuss key areas of focus. For example, the Shadow Report allows a provider in Health Care Payment Learning & Action Network (HCP-LAN) Category 1 or Category 2 to begin to understand what would happen if they were in a Category 3 gain share or risk arrangement.

**Introducing HIT Tools for VBP.** We take a proactive approach to implementing provider HIT tools that support VBP arrangements to ensure successful provider adoption and ongoing use. We will continue to host a monthly learning collaborative on HIT. Additionally, we recently presented to our Clinical Advisory Panel during the RFA process a summary of the HIT tools to elicit provider feedback to ensure we are meeting the needs of our providers. For CCO 2.0, we will continue to adopt an implementation approach focused on preparation, communication, and engagement as we onboard providers to HIT tools, such as our Total Cost of Care Report suite and our Interactive Performance Dashboards as described below. Summarized in the table below is an example of our Implementation Checklist for HIT Tools for VBP.

<table>
<thead>
<tr>
<th>Example Implementation Checklist for HIT Tools for VBP</th>
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<tbody>
<tr>
<td><strong>Prepare</strong></td>
</tr>
<tr>
<td>Train-the-trainer sessions on HIT tools</td>
</tr>
<tr>
<td>Review support and reference materials on HIT tools</td>
</tr>
<tr>
<td>Identify key providers and plan to incorporate training into existing provider meetings</td>
</tr>
<tr>
<td><strong>Communicate</strong></td>
</tr>
<tr>
<td>Post website articles on HIT tools</td>
</tr>
<tr>
<td>Publish newsletter articles to raise awareness of availability and benefits of HIT tools</td>
</tr>
<tr>
<td>Prepare a provider meeting packet (e.g., Getting Started and Navigation Guide)</td>
</tr>
<tr>
<td>Prepare USPS mail, email, and/or fax blast packet</td>
</tr>
<tr>
<td><strong>Engage Providers</strong></td>
</tr>
<tr>
<td>Identify appropriate meeting attendees to ensure providers will be in attendance</td>
</tr>
<tr>
<td>Plan for training/support (e.g., include a review of a sample report)</td>
</tr>
<tr>
<td>Send follow-up communication</td>
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**Implementation Approach to Ensure Consistent Payments for VBP.** Provider agreement details for VBP arrangements are implemented and configured in our HIT by Analysts who specialize in provider VBP.
compensation and contract implementation. During implementation, our Analysts follow structured protocols to ensure contracts are accurately loaded to help ensure consistent downstream payment according to VBP models. Our Analytics and Finance team also implement extensive validation processes to ensure consistent payment based on performance and quality. Since 2013, we have used a financial reconciliation process as an additional layer of validation to assess provider performance according to specific contract agreements as a way to audit proper payment, which we will adapt for CCO 2.0. Our Finance Department audits cover multiple reimbursement methods with separate controls for each method. We also conduct quarterly audits as an additional control to ensure consistent payments in alignment with provider contracts.

**Ensuring the Necessary HIT as VBP Arrangements are Scaled and Spread.** We work collaboratively with our provider network to understand provider HIT challenges and improve contract performance. For example, we currently host quarterly data collaborative sessions to educate providers on HIT tools and reports. These types of in-person provider meetings allow us to understand a provider’s HIT challenges and will ensure that providers have the necessary HIT as VBP arrangements are scaled and spread. We support continual improvement and have a dedicated Provider Partnership Management Team to support and assist our providers with HIT as they move through the four categories of VBP as documented by the HCP-LAN. Through our Provider Partnership Management Team, our staff will help assess a provider’s current capabilities in relation to the HCP-LAN continuum, their ability to be successful within that continuum level, and any support and HIT needed for success. We will also use our annual EHR/HIE survey as another indicator for ensuring provider needs related to HIT for VBP are met.

**Plans for Enhancing HIT to Administer VBP Arrangements.** In 2020, we are enhancing our quality program and significantly augmenting our predictive risk identification capabilities through Interpreta, Inc., an informatics firm focused on delivering both population and single member analytic precision medicine capabilities on a daily basis, a truly unique capability in healthcare today. Interpreta’s analytics engine is certified by NCQA for HEDIS 2018 Measures and was recently selected as one of two NCQA Measure Certification℠ HEDIS® 2019 national beta testers. Additionally, Interpreta is certified by the Integrated Healthcare Association (IHA) for pay-for-performance (P4P) metrics, real-time HEDIS and Risk Adjustment (RA) gap analytics with a member-centric view. Interpreta will enhance our ability to calculate provider performance and quality metrics to support the administration of VBP arrangements. Interpreta will also enable more timely information to help VBP providers better identify and execute on preventive and Care Coordination opportunities to support population health management.

**Activities, Milestones, and Timelines.** See items labeled “2.a.” in **Figure 9 Draft HIT Roadmap, Timeline, Activities, and Milestones for VBP and Population Health** located at the bottom of Attachment 9.

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, the 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.

Powered by Centelligence, we will generate and distribute actionable data through a variety of VBP Report Packages, Interactive Performance Dashboards, such as our Patient and Provider Analytics tools, and clinical risk indicators made available at the point-of-service, as well as during monthly and quarterly meetings with staff dedicated to supporting provider performance. Our Report Packages will align with the needs of specific
provider types, and cost data contained in our Report Packages will be stratified by provider type. Our dedicated Provider Performance Management Team will serve as a resource and primary point of contact for VBP technical assistance to help move providers along the HCP-LAN continuum. Our staff will work shoulder-to-shoulder with providers to guide them through the Report Packages and coach them when opportunities for improvement exist. Our Report Packages and Interactive Performance Dashboards are intended to allow providers transparency into the measures that ultimately influence their success in their VBP arrangement.

PLANS FOR START OF YEAR 1

Our Provider Partnership Management Team will educate providers on the calculations used to determine bonus/incentive amounts; incentive payment schedules; and concepts such as total cost of care, outcomes/quality scores, and shared savings/shared losses. We plan to schedule quarterly meetings with providers participating in a VBP arrangement to review performance and discuss opportunities for improvement. Staff will have access to clinical, financial, relative practice and individual provider performance reports and innovative tools to support these efforts. For example, the Shadow Reports provide a hypothetical gain share performance evaluation, educating providers on VBP model mechanics and opportunities. We will host meetings with providers to discuss provider performance in their VBP arrangement and follow up with tailored reporting and ad hoc VBP training covering various systems and structures. We will also offer customized training and reporting upon request as well as when we identify issues through training evaluations, provider analysis, and analysis of claims submission errors or member complaints that may be contributing to unfulfilled VBP performance potential. Our staff will proactively outreach to schedule individualized in-person or virtual training and technical assistance to address identified issues.

(1) Timely Information on Measures Used in VBP Arrangements.

Quarterly Report Package. To complement our outreach initiatives, the Quarterly Report Package will include a quality and financial snapshot of the provider’s VBP arrangement; a prioritized list of measures aligned with their VBP arrangement; a prioritized list of member care gaps that require closure; a detailed, panel-level list of all member care gaps; a list of members not engaged in primary care; a list of member engagement and loyalty scores in primary care; a list of members with complex needs; a summary of their members’ ED and inpatient stays; a breakdown of the provider’s financial performance; risk-adjusted member cost and utilization reports (including high utilizers, pharmacy utilization, out-of-network utilization; episode-based panel outcomes stratification; and peer comparisons organized at the enterprise, practice, provider, and member levels.

(2) Accurate and Consistent Information on Patient Attribution. We will promptly alert providers of new member assignments, including new member demographics, contact information, effective assignment date, and special needs indicators through our Member Roster Report and via our secure web-based Provider Portal. Providers will also be able to use the Patient Analytics tool in Trillium’s Provider Portal to view up-to-date reports on their attributed members, and we will discuss member attribution with providers on-site at their practices. We will also ensure all providers are informed of their contract requirement to make best efforts in scheduling initial appointments with assigned members. We will continue to provide details on the importance of provider engagement in their patient panels at provider engagement meetings.

(3) Identification of Patients Needing Intervention through the Year.

Monthly Report Package. As we do today with PH, BH, and OH providers, we will share our monthly Hot-Spotter Report with providers, which includes health risk scores and targeted data on a provider’s member panel with clinical information. Providers will receive a monthly secure email with the Hot-Spotter and Member Care Gap Report for their assigned member panel, which enables providers to take action for targeted intervention. As an additional component of the monthly Report Package, for PCP groups at risk, we will also share with PCPs who are in risk-based contracts, a monthly Care Gap Report and our monthly Total Cost of Care Report suite. The Total Cost of Care Report suite includes a:

- **Financial Settlement Report.** YTD performance against operating fund target.
Member Roster Report. Financial elements reported on a financial settlement report at an individual member level.

Member Utilization Detail Report. Report of all claims incurred yea-to-date by members.


PLANS OVER THE 5 YEAR CONTRACT

As we introduce new and expanded VBP programs over the 5-year Contract, our Provider Partnership Management Team will provide a basis for developing forums to target providers for these VBP models, introduce the new programs and HIT tools, answer providers’ questions, and serve as a forum to discuss challenges and lessons learned. For example, we will refine our provider Report Packages based on provider feedback received in the field.

Interactive Performance Dashboards. We recognize that providers benefit from the convenience of on-demand, self-service data reporting and analytics to complement our suite of Report Packages. In 2020, providers will have access to our Interactive Performance Dashboard tools: Provider Analytics and Patient Analytics, both available on our secure Provider Portal. In use by our affiliates today, these tools report medical cost and utilization, pharmacy, lab results, ED, population health, and quality outcome data to help providers understand trends and supports custom selection, drill-down, and export capabilities. These tools also contain information on patient attribution, patient loyalty (e.g., the affinity of the patient to the assigned VBP provider), top measures with the highest amount of unearned dollar potential, and information on how their bonus is calculated by measure.

Activities, Milestones, and Timelines. See items labeled “2.b.” in Figure 9 Draft HIT Roadmap, Timeline, Activities, and Milestones for VBP and Population Health located at the bottom of Attachment 9.

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.

OTHER PLANS TO PROVIDE ACTIONABLE DATA TO PROVIDERS

What Trillium Currently Does. We currently provide our Hot-Spotter Report to our PH, BH and OH providers. We also offer actionable data through our secure Provider Portal. For example, the Member Health Record which is a feature of our Provider Portal allows providers to view clinical history and current interventions on their patients. Providers can view claims, lab results, individualized care plans, care gaps, eligibility history, and completed assessments (e.g., Notice of Pregnancy) to support the effective delivery of care.

What Trillium Plans to do by Start of Contract (1/1/20). We are currently in the process of expanding our use of the Multi-Payer Market-Driven Portal to support our CCO program, including support for enabling providers to monitor and close any care gaps directly related to OHA’s 2019 CCO Incentive Measures, to further align our provider VBP strategies, as well as OHA goals. In addition, we will implement our Multi-Payer Market-Driven Portal solution for additional providers throughout our proposed Service Area.

What Trillium Intends to do in the Future. As part of our commitment to offering providers access to timely and actionable information to support the achievement of their VBP quality goals, we will be introducing our Interpreta analytics engine in 2020. Interpreta will power daily care gaps, which will be directly available to providers on the Multi-Payer Market-Driven Portal to help providers achieve their VBP quality goals and identify preventive and care management opportunities for population health management. Interpreta-powered daily care gaps will also be made available on our secure Provider Portal.

Roadmap, Activities, Milestones, and Timelines. See items labeled “2.d.” in Figure 9 Draft HIT Roadmap, Timeline, Activities, and Milestones for VBP and Population Health located at the bottom of Attachment 9.

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.
A foundational component of our VBP strategy is our Provider Partnership Management Team to ensure providers receive the appropriate level of staff support and education on use of HIT tools and data for maximizing their VBP program success. Trillium’s dedicated Provider Partnership Management Team will share relevant, actionable data with our PH, BH, and OH providers, including those on VBP arrangements, in a consistent and transparent manner that empowers providers to improve quality. For example, our staff will provide reports and side-by-side comparisons when they visit with providers to discuss and show them their performance trends over time in quality improvement. We will schedule quarterly meetings with providers participating in a VBP arrangement to review performance and discuss opportunities for improvement. Our staff will have access to clinical, financial, relative practice and individual provider performance reports and innovative tools to support these efforts.

**Proactive Staff Outreach.** Our staff will proactively outreach and engage our providers to schedule individualized in-person or telephonic training to address identified issues or provider needs. We will track trends related to quality performance and educate our staff on how to use data and communicate in a way that is actionable for providers. For example, we will provide extensive training for staff on our revised VBP program before launching to ensure a successful implementation. Our staff will share data with providers to track performance on VBP arrangements and will provide comparisons, year over year, including quality metrics by quarter and operating fund tracking. Our staff will analyze data and generate reports to share with and educate providers during onsite meetings. And our staff will drive adoption and ongoing use of the Report Packages, Multi-Payer Market-Driven Portal, Interactive Performance Dashboards, and Provider Portal to ensure providers understand the value of how to use the data and analytic tools to track their performance and improve their quality.

We will also offer targeted online communications with our providers via webinars (e.g., on HIT and web tools), training resources on our Provider Resource Center, and provider email alerts. We will issue actionable provider news frequently and will offer a Provider Email Alert program powered by an email notification service with frequent, but topically focused communications.

**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 targeting of interventions to improve outcomes? Please include the tools and data sources that will be used (e.g., claims), and how often Applicant will re-stratify the population.**

In recognition of OHPB Policy #34, we understand the importance of managing population health efforts through risk stratification and targeting of interventions. We will report to OHA on how we use HIT for population health management, including risk stratification and identification of member characteristics (e.g., past diagnoses and services) that inform the targeting of interventions to improve outcomes.

**Using HIT to Risk Stratify and Identify Member Characteristics.** Built into our Centelligence population health informatics engine is our predictive modeling and risk stratification logic to identify and report potential health risks, including gaps in recommended care based on evidence-based guidelines for chronic conditions as well as compliance with screenings and preventive services. We use Centelligence to re-stratify the population on a weekly basis. Centelligence integrates data from multiple sources and provides actionable data on member characteristics to inform the targeting of interventions to improve outcomes. Centelligence electronically receives, integrates, and continually analyzes data such as PH, BH, and OH claims; lab test results; assessments; and member demographics. We use our proprietary predictive modeling and care gap/health risk identification...
tools to anticipate, identify, monitor, and address issues and improvement opportunities. Using our Centelligence population health informatics engine, we will be able to risk stratify and identify and report on member characteristics by the start of Contract Year 1.

**PLANS FOR THE START OF YEAR 1**

Today, we produce a monthly Hot-Spotter from Centelligence for PH, BH, and OH providers and we plan to continue this for the Start of Year 1. The Hot-Spotter includes over 40 data elements that support population health management including but not limited to the following, future risk (Prospective relative risk scores), ED and inpatient visits, BH risk, last PCP visit, demographic information, indicators for conditions such as SPMI, ER visit probability, inpatient stay probability, and SDOH ICD-10 codes such as those ranging inclusively from Z55 to Z65. Providers can use data elements such as “ER Visit Probability”, “Inpatient Stay Probability”, and “Maximum Impact Score” as opportunities to provide support, education, and build engagement with members.

We are also adding potentially preventable ED diagnoses to the Hot-Spotter to support providers with VBP arrangement that contain ED diversion targets and additional data that will identify members past due for oral health (OH) screenings. We also use the Hot-Spotter to guide development of population health management initiatives for members.

**Plans over the 5-year Contract.** In order to capture a more comprehensive picture of our members’ risk and population-level health, we will be including measures that evaluate SDOH-HE into both our risk scoring model and population health stratification model. For our risk scoring, we will include Z codes from claims, such as Z59, which indicates problems related to housing and economic circumstances, and Z60, which indicates problems related to social environment. Including these Z codes in our risk scoring, enables us to take social health into account, when evaluating a member’s risk. The SDOH-HE risk score will help our Care Coordinators identify and target members at-risk for adverse health outcomes due to the social, economic, and environmental conditions they experience. The SDOH-HE risk score will be a significant predictor of member healthcare spend associated with the SDOH-HE factors they experience. Additionally, the SDOH-HE measures collected via the Initial Risk Screen (IRS) will be incorporated into our population health risk stratification methodology.

Our population health risk stratification categorizes members’ health, based on a variety of variables, and into segments such as: healthy, acute, chronic, catastrophic, and terminal. Including social measures into our population health stratification model allows us to more accurately segment the members in our population, leading to better member-level and population health-level interventions.

**Activities, Milestones, and Timelines.** See items labeled “2.e.” in Figure 9 Draft HIT Roadmap, Timeline, Activities, and Milestones for VBP and Population Health located at the bottom of Attachment 9.

**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)?**

We provide the following risk stratification and member characteristics to providers with VBP arrangements. **Hot-Spotters for Providers.** We currently produce a monthly Hot-Spotter for our PH, BH, and OH providers. We will share this monthly Hot-Spotter with providers on a VBP arrangement, which will include health risk scores and targeted data on a provider’s member panel with clinical information. For example, our Hot-Spotter includes a BH prospective risk score based on member demographics and BH conditions in the past year. The Hot-Spotter also includes the date of the last mental health visit and name/location of the last mental health provider seen. As mentioned above, we are also adding potentially preventable ED diagnoses and additional data that will identify members past due for OH screenings. Providers will receive a monthly secure email with the Hot-Spotter list with their assigned member panel, which enables providers to take action for targeted intervention. Our Hot-Spotter
allows providers to integrate their own datasets with our Trillium data, which allows providers to conduct a truly comprehensive population health analysis on their patients. For Contract Years 2-5, we will report on provision of risk stratification and member characteristics to contracted providers with VBP arrangements for the populations included in the arrangements.

Provider Analytics. We will also be offering the Provider Analytics tool available to providers on our secure Provider Portal. Provider Analytics will offer on-demand access to actionable data on a rolling 12 or 24-month period and allow several ways for users to engage with VBP data, including data visualizations, data tables, drill-down capabilities, and exportable reports. Providers can view care gap closure opportunities by quality measure. Providers can use the quality view, coupled with the engagement view, to see if a member with care gaps has not been to their PCP. They can also view their VBP performance scorecard detailing the number of members that they need to see to close a care gap, incentives earned by the provider and future opportunities for earnings, including dollars missed.

Patient Analytics. The Patient Analytics tool will also support providers in identifying members needing intervention so that providers can take action before the year end. Patient Analytics uses member-level claims data to create a detailed profile of each member, allowing users to access their patient disease registries (at the PCP or practice level) to view critical member information. The landing page includes providers' assigned member panel, with demographic information, risk scores, ED visits in the last 90 days, open care gaps, and more. Providers can also view medications and create disease registries by condition.
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, etc.).

We use evidence-based population health methodologies to gather information to assess the distribution of members and costs to prioritize interventions likely to have the largest impact on population health status, outcomes, and costs. Summarized in the table below are other ways that Trillium will gather information on and measure population health.

<table>
<thead>
<tr>
<th>Other Ways Trillium will Gather Information on and Measure Population Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trillium Resource Exchange</strong></td>
</tr>
<tr>
<td>We will track, trend, and report on members’ SDOH-HE needs and utilization of social services across Oregon using our Trillium Resource Exchange, which includes reporting functions for population-level analysis and management. Our Trillium Resource Exchange allows us to analyze ZIP codes and SDOH-HE categories, such as employment, housing/utilities, and transportation.</td>
</tr>
<tr>
<td><strong>Simple Screens and PRAPARE Assessment</strong></td>
</tr>
<tr>
<td>We will integrate SDOH-HE data (e.g., PRAPARE assessment) collected via the Simple Screens web app into TruCare and our EDW to support population health reporting and Care Coordination.</td>
</tr>
<tr>
<td><strong>Homeless Management Information System (HMIS)</strong></td>
</tr>
<tr>
<td>We will partner with organizations such as Home Forward in Multnomah County to gather information from HMIS to enhance our population reporting on homelessness, which will inform interventions to connect members to stable housing (e.g., FUSE program). Our affiliate in Arizona directly integrates with their statewide HMIS, which supported their efforts in reducing the number of homeless members by 20% from 2016 to 2017.</td>
</tr>
<tr>
<td><strong>Local Emergency Medical Services (EMS)</strong></td>
</tr>
<tr>
<td>As we do today, Trillium in partnership with the local EMS and Fire Chief of Eugene and Springfield, will track and gather information on Trillium members who use ambulance services. We will continue to analyze this data to target areas and cohorts of high ED utilizers. We will also explore gathering additional ambulance utilization information by expanding our partnerships with more local EMS and Fire Departments outside of our current Service Area to support population health efforts.</td>
</tr>
<tr>
<td><strong>Intensive Community Care Management (ICCM) Program</strong></td>
</tr>
<tr>
<td>We will measure the health and cost outcomes of our ICCM program, which will inform our refinement/expansion of ICCM throughout our proposed Service Area. This work supports our 2019 Transformation Quality Strategy (TQS) Component 6: ICCM Referrals for OH Care and Component 10: Quality Metrics related to Members with Special Health Care Needs.</td>
</tr>
<tr>
<td><strong>EDIE/PreManage</strong></td>
</tr>
<tr>
<td>As we do today, we will identify ED high utilizers using data gathered from EDIE/PreManage to inform the Lane County ED High Utilizers Community Collaborative, which will enable us to expand the use cases for PreManage for Trillium and our providers.</td>
</tr>
</tbody>
</table>

h. Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Include information about the following items:

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?

2. Data storage: Where do you store data (e.g., enterprise data warehouse)?

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)?

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?
(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?

(6) Effectiveness: How will you monitor progress on your roadmap and the effectiveness of the HIT supports implemented or to be implemented?

(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 or IT upgrades or transitions that would affect your ability to have the appropriate HIT for VBP?

Trillium’s is backed by a scalable and integrated suite of HIT capabilities, including our Centelligence health informatics platform and payment/financial software to support VBP arrangements and population health management.

PLANS FOR THE START OF YEAR 1

We will introduce the Multi-Payer Market-Driven Portal for OHP providers and our Report Packages for the Start of Year 1 to support VBP and population management, including our Hot-Spotter and Total Cost of Care Report suite. As mentioned above, we are also adding potentially preventable ED diagnoses and additional data that will identify members past due for OH screenings to our Hot-Spotter. We will transmit monthly claims data to providers via our Total Cost of Care Report suite. Our HIT supports these types of claims data extracts with VBP providers, via HIPAA compliant secure file transfer protocol (SFTP) or other secure transmission method. These claims feeds mean providers will receive processed claims for services incurred by their members that can be uploaded into the providers’ own population health platform.

PLANS OVER THE 5-YEAR CONTRACT

The following is a summary of our plans over the 5-year Contract for new HIT capabilities that will support VBP and population management:

- **Interpreta analytics engine:** Will calculate provider performance and quality metrics to support the administration of VBP arrangements and enable more timely information to help VBP providers with population management.

- **Interactive Performance Dashboards:** Will report medical cost and utilization, pharmacy, lab results, ED, population health, and quality outcome data (Provider Analytics) and will provide access to patient disease registries (Patient Analytics).

- **Community Partner Portal:** Will support the ability to bi-directionally share and access key member and provider demographic and clinical information for authorized community partners supporting Care Coordination and population management, such as Area Agencies on Aging and Aging and Physical Disability (APD) local offices.

- **SDOH-HE in Risk Scoring and Stratification:** Will capture a more comprehensive picture of our members' risk and population-level health.

- **Provider Engagement Effectiveness Dashboard:** Will contain metrics that evaluate utilization of HIT tools among providers and Trillium staff to identify opportunities for training and to help our staff best prepare for provider engagement meetings.

**Activities, Milestones, and Timelines.** Please see Figure 9 Draft HIT Roadmap, Timeline, Activities, and Milestones for VBP and Population Health located at the bottom of Attachment 9.

**Data Sources.** Through our EDW we collect, validate, integrate, store, and transmit data from internal and external sources as outlined in the below table.

<table>
<thead>
<tr>
<th>EDW Data Sources</th>
<th>Clarity Information, such as daily chart files, care gaps, ADTs, and transactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims data from providers including PH, BH, OH services, lab, and pharmacy</td>
<td>Clinical information, such as daily chart files, care gaps, ADTs, and transactions</td>
</tr>
<tr>
<td>Medical management information, such as referrals and authorizations</td>
<td>Provider information, such as participation status, specialty, demographics, and accessibility</td>
</tr>
</tbody>
</table>

Attachment 9

32
**EDW Data Sources**

<table>
<thead>
<tr>
<th>Population health information, such as state immunization registries and health disparity data including by race/ethnicity</th>
<th>Financial information necessary to support quality and VBP arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member information, such as the Initial Risk Screen (IRS), eligibility history, demographics, member outreach, service utilization, and SDOH-HE, including PRAPARE and HMIS for CCO 2.0</td>
<td>Paper and/or fax documents scanned and stored in our Document Management System</td>
</tr>
</tbody>
</table>

**Methods for Data Collection, Updates, and Additions.** Our interoperable HIT adheres to all open industry, state proprietary, and government mandated formats for data collection, including HIPAA transactions and code sets, HIPAA compliant security controls, and HL7 clinical data exchange formats. Our HIT is informed by the CMS Medicaid Information Technology Architecture (MITA) guidelines, which allows us to automatically update data elements across our HIT systems. We maintain adequate, flexible, and growing computing and storage capacity to collect, process, add, and update data. Through our extract, translate, and load (ETL) capabilities, data is ingested, analyzed for consistency, normalized, and loaded for use (e.g., reporting and analytics). Our Centelligence Data Service Bus automatically updates data elements across our systems within the appropriate business cycle, including up to real-time processing, 15-minute update schedules, and 24-hour update schedules. Our publish/subscribe messaging approach to data processing allows our systems to subscribe to data updates, and receive those updates automatically, and can be adjusted based on business need.

**Addressing Data Quality.** To address data quality issues, we perform audit variance reports, data scans, and log checking. Our data collecting process includes multiple levels of accountability from data capture to data storage to report presentation. This helps ensure that valid, reliable, and accurate results are obtained. Our EDW uses integrated tools based on data quality validation and metadata, including data lineage tracking and active data cataloguing. Our EDW’s logical design ensure data integrity and best practice data governance. In addition, the data communication features of our EDW and its data load processes allow us to receive data as frequently as our data sharing partners can supply the data to us.

**Data Storage.** The foundation of Centelligence is our comprehensive EDW powered by high performance Teradata technology. Our EDW systematically receives, integrates, and transmits internal and external administrative and clinical data, including PH, BH, OH, and pharmacy claims data, as well as lab test results and health assessment information. EDW supplies the data needed for all of our Centelligence analytic and reporting applications. Housing all information in the Centelligence EDW allows staff to generate standard and ad-hoc reports from a single data repository.

**Tools:**

- **Manage Data and Assess Performance.** As we receive and process data, the Service Oriented Architecture design of our HIT, along with our master data management approach to data storage, ensures our data is represented and stored accurately, completely, and uniquely (e.g., no data discrepancies or duplicates). Our HIT uses Application Programming Interfaces (APIs) and microservices to service user and application functions in a scalable manner. Our HIT architecture, as well as the near real time Change Data Capture capabilities of our middleware, integrates and consolidates data to create meaningful and actionable data. To assess data performance, we use Teradata Viewpoint, which provides powerful systems management and performance monitoring and insights into our EDW and Centelligence analytics environment.

- **Analytic Tool(s) Used and Routine Reports.** Centelligence allows us to generate daily, monthly (e.g., Hot-Spotters), and quarterly reports. The Centelligence Ad-hoc Report Builder allows our staff to generate standard and ad-hoc reports from a single data repository, and features industry-leading business intelligence tools, integrated with our EDW, to manage and develop every aspect of reporting from report design, testing, scheduled production and submission, and development of ad-hoc reports.
(4) **Workforce.** Trillium’s local Reporting and Analytics workforce is composed of 20 FTEs who write and run reports (e.g., standard and ad hoc reports for OHA), implement quality controls to ensure reporting requirements are met, and generate innovative population health reporting and analytics. Within the Reporting and Analytics team, staff focus on operational reporting initiatives and reporting to support VBP and population health management. Our local reporting and analytics workforce is supported by 10 Centene Analysts who support Trillium with quality and care gap reporting and analyses. Due to the standardization of our EDW (e.g., data dictionaries), we will scale and modify our HIT to support reporting needs for our proposed Service Area. We also anticipate an increase in the number of FTEs to support reporting needs for our proposed Service Area. Informed by staffing models of our affiliates, we will scale our staffing model accordingly.

**Helping Staff Understand Data.** Our local workforce includes HIT Liaisons and a team of Analysts and Specialists from our Quality Improvement (QI) Department who review reports and are available to help other staff understand the data. HIT Liaisons coordinate our strategic HIT supports for our Care Coordination, quality, and provider EHR/HIE engagement & reporting, and VBP initiatives. We are also supported by our parent company’s Centelligence Customer Enablement team. To ensure our staff optimize the Centelligence suite of VBP and population health reporting tools, the Centelligence Customer Enablement team will provide multiple levels of support to Trillium staff, ranging from initial orientation and onboarding, to detailed and topic-specific training material.

**Staffing Model.** Our reporting and analytics workforce is led by our Director of Finance and Manager of Data Analytics & Reporting. Our Analytics team is made up of a Supervisor, Lead Data Analyst, a team of Data Analysts, and a Finance Analyst. These staff have over 125 cumulative years of experience working in the field of healthcare and have a diverse set of educational credentials including Master of Public Health in Infectious Diseases and Ph.D. in Economics. Our Manager of Data Analytics & Reporting is responsible for ensuring accurate, timely, and efficient reporting, and input of data related to all core business functions: provider data, clinical data, member data, and other data types. The Manager of Data Analytics & Reporting reports directly to our Director of Finance.

(5) **Dissemination.** As part of our ‘no wrong door approach’, we support multiple dissemination methods attuned to the provider’s needs and capabilities, including secure portals, SFTP, secure email exchange, and in-person meetings. Upon request, we can also make reporting and analysis available in paper/PDF format. As part of our approach, we collaborate closely with providers to ensure data we disseminate is truly actionable. For example, we host quarterly collaborative working sessions with providers to elicit feedback and adjustments to our reports. This approach creates a transparent feedback loop with providers to inform ongoing improvements to our reporting and analysis. As discussed above, we also disseminate a monthly claims feed to providers for analysis as part of our Total Cost of Care Report suite via HIPAA compliant SFTP and our interoperable HIT supports other secure transmission methods with providers.

We disseminate analysis to Care Coordinators via secure role-based access to TruCare and through our Community Partner Portal. We will introduce the Community Partner Portal for CCO 2.0 for authorized users supporting Care Coordination, such as Area Agencies on Aging that are serving our CCO members that are eligible for DHS-funded LTC services. TruCare and our Community Partner Portal are integrated with our HIT subsystems resulting in a unified, comprehensive member profile analysis for Care Coordinators. For other Trillium staff, we disseminate data via our Centelligence health informatics platform, which provides expansive business intelligence support, including flexible desktop reporting and online Executive KPI Dashboards with drill down capabilities. Through Centelligence, we have the ability to report on all datasets in our platform, including quality, BH services, claims timeliness, performance improvement projects, and other critical aspects of operations.
(6) **Effectiveness.** We will provide to OHA supporting information on roadmap progress, will provide an annual HIT Roadmap Update, and will participate in an annual interview. To monitor incremental progress, we will hold quarterly internal meetings to track our roadmap progress, including an assessment of milestones. Through Trillium’s EHR/HIE survey, we will gauge providers’ use of HIT tools. We will also be implementing a Provider Engagement Effectiveness Dashboard, which will contain metrics that evaluate utilization of HIT tools among providers and Trillium staff to identify opportunities for training and to help our staff best prepare for provider engagement meetings. To manage these efforts, HIT Liaisons will coordinate our strategic HIT supports for our Care Coordination, quality, provider EHR/HIE engagement & reporting, and VBP initiatives. The HIT Liaisons will be managing the HIT Roadmap and will serve as our primary link to our parent company’s HIT Department.

(7) **Addressing Challenges.** One of the challenges we anticipate related to HIT to support VBP arrangements is assisting providers on how to use HIT tools and understand data. This is especially true among small providers and/or providers with limited or no experience operating under a VBP arrangement. We plan to mitigate these challenges through the efforts of our Provider Partnership Management Team who will systematically assess and assist providers to move along the HCP-LAN continuum. We also train providers on how to pull, view, and interpret practice-level data. We share relevant, actionable data with our providers, including those on VBP arrangements, in a consistent and transparent manner that empowers providers to improve quality.

**Planned Projects or IT Upgrades or Transitions that Affect HIT for VBP.** As a data driven organization with best in class HIT solutions, our parent’s HIT Department constantly improves our HIT framework and systems to ensure smooth continuity during IT upgrades and transitions that may impact HIT for VBP. For any new IT upgrades or transitions, we implement our standard, proven approach to change management. Our change management processes provide regular and prompt deployment of system enhancements. To support VBP, we are enhancing our HIT with Interpreta and our Interactive Performance Dashboards.
### Figure 9 Draft HIT Roadmap, Timeline, Activities, and Milestones for VBP and Population Health

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>TIMELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIOR TO GO-LIVE</td>
<td>YEAR 1 (2020)</td>
</tr>
<tr>
<td>Work with OHA toward an approved HIT Roadmap (2.g)</td>
<td>Perform data integrations, validations, and system/user testing for new HIT (2.a) (2.b) (2.e)</td>
</tr>
<tr>
<td>Educate providers on VBP mechanics/opportunities (2.b)</td>
<td>Facilitate quarterly/ongoing training/education with providers on HIT tools</td>
</tr>
<tr>
<td>Schedule quarterly/ongoing meetings with potential VBP providers (2.b)</td>
<td>Refine VBP Report Package as needed for providers</td>
</tr>
<tr>
<td>Host training sessions on provider HIT tools</td>
<td></td>
</tr>
<tr>
<td>Publish provider communications on HIT tools</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MILESTONES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-Payer Market-Driven Portal launch for OHP (2.c)</td>
<td>Interactive Performance Dashboards: Patient/Provider Analytics launch (2.b.)</td>
</tr>
<tr>
<td>Shadow Reports developed for targeted VBP providers (2.b)</td>
<td>Interpreta launch (2.a.)</td>
</tr>
<tr>
<td>VBP Report Package developed/modified (2.b.)</td>
<td>Community Partner Portal launch (2.g)</td>
</tr>
<tr>
<td>CCO 2.0 Readiness Review</td>
<td>SDOH-HE integration with risk scoring/stratification (2.e.)</td>
</tr>
<tr>
<td>OHA approval of HIT Roadmap</td>
<td>Scale/modify HIT to support development of two new, or expanded from an existing contract, VBP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>YEAR 3 (2022)</th>
</tr>
</thead>
</table>
| Facilitate quarterly/ongoing training/education with providers on HIT tools | (

<table>
<thead>
<tr>
<th>MILESTONES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Engagement Dashboard launch (2.g.)</td>
<td>Report on provision of risk stratification/member characteristics to contracted VBP providers (2.f)</td>
</tr>
<tr>
<td>Scale/modify HIT to support implementation of two new or expanded VBPs developed in 2020</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>YEAR 4 (2023)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale/modify HIT to support implementation of a new or expanded VBP in one more care delivery area. By the end of 2022, new or expanded VBPs in both hospital care and maternity care must be in place</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MILESTONES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitate quarterly/ongoing training/education with providers on HIT tools</td>
<td>Refine VBP Report Package as needed for providers</td>
</tr>
<tr>
<td>Report on provision of risk stratification/member characteristics to contracted VBP providers (2.f)</td>
<td>Quarterly internal meetings to monitor HIT Roadmap progress (2.g.)</td>
</tr>
<tr>
<td>Quarterly internal meetings to monitor HIT Roadmap progress (2.g.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>YEAR 5 (2024)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale/modify HIT to support implementation of one new or expanded VBP in each of the remaining care delivery areas (by the end of 2024, new or expanded VBPs in all five care delivery areas must be in place)</td>
<td></td>
</tr>
</tbody>
</table>

### E. Reference Documents

- **2020 HIT Commons MOU**

  Trillium has reviewed the 2020 HIT Commons MOU reference document and will comply with all requirements set forth as they relate to fulfilling CCO 2.0 obligations.

Attachment 9

36
2015-2016 Lane County Regional Community Health Needs Assessment

Working together to create a caring community where all people can live a healthier life.

Report prepared by Heather Amrhein, United Way of Lane County
Adopted May 11, 2016
HEALTH

“A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

– World Health Organization

HEALTHY COMMUNITY

“One that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.”

– World Health Organization
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Executive Summary

A **Community Health Needs Assessment** (CHNA) is an assessment of the significant health needs of the community. In our case, the community is defined as all those who live, learn, work, or play in the Lane County region. The 2015-2016 Lane County Regional Community Health Needs Assessment introduces a new approach to community health, one where decisions about programs and interventions are not based solely on “the numbers,” but also on what community members feel is important as they strive to live a healthier life. A major function of local public health agencies is to monitor the health status of their community. In the past, community health assessments were heavily focused on data and lacked the voice of the community. For this assessment, we have been committed to investing our time and resources in order to hear directly from community members and consumers.

To guide the process, we chose to use the Mobilizing for Action through Planning and Partnerships (MAPP) framework because of its strong emphasis on community input. MAPP is a nationally-recognized community-driven process to aid organizations in the development of health needs assessments. Early in our MAPP process, community members developed a vision statement. During the remainder of the process, at every step, this vision was the guiding factor for all decisions: **Working together to create a caring community where all people can live a healthier life.**

Four interdependent assessments were then conducted, which provide a comprehensive snapshot of the specific health needs and opportunities in the region. This community-driven process would not have been possible with the participation of our local public health system partners and community members, who provided input and used data from the assessments to develop two strategic issues. A special thanks to the nearly 3,000 community members who took the time to share their views, experiences, and priorities thus far.

In the coming months, we will continue to work with our partners, stakeholders, and community members to develop a **Community Health Improvement Plan** (CHIP) that identifies goals, strategies, activities, and resources to address the two strategic issues identified in the CHNA. By working together, the CHIP will be implemented over the next three years. Through this collaborative effort, we will evaluate our programs and measure outcomes to improve planning efforts. We are committed to developing data-driven performance measures and adopting evidence-based interventions to ultimately, make a healthier community. Most importantly, we strive to ensure that this work is beneficial to all who live, learn, work and play in the region.

We invite you to use this report and the plan to help inform and enhance the work underway to improve the community’s health. We encourage you to get involved and contribute to this effort as we work together to create a caring community where all people can live a healthier life.
Overview of Our Region

For the purposes of this 2015-2016 Community Health Needs Assessment, our community’s region includes Lane County and Reedsport, Oregon.

Reedsport, Oregon is located in Douglas County on the central Oregon coast and is 87 miles southwest of Eugene, Oregon and has 4,090 residents (97% urban, 3% rural).

Extending from the Pacific Ocean to the Cascade mountain range, Lane County is a vibrant mix of communities and people. Lane County is the fourth most populous county in Oregon, with a population just over 350,000 residents. The Eugene-Springfield area contains over 60% of the county’s population and is the third-largest Metropolitan Statistical Area in Oregon. Outside of the metro area, Lane County is largely rural and unincorporated. The concentrated population, yet large geographic area of the county creates disparities in access to health and human services, as well as resources.

The 2016 County Health Rankings and Roadmaps rank Lane County 12th out of 36 counties in Oregon for overall health outcomes (length of life and quality of life) and 9th for health factors (health behaviors, clinical care, social and economic factors, and physical environment). Our region is a moderately healthy community with well-educated and active residents. The population is increasing, living longer, and becoming more diverse. Although good health outcomes and behaviors are prominent, there are still gaps to be addressed. Disparities exist between racial, geographic, and socioeconomic groups. For some issues, the gap is markedly wide.
Vision Statement

Live Healthy Lane: Working together to create a caring community where all people can live a healthier life.

Community Values

- **Compassion** – We are creating a community where all people are treated with dignity and respect.
- **Equity** – We believe everyone should have the opportunity to live a healthy life.
- **Inclusion** – We strive to embrace our differences and treat the whole person.
- **Collaboration** – We have committed our collective resources to innovation, coordination, and integration of services.
Strategic Issues

Strategic issues are critical challenges to be addressed, as well as significant opportunities to be levered in order for our community to achieve our vision. Data from the community health assessments were used to develop the strategic issues. During a multi-site community event in February 2016, hundreds of community members voted on the final strategic issues. Those two issues are:

1. **How can we promote access to economic and social opportunities necessary to live a healthy life?**

   Social and economic opportunities create a better life: high quality education, secure jobs with good wages, and housing that is both safe and affordable. These support a strong community and healthy people.

2. **How can we promote healthy behaviors and engage the community in healthy living?**

   Healthy actions and choices lead to good health. To create good health, we must make the healthy choice the easy choice. We can support individuals and the community to take positive actions that support a lifetime of healthy living.
Process Overview

The 2015-2016 Community Health Needs Assessment followed the six-phase *Mobilizing for Action through Planning and Partnerships (MAPP)* framework, a comprehensive community-driven strategic planning model for improving community health developed by the National Association of County and City Health Officials (NACCHO).

MAPP comprises distinct assessments that are the foundation of the process, and concludes with the prioritization of strategic issues. The strategic issues will then be addressed through a three-year, action-oriented Community Health Improvement Plan (CHIP).

Organize for Success and Partner Development

The assembly of the Live Healthy Lane partnership completed **Phase One** of the process in the spring of 2015. United Way of Lane County, Lane County Public Health, Trillium Community Health Plan, and PeaceHealth collaborated with members of the local public health system to form the organizational structure for the MAPP process. The assessment engaged community members and local public health system partners through the following avenues:

- **Steering Committee:** provided guidance and direction for CHNA and CHIP. The 100% Health Executive Committee serves as the steering committee for the work in providing the infrastructure, system and support for ongoing management and implementation of the plans.
- **Core Team:** conducted the CHNA, implement the CHIP, and will provide the overall management of the process. The Core Team is made up of individuals from United Way of Lane County, Lane County Health and Human Services, Trillium Community Health Plan and the Trillium Community Advisory Council, and PeaceHealth Oregon West.
- **Additionally,** community members and local public health system partners provided input and direction throughout the process.

Visioning

**Phase Two:** The visioning phase was a community-based process where more than 135 people from across the region participated in a multi-site simulcast community brainstorming session on June 25, 2015. The community vision and values that were selected are:

> Working together to create a caring community where all people can live a healthier life.
> *Compassion • Equity • Inclusion • Collaboration*
Four MAPP Assessments

**Phase Three:** The four MAPP assessments included for the collection of quantitative and qualitative data. These data offered critical insights into the challenges and opportunities for our community. Phase Three was conducted from May through December 2015.

- **THE COMMUNITY HEALTH STATUS ASSESSMENT** provided quantitative information on the community’s health. To complete this assessment, a subcommittee was formed to focus on identifying and analyzing key issues from over 200 broad indicators.

- **THE COMMUNITY THEMES AND STRENGTHS ASSESSMENT** gathered the thoughts, opinions, and perceptions of thousands of community members and consumers in order to understand which issues are important to the community. Three methods of data collection were utilized: 2,295 surveys were gathered, 50 focus groups conducted (with 500 participants), and 53 key informants were interviewed.

- **THE LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT** evaluated the components, activities, competencies, and capacities of our local public health system and how well the 10 Essential Services of Public Health are being provided. To complete this assessment, members of the local public health system met to assess the system’s performance.

- **THE FORCES OF CHANGE ASSESSMENT** identified the trends, factors, and events that were likely to influence community health and quality of life, or impact the work of the local public health system. To complete this assessment, the Core Team and Steering Committee worked together to form a comprehensive picture of the region’s strengths, weaknesses, opportunities, and threats.

Identify Strategic Issues

**Phase Four:** Strategic issues are critical challenges to be addressed, as well as significant opportunities to be leveraged, in order for a community to achieve its vision. Phase Four was conducted between December 2015 and February 2016, concluding with a multi-site community event to present the CHNA findings and vote on the strategic issues. While many areas are significant, identifying priority areas creates opportunities for collective impact. Two strategic issues were prioritized by over 260 people in our community to mark the end of the CHNA and form the foundation for the 2016-2019 Community Health Improvement Plan.

Formulate Goals and Strategies

**Phase Five:** This phase involves the formation of goals related to each strategic issue and identifying strategies for achieving each goal. Phase Five was conducted between February and April 2016, during which time meetings were held with the Core Team, Steering Committee, previous CHIP Workgroups, and stakeholders to evaluate potential strategies on various criteria. The Goals and Strategies report is available at [www.LiveHealthyLane.org](http://www.LiveHealthyLane.org).

Action Cycle

**Phase Six:** The action cycle is a continuous cycle of planning, implementation, and evaluation that seeks to move the needle on key health priorities over the course of the three year plan. Implementation of Phase Six begins in April 2016 with the identification of objectives and the development of the 2016-2019 Community Health Improvement Plan. The action cycle will continue through 2019.
Visioning

EXECUTIVE SUMMARY

Reducing health disparities, promoting health equity, and improving overall population health is the central purpose of any health assessment and health improvement planning effort. The Community Health Visioning Session served as the public launch for the 2015 Community Health Needs Assessment (CHNA), a collaborative project between PeaceHealth, United Way of Lane County, Lane County Public Health, and Trillium. To guide the community-driven strategic planning process for improving community health, residents from across the county convened to discuss their hopes for the region’s health future.

The purpose of the visioning session was to:
- Increase community awareness, enthusiasm, commitment, and engagement
- Establish focus, purpose, and direction to the MAPP process
- Create a shared vision and corresponding value statements

For the purpose of this event, the following definitions were used:
- Vision: a statement of what the ideal future looks like
- Values: fundamental principles and beliefs that guide a community-driven planning process

The input from the community event was used in the development of our community vision and values:

Vision Statement
*Live Healthy Lane:* Working together to create a caring community where all people can live a healthier life.

Community Values
- Compassion – We are creating a community where all people are treated with dignity and respect.
- Equity – We believe everyone should have the opportunity to live a healthy life.
- Inclusion – We strive to embrace our differences and treat the whole person.
- Collaboration – We have committed our collective resources to innovation, coordination, and integration of services.

The community health visioning session resulted in enthusiastic engagement and set the tone for future broad participation in the comprehensive health assessment and improvement process. The vision statement and values will ensure that the latter steps of the strategic planning process align with the image of a desired and possible future that our community seeks to achieve. With a shared vision and commitment to improved health, working together will yield better results than working alone.
PROCESS

Due to the large and diverse geographic area of the region, it was decided to have a county-wide simulcast meeting. PeaceHealth Medical Group locations in Springfield, Florence, and Cottage Grove served as the three visioning session sites. Invitations were openly extended to the broad community through email, social media, traditional media, and word of mouth. On June 25, 2015 from 5:30-8:00pm, a broad representation of approximately 130 individuals convened across the three sites to actively participate in the community health visioning session. Mary Minniti served as the lead facilitator for this interactive and inclusive brainstorming process.

Through facilitated small group discussion, the following questions were addressed:
- What would community health look and feel like here in Lane County?
- What values need to be alive and present as we move forward to create this kind of community health?

Participants also completed and submitted individual worksheets and event evaluations, which were then compiled and summarized. One participant commented: "Thank you so much. It doesn't have to be perfect to be deeply meaningful. As a member of this community, I am very grateful that you took leadership with this effort to convene community members in this way. This IS the work. A visioning process is encouraging; it can counter the discouragement that dampens momentum. If we begin with the end in mind, we are more likely to achieve that end. I look forward to the next step. With gratitude."
FINDINGS

What values need to be present as we move forward to create community health?

Number of Individual Responses

Compassion (12) Community (1) Open-mindedness (1)
Inclusion (10) Innovation (1) Participatory (1)
Equity (9) Dignity (1) Resilience (1)
Collaboration (6) Education (1) Safety (1)
Equality (5) Hope (1) Tolerance (1)
Access (4) Humanity (1) Trust (1)
Responsibility (4) One-ness (1) Vibrant (1)
Commitment (3) Otherness (1) Empowerment (1)
Engagement (3) Understanding (1) Honesty (1)
Prevention (3) Unity (1) Integrity (1)
Respect (2) Vested (1) Love (1)
Connectivity (2) Active (1) Listening (1)
Holistic (2) Caring (1) Peace (1)
Integration (2) Interdisciplinary (1) Relationships (1)
Coordination (2) Knowledge (1) Transparency (1)

What would community health look and feel like here in Lane County?

- Mental Health Care/Services & Mental Wellness: 36
- Prevention Services/Resources: 29
- Healthy Foods & Food Security: 28
- Community Activities/Engagement/Support: 20
- Parks & Outdoor Spaces: 20
- Physical Activity & Recreation: 20
- Housing: 19
- Walking & Biking Paths: 19
- Accessible & Affordable Healthcare: 18
- Collaboration, Coordination & Navigation of…: 18
- System Capacity: 17
- Education/Schools: 15
- Public Transportation: 15
- Services for Vulnerable Populations: 15
- Addiction Treatment/Behavioral Health: 14
- Obesity Prevention: 11
- Specialty Care: 11
- No Tobacco Use: 10
- School & Community Gardens: 10
- Childcare/Early Childhood Development: 8
- Employment & Job Security/Options: 8
- Income Stability: 7
- Social/Community Connectedness: 6
- Dental Care: 5
- Alternative Care: 4
- Clean Environment (water, air, land): 4
- Health Education: 4
- Health Insurance: 4
- Chronic Disease: 3
- Lay Health Service Providers: 3
- Primary Care: 3
- Economic Stability: 2
- Substance Abuse Prevention: 2
- Safety: 1
EXECUTIVE SUMMARY

The Community Themes and Strengths Assessment (CTSA) is a component of the Community Health Needs Assessment (CHNA), a community-driven strategic planning process for improving community health. In an effort to gain a better understanding of the health and quality of life perceptions of the people who live, work, or play in the Lane County region, the CTSA was conducted to:

- Identify concerns, opinions, and issues that are important to the community
- Determine how quality of life is perceived in the community
- Encourage community ownership and responsibility of the process

The size and diversity of the population in the region required the use of multiple data collection approaches to gather community and consumer input for the CTSA:

- 2,295 surveys were completed
- 50 focus groups were facilitated with 500 participants
- 53 key informant interviews were conducted

Overall, people feel that the Lane County region is a healthy and safe community with active residents. Our community strengths include our availability of parks and recreational areas, strong collaboration and sense of community, public awareness of the social determinants of health, local healthy food, clean environment, and valued healthy living. Collaborative partnerships and community engagement are strong and should serve as the foundation for planning and implementing initiatives to improve health.

The CTSA identified that populations experiencing social, economic, and/or geographic disadvantages are most affected by critical health issues and have greater obstacles to health. The overarching theme of the data collected reflects a community divided between a high quality of life and limited resources for those in need. While these health and quality of life disparities are well-known, more action is needed to improve and eliminate these inequities. An inclusive community, strong economy, equitable opportunities, and coordinated collaboration are needed to reach our community vision. While most admit to the enormity of the challenges ahead, community members and stakeholders confidently believe that positive change can and will take place with systematic and coordinated action.

Survey responses revealed the region’s strengths as our availability of parks and recreation/natural areas, strong sense of community and community engagement, and the clean environment. The biggest health concerns we face were identified as alcohol and drug abuse, lack of affordable housing and homelessness, lack of access to healthcare, poverty, and shortage of health and social services. Focus group findings highlight the vital importance of housing, access to healthcare, collaborations and resource coordination and navigation, services for vulnerable populations, education, access to healthy food, and mental health care and wellness in order to cultivate a healthy and thriving community. Key informant interviews exposed the most critical local health and quality of life issues to be the glaring health disparities, services for vulnerable populations, mental health care, drug and alcohol abuse and addiction treatment, housing, poverty and homelessness, and affordable healthcare access.

The responses and feedback will help pinpoint important community health concerns and highlight possible solutions. The information gathered will be used in conjunction with the other assessments to identify our strategic issues and reach our community vision of healthier lives for all.
Community Themes and Strengths Assessment

† Survey †

Process

Surveys are a commonly used approach to gathering community input and are a useful method for reaching large numbers of people and capturing measurable data. However, the survey methodology has some limitations: they do not allow for in-depth feedback on issues and may not reach the generally underrepresented populations.

The subcommittee crafted the questionnaire based on a review of quality-of-life surveys conducted in other communities through the MAPP process. The survey focused on identifying respondents’ perceptions of the community’s greatest strengths, important health-related issues and concerns, and areas for potential improvement. The survey was customized for the community and consisted of eight community health questions, eight demographic questions, and an open-ended comments section. The ‘Live Healthy Lane Community Health Survey’ asked participants to make three top selections from an extensive list of quality-of-life factors and health-related issues for the following questions:

1. Which of the following do you feel are important for creating a healthy community?
2. Which of the following problems do you feel have the biggest impact on health in your community?
3. What do you enjoy most about living in the Lane County region?

The demographic questions included home zip code, age, household language, marital status, gender identity, education level, race/ethnicity, and income. The language (English or Spanish) in which the survey was taken was also recorded for analysis. Finally, there was an opportunity for respondents to convey any additional comments.

The survey was broadly distributed between July 21 and November 20, 2015 and made available in English and Spanish, both electronically via SurveyMonkey and on paper. Community partners shared the electronic survey link with their email contact lists and constituents. Paper copies of the survey and promotional posters were made available to community partners for expanded distribution in an effort to target specific groups that otherwise might have been underrepresented. These data collection approaches allowed the subcommittee to reach a broad spectrum of those who live, work, and play in the Lane County region by utilizing existing networks across the community and local public health system.

Through the collective efforts of the subcommittee, coalition members, partner organizations, and community members, the survey reached thousands. A total of 2,295 surveys were completed – 473 paper surveys were received and 1,822 were submitted online. Although the number of surveys received was substantial, the results can only be considered the views of those who participated and do not necessarily represent the views of all those who are a part of the community. Nevertheless, outreach efforts appear to have been effective as the demographic characteristics of the respondents closely mirrored the general population in most categories.
DATA ANALYSIS

The Community Themes and Strengths Subcommittee analyzed the survey results by examining both the overall responses to the questions, as well as the specific responses for each demographic group. The overall results are listed below.

SURVEY RESULTS

What are most important for creating a healthy community?

The following table and graph illustrates the most important indicators for a healthy community as identified by survey respondents.

### Top Responses

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to health care (e.g., mental, medical, dental, primary care)</td>
<td>62.3%</td>
</tr>
<tr>
<td>Access to affordable, healthy food</td>
<td>51.1%</td>
</tr>
<tr>
<td>Good jobs and healthy economy</td>
<td>35.9%</td>
</tr>
<tr>
<td>Affordable housing</td>
<td>32.8%</td>
</tr>
<tr>
<td>Access to services for children and families</td>
<td>26.7%</td>
</tr>
</tbody>
</table>

The table above depicts the percent of respondents who selected the answer option. Percentages total more than 100% as respondents were asked to select three areas.

### Total Responses

<table>
<thead>
<tr>
<th>Category</th>
<th>Paper Responses</th>
<th>Online Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Healthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Affordable, Healthy Food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good Jobs and Healthy Economy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affordable Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Services for Children and Families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good Schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Crime/Safe Neighborhoods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clean Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Parks/Recreation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walkability/Bike-ability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welcoming to Diverse Cultures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessibility for Individuals with Disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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What problems have the biggest impact on health in your community?
The following table and graph illustrates the problems that have the biggest impact on health in the community as identified by survey respondents.

### Top Responses

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug &amp; alcohol abuse</td>
<td>60.8%</td>
</tr>
<tr>
<td>Lack of affordable housing &amp; homelessness</td>
<td>49.5%</td>
</tr>
<tr>
<td>Lack of access to healthcare (e.g., mental, medical, dental, primary care)</td>
<td>43.4%</td>
</tr>
<tr>
<td>Poverty</td>
<td>38.4%</td>
</tr>
<tr>
<td>Child abuse/neglect</td>
<td>22.9%</td>
</tr>
</tbody>
</table>

*The table above depicts the percent of respondents who selected the answer option. Percentages total more than 100% as respondents were asked to select three areas.*

### Total Responses

![Graph showing total responses](#)
What do you enjoy most about living in the Lane County region?
The following table and graph illustrates what respondents enjoy most about living in the region.

### Top Responses

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of parks and recreation/natural areas</td>
<td>66.4%</td>
</tr>
<tr>
<td>Clean environment</td>
<td>38.7%</td>
</tr>
<tr>
<td>Strong sense of community and community engagement</td>
<td>35.7%</td>
</tr>
<tr>
<td>Access to affordable, healthy food</td>
<td>30.3%</td>
</tr>
<tr>
<td>Transportation options</td>
<td>29.1%</td>
</tr>
</tbody>
</table>

The table above depicts the percent of respondents who selected the answer option. Percentages total more than 100% as respondents were asked to select three areas.

### Total Responses

In addition to the choices provided, a number of respondents indicated in the comments that other community assets include the local colleges, nonprofit work, community gardens and school garden education, natural beauty, proximity to ocean and mountains, church options, friendly and welcoming people, and community values.
The following charts illustrate respondents’ subjective perceptions of themselves and the community. While the majority (76%) of survey respondents indicated that they are either healthy or very healthy, they perceive the health of the community to only be somewhat healthy (64%). Positively, 90% of respondents indicated that the community is either safe or somewhat safe.

**How healthy are you?**

- Very Healthy: 20%
- Healthy: 50%
- Somewhat Healthy: 26%
- Unhealthy: 3%
- Very Unhealthy: 1%

**How healthy is your community?**

- Very Healthy: 1%
- Healthy: 1%
- Somewhat Healthy: 25%
- Unhealthy: 63%
- Very Unhealthy: 10%

**How safe is your community?**

- Very Safe: 6%
- Safe: 41%
- Somewhat Safe: 49%
- Unsafe: 0%
- Very Unsafe: 4%
Survey respondents were asked to indicate how much they agree or disagree with the following statements. Almost all reported that they have opportunities to be involved, the community is welcoming to people of different sexual orientations, and this is a safe place to live. In contrast, most respondents believe there are not enough health and social services to meet the needs of the community.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have opportunities to be involved in my community.</td>
<td>94%</td>
<td></td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>My community is welcoming to people of different sexual orientations.</td>
<td>87%</td>
<td>13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This community is a safe place to live.</td>
<td>87%</td>
<td>13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This community is a good place to age.</td>
<td>83%</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with the quality of life in our community.</td>
<td>82%</td>
<td>18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My community is welcoming to people of different religions.</td>
<td>79%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My community is supportive of individuals and families during times of stress.</td>
<td>75%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with my access to the health care system in my community.</td>
<td>74%</td>
<td>26%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My community is welcoming to people of different racial and/or ethnic backgrounds.</td>
<td>72%</td>
<td>28%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My opinion matters in my community.</td>
<td>68%</td>
<td>32%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with the quality of the health care system in my community.</td>
<td>61%</td>
<td>39%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with the availability of health care providers in my community.</td>
<td>57%</td>
<td>43%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are enough health and social services to meet the needs of the community.</td>
<td>30%</td>
<td>70%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The purpose of the demographic analysis was to identify the ranges of priorities in such a diverse community. Each of the survey questions was analyzed across race and ethnic groups, gender, education, income, geography and type of survey (paper vs. online, in Spanish vs. English). The results in this section highlight the choices made by specific demographic subgroups that were different from the overall results. Detailed demographic analysis results can be found in the Appendix. It is important to note that the analyses were conducted only on the group of respondents who chose to answer a particular demographic prompt, as none of those survey fields were required. Demographic groups with less than twenty respondents are not reported due to reliability and potential confidentiality issues. It should also be noted that none of the areas of divergence were tested for statistical significance, unless otherwise noted.

Findings were strikingly consistent with the overall survey results. With a few notable exceptions, there was consistent agreement on the leading issues regardless of race/ethnicity, gender, age, education, or geography.

### Top Issues by Question

<table>
<thead>
<tr>
<th>Most Important to Create a Healthy Community</th>
<th>Problem with the Biggest Impact on Community Health</th>
<th>Enjoy Most About Living in Lane County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to health care; Access to affordable, healthy food</td>
<td>Drug &amp; alcohol abuse</td>
<td>Availability of parks &amp; recreation/natural areas</td>
</tr>
</tbody>
</table>

### Notable Differences:
The following tables summarize notable differences across groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>Problem with the Biggest Impact on Community Health</th>
<th>Enjoy Most About Living in Lane County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income $20,000 or less &amp; 18-25 year olds</td>
<td>Homelessness &amp; lack of affordable housing</td>
<td>Availability of parks &amp; recreation/natural areas</td>
</tr>
<tr>
<td>Ages 75 years or older</td>
<td>Drug &amp; alcohol abuse</td>
<td>Access to affordable healthy food</td>
</tr>
</tbody>
</table>

### Other Notable Differences in Ranking by Issue

#### Most Important to Create a Healthy Community:

<table>
<thead>
<tr>
<th>Question and Issue</th>
<th>Group (ranked higher than others)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable housing; Services for children</td>
<td>Less than college education</td>
</tr>
</tbody>
</table>

#### Problem with the Biggest Impact on Community Health:

<table>
<thead>
<tr>
<th>Question and Issue</th>
<th>Group (ranked lower than others)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discrimination and racism</td>
<td>Spanish language survey, Persons of color</td>
</tr>
<tr>
<td>Poverty</td>
<td>College education or higher</td>
</tr>
</tbody>
</table>

#### Enjoy Most About Living in Lane County:

<table>
<thead>
<tr>
<th>Question and Issue</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong sense of community</td>
<td>Spanish language survey</td>
</tr>
<tr>
<td>Access to affordable healthy food</td>
<td>West Lane County</td>
</tr>
<tr>
<td>Transportation options</td>
<td>East Lane County</td>
</tr>
<tr>
<td>Perception of Community Safety</td>
<td>Women</td>
</tr>
</tbody>
</table>
**What are most important for creating a healthy community?**

‘Access to health care’ and ‘access to affordable, healthy food’ ranked in the top two across all demographic groups. ‘Good jobs and a healthy economy’ also ranked in the top five indicators across groups, with women ranked ‘affordable housing’ above ‘good jobs’, while men ranked them in reverse order. Community members living in North Eugene also ranked ‘affordable housing’ before ‘good jobs’, while the residents of other areas ranked jobs’ before housing.

Also of note, there were statistically significant differences in the ranking of ‘affordable housing’ and ‘access to services for children and families’ between respondents with college degrees and those with less than a college education. Those with a college education tended to rank these indicators of a healthy community lower than those without.

**Which problems do you feel have the biggest impact on health in your community?**

The top five problems that impact community health, with minor differences in priority ranking, remained the same across all demographic categories. While ‘poverty’ ranked in the top four overall, there was a statistically significant difference in rank between respondents with a college education compared to those without.

Another notable and statistically significant (at 95% confidence) exception is that 39.1% of respondents that took the survey in Spanish reported ‘discrimination and racism’ as a top three community health problem, ranking it fourth overall. Only 7.9% of respondents who took the survey in English included ‘discrimination and racism’ as one of the top three problems, and it ranked 11th overall. Other racial and ethnic groups also tended to rank ‘discrimination and racism’ higher than white or Caucasian-identified respondents. Respondents who identified as Native American also ranked ‘discrimination and racism’ among the top five biggest problems affecting health in our community. Respondents who earn less than $20,000 in income also ranked ‘discrimination and racism’ in the top five problems. It should be noted that there is significant overlap between this group and the respondents who completed the survey in Spanish.

The following chart indicates the percent of survey respondents who ranked ‘discrimination and racism’ among the top three problems impacting health in their community.

<table>
<thead>
<tr>
<th>Ranked Higher</th>
<th>Ranked Lower</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Race/Ethnicity:</td>
<td>Caucasian, 7% Non-Hispanic, 7.7%</td>
</tr>
<tr>
<td>Asian, 12%</td>
<td></td>
</tr>
<tr>
<td>Native American, 19%</td>
<td></td>
</tr>
<tr>
<td>Mixed, 23%</td>
<td></td>
</tr>
<tr>
<td>Hispanic, 21.8%</td>
<td></td>
</tr>
<tr>
<td>Unknown, 20%</td>
<td></td>
</tr>
<tr>
<td>By Geography:</td>
<td>West Lane, 7.8% South Eugene, 7.7% East Lane, 3.9%</td>
</tr>
<tr>
<td>Springfield, 12.3%</td>
<td></td>
</tr>
<tr>
<td>North Eugene, 10.6%</td>
<td></td>
</tr>
<tr>
<td>By Age:</td>
<td>40-54, 7.3% 55-64, 7.1% 65-74, 4.6% 75-84, 0%</td>
</tr>
<tr>
<td>18-25, 15.5%</td>
<td></td>
</tr>
<tr>
<td>26-39, 11.8%</td>
<td></td>
</tr>
<tr>
<td>By Type of Survey:</td>
<td>English Language, 7.9% Online, 8%</td>
</tr>
<tr>
<td>Spanish Language, 39.1%</td>
<td></td>
</tr>
<tr>
<td>Paper, 13.2%</td>
<td></td>
</tr>
</tbody>
</table>

*2015-2016 Community Health Needs Assessment | 21*
What do you enjoy most about living in the Lane County region?
There was widespread agreement across all demographic groups of survey respondents that the ‘availability of parks and recreational opportunities’ is the top enjoyment about living in the Lane County region. The only exception was that respondents in age group 74-85 reported ‘access to affordable, healthy food’ as what they enjoy most.

The top five things people enjoy most about living in the region tend to be the same across the demographic groups with minor difference in the order of priority. The most notable exception is among respondents who took the survey in Spanish, “strong sense of community and community engagement” did not rank in the top ten – only 7.8% of respondents included this in their top three.

Also of note, respondents from West Lane did not rank ‘access to affordable, healthy food’ in their top five and respondents from East Lane did not rank ‘transportation options’ in their top five. Both of those communities included ‘safe neighborhoods’ in their top five.

How healthy are you?
Like the rest of the demographic analysis, there are tremendous similarities in these responses across most demographic groups. A notable difference is that 46% of Native Americans reported they were ‘somewhat healthy’ and 31% reported they were ‘healthy’, compared to 30% and 50% respectively in the overall respondent population. Also of note, 40% of South Eugene residents reported that they were ‘very healthy’ compared to 20-25% of the respondents overall and only 10% of South Eugene residents reported being ‘somewhat healthy’ compared to 20% overall. Lower income was associated with fewer respondents reporting to be ‘very healthy’ and greater rates of those reporting to be ‘somewhat healthy’.

How healthy is your community?
As with the overall survey, respondents reported their community to be less healthy than they themselves were. There were no exceptions to this when analyzed by demographic groups.

How safe is your community?
West Lane residents had the highest percentage of respondents reporting that they consider their community ‘very safe’ (10.5%). Also of note, women tended to rate their community as ‘somewhat safe’ compared to ‘safe’ at higher rates than men, but overall our community is considered safe by a vast majority of our residents.
Agree/Disagree Statements
Overall, there were only a few differences when conducting a demographic analysis of the agree/disagree statement, which are reported in the following table.

<table>
<thead>
<tr>
<th>Overall</th>
<th>Native American</th>
<th>West Lane</th>
<th>Spanish</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>My opinion matters in my community.</td>
<td>68%</td>
<td>32%</td>
<td>46%</td>
</tr>
<tr>
<td>I am satisfied with the quality of the health care system in my community.</td>
<td>61%</td>
<td>39%</td>
<td>40%</td>
</tr>
<tr>
<td>I am satisfied with the availability of health care providers in my community.</td>
<td>57%</td>
<td>43%</td>
<td>39%</td>
</tr>
<tr>
<td>There are enough health and social services to meet the needs of the community.</td>
<td>30%</td>
<td>70%</td>
<td>54%</td>
</tr>
</tbody>
</table>

DEMOGRAPHICS
The eight demographic questions included home zip code, age, household language, marital status, gender identity, education level, race/ethnicity, and income. The language (English or Spanish) in which the survey was taken was also recorded. Some information is incomplete due to respondents choosing not to answer all demographic questions. Demographic totals are reported below.

When compared to the Lane County population (U.S. Census 2013 5-Year Estimates), the survey population is generally younger, higher educated, more racially and ethnically diverse, and more likely to be a woman than the general population. All regions of the county are represented, although residents are slightly more likely to be from districts 3 & 4 (North and South Eugene) and West Lane is underrepresented. Survey population and Lane County population comparison charts can be found in the Appendix.
Language Survey Taken
The community health survey was made available in two languages: English and Spanish. The majority of respondents took the survey in English, and about 5% took it in Spanish.

<table>
<thead>
<tr>
<th>Language</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>2201</td>
</tr>
<tr>
<td>Spanish</td>
<td>94</td>
</tr>
</tbody>
</table>

Age
Participants were asked to identify their age by selecting the applicable age range from the options provided. The majority of the respondents who answered this question were between the ages of 26 and 64, and about 10% were 65 or older.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>20</td>
</tr>
<tr>
<td>18-25</td>
<td>162</td>
</tr>
<tr>
<td>26-39</td>
<td>546</td>
</tr>
<tr>
<td>40-54</td>
<td>556</td>
</tr>
<tr>
<td>55-64</td>
<td>431</td>
</tr>
<tr>
<td>65-74</td>
<td>144</td>
</tr>
<tr>
<td>75-84</td>
<td>27</td>
</tr>
<tr>
<td>85 and older</td>
<td>2</td>
</tr>
<tr>
<td>Prefer Not to Answer</td>
<td>47</td>
</tr>
</tbody>
</table>

Gender Identity
Nearly 75% of the respondents who selected a gender option identified themselves as female. Males were underrepresented in this survey as they account for approximately half of the general population in Lane County.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>1401</td>
</tr>
<tr>
<td>Male</td>
<td>446</td>
</tr>
<tr>
<td>Intersex</td>
<td>1</td>
</tr>
<tr>
<td>Transgender</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>Prefer Not to Answer</td>
<td>73</td>
</tr>
</tbody>
</table>
Marital Status
Over half of the respondents indicated they were married or partnered.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>465</td>
</tr>
<tr>
<td>Widowed</td>
<td>49</td>
</tr>
<tr>
<td>Divorced</td>
<td>220</td>
</tr>
<tr>
<td>Married/Partnered</td>
<td>1109</td>
</tr>
<tr>
<td>Prefer Not to Answer</td>
<td>89</td>
</tr>
</tbody>
</table>

Annual Income
Approximately 60% of the survey respondents earn less than $50,000 per year.

<table>
<thead>
<tr>
<th>Annual Income</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $20,000</td>
<td>386</td>
</tr>
<tr>
<td>$20,000 - $29,999</td>
<td>215</td>
</tr>
<tr>
<td>$30,000-$49,000</td>
<td>362</td>
</tr>
<tr>
<td>Over $50,000</td>
<td>710</td>
</tr>
<tr>
<td>Prefer Not to Answer</td>
<td>230</td>
</tr>
</tbody>
</table>

Highest Level of Education Completed
Slightly more than two thirds of the respondents who answered this question held an associate or technical degree or higher.

<table>
<thead>
<tr>
<th>Highest Level of Education</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school diploma</td>
<td>65</td>
</tr>
<tr>
<td>High school diploma/GED</td>
<td>165</td>
</tr>
<tr>
<td>Some college, no degree</td>
<td>363</td>
</tr>
<tr>
<td>Associate/technical degree</td>
<td>209</td>
</tr>
<tr>
<td>Bachelors Degree</td>
<td>531</td>
</tr>
<tr>
<td>Advanced Degree</td>
<td>504</td>
</tr>
<tr>
<td>Prefer Not to Answer</td>
<td>66</td>
</tr>
</tbody>
</table>
Residence
Analysis of the home zip codes confirmed that the survey reached all corners of the Lane County community and that the perspectives of those who work and play in the region were also captured. These numbers are relatively similar to the Lane County population.

<table>
<thead>
<tr>
<th>Residence</th>
<th>Paper Responses</th>
<th>Online Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eugene/Springfield Metro</td>
<td>266</td>
<td>1097</td>
</tr>
<tr>
<td>Rural</td>
<td>123</td>
<td>249</td>
</tr>
<tr>
<td>Prefer Not to Answer</td>
<td>39</td>
<td>132</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eugene</td>
</tr>
<tr>
<td>Fall Creek</td>
</tr>
<tr>
<td>Florence</td>
</tr>
<tr>
<td>Harrisburg</td>
</tr>
<tr>
<td>Junction City</td>
</tr>
<tr>
<td>Leaburg</td>
</tr>
<tr>
<td>Lowell</td>
</tr>
<tr>
<td>Mapleton</td>
</tr>
<tr>
<td>Marcola</td>
</tr>
<tr>
<td>Noti</td>
</tr>
<tr>
<td>Oakridge</td>
</tr>
<tr>
<td>Pleasant Hill</td>
</tr>
<tr>
<td>Reedsport</td>
</tr>
<tr>
<td>Springfield</td>
</tr>
<tr>
<td>Swisshome</td>
</tr>
<tr>
<td>Tangent</td>
</tr>
<tr>
<td>Veneta</td>
</tr>
<tr>
<td>Vida</td>
</tr>
<tr>
<td>Walterville</td>
</tr>
<tr>
<td>Walton</td>
</tr>
<tr>
<td>Westfir</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>
Race/Ethnicity
The majority of respondents identified themselves as White/Caucasian, but there were respondents from all race/ethnic groups listed.

- Other White: 100
- Eastern European or Slavic: 37
- Western European: 132
- Middle Eastern or Northern African: 10
- White/Caucasian: 1430
- Other Latino: 22
- South American: 20
- Central American: 19
- Mexican-American: 56
- Mexican: 64
- Other Pacific Islander: 11
- Guamanian or Chamorro: 3
- Native Hawaiian: 11
- Native American: 121
- Other Asian: 11
- Asian American: 33
- Laotian: 4
- Hmong: 3
- Korean: 7
- Vietnamese: 6
- Chinese: 13
- Other Black: 10
- Caribbean: 10
- African-American: 44
- Other: 40
- Prefer Not to Answer: 111

Preferred Language at Home
Most respondents indicated that they speak either English or Spanish at home.

- English: 1648
- Spanish: 67
- Both English and Spanish: 18
- Cantonese: 1
- Danish: 1
- Russian: 1
- Mam: 2
- French: 3
- Navajo: 1
- Hini: 1
- Norwegian: 1
- American Sign Language: 3
- Other: 2
- No Answer: 146
COMMENTS

Included at the end of community health survey was a section for respondents to contribute any additional comments. Nearly 300 of the survey respondents took advantage of this opportunity. Review of the commentary was helpful for the subcommittee to gain a greater understanding of the issues community feel are most important. Below are select comments.

This community feedback and input was categorized according to content. The comments covered a vast array of topic areas, including the role of local government and healthcare, education issues, homelessness and poverty, recreation, human services, community development, mental health, and access to services. A large majority of comments focused on the importance of collective impact to achieve our vision of a healthy community.

The commentary provided a greater level of depth to the survey as the subcommittee members learned more about why the respondents made the selections they did. In the future, this community input will also be useful to the community as Live Healthy Lane begins to address emerging strategic issues.

“Thanks for engaging the community and asking for my opinion!”

“This kind of program is very important to the health of the community. Lane County is a great place but we all can make it better.”

“We all need to work together as a local community to insure the health of ALL; regardless of education, income, legal status.”

“I believe if all health care providers, (PCP, mental health, specialists, social services) pulled together to meet all of the needs of a consumer that person would be better served and healthier and in the end so would our community!”

“The health care providers in Lane County need to work together to provide a solid connected (wired) framework to manage the health care needs of the population. There is enough money being spent, it needs to be re-allocated and re-distributed.”

“A continued commitment to safety, education, health services, good public transportation and good access to food and affordable housing for those in need is very important.”

“Please continue to broaden the definition of preventative health care practices to include all aspects of a healthy lifestyle: walkable neighborhoods, school garden education, community gardens, farmers markets, healthy school meals.”

“While access to healthcare continues to be an issue in Lane County, the bigger challenge is being able to pay for it once accessed. Prevention is key to a healthier community. Treating illness and disease after the fact is costlier and prohibitive.”

“We recently moved to Lane County and chose this community because we saw a lot of community involvement and a real desire to improve the town.”
“I think Lane County is on a great path to becoming a very healthy community; however I think we still need to make access to mental health more assessable.”

“Thank you for giving the Hispanic community services and opportunities to participate.”

“I appreciate all of the help being provided for the needy, including me, in this community -- And appreciate too, the attitudes and helpfulness of the people providing information and volunteer help at various agencies.”

“Safety and access are completely driven by socioeconomic status.”

“We must be mindful of sustainability and our impact on our beautiful environment as we move forward in our community.”

“I live in a small town in Lane County; realities are different in rural communities than they are in the Eugene/Springfield metro communities. I hope we can strengthen our rural networks in the years to come.”

“It is important that large health care organizations take into account that population demographics vary dramatically in each region---and that staffing needs should reflect that diversity. There cannot be a "standard, across the board or region" approach to providing care in each location---it needs to be regionally tailored.”

“I appreciate this attempt to look at these complex issues. I have already registered my questioning of these types of break-down issues we face. My higher socioeconomic status, education, professional experiences, and being white skinned obviously bring me more access to resources for my well-being.”

“There appear to be many needs in our community that others are simply not aware of. This leaves a big spread between the haves and have nots.”

“Supporting people to make informed lifestyle choice to optimize their health seems to be more and more important. Hopefully, the community needs assessment will include a robust plan to address this issue. Thanks for the work that you are doing to improve health in Lane County!”

“It is imperative for social services, health services, and educational organizations to work together to create a plan for the health of our county.”

“Thank you for this opportunity and I appreciate all efforts by all of us working together to continue to improve our community on many levels.”

“Thank you for working on these issues in our community!”
Community Themes and Strengths Assessment
♦ Focus Groups ♦

PROCESS

The CTS subcommittee recognized the value of focus groups to gain a more in-depth understanding of the issues that were most important to the community. Conducting facilitated focus groups as a data collection tool was considered a good supplement to the data acquired through the community health survey. Utilizing this qualitative data collection method, the subcommittee aimed to engage leadership stakeholder groups and acquire meaningful input from a broad representation of community members.

Fifty focus groups were held across the region between August 24 and December 9, 2015. Of the focus groups, thirty were provider/leadership stakeholder groups representing diverse organizational sectors. Twenty of the focus groups consisted of targeted community members with participation from a number of underrepresented populations, including rural residents, Latinos, youth, LGBTQ+, disabled, homeless, and low income. Forty-seven focus groups were conducted in English, and three were conducted in Spanish. The complete list of focus groups is listed in the Appendix. In total, 500 community members and stakeholders participated in the focus groups. On average, each focus group included ten participants and took approximately one hour to complete.

In order to promote consistency in data collection and reporting, the subcommittee developed a detailed focus group guide (available in English and Spanish) and all facilitators completed a one-hour training. The focus group guide included the facilitator’s script, recommendations on how to effectively conduct the focus group (facilitate and record), and a summary table template to document the findings.

After being informed of the purpose of the Community Health Needs Assessment focus group, and reading and signing a consent form agreeing to serve as a participant, four questions were presented to each group:

Community Members Focus Groups:
1. Thinking about your life right now, what helps you or your family to be healthy and thriving?
2. What else would help you to be healthy and thriving?
3. Where is our community doing well and where are we not doing well?
4. Based on the list created from questions 1 and 2, which three are most important to you?

Provider/Leadership Stakeholders Focus Groups:
1. Thinking about the people your organization serves, what do you see as helping them to be healthy and thriving right now?
2. What else would help them to be healthy and thriving?
3. Where is our community doing well and where are we not doing well?
4. Based on the list and from the perspective of your organization, which three would be most important to the people served?

For the purposes of the focus group discussions:
“Community” refers to all those who live, work or play in the Lane County region.
“Healthy” refers to the broad definition: a state of complete physical, mental, and social well-being and not just the lack of disease or illness.
“Thriving” means more than just surviving, it includes growth and positive development.
Each facilitator focused on encouraging conversation that revealed participants’ feelings and thoughts. Responses to Questions #1 and #2 were solicited via round-robin discussion with responses recorded on flipcharts. Question #3 was approached popcorn style. Identified community strengths were highlighted with a green marker on a flipchart, while community weaknesses were highlighted with a red marker. Health disparities were characterized by topics receiving both red and green marks. Finally, participants individually answered Question #4 based off the list of responses created from Questions #1 and #2. Upon completion of the focus group discussion, participants were informed of the next steps and completed a demographics survey and a focus group evaluation form.

**DATA ANALYSIS**

Focus groups responses captured on the flip charts were entered into a spreadsheet and coded categorically around similar topics. Focus group data was twice coded to ensure inter-rater reliability. After the qualitative data was coded, each topic was assigned a priority score based on the number of participants identifying it as high importance (focus group Question #4). Each topic was also assigned a strength/weakness/disparity score based on the average of responses from focus group Question #3.

Focus group data was analyzed collectively, as well as by sector and target population. While the overall results were strikingly consistent, the CTS Subcommittee members probed further and examined the data within each focus group and target population. The purpose of the detailed analysis was to identify the ranges of priorities in a diverse community. However, the findings illustrated that there was relatively little divergence and a high level of agreement across most sectors and demographic groups on the most significant community strengths, health-related issues, and areas for improvement.

The discussions from each focus group provided a greater level of detail about what is necessary for a healthy and thriving community, and identified where health disparities are perceived to be most prominent. The following sections provide the key themes of the focus group discussions as well as select comments. It is important to note that the responses and findings reflect the perceptions of those participating in the focus groups and may not necessarily represent all community members and providers in the Lane County region.
FOCUS GROUP RESULTS – COMMUNITY STRENGTHS

Parks and Outdoor Spaces
Focus group participants frequently mentioned the quality and quantity of local parks and outdoor spaces. The ease of accessing clean parks and outdoor activities helps our community members to be healthy and enjoy outdoor activities.

- “There are so many community parks, bike paths, safe and well kept running trails and other outdoor exercise opportunities.”
- Because of the climate and where we live, there are a lot of options to outdoor recreation for physical activity.”
- “We are lucky that we have parks and open space here.”
- “I think Lane County is very beautiful. We have a lot of nature and areas to walk.”

Organizational Collaboration
The ongoing work between agencies throughout the region demonstrates excellent organizational collaboration. The partnering between local non-profits, government agencies, and other organizations were identified as successful collaborations that aim to make collective community impact.

- “Lane County is really different than a lot of communities. There is a lot of collaboration between organizations and community members to work toward the common good.”
- “Our community is really trying to support each other in changes and trying to move the impact needle.”
- “We aren’t trying to do good work because it’s the right thing to do, we are trying to do good work because we want better outcomes.”

Community Engagement and Involvement
Volunteerism and community support in the county is strong and there are numerous opportunities to be involved. Overall, there is strong engagement, investment, and involvement across the community.

- “I think we have an amazing community.”
- “There are so many places to volunteer, and I know many people who volunteer.”
- “When there is a need people pull together and step up to the plate.”

Public Awareness of the Social Determinants of Health
Knowledge of the social determinants of health puts the community on a progressive track for improved health and addressing issues such as housing, income, and access to education. Focus group participants appreciated the community based organization’s recognition of these social determinants of health and the gaining momentum of addressing these root issues.

- “A few years ago it was all about repair. We are now starting to see incremental changes in investing in prevention.”
- “Your location can make it very difficult even if you want to live healthy.”
- “Living on the streets makes it hard for people to be healthy.”
- "When it comes to healthcare, it isn't just about providers, but also about helping people with the access to living healthy lives."
**Focus Group Results - Priorities**

*What are most important for you, your family, and/or the people your organization serves to be healthy and thriving?*

Results from the 50 focus groups found the most frequently selected indicators of a healthy and thriving community to be:

- Services for Vulnerable Populations
- Access to Affordable and Quality Housing
- Collaboration, Coordination and Navigation of Resources/Services
- Access to Affordable Healthcare
- Mental Health Care and Mental Wellness
- Food Security and Access to Healthy Foods
- Education and Schools

![Diagram of health-related focus areas]
The table above depicts the number of participants who selected the option. The total is more than the number of focus group participants as each participant was asked to select three priorities for health and quality of life.
FOCUS GROUP RESULTS – TOP PRIORITY DISCUSSION

The following section provided a greater level of detail from the focus groups and select quotes from participants regarding the top identified indicators of a healthy and thriving community.

Services for Vulnerable Populations

Focus group results identified services for certain populations as one of the highest priorities for the community and its members to be healthy and thriving. Residents appreciate the organizations that provide critical services and resources in the region. However, there are still not enough health and social services to meet the growing needs of vulnerable populations in the community.

- “We are a resource rich community, but the resources aren’t available to everyone.”
- “Access is an issue across the board for our community - there are huge disparities depending on the population.”
- “Some residents - including vulnerable populations - have access to programs and services that encourage healthy living. In many other communities it is only the wealthy that has access.”

Populations Needing Appropriate Services

Homeless

Children & Families

Low-Income

Undocumented

Ethnic Minorities

Seniors

Disabled

Un- or Under-Employed

Rural

LGBTQ+

The graph above depicts the number of participants who indicated the population as in need of services.

Homeless

There is an increasing need for homeless shelters and other services (e.g. medical) for the homeless population. Occupy Medical, a homeless medical care bus, was recognized as a community asset. In addition to providing services, health and human service organizations should focus on identifying and addressing the root causes of homelessness.

- “People here are very attentive to trying to find solutions, but it is still so overwhelming.”
- “As a community we have a willingness to see the problem, we don’t hide our homeless and we haven’t yet made it illegal to pan handle. I appreciate the fact that our problems are visible, and that is the first step to solving them.”
Children and Families
Access to youth scholarships, summer programs, teen programs and activities, school health and dental clinics, and parenting classes were identified as crucial to the health and quality of life in our community. Often there are cost barriers associated with activities for children and families, but many indicated the availability of free local activities and services.

- “Services for children and families are fragmented, and we have trouble connecting families to resources.”

Low-Income
Low-income individuals and families often struggle with the stress of the high cost of living (including housing and child care), access to financial resources, and affordable healthcare. They also encounter difficulties in accessing resources and services to improve their health and quality of life.

- “It’s important that the system understands that for the people we work with, there is a culture of poverty and hopelessness.”
- “People who are lower income can’t pay fees so they can’t participate in a lot of activities that lead to positive social connections.”

Spanish Speaking Community
Discussions focused on the current challenging issues for the Latino and Hispanic population—specifically the lack of culturally and linguistically appropriate care and limited educational and employment opportunities. Barriers such as language, transportation and citizen status often inhibit this population from accessing and receiving services. Services do exist, but cannot fulfill the needs of the growing Hispanic and Latino population. There is a lack of local bilingual providers and interpretation services. Incorrect interpretation is often an additional issue. It was frequently mentioned that the inability to obtain a driver’s license is a barrier to employment and receiving services.

- “We need more culturally appropriate bilingual health care and human services.”

Seniors
Our community has a rapidly aging population, resulting in a growing need for more appropriate health and human services, activities, and programs for seniors.

- “There are a lot of elderly people that are isolated in rural areas and they are semi homebound. There are not a lot of activities for them to participate in. There is no transportation for them to go and meet with other people and do activities. We have a large senior population and no senior center.”

Disabled
Participants mentioned the need for more physical activity services for those with disabilities. Additionally, there is a need for more extensive and special education for disabled children.

- “The things that keep people with disabilities safe when they are out and in the community need to be improved.”

Rural
Rural community members’ greatest barrier is that services are located in the metro area. The problem is further exacerbated by the lack of public transportation to the rural communities.

- “Your location can make it very difficult even if you want to live healthy.”
- “We have a lot of resources in Lane County, but the access is the questionable part. In the metro we have a lot of resources, but not in rural.”
- “Rural Lane County struggles with obtaining funding and resources.”
Access to Affordable and Quality Housing

Challenges around access to affordable and quality housing were mentioned in almost every focus group. Residents described the struggle to pay the disproportionally high housing costs compared to income.

Rising housing costs were described as forcing residents to move to more affordable areas which could be further from reliable public transportation and other community resources. Participants also indicated that the lack of affordable housing is resulting in a transient population; this instability was described as creating challenges for the school system to educate frequently mobile children. In addition to affordability, substandard housing was also mentioned as a concern and frustration was expressed with the lack of apartment and facility maintenance.

University of Oregon students also noted the challenges of finding affordable housing close to the University and without substandard conditions. Due to a large student population, housing access is a difficulty for many students.

Homelessness was commonly discussed as a concern due to the lack of affordable and supportive housing. Participants indicated that this vulnerable population, including children who are homeless, is growing. Participants also identified increased costs in the housing market, monthly rent, utilities, and other challenges that lead to homelessness.

Collaboration, Coordination, and Navigation of Resources and Services

Collaboration

Throughout the discussions, focus group participants recognized the strong collaborative health work between organizations. There are numerous partnerships, many of which address the health and quality of life issues identified throughout this assessment. These collaborations are considered critical to achieving change in the region. Participants also credited public engagement and leaders who value health for their dedication towards tackling these issues.

Numerous services, resources, and organizations are working to tackle the population’s health and social service needs. Residents appreciated the quantity of organizations that provide critical services, especially for vulnerable populations. These organizations were described as community assets, especially for their willingness to collaborate and their committed, innovative leadership.

Coordination

Despite the strong history of collaboration, it was repeatedly commented that many efforts and services in the area are fragmented, uncoordinated, and under-funded. Also, participants highlighted that access to services and resources should be more integrated and better coordinated. By focusing on integration and coordination needs across sectors and within agencies, system-wide measurable outcomes would increase and a duplication of efforts would decrease. Additionally, limited resources would be efficiently utilized.
Participants also expressed that there are sticking points between moving past the planning phase of collaborative efforts and into the action cycle. There was strong interest for these issues to be addressed via a more strategic, coordinated approach with multiple organizations and agencies working together. Overall, participants were hopeful for the future and saw that the work occurring in the region would increase in momentum to implement innovative, collaborative approaches towards health.

**Awareness of Resources and Services**

Participants repeatedly stated that people in the community are not always aware of the resources that are available to them. The need to improve communication and awareness about existing resources and services was emphasized. While resources such as 211 are considered helpful, more than just information or a list of resources is necessary to navigate the system. In addition, participants saw the need for more community outreach and health education.

Despite the challenges to accessing services, focus group participants did note the multitude of resources available in the metro area. Residents living in more densely populated areas of Eugene and Springfield described having easier access to health care facilities, supermarkets, and other services and resources. However, there are numerous barriers in accessing these resources and services in the outlying rural areas.

**Navigation**

The importance and challenge of navigating systems, services, and resources was repeatedly mentioned throughout the focus groups. Participants described the health care system as complicated and difficult to navigate. Many highlighted health literacy and lack of knowledge as adding to the challenges of navigating a complex system, which creates a significant barrier to accessing services. Providers indicated that their clients often do not have the knowledge and skills to navigate the system and receive available resources.

**Access to Affordable Healthcare**

While it was recognized that there are large healthcare organizations in the region, many noted that affordable and timely care is lacking. Though the majority of the population now has health insurance, there are still barriers to accessing health care. There are also still individuals without health insurance or who are underinsured.

It is important for the system to create and maintain partnerships and expand access by adding staff, reducing costs, and increasing availability of services. Participants expressed frustration in trying to find providers that accept their insurance. Some indicated that they were fearful of using the health care system due to the unexpected costs, especially if they do not qualify for public assistance. Eligibility requirements, extent of coverage, and cost of prescription drugs were also frequently raised as barriers to care. Those who are not eligible for Oregon Health Plan but cannot afford private insurance or high deductibles were considered a vulnerable population.

It was also mentioned that the healthcare system capacity cannot meet the new demand since the expansion of Medicaid. Many expressed concern regarding a shortage of primary and specialty care physicians, facilities and clinics, and dental providers, especially in the context of a rapidly growing and aging population.
Focus group participants reported mixed experiences regarding quality of care. A few participants reported having negative experiences relating to stigma and discrimination, while other participants shared positive experiences.

Transportation can also be a barrier in accessing healthcare. There is a local county bus system, and a shuttle transportation service for seniors and people with disabilities, as well as Medicare and Medicaid clients through RideSource. According to many rural participants, the metro locations of facilities often are barriers to due to limited and costly transportation options.

**Mental Health Care and Mental Wellness**

Throughout the focus groups it was stated that the current need for mental health care surpasses the availability of services. People with mental health issues often experience stigma around seeking help, do not know where to access care, and find services difficult to navigate. People also experience lengthy wait times to meet with a mental health provider. Many indicated that affordability was an issue due to either coverage of health insurance or lack of health insurance. Concern was also expressed regarding mental health and wellness services available in schools. There is a growing need for early intervention and preventative mental health services.

Many noted that the issues of substance abuse and mental health are intricately intertwined, which makes addressing these issues even more challenging. Local treatment programs do exist, but the demand exceeds what is currently available. Integrating health care services and providing a continuum of care were seen as viable options for improving the capacity of the behavioral health system.

Many who are struggling with mental health issues are coming into contact with law enforcement, which often results in an arrest and is not an appropriate use of law enforcement services. Same day clinics and local organizations like Cahoots are working to fulfill the need for crisis intervention as an alternative for law enforcement intervention. The community feels that these organizations are doing well, but the services need to be expanded.

Community members and consumers who live in underserved and rural areas have added barriers to accessing mental health services. Additionally, many participants from non-English-speaking communities felt there is a lack of appropriate services. The lack of mental health care providers that are bilingual directly affects the timeliness of mental health services received by community members.
Access to Healthy Foods; Food Security

Having access to healthy foods was identified as necessary for the community to be healthy and thriving. An increasing number of stores across the region now have more of a variety of foods available to shoppers. However, a hindrance for purchasing these fresh foods continues to be affordability and location. Many expressed that some grocery stores are hard to access due to transportation barriers.

As a community, we do a good job of providing food for today, but we really need to work on how to provide access to food for tomorrow. Long-term food security and stability is a struggle for low-income and rural families in the county. Local non-profits such as FOOD for Lane County were mentioned as successfully providing food for a large number of individuals and families in need.

The growing school garden projects and local community gardens have helped make fresh foods affordable and available to many residents who would otherwise not have access. Additionally, the region is known for the abundance of Farmers Markets which offers local produce.

Education and Schools

Focus group participants expressed deep concern for the low high school graduation rate across the region compared to the state and national rates. Many felt that this could be improved, but also recognized that schools in the county have seen reduced funding leading to stretched resources.

Additionally, concern was expressed with families and children not receiving proper education in schools to support healthy behaviors (i.e. nutrition, exercise, and alcohol/drug prevention). Some were also troubled by the reduction of important school programs like PE, art, and music due to funding cuts. These programs are necessary in the education system to build a healthier community starting with the school age population. There was also noted to be an increasing need for more cultural diversity education in school.

The associated costs were mentioned as barriers to accessing higher education and vocational training. Peer, financial and academic support services are necessary for students to be able to thrive as they transition from the school to the workforce.

“There are a lot of organic and fresh produce here, but affordability is an issue.”

“We aren’t solving hunger, but we are feeding people.”

“In the past 20 years, I’ve seen Lane County go from being at the ‘top of our education game’ to the bottom at a national level.”

“We need better early education so kids have the best possible chance of doing well later in school and in life.”

“We need more academic support, especially for people of color.”

“In the past 20 years, I’ve seen Lane County go from being at the ‘top of our education game’ to the bottom at a national level.”
FOCUS GROUP THEMES BY SECTOR

What are most important for the people your organization serves to be healthy and thriving?

Results from the 30 provider/stakeholder focus groups found the priorities to be:

- Access to Affordable and Quality Housing
- Collaboration, Coordination, & Navigation of Resources/Services
- Services for Vulnerable Populations
- Access to Affordable Healthcare
- Mental Health Care and Mental Wellness

Focus group results were additionally organized by sector. The following section highlights the identified themes and select participant quotes. It is important to note that the each quote reflects an individual’s perspective and the themes reflect the perceptions of those participating in the focus groups and may not necessarily represent all providers in the Lane County region.

Mental/Behavioral Health

“We need more rapid access support centers like Whitebird. In terms of outreach, it’s hard to access care. Having somewhere where people can call or go with an open door.”

“There aren’t enough mental health resources in schools.”

Education

“Access to a quality education is an issue across the board for our community- there are huge disparities depending on the district.”

“In general our schools are safe and our kids have access to receiving a good education, but they are still lacking quite a bit.”
**Health Systems**

“Even in the face of significant disease, we try to treat the whole person and family unit as well.”

“Just because you have insurance doesn’t mean you have access to care.”

“One of the things we find to be extremely helpful is community health workers. That’s how we’ve been able to solve the access issues for many of our folks.”

**Human/Social Services**

“We get told all the time ‘you’re the first ones who have really listened to me’.”

“We aren’t where we want to be, but we work hard to be respectful and provide equitable access. But we want to be even better.”

“It requires a lot more than food and shelter to support homeless and get people back on their feet.”
Food Security Services

“We need to step out of the food box, and we need more focus on jobs, job training, and more long term access to food.”

“There needs to be more of a focus on nutritious food in the food box, families can’t get fully nutritional meals out of one pantry box.”

Housing

“There is a large focus on getting families in safe affordable housing, but individuals are falling through the cracks, and the waiting lists can be years long.”

“Affordable housing: what we do, we do well. But we don’t have enough.”

Public Safety

“There is not enough access to substance abuse treatment for those who need it.”

“Clients with serious mental health problems are being held in jail without proper mental health treatment.”

“We do a great job at protecting people from physical crime and harm.”
Focus Group Themes by Target Population

What are most important for you and your family to be healthy and thriving?
Results from the 20 community member focus groups found the priorities to be:

- Services for Vulnerable Populations
- Access to Affordable and Quality Housing
- Access to Affordable Healthcare
- Education and Schools
- Food Security and Access to Healthy Foods

Focus group results were additionally analyzed by target population. The following section highlights the identified themes and select participant quotes. It is important to note that the each quote reflects an individual’s perspective and the themes reflect the perceptions of those participating in the focus groups and may not necessarily represent all community members in the Lane County region.

Rural

“There is no access to mental health services in the rural area.”

“When there is a need in this community people pull together and step up to the plate.”

“A big glaring problem here is lack of mental health services and general preventative health services and prescriptions.”

Low-Income

“We need local access for those who fall between the cracks: those of us who make too much money to get OHP but not enough to pay for private insurance.”

“I think having a livable wage takes so much stress off people, so then they are able to live a healthy life and make healthy choices.”
**Homeless**

“There aren’t enough places for people who want to get clean to go for drug and alcohol treatment.”

“Eugene and Springfield are doing really well at feeding the homeless.”

“There are still negative stereotypes around how people feel about homelessness.”

**Latinos**

“We need more interpreters to fill out forms.”

“Volunteers in Medicine provide medicine and doctors.”

“There is a need for more English language programs that are available and affordable to all.”

**Teens**

“Homelessness is a huge problem. Instead of addressing it productively they are creating laws that are prohibiting homelessness”

“There are some teen sexual assault services but there aren’t enough.”

“We need better resources for homeless kids at school.”
College Students

“The transportation system is very good compared to a lot of places, but we need help navigating the LTD system.”

“There is an availability of resources and non-profits in the area, but as students, we need to have more knowledge on resources in the community and how to access them. There feels like a separation between campus and the community.”

“Lane County does a great job supporting active lifestyles”

“There are a lot of options for quality education, but none is really affordable because of the budget cuts and our costs are not affordable.”

“The UO campus culture is supportive for some, but not inclusive for all. There is a lack of focus on education about cultural diversity, and lack of spaces and groups that promote cultural diversity. We also need more resources for minorities to access and acknowledge that there are not resources for all minorities and all groups of people.”

Young Professionals

“We need more financial education for people who are in our age range. Our generation is very different and a lot of us are coming into adulthood with a lot of student loans. So even if we get to the place where we want to own our own home, how do we get there?”

“Time is always the limiting factor in my ability to be healthy and thriving.”
Parents

“The social environment in schools is very healthy. Kids are very compassionate and inclusive and tolerant of each other.”

“They just made marijuana legal, but don’t have anything around educating our youth.”

Disabled

“We need doctors who are aware that this is a team and not a hierarchy of leader and patient.”

“The things that keep people with disabilities safe when they are out and in the community need to be improved.”

LGBTQ+

“To feel welcomed in when you arrive is really important.”

“It is difficult to find a culturally appropriate mental health therapist for the LGBQT+ community.”

“We need to have some very clear way locally to get gay men on prep. Primary care physicians are refusing to treat HIV-related illnesses, which isn’t the case in other metro areas.”

“There aren’t any trans-specific medical healthcare providers in Lane County”
**DEMOGRAPHICS**

Focus group participants were asked to complete a demographic information sheet. This was a self-reporting form that mirrored the demographics questions included in the community health survey. The eight demographic questions included home zip code, age, household language, marital status, gender identity, education level, race/ethnicity, and income. Some demographic information is incomplete due to participants choosing not to answer all the questions. Compiled demographic results from all focus group participants who answered the demographic questions are listed below.

### Focus Group Language

The community health focus groups were conducted in two languages: English and Spanish. 454 individuals participated in Spanish focus groups, and 455 participated in English focus groups.

<table>
<thead>
<tr>
<th>Language</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>444</td>
</tr>
<tr>
<td>Spanish</td>
<td>45</td>
</tr>
</tbody>
</table>

### Age

Participants were asked to identify their age by selecting the applicable age range from 8 options. The majority of the respondents who answered this question were between the ages of 26 and 64, 14% were 25 or younger, and about 10% were 65 or older.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>19</td>
</tr>
<tr>
<td>18-25</td>
<td>49</td>
</tr>
<tr>
<td>26-39</td>
<td>95</td>
</tr>
<tr>
<td>40-54</td>
<td>132</td>
</tr>
<tr>
<td>55-64</td>
<td>97</td>
</tr>
<tr>
<td>65-74</td>
<td>46</td>
</tr>
<tr>
<td>75-84</td>
<td>4</td>
</tr>
<tr>
<td>85+</td>
<td>0</td>
</tr>
</tbody>
</table>

### Gender Identity

Nearly 70% of the participants who selected a gender option identified themselves as female. Males were underrepresented in this survey as they account for approximately half of the general population in Lane County.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>300</td>
</tr>
<tr>
<td>Male</td>
<td>132</td>
</tr>
<tr>
<td>Transgender</td>
<td>2</td>
</tr>
</tbody>
</table>
**Marital Status**
Well over half of the participants indicated they were married or partnered.

- Single: 115
- Widowed: 14
- Divorced: 42
- Married/Partnered: 260

**Annual Income**
Of the participants who indicated their annual income, 27% earn less than $20,000 while 45% earn $50,000 or more.

- Less than $20,000: 102
- $20,000-$29,999: 28
- $30,000-$49,999: 82
- $50,000 or more: 175

**Highest Level of Education Completed**
Slightly more than two thirds of the respondents who indicated their highest level of education completed held an associate or technical degree or higher.

- Less than High School: 32
- High School Diploma or Equiv.: 23
- Some College, No Degree: 62
- Associate or Technical Degree: 32
- Bachelor's Degree: 128
- Advanced Degree: 151
Preferred Language at Home
Most participants indicated that they speak either English or Spanish at home, with other languages were also noted.

<table>
<thead>
<tr>
<th>Language</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>377</td>
</tr>
<tr>
<td>Spanish</td>
<td>26</td>
</tr>
<tr>
<td>Both English and Spanish</td>
<td>10</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
</tr>
<tr>
<td>Bambana</td>
<td>1</td>
</tr>
<tr>
<td>French</td>
<td>2</td>
</tr>
<tr>
<td>Mam</td>
<td>2</td>
</tr>
<tr>
<td>Mandarin</td>
<td>2</td>
</tr>
<tr>
<td>Oromo</td>
<td>1</td>
</tr>
<tr>
<td>Catonese</td>
<td>1</td>
</tr>
</tbody>
</table>

Race/Ethnicity
The majority of focus group participants indicated themselves to be White/Caucasian, but there were participants from all race/ethnic groups.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other White</td>
<td>9</td>
</tr>
<tr>
<td>Eastern European or Slavic</td>
<td>8</td>
</tr>
<tr>
<td>Western European</td>
<td>23</td>
</tr>
<tr>
<td>Middle Eastern or Northern African</td>
<td>3</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>326</td>
</tr>
<tr>
<td>Other Latino</td>
<td>8</td>
</tr>
<tr>
<td>South American</td>
<td>4</td>
</tr>
<tr>
<td>Central American</td>
<td>14</td>
</tr>
<tr>
<td>Mexican American</td>
<td>17</td>
</tr>
<tr>
<td>Mexican</td>
<td>26</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>5</td>
</tr>
<tr>
<td>Guamanian/Chamorro</td>
<td>2</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>2</td>
</tr>
<tr>
<td>Native American</td>
<td>20</td>
</tr>
<tr>
<td>Other Asian</td>
<td>3</td>
</tr>
<tr>
<td>Asian American</td>
<td>5</td>
</tr>
<tr>
<td>Laotian</td>
<td>2</td>
</tr>
<tr>
<td>Hmong</td>
<td>2</td>
</tr>
<tr>
<td>Korean</td>
<td>2</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>2</td>
</tr>
<tr>
<td>Chinese</td>
<td>6</td>
</tr>
<tr>
<td>Other black</td>
<td>6</td>
</tr>
<tr>
<td>Caribbean</td>
<td>3</td>
</tr>
<tr>
<td>African-American</td>
<td>17</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
</tr>
</tbody>
</table>
Residence
Analysis of the provided home zip codes confirmed that focus group participants represented most areas of the Lane County community.

<table>
<thead>
<tr>
<th>Residence</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue River</td>
<td>2</td>
</tr>
<tr>
<td>Coburg</td>
<td>14</td>
</tr>
<tr>
<td>Cottage Grove</td>
<td>31</td>
</tr>
<tr>
<td>Creswell</td>
<td>4</td>
</tr>
<tr>
<td>Dexter</td>
<td>1</td>
</tr>
<tr>
<td>Elmira</td>
<td>5</td>
</tr>
<tr>
<td>Eugene</td>
<td>255</td>
</tr>
<tr>
<td>Florence</td>
<td>1</td>
</tr>
<tr>
<td>Junction City</td>
<td>4</td>
</tr>
<tr>
<td>Leaburg</td>
<td>1</td>
</tr>
<tr>
<td>Oakridge</td>
<td>15</td>
</tr>
<tr>
<td>Pleasant Hill</td>
<td>3</td>
</tr>
<tr>
<td>Springfield</td>
<td>61</td>
</tr>
<tr>
<td>Veneta</td>
<td>6</td>
</tr>
<tr>
<td>Westfir</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

**Final Thoughts**

The focus group participants were grateful for the opportunity to share their thoughts, concerns, and experiences. Many expressed their support for community-wide efforts to improve health in and look forward to being involved in the future. Below are select comments.

- “I appreciated people taking their time to come and see us, and listen to our voices. Every voice and idea was heard.”
- “I like how much community involvement there was.”
- “I learned some new things about what our community is doing well, and the areas for improvement.”
- “It was a very thought provoking process.”
- “I am excited to see where the next Community Health Improvement Plan goes.”
- “I appreciated the willingness to listen to our opinions.”
- “I liked the level of compassion.”
- “I liked everyone’s ideas of how we can make the community better.”
- “I felt like this actually may have an impact.”
- “It is inspiring to know how our voices will be used.”
Key informant interviews were selected as a qualitative data collection tool to gather in-depth input feedback from key leaders across the county and build awareness and support of the Community Health Needs Assessment and Community Health Improvement Plan.

Key informants are recognized as experts in their area who have authority or decision making power, access to resources, and can influence change. The CHNA Core Team, CHIP Workgroups, and Steering Committee identified potential key informants, who were contacted via email to request participation in an interview. The final key informants represented the following sectors: business, community and human services, criminal justice, education, emergency services, faith, government, law enforcement, media, medical/health services, mental/behavioral health, philanthropy, and transportation.

A total of 53 key informants from across the region were interviewed between September 25 and November 24, 2015. Each interview was conducted over the telephone by a trained United Way interviewer, and detailed notes were taken during the conversations. On average, the interviews lasted approximately 30 minutes.

In order to promote consistency in data collection and reporting, the CTS subcommittee developed a detailed key informant interview guide and all interviewers completed a one-hour training. The key informant interview guide includes the interviewer’s script and questions, recommendations on how to effectively conduct an interview, and a template to document the interview notes.

Key informants were asked to keep in mind the broad definition of health adopted by the World Health Organization: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity,” while sharing the perspectives they have from their current position as well as experiences living in this community. The following interview questions explored participants’ perceptions of the community’s critical health issues and suggestions for addressing these issues:

1. In general, how would you rate health and quality of life in the Lane County region?
2. In your opinion, has health and quality of life in the Lane County region improved, stayed the same, or declined over the past few years?
   a. Why? What factors have contributed to this?
3. Are there people or groups of people in the Lane County region whose health or quality of life may not be as good as others?
   a. Who are these people/groups?
   b. Why do you think their health/quality of life is not as good as others?
4. What barriers, if any, exist to improving health and quality of life in the Lane County region?
5. In your opinion, what are the most critical health and quality of life issues in the Lane County region?
6. What needs to be done to address these issues?
7. In your opinion, what else will improve health and quality of life in the Lane County region?
8. Is there someone who you would recommend as another “key informant” for this assessment?

Upon completion of the interviews, the notes were electronically entered and the key informants were informed of the next steps in the CHNA process and mailed a thank-you card.
**KEY INFORMANT CHARACTERISTICS**

The 53 key informants represented the following sectors from across Lane County and Reedsport: business, community and human services, criminal justice, education, emergency services, faith, government, law enforcement, media, medical/health services, mental/behavioral health, philanthropy, and transportation. The average number of years living in the county was 26.6 and the average length in the current job position was 10.7 years.

**Key Informants by Sector**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Number of Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business</td>
<td>2</td>
</tr>
<tr>
<td>Community &amp; Human Services</td>
<td>10</td>
</tr>
<tr>
<td>Criminal Justice</td>
<td>5</td>
</tr>
<tr>
<td>Education</td>
<td>5</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>1</td>
</tr>
<tr>
<td>Faith</td>
<td>1</td>
</tr>
<tr>
<td>Government</td>
<td>11</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>2</td>
</tr>
<tr>
<td>Media</td>
<td>2</td>
</tr>
<tr>
<td>Medical/Health</td>
<td>6</td>
</tr>
<tr>
<td>Mental/Behavioral Health</td>
<td>4</td>
</tr>
<tr>
<td>Philanthropy</td>
<td>3</td>
</tr>
<tr>
<td>Transportation</td>
<td>3</td>
</tr>
</tbody>
</table>

**Key Informants by Area Served**

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>1</td>
</tr>
<tr>
<td>Lane County</td>
<td>9</td>
</tr>
<tr>
<td>Eugene/Springfield</td>
<td>35</td>
</tr>
<tr>
<td>Creswell</td>
<td>2</td>
</tr>
<tr>
<td>Florence</td>
<td>3</td>
</tr>
<tr>
<td>Oakridge</td>
<td>1</td>
</tr>
<tr>
<td>Reedsport</td>
<td>1</td>
</tr>
<tr>
<td>Veneta</td>
<td>1</td>
</tr>
</tbody>
</table>
**Data Analysis**

Key informant interview responses were entered into a spreadsheet and coded categorically around similar topics. After the qualitative data was coded, each topic was assigned a total score based on the number of key informants who mentioned the topic.

Key informant data was analyzed collectively. When relevant, the findings were compared with the 2012 Community Health Needs Assessment, which consisted of 36 key informant interviews.

The following sections provide the results of the key informant interviews as well as select comments. It is important to note that the responses and findings reflect the perceptions of those participating in the interviews and may not necessarily represent all those who live or work in the Lane County region.

**Interview Results**

**How would you rate health and quality of life in the Lane County region?**

The 2012 key informant responses were similar to the 2015 interviews.

*Some key informants provided multiple responses*

**Has health and quality of life in the Lane County region improved, stayed the same, or declined over the past few years?**

In 2012 the majority of key informants indicated that health and quality of life in the Lane County region had declined over the past few years. The 2015 interviews indicate a notable shift: an almost even split between those who view health and quality of life as recently declining versus improving.
Why has the health and quality of life in the Lane County region either improved or declined?

<table>
<thead>
<tr>
<th>Declined</th>
<th>Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health System</strong></td>
<td><strong>Health System</strong></td>
</tr>
<tr>
<td>• Funding cuts &amp; over capacitated system</td>
<td>• Affordable Care Act/ OHP/ Insurance Access</td>
</tr>
<tr>
<td>• Fewer younger doctors; not enough providers</td>
<td>• Specialty care</td>
</tr>
<tr>
<td>• For-profit health systems: increased cost of care</td>
<td>• Disease is being treated</td>
</tr>
<tr>
<td>• Quality of life depends on insurance coverage</td>
<td>• Increased access to dental and behavioral health</td>
</tr>
<tr>
<td>• Less options for affordable &amp; quality healthcare</td>
<td>• Integrated behavioral health</td>
</tr>
<tr>
<td>• Lack of preventative medicine</td>
<td>• Mental health services available in jail</td>
</tr>
<tr>
<td>• ER &amp; urgent care access; Long wait times</td>
<td>• Prevention efforts</td>
</tr>
<tr>
<td>• Mental health resources</td>
<td>• More effort from health departments</td>
</tr>
<tr>
<td>• Focus on mental health crisis, not prevention</td>
<td>• Higher density of social services</td>
</tr>
<tr>
<td><strong>Healthy Behaviors and Health Status</strong></td>
<td><strong>Healthy Behaviors and Health Status</strong></td>
</tr>
<tr>
<td>• Increase of teen pregnancy</td>
<td>• Declining tobacco rates</td>
</tr>
<tr>
<td>• Rising obesity rates</td>
<td>• Smoking cessation of pregnant women</td>
</tr>
<tr>
<td>• Increasing suicide rate</td>
<td>• More active due to geographic location</td>
</tr>
<tr>
<td>• High accidental death rate</td>
<td>• Lifestyle awareness</td>
</tr>
<tr>
<td>• Increase in smoking</td>
<td>• Personal accountability for health</td>
</tr>
<tr>
<td>• Drug and alcohol abuse</td>
<td>• College town that is interested in access to education, mental, &amp; physical health</td>
</tr>
<tr>
<td>• Increased addictions &amp; mental health issues</td>
<td><strong>Environment and Safety</strong></td>
</tr>
<tr>
<td>• Increase in crime &amp; violence</td>
<td>• More farmers markets &amp; healthy food in stores</td>
</tr>
<tr>
<td>• Public safety in communities</td>
<td>• Metro area transportation</td>
</tr>
<tr>
<td>• Poor housing quality/safety</td>
<td>• Metro area parks &amp; walking/biking trails</td>
</tr>
<tr>
<td><strong>Socioeconomics</strong></td>
<td>• Traffic safety has increased</td>
</tr>
<tr>
<td>• Growth of poverty &amp; economic disparity; Recession/economic conditions</td>
<td>• Cleaner air than 50 years ago</td>
</tr>
<tr>
<td>• Inadequate amount of living wage jobs</td>
<td><strong>Socioeconomics</strong></td>
</tr>
<tr>
<td>• Continuing unemployment</td>
<td>• More available jobs &amp; resources</td>
</tr>
<tr>
<td>• Lack of affordable housing</td>
<td>• Improving economic situation; decrease of financial stress</td>
</tr>
<tr>
<td>• Increase of homeless population</td>
<td>• Awareness of social determinants of health &amp; emphasis of health as a broad perspective</td>
</tr>
<tr>
<td>• Difficult for homeless to be healthy</td>
<td>• Public is educated about privilege</td>
</tr>
<tr>
<td>• Declining quality of life for those without resources</td>
<td><strong>Community and Organizations/Services</strong></td>
</tr>
<tr>
<td>• Lack of cultural diversity</td>
<td>• Communication &amp; collaboration around projects between agencies (i.e. LTD and Trillium)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>• Involvement of rural communities</td>
</tr>
<tr>
<td>• Declining K-12 education systems</td>
<td>• Engaged institutions</td>
</tr>
<tr>
<td><strong>Community and Organizations/Services</strong></td>
<td>• Effort on improvement &amp; addressing problems</td>
</tr>
<tr>
<td>• Incoordination between gaps</td>
<td>• Investments in good population health outcomes</td>
</tr>
<tr>
<td>• Not looking at problems systematically</td>
<td>• Conversations about how we grow a sustainable community</td>
</tr>
<tr>
<td>• Ideas are not progressive or integrative</td>
<td>• Paying attention to homelessness issue</td>
</tr>
<tr>
<td>• Decline of relationship &amp; trust building</td>
<td>• More resources available for low-income</td>
</tr>
<tr>
<td>• Lack of implementation for good policies</td>
<td>• Active churches</td>
</tr>
<tr>
<td>• Difficult to access services &amp; agencies</td>
<td>• Use of libraries</td>
</tr>
<tr>
<td>• Allocation of resources is not equitable</td>
<td></td>
</tr>
<tr>
<td>• Few resources/services available for veterans</td>
<td></td>
</tr>
</tbody>
</table>
INTERVIEW RESULTS – CRITICAL ISSUES

What are the most critical health and quality of life issues in the Lane County region?

Results from the 2015 key informant interviews found the most frequently mentioned critical health and quality of life issues in the Lane County region are:

- Mental Health Issues and Care
- Health Disparities and Services for Vulnerable Population
- Healthcare Access and Affordability
- Access to Affordable Housing
- Alcohol/Drug Abuse and Addiction Treatment
- Poverty and Homelessness

In comparison, the 2012 key informant interviews revealed the most frequently reported critical health and quality of life issues to be:

- Poverty
- Access to Healthcare
- Obesity
- Substance Abuse and Services

Number of Key Informants Who Indentified Each Critical Issue

<table>
<thead>
<tr>
<th>Critical Issue</th>
<th>Number of Key Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Care</td>
<td>28</td>
</tr>
<tr>
<td>Services for Vulnerable Populations</td>
<td>17</td>
</tr>
<tr>
<td>Access to Affordable Healthcare</td>
<td>13</td>
</tr>
<tr>
<td>Addiction Treatment/Behavioral Health</td>
<td>13</td>
</tr>
<tr>
<td>Housing</td>
<td>12</td>
</tr>
<tr>
<td>Alcohol &amp; Drug Abuse</td>
<td>11</td>
</tr>
<tr>
<td>Homelessness</td>
<td>11</td>
</tr>
<tr>
<td>Finances/Income; Poverty</td>
<td>10</td>
</tr>
<tr>
<td>Education/Schools</td>
<td>9</td>
</tr>
<tr>
<td>Obesity</td>
<td>9</td>
</tr>
<tr>
<td>Prevention Services/Resources</td>
<td>9</td>
</tr>
<tr>
<td>Food Security</td>
<td>8</td>
</tr>
<tr>
<td>Collaboration, Coordination, &amp; Navigation</td>
<td>7</td>
</tr>
<tr>
<td>System Capacity</td>
<td>7</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>7</td>
</tr>
<tr>
<td>Community Attitudes &amp; values</td>
<td>6</td>
</tr>
<tr>
<td>Chronic Disease &amp; Condition</td>
<td>5</td>
</tr>
<tr>
<td>Employment</td>
<td>4</td>
</tr>
<tr>
<td>Economy</td>
<td>2</td>
</tr>
<tr>
<td>Food &amp; Nutrition</td>
<td>2</td>
</tr>
<tr>
<td>Public Transportation</td>
<td>2</td>
</tr>
<tr>
<td>Social/Community Connectedness</td>
<td>2</td>
</tr>
<tr>
<td>Dental Care</td>
<td>1</td>
</tr>
<tr>
<td>Environment</td>
<td>1</td>
</tr>
<tr>
<td>Ethnic/Cultural Diversity</td>
<td>1</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>1</td>
</tr>
<tr>
<td>Mental Wellness</td>
<td>1</td>
</tr>
<tr>
<td>Safety/Crime</td>
<td>1</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>1</td>
</tr>
</tbody>
</table>

In comparison, the 2012 key informant interviews revealed the most frequently reported critical health and quality of life issues to be:

- Poverty
- Access to Healthcare
- Obesity
- Substance Abuse and Services
INTERVIEW RESULTS – KEY THEMES

The following section provided a greater level of detail from the key informant interviews regarding the top six critical health and quality of life issues, the barriers that exist to making improvements to the issues, and what needs to be done to address the issues.

What needs to be done to address these critical health and quality of life issues?

In general, the key informants agreed that in order to address the current critical health and quality of life issues in the Lane County region, the local public health system needs to focus on collectively and creatively coordinating their efforts, services, and resources. By working toward a common goal and following a specific action plan, we will be able to efficiently and effectively utilize the resources we do have. While we are successfully mobilizing our community to address issues, more focus needs to be placed on the next step: banding together to work on the solutions utilizing a collective impact model.

“Let’s make the healthy choice the easy choice.”

“Health is everyone’s business, not just healthcare business.”

“Everyone in our community has a willingness to come to the table.”

“Rather than blame the lack of resources, we need to creatively figure out how to efficiently use utilize the resources we do have. The prioritization of resources needs to evolve.”

“Our community has great organizational programs that need to look further up the chain.”

“Lane County is rich in resources, but each person and organization is too busy just doing their own piece of the pie and aren’t seeing what others are doing.”

“We need to stop reinventing the wheel over and over again on an individual basis.”

“We have good social programs, but they are not well coordinated.”

“There needs to be a one stop location to connect all the resources.”

“We need to partner with other agencies to make resources more accessible, just like how LTD partnered with Trillium for RideSource.”
Mental Health

Mental health was the most frequently mentioned critical health and quality of life issue in the Lane County region by key informants. Interviewees reported rising rates of mental health conditions among residents in the region and the challenges caused by a shortage of mental health care providers and services. This shortage particularly impacts rural areas, ethnic minorities, homeless, and low-income individuals.

Due to the difficulty of navigating the mental health care system, there is a large population experiencing mental health issues but waiting until a crisis arises to seek treatment. Because many organizations focus on mental health crisis treatment, early intervention is not as widely available due to the constraint of the lack of resources in the community. The stigma associated with mental illness and experiences of discrimination were identified as additional challenges to seeking early intervention.

Several key informants described the local mental health system as “crisis driven.” As a result of the growing number of mental health needs, Eugene/Springfield metro services such as Cahoots cannot manage all the mental health crisis calls and law enforcement is commonly substituted for assistance. This scenario often results in the individual experiencing a mental health crisis being brought to jail. It was mentioned that a high percentage of the incarcerated population is dealing with mental health issues, so there is a growing need of expanding the mental health services in local jails.

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• System Capacity and Appropriateness of Care</td>
<td>• Expanding System Capacity</td>
</tr>
<tr>
<td>o Lack of mental health providers &amp; services, and too many patients</td>
<td>o Increase number of providers</td>
</tr>
<tr>
<td>o Increasing caseload of school counselors</td>
<td>o More mental health crisis beds in centers</td>
</tr>
<tr>
<td>o Shortage of bilingual/bicultural services</td>
<td>o More rapid access to mental health (White Bird &amp; Cahoots)</td>
</tr>
<tr>
<td>o Timeliness of mental health care</td>
<td>o Expand Cahoots services in rural areas</td>
</tr>
<tr>
<td>o Waiting until crisis/law enforcement gets called</td>
<td>o Increase number of bilingual/bicultural mental health providers that take into account religion &amp; cultural practices</td>
</tr>
<tr>
<td>o University campus care allows a limited number of mental health visits</td>
<td>o Increased psychiatry services</td>
</tr>
<tr>
<td>o Inconsistency of insurance coverage offered for mental health services</td>
<td>• Coordination</td>
</tr>
<tr>
<td>• Socioeconomics &amp; Access</td>
<td>o Coordinate mental health &amp; primary care</td>
</tr>
<tr>
<td>o Isolated rural areas &amp; a lack of access to transportation</td>
<td>• Treatment</td>
</tr>
<tr>
<td>o Low-income and working poor do not have time to make mental health appointments (also have the economic stress of taking time off work)</td>
<td>o Focus on ongoing treatment; services beyond Cahoots</td>
</tr>
<tr>
<td>o Access to health care insurance for the undocumented and gap population</td>
<td>o Create a system of treating &amp; managing mental health outside of the court/jail</td>
</tr>
<tr>
<td>• Education and Awareness</td>
<td>• Education and Awareness</td>
</tr>
<tr>
<td>o Stigma surrounding seeking treatment/care</td>
<td>o Improved understanding of mental health issues and cultural acceptance of mental health services</td>
</tr>
<tr>
<td>o Failing to deal with health as a broad concept</td>
<td>• Prevention</td>
</tr>
<tr>
<td>o Inconsistency of insurance coverage offered for mental health services</td>
<td>o Focus on the prevention of mental illness</td>
</tr>
<tr>
<td>o Increased psychiatry services</td>
<td>o Increase number of counselors in schools to have early intervention</td>
</tr>
</tbody>
</table>

“There are a lot of organizations that focus on mental health crisis, but not enough focus on prevention.”

“The struggle of the economy has left a lot of people with mental health issues behind.”
Healthcare Access and Affordability
There is a collective recognition on the importance of shifting healthcare from a business to a community investment. Key informants indicated that while the Affordable Care Act improved access to health insurance, access to affordable and quality healthcare is still a critical issue in the Lane County region. There still are a substantial number of people that do not have access to basic health services. Despite the healthcare reform, it can be extremely difficult to find providers who accept Medicare/Medicaid, and many informants felt that these individuals were not treated the same as people with private insurance. Additionally, the healthcare system is extremely difficult to navigate, and not everyone can understand insurance plans and medical billing procedures.

"All the burden is on the consumers of the health care system and navigating it can be extremely stressful."

In general, informants indicated that there is a shortage of local healthcare providers. It is not uncommon for residents to be assigned a primary care provider outside of the Lane County region. Positively, local hospitals and nonprofit organizations offer numerous free services to the community and are trying to find solutions to meet the increased need.

Dental care and dental emergency care were also identified as being difficult to access. Low-income children can get dental coverage through school dental clinics, but adults cannot. Some of the local dentistry schools offer reduced cost dental clinics, but not everyone is aware of these services.

### Barriers

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• System Capacity</td>
<td>• System Capacity</td>
</tr>
<tr>
<td>o Lack of providers</td>
<td>o Increase supply of PCPs</td>
</tr>
<tr>
<td>o Some clinics are not</td>
<td>o Create incentives for PCPs to accept more OHP patients</td>
</tr>
<tr>
<td>accepting new patients;</td>
<td>o Incentivize rural care</td>
</tr>
<tr>
<td>Doctors don’t want to</td>
<td>o Create mobile care for rural areas/extend city services</td>
</tr>
<tr>
<td>take on OHP</td>
<td>to rural areas/other vulnerable populations</td>
</tr>
<tr>
<td>o People go through</td>
<td>o Increase public health workers to improve the health</td>
</tr>
<tr>
<td>several Primary Care</td>
<td>of the community</td>
</tr>
<tr>
<td>Physicians because</td>
<td>o More home-based care</td>
</tr>
<tr>
<td>doctors are leaving</td>
<td>o Urgent care facility with X-ray in more rural areas</td>
</tr>
<tr>
<td>• System Complexity</td>
<td>• System Complexity</td>
</tr>
<tr>
<td>o Difficulty navigating</td>
<td>o Make it easier to navigate/understand</td>
</tr>
<tr>
<td>the health care system;</td>
<td>o CCOs provide more education about their services</td>
</tr>
<tr>
<td>burden/stress is on the</td>
<td>• Affordable Services</td>
</tr>
<tr>
<td>consumer</td>
<td>o Lift insurance limitation bans</td>
</tr>
<tr>
<td>o Complexity of OHP</td>
<td>o Create an Oregon insurance company</td>
</tr>
<tr>
<td>o Understanding of</td>
<td>• Insurance</td>
</tr>
<tr>
<td>medical rights</td>
<td>o Language and cultural barriers</td>
</tr>
<tr>
<td>• Insurance</td>
<td>• Appropriate Care</td>
</tr>
<tr>
<td>o Quality of care</td>
<td>o Access for Certain Groups (i.e. undocumented,</td>
</tr>
<tr>
<td>depends on coverage</td>
<td>gap population, homeless, rural)</td>
</tr>
<tr>
<td>o Not everyone has</td>
<td>• Socioeconomics</td>
</tr>
<tr>
<td>access to insurance</td>
<td>o Spiral of issues gets worse with stress</td>
</tr>
<tr>
<td>o Insurance structure</td>
<td>o Transportation barriers for rural population-less volunteer</td>
</tr>
<tr>
<td>is dictating how</td>
<td>drivers to pick up rural clients</td>
</tr>
<tr>
<td>medical business is run</td>
<td></td>
</tr>
<tr>
<td>• Cost</td>
<td>• Transportation Programs</td>
</tr>
<tr>
<td>o Cost of services &amp;</td>
<td>o Coordinate mental health &amp; primary care</td>
</tr>
<tr>
<td>copays are increasing</td>
<td>• Coordination across the healthcare system</td>
</tr>
<tr>
<td>• Appropriateness of</td>
<td></td>
</tr>
<tr>
<td>Care</td>
<td></td>
</tr>
<tr>
<td>o Language and cultural</td>
<td></td>
</tr>
<tr>
<td>barriers</td>
<td></td>
</tr>
<tr>
<td>• Access for Certain</td>
<td></td>
</tr>
<tr>
<td>Groups (i.e. undocumented,</td>
<td></td>
</tr>
<tr>
<td>gap population, homeless,</td>
<td></td>
</tr>
<tr>
<td>rural)</td>
<td></td>
</tr>
<tr>
<td>• Socioeconomics</td>
<td></td>
</tr>
<tr>
<td>o Spiral of issues gets</td>
<td></td>
</tr>
<tr>
<td>worse with stress</td>
<td></td>
</tr>
<tr>
<td>o Transportation barriers</td>
<td></td>
</tr>
<tr>
<td>for rural population-</td>
<td></td>
</tr>
<tr>
<td>less volunteer drivers</td>
<td></td>
</tr>
<tr>
<td>to pick up rural clients</td>
<td></td>
</tr>
</tbody>
</table>
Substance Abuse Issues and Addiction Treatment

Issues around drug and alcohol abuse were commonly mentioned by key informant participants. Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse significantly contribute to costly social, physical, mental, and public health problems, including: teenage pregnancy, STDs, domestic violence, child abuse, unintentional injuries, physical fights, crime, homicide, and suicide. In addition to addressing the addiction and other health implications, a major focal point in key informant interviews was the importance of substance abuse prevention, particularly among youth. Substance use is beginning early in adolescence, and informants worry that the age of first use continues to lower due to changing social norms.

Additionally, there is an unmet need for more rehabilitation and transitional services for individuals seeking affordable addiction treatment. Key informants worry about limited treatment facilities and lack of capacity to handle substance abuse referrals. Lane County does have several substance abuse treatment centers; however, these treatment centers cannot meet the overall needs of the community. Increasingly, local law enforcement is responding to substance abuse crises and there are then few alternatives available other than jail.

Key informants acknowledge that there is a lack of community knowledge of treatment services available and that the focus is often on the negative issues of alcohol and drug use, rather than the positive services available in the community. Interviewees centered heavily on the need for community to create the conversation by getting leaders involved, the community excited, and communication started.

### Barriers

<table>
<thead>
<tr>
<th>Restrictions</th>
<th>System Capacity - Treatment Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too strict for treatment facilities</td>
<td>Successful rehab process</td>
</tr>
<tr>
<td>System capacity</td>
<td>Treatment for substance abuse</td>
</tr>
<tr>
<td>Lack of services for behavioral health</td>
<td>More addiction recovery services</td>
</tr>
<tr>
<td>Lack of qualified addiction services</td>
<td></td>
</tr>
<tr>
<td>Lack of bed space</td>
<td></td>
</tr>
<tr>
<td>Lack of treatment facilities in rural areas</td>
<td></td>
</tr>
<tr>
<td>Prevalence</td>
<td></td>
</tr>
<tr>
<td>Addiction and drug issues are very prevalent in</td>
<td></td>
</tr>
<tr>
<td>certain areas of Lane County</td>
<td></td>
</tr>
<tr>
<td>Community Awareness</td>
<td></td>
</tr>
<tr>
<td>Lack of concern about drug use</td>
<td></td>
</tr>
</tbody>
</table>

### Potential Solutions

- Public Awareness
  - Taking a firm stance on drug problems
- Education and Policies
  - Comprehensive education and restriction on retail marijuana

“We need to have places for people to go when they are ready for treatment.”
### Homelessness and Poverty

Poverty and homelessness arose in nearly every interview as a critical factor that permeates the lives of many residents. While the economy has improved since coming out of the recession, there is still much work to be done. Over the past few decades, there has been a widening split between the low and high-income households.

Poverty was also discussed as a generational issue that was intensified by the economic recession and was a major contributor to many of the community's problems. Many identified poverty as the root of chronic stress experienced by families: parents needing to work multiple jobs, influencing the time available to provide support for their children, and affecting their mental and physical health.

Homelessness and poverty are inextricably linked. People at or below the poverty line are frequently unable to pay for housing, food, childcare, healthcare, and education. When limited resources are available to cover only some of these necessities, housing is often first priority. If you are low-income, you are essentially an illness, an accident, or a paycheck away from experiencing homelessness.

Key informants continuously noted that the percentage of homeless population steadily rose after the recession. The need for homeless services outweighs the resources available. Homeless people face specific challenges regarding health; interviewees stated that it is challenging for someone to think about health when that person is trying so hard just to survive. Positively, the community and organizations are beginning to focus on addressing these issues. Key informants mentioned community programs to address specific homeless populations such as the homeless youth with the “Fifteenth Night” Initiative.

#### Barriers

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economy</td>
<td>Policies</td>
</tr>
<tr>
<td>o Loss of the middle class</td>
<td>o Make legal campgrounds</td>
</tr>
<tr>
<td>Resources</td>
<td>o Poverty &amp; Homelessness</td>
</tr>
<tr>
<td>o There are not many resources</td>
<td>Board needs to work on</td>
</tr>
<tr>
<td>to help the homeless</td>
<td>housing</td>
</tr>
<tr>
<td>population</td>
<td>o Massive government</td>
</tr>
<tr>
<td>o Unequal distribution of</td>
<td>assistance</td>
</tr>
<tr>
<td>resources</td>
<td>o Every family needs a case</td>
</tr>
<tr>
<td>Access</td>
<td>manager, individualized</td>
</tr>
<tr>
<td>o Rural access to services &amp;</td>
<td>financial plan, or outreach</td>
</tr>
<tr>
<td>quality jobs</td>
<td>coordinator</td>
</tr>
<tr>
<td>o Unhoused have no access to</td>
<td>o Find creative ways to find</td>
</tr>
<tr>
<td>healthcare services</td>
<td>shelter for the unhoused</td>
</tr>
<tr>
<td>Homeless issues are tied to mental health</td>
<td>o Ask for input from the unhoused</td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
</tr>
<tr>
<td>Failing to deal with health</td>
<td></td>
</tr>
<tr>
<td>as a broad concept</td>
<td></td>
</tr>
</tbody>
</table>
Access to Affordable and Quality Housing

Access to housing was repeatedly mentioned as a critical health issue. Key informants focused on two aspects of housing and the links to health:

- **Housing affordability** which shapes home and neighborhood conditions and also affects the overall ability of people to make healthy choices.
- **Housing quality** which can impact physiological health (e.g., lead, asbestos, mold), psychological health (e.g., noise, inadequate light), and safety (e.g., falls, fires).

Numerous key informants indicated that housing is a basic human right. Where we live is at the very core of our daily lives. Given its importance, it is not surprising that factors related to housing have the potential to help—or harm—our health in major ways.

An overwhelmingly high percentage of households in the region are cost-burdened. With a high cost of living compared to median income, housing ends up absorbing a high proportion of a household’s income. Unaffordable housing costs affect health by reducing the income that a household has available for nutritious food and necessary health care expenses. In addition, the burden takes a toll on one’s mental health and wellness, which increases susceptibility to physical illness. Frequent moves, eviction, foreclosure, and living in doubled-up housing are also related to elevated stress levels, depression, and hopelessness. In extreme cases, residential instability affects health through the physical and mental deprivations of homelessness.

### Barriers

- **System Capacity**
  - People on housing waiting lists don’t have shelter while they wait
- **Cost of Living vs. Income**
  - People are spending the majority of their income on housing
  - Low-income people spend too much of their resources on housing
  - The cost of housing is high
- **Housing Quality**
  - There are more people living in marginal housing

### Potential Solutions

- **Integration**
  - Trillium should look at housing based services
  - Implement the Housing First model: an approach that centers on providing homeless people with housing quickly and then providing wrap-around services

“It isn’t uncommon for people to spend over half their income on housing.”

“Because of the lack of affordable housing for the low-income, everything else goes downhill.”
Health Disparities and Services for Vulnerable Populations

Healthy People 2020 National Stakeholder Strategy for Achieving Health defines health disparity as: “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

Key informants recognized that socioeconomic and geographic factors have a significant impact on people’s health priorities, their ability to seek services, access to resources, stress level, and opportunities to engage in healthful lives. The constraint of organizational resources creates a challenge for delivering services and care that aim to meet the multitude of needs across the region. While strong health care and human services were reported to exist in the Eugene/Springfield metro area, vulnerable populations—such as the socially isolated elderly, non-English speaking residents, those living with disabilities, geographically isolated, and the low-income—encounter continued difficulties in accessing resources and services. While more services resources are reported to be available for these vulnerable populations than there have been in the past, the need exceeds the current supply.

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Potential Solutions</th>
</tr>
</thead>
</table>
| • Transportation  
  o Rural areas struggle with access to services due to limited/slow public transportation | • Technology  
  o Telemedicine options for rural |
| • Language and Culture  
  o Language & cultural barriers  
  o Language barrier to high wage jobs for English as second language population | • Community Outreach, Education, & Communication  
  o Figure out how to convey to the families that we understand the struggle & we are not going to stop & these are the steps we are going to take  
  o More outreach for the most vulnerable & support these people  
  o Educate the public about disparities |
| • System Complexity  
  o Complexity of navigating the system | • Equitable Health Insurance |
| • Access to Healthcare  
  o Lack of health insurance coverage for the undocumented & gap population  
  o Unhoused have no access to healthcare services | • Collaboration and Coordination  
  o Partnering with county  
  o Incentives for clinics to open  
  o Speed up actions of CCOs  
  o Residency program  
  o Working with Kaiser & leveraging their resources |
| • System Capacity  
  o Time or cost constraints (e.g., limited hours of operation of health care & human services)  
  o Lack of emergency services for rural population  
  o Funding cuts | “A lot of people are being left behind and we need to find and implement non-traditional solutions.” |
| • Lack of Resources  
  o Veterans need help, not enough resources; no facilities in our community, live at the ER for months  
  o Information isn’t available for those with disabilities and medically disadvantaged | |
| • Socioeconomics  
  o Inequities in low-income population  
  o Low-income population needs access to financial resources  
  o Poverty can be cyclical & generational  
  o SES discrepancies growing | |
All 53 key informants indicated that there are people and/or groups of people whose health and quality of life is not as good as others. Key informants stressed that populations experiencing social, economic, and/or geographic disadvantage(s) are most affected by critical health issues and have greater obstacles to health.

**What people or groups of people experience worse health and quality of life than others?**

<table>
<thead>
<tr>
<th>Number of Key Informants Who Identified Each Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-Income</td>
</tr>
<tr>
<td>Homeless</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>Mentally Ill</td>
</tr>
<tr>
<td>Racial/Ethnic Minorities</td>
</tr>
<tr>
<td>Working Poor/Gap</td>
</tr>
<tr>
<td>Children/Youth</td>
</tr>
<tr>
<td>Latinos</td>
</tr>
<tr>
<td>Substance Addicts</td>
</tr>
<tr>
<td>Seniors</td>
</tr>
<tr>
<td>Low Educational Attainment</td>
</tr>
<tr>
<td>Disabled</td>
</tr>
<tr>
<td>Women</td>
</tr>
<tr>
<td>English as Second Language</td>
</tr>
<tr>
<td>Medicaid/Medicare Clients</td>
</tr>
<tr>
<td>Veterans</td>
</tr>
<tr>
<td>Under/Un-Insured</td>
</tr>
<tr>
<td>Teen parents</td>
</tr>
<tr>
<td>Students</td>
</tr>
<tr>
<td>New Residents</td>
</tr>
</tbody>
</table>

**Why is their health and quality of life worse than others?**

**Low-Income**
Economically disadvantaged populations in the region have lower median incomes and fewer health-related outlets (e.g., access to healthy foods and recreational facilities). Families often consist of parents working multiple jobs and still not being able to make ends meet. Key informants stated that low-income families experience stress due to multiple factors including: the high cost of living (housing and child care), access to financial resources, and affordability of healthcare.

**Homeless**
People experiencing homelessness suffer different health outcomes due to the instability of their circumstances. Lack of shelter, access to resources and housing, and the focus on survival were mentioned as barriers to better health outcomes.
Rural
The split between the “haves and the have not’s” is additionally evident when comparing the Eugene/Springfield metro to the outlaying rural areas. Rural residents experience different health outcomes due to their geographic location. There are limited resources as far as health care; for example, there are no x-ray machines or urgent care in Oakridge so they must travel to Eugene in order to see a physician and receive care. There is a lack of employment opportunities for the rural community and a lack of public transportation options.

Ethnic Minorities
The increasing diversity of the region presents a need for significantly more culturally and linguistically appropriate services. Latinos were identified as a vulnerable population whose concerns stand to be exacerbated by the population growth in the region, particularly among youth. Several key informants focused on how current challenging issues in the community—specifically, lack of culturally and linguistically appropriate care and limited educational and employment opportunities—disproportionately affect this population.

Undocumented
People who are undocumented have difficulty accessing social service benefits as well as access to the healthcare system due to their citizenship status. Immigrants and the undocumented experience stress because of language barriers, stigma and discrimination, and the lack of readily available information regarding services.

Seniors
The senior population experiences different health outcomes and has an increased need for specialized services. The burden of chronic disease management as well as economic situation (rely on social security) affects this population’s daily lives.

Disabled
The disabled experience disparities in the form of unequal/insufficient employment opportunities, non-ADA compliant environments, and discrimination.
### CTSA: APPENDIX A

**SURVEY RESULTS - DEMOGRAPHIC ANALYSIS TOP RESPONSES**

**What are most important for creating a healthy community?**

#### By Survey Language:

<table>
<thead>
<tr>
<th></th>
<th>English</th>
<th>Spanish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to healthcare</td>
<td>(63.7%)</td>
<td>(73.4%)</td>
</tr>
<tr>
<td>Access to affordable, healthy food</td>
<td>(51.3%)</td>
<td>(60.9%)</td>
</tr>
<tr>
<td>Good jobs &amp; healthy economy</td>
<td>(34.8%)</td>
<td>(35.9%)</td>
</tr>
</tbody>
</table>

#### By Gender:

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to healthcare</td>
<td>(64.4%)</td>
<td>(62.5%)</td>
<td>Access to affordable, healthy food (69.2%)</td>
</tr>
<tr>
<td>Access to affordable, healthy food</td>
<td>(53.6%)</td>
<td>(46.3%)</td>
<td>Access to healthcare (48.7%)</td>
</tr>
<tr>
<td>Affordable housing</td>
<td>(33.6%)</td>
<td>Good jobs &amp; healthy economy (38.3%)</td>
<td>Low crime/safe neighborhoods (41%)</td>
</tr>
</tbody>
</table>

#### By Race/Ethnicity:

<table>
<thead>
<tr>
<th></th>
<th>Asian</th>
<th>Caucasian</th>
<th>Native American</th>
<th>Mixed Race</th>
<th>Hispanic</th>
<th>Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to healthcare</td>
<td>(60%)</td>
<td>(63.9%)</td>
<td>(57.7%)</td>
<td>(65.5%)</td>
<td>(66%)</td>
<td>(63.8%)</td>
</tr>
<tr>
<td>Access to affordable, healthy food</td>
<td>(44%)</td>
<td>(50.9%)</td>
<td>(53.8%)</td>
<td>(58.4%)</td>
<td>(53.2%)</td>
<td>(51.2%)</td>
</tr>
<tr>
<td>Good jobs &amp; healthy economy</td>
<td>(44%)</td>
<td>Good jobs &amp; healthy economy (36%)</td>
<td>Access to services for children &amp; families (42.3%)</td>
<td>Affordable housing (36.3%)</td>
<td>Access to services for children &amp; families (32.1%)</td>
<td>Good jobs &amp; healthy economy (35.4%)</td>
</tr>
</tbody>
</table>

#### By Geography:

<table>
<thead>
<tr>
<th></th>
<th>West Lane (District 1)</th>
<th>Springfield (District 2)</th>
<th>South Eugene (District 3)</th>
<th>North Eugene (District 4)</th>
<th>East Lane (District 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to healthcare</td>
<td>(65.2%)</td>
<td>(65.8%)</td>
<td>(64.8%)</td>
<td>(63.5%)</td>
<td>(61.9%)</td>
</tr>
<tr>
<td>Access to affordable, healthy food</td>
<td>(51.3%)</td>
<td>Access to affordable, healthy food (53.2%)</td>
<td>Access to affordable, healthy food (47.2%)</td>
<td>Access to affordable, healthy food (54.4%)</td>
<td>Access to affordable, healthy food (50%)</td>
</tr>
<tr>
<td>Good jobs &amp; healthy economy</td>
<td>(38.3%)</td>
<td>Good jobs &amp; healthy economy (36.5%)</td>
<td>Good jobs &amp; healthy economy (33.9%)</td>
<td>Good schools (36.8%)</td>
<td>Good jobs &amp; healthy economy (37.3%)</td>
</tr>
</tbody>
</table>
### By Age:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Access to Healthcare (%)</th>
<th>Access to Affordable, Healthy Food (%)</th>
<th>Affordable Housing (%)</th>
<th>Good Jobs &amp; Healthy Economy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>62.7%</td>
<td>64.1%</td>
<td>42.3%</td>
<td>53.6%</td>
</tr>
<tr>
<td>26-39</td>
<td>59.4%</td>
<td>53.6%</td>
<td>34%</td>
<td>36.4%</td>
</tr>
<tr>
<td>40-54</td>
<td>61.4%</td>
<td>51%</td>
<td>34%</td>
<td>36.4%</td>
</tr>
<tr>
<td>55-64</td>
<td>69.5%</td>
<td>47.1%</td>
<td>34%</td>
<td>36.4%</td>
</tr>
<tr>
<td>65-74</td>
<td>74.8%</td>
<td>48.1%</td>
<td>39.7%</td>
<td>37.7%</td>
</tr>
<tr>
<td>75-84</td>
<td>73.1%</td>
<td>53.8%</td>
<td>53.8%</td>
<td>53.8%</td>
</tr>
</tbody>
</table>

### By Education:

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Access to Healthcare (%)</th>
<th>Access to Affordable, Healthy Food (%)</th>
<th>Affordable Housing (%)</th>
<th>Good Jobs &amp; Healthy Economy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School Diploma</td>
<td>64.8%</td>
<td>50%</td>
<td>38.9%</td>
<td>41.7%</td>
</tr>
<tr>
<td>High School Diploma/GED</td>
<td>65.3%</td>
<td>51.4%</td>
<td>41.7%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Some College, No Degree</td>
<td>67.2%</td>
<td>56.3%</td>
<td>37.2%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Associate/Technical Degree</td>
<td>68.9%</td>
<td>59.6%</td>
<td>37.2%</td>
<td>35%</td>
</tr>
<tr>
<td>Bachelor's Degree</td>
<td>62.1%</td>
<td>50.9%</td>
<td>37.2%</td>
<td>33.7%</td>
</tr>
<tr>
<td>Advanced Degree</td>
<td>66%</td>
<td>56.6%</td>
<td>33.7%</td>
<td>Affordable housing (56.6%)</td>
</tr>
</tbody>
</table>

### By Income:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Access to Healthcare (%)</th>
<th>Access to Affordable, Healthy Food (%)</th>
<th>Affordable Housing (%)</th>
<th>Good Jobs &amp; Healthy Economy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $20,000</td>
<td>67.8%</td>
<td>57.7%</td>
<td>46.8%</td>
<td>38.8%</td>
</tr>
<tr>
<td>$20,000-$29,999</td>
<td>57.7%</td>
<td>57.7%</td>
<td>46.8%</td>
<td>Affordable housing (34%)</td>
</tr>
<tr>
<td>$30,000-$49,999</td>
<td>67.8%</td>
<td>53.3%</td>
<td>Affordable housing (38.8%)</td>
<td>Affordable housing (34%)</td>
</tr>
<tr>
<td>Over $50,000</td>
<td>62%</td>
<td>45.7%</td>
<td>Affordable housing (37.8%)</td>
<td>Affordable housing (37.8%)</td>
</tr>
</tbody>
</table>
### Which problems do you feel have the biggest impact on health in your community?

#### By Survey Language:

<table>
<thead>
<tr>
<th>English</th>
<th>Spanish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol &amp; drug abuse (60.8%)</td>
<td>Alcohol &amp; drug abuse (61.9%)</td>
</tr>
<tr>
<td>Lack of affordable housing &amp; homelessness (51%)</td>
<td>Lack of access to healthcare (48.4%)</td>
</tr>
<tr>
<td>Lack of access to healthcare (42.7%)</td>
<td>Discrimination &amp; racism (39.1%)</td>
</tr>
</tbody>
</table>

#### By Gender:

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol &amp; drug abuse (61.9%)</td>
<td>Alcohol &amp; drug abuse (59.4%)</td>
</tr>
<tr>
<td>Lack of affordable housing &amp; homelessness (51.6%)</td>
<td>Lack of affordable housing &amp; homelessness (46.1%)</td>
</tr>
<tr>
<td>Lack of access to healthcare (42.8%)</td>
<td>Lack of access to healthcare (43.1%)</td>
</tr>
</tbody>
</table>

#### By Race/Ethnicity:

<table>
<thead>
<tr>
<th>Asian</th>
<th>Caucasian</th>
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<th>Mixed Race</th>
<th>Hispanic</th>
<th>Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol &amp; drug abuse (48%)</td>
<td>Alcohol &amp; drug abuse (61%)</td>
<td>Alcohol &amp; drug abuse (73.1%)</td>
<td>Alcohol &amp; drug abuse (59.8%)</td>
<td>Alcohol &amp; drug abuse (61.5%)</td>
<td>Alcohol &amp; drug abuse (60.9%)</td>
</tr>
<tr>
<td>Poverty (48%)</td>
<td>Lack of affordable housing &amp; homelessness (51.4%)</td>
<td>Lack of affordable housing &amp; homelessness (50%)</td>
<td>Lack of access to healthcare (44.2%)</td>
<td>Lack of affordable housing &amp; homelessness (51.2%)</td>
<td></td>
</tr>
<tr>
<td>Lack of access to healthcare (44%)</td>
<td>Lack of access to healthcare (42.8%)</td>
<td>Lack of access to healthcare (30.8%)</td>
<td>Poverty (42%)</td>
<td>Lack of affordable housing &amp; homelessness (41.7%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<th>North Eugene (District 4)</th>
<th>East Lane (District 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol &amp; drug abuse (69.6%)</td>
<td>Alcohol &amp; drug abuse (67.9%)</td>
<td>Lack of affordable housing &amp; homelessness (54.1%)</td>
<td>Alcohol &amp; drug abuse (60.2%)</td>
<td>Alcohol &amp; drug abuse (64.5%)</td>
</tr>
<tr>
<td>Lack of affordable housing &amp; homelessness (46.1%)</td>
<td>Lack of affordable housing &amp; homelessness (44.4%)</td>
<td>Alcohol &amp; drug abuse (51.8%)</td>
<td>Lack of affordable housing &amp; homelessness (55.6%)</td>
<td>Lack of access to healthcare (43.2%)</td>
</tr>
<tr>
<td>Lack of access to healthcare (39.1%)</td>
<td>Lack of access to healthcare (39.1%)</td>
<td>Poverty (44.4%)</td>
<td>Lack of access to healthcare (44.4%)</td>
<td>Poverty (40.5%)</td>
</tr>
</tbody>
</table>
### By Age:

<table>
<thead>
<tr>
<th>Age</th>
<th>Lack of affordable housing &amp; homelessness (55.6%)</th>
<th>Alcohol &amp; drug abuse (61.4%)</th>
<th>Alcohol &amp; drug abuse (63.6%)</th>
<th>Alcohol &amp; drug abuse (62.1%)</th>
<th>Lack of affordable housing &amp; homelessness (54.2%)</th>
<th>Alcohol &amp; drug abuse (65.4%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>Lack of affordable housing &amp; homelessness (54.2%)</td>
<td>Lack of affordable housing &amp; homelessness (50.8%)</td>
<td>Lack of affordable housing &amp; homelessness (46.3%)</td>
<td>Lack of affordable housing &amp; homelessness (50.1%)</td>
<td>Alcohol &amp; drug abuse (52.7%)</td>
<td>Lack of access to healthcare (50%)</td>
</tr>
<tr>
<td>Poverty (36.6%)</td>
<td>Lack of access to healthcare (45%)</td>
<td>Lack of access to healthcare (40.7%)</td>
<td>Lack of access to healthcare (43.3%)</td>
<td>Lack of access to healthcare (49.6%)</td>
<td>Lack of affordable housing &amp; homelessness (46.2%)</td>
<td></td>
</tr>
</tbody>
</table>

### By Education:

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Lack of affordable housing &amp; homelessness (46.3%)</th>
<th>Alcohol &amp; drug abuse (71.5%)</th>
<th>Alcohol &amp; drug abuse (66.3%)</th>
<th>Alcohol &amp; drug abuse (64.5%)</th>
<th>Lack of affordable housing &amp; homelessness (51.3%)</th>
<th>Alcohol &amp; drug abuse (56.5%)</th>
<th>Alcohol &amp; drug abuse (55.2%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School Diploma</td>
<td>Lack of affordable housing &amp; homelessness (52.1%)</td>
<td>Lack of affordable housing &amp; homelessness (50.8%)</td>
<td>Lack of affordable housing &amp; homelessness (46.3%)</td>
<td>Lack of affordable housing &amp; homelessness (50.1%)</td>
<td>Alcohol &amp; drug abuse (52.7%)</td>
<td>Lack of access to healthcare (50%)</td>
<td>Poverty (49.7%)</td>
</tr>
<tr>
<td>Some College, No Degree</td>
<td>Lack of access to healthcare (34.7%)</td>
<td>Lack of access to healthcare (39.4%)</td>
<td>Lack of access to healthcare (45.4%)</td>
<td>Lack of affordable housing &amp; homelessness (51.7%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate/Technical Degree</td>
<td>Lack of access to healthcare (45.4%)</td>
<td>Lack of affordable housing &amp; homelessness (46.3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor's Degree</td>
<td>Lack of affordable housing &amp; homelessness (46.2%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Degree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### By Income:

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Lack of affordable housing &amp; homelessness (59.9%)</th>
<th>Alcohol &amp; drug abuse (62.9%)</th>
<th>Alcohol &amp; drug abuse (56.5%)</th>
<th>Alcohol &amp; drug abuse (71.3%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $20,000</td>
<td>Lack of affordable housing &amp; homelessness (55.2%)</td>
<td>Lack of affordable housing &amp; homelessness (51.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$20,000-$29,999</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$30,000-$49,999</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over $50,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of access to healthcare (39.5%)</td>
<td>Lack of access to healthcare (47.8%)</td>
<td>Lack of access to healthcare (44.7%)</td>
<td>Lack of access to healthcare (35.7%)</td>
<td></td>
</tr>
</tbody>
</table>
What do you enjoy most about living in the Lane County region?

**By Survey Language:**

<table>
<thead>
<tr>
<th>English</th>
<th>Spanish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of parks &amp; recreational/ natural areas (67.2%)</td>
<td>Availability of parks &amp; recreational/ natural areas (71.9%)</td>
</tr>
<tr>
<td>Clean environment (38.8%)</td>
<td>Clean environment (34.4%)</td>
</tr>
<tr>
<td>Strong sense of community &amp; community engagement (38.3%)</td>
<td>Access to affordable, healthy food (34.4%)</td>
</tr>
</tbody>
</table>

**By Gender:**

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of parks &amp; recreational/ natural areas (69.1%)</td>
<td>Availability of parks &amp; recreational/ natural areas (61.9%)</td>
</tr>
<tr>
<td>Clean environment (43.9%)</td>
<td>Clean environment (38%)</td>
</tr>
<tr>
<td>Strong sense of community &amp; community engagement (38%)</td>
<td>Strong sense of community &amp; community engagement (35.3%)</td>
</tr>
</tbody>
</table>

**By Race/Ethnicity:**

<table>
<thead>
<tr>
<th>Asian</th>
<th>Caucasian</th>
<th>Native American</th>
<th>Mixed Race</th>
<th>Hispanic</th>
<th>Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of parks &amp; recreational/ natural areas (64%)</td>
<td>Availability of parks &amp; recreational/ natural areas (68.8%)</td>
<td>Availability of parks &amp; recreational/ natural areas (69.2%)</td>
<td>Availability of parks &amp; recreational/ natural areas (66.1%)</td>
<td>Availability of parks &amp; recreational/ natural areas (57.7%)</td>
<td>Availability of parks &amp; recreational/ natural areas (68.9%)</td>
</tr>
<tr>
<td>Strong sense of community &amp; community engagement (40%)</td>
<td>Strong sense of community &amp; community engagement (40%)</td>
<td>Transportation options (42.3%)</td>
<td>Clean environment (40.2%)</td>
<td>Clean environment (38.5%)</td>
<td>Strong sense of community &amp; community engagement (39.1%)</td>
</tr>
<tr>
<td>Clean environment (28%)</td>
<td>Clean environment (38.8%)</td>
<td>Clean environment (38.5%)</td>
<td>Access to affordable, healthy food (32.1%)</td>
<td>Transportation options (33.3%)</td>
<td>Clean environment (39.1%)</td>
</tr>
</tbody>
</table>

**By Geography:**

<table>
<thead>
<tr>
<th>West Lane (District 1)</th>
<th>Springfield (District 2)</th>
<th>South Eugene (District 3)</th>
<th>North Eugene (District 4)</th>
<th>East Lane (District 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of parks &amp; recreational/ natural areas (59.5%)</td>
<td>Availability of parks &amp; recreational/ natural areas (72.2%)</td>
<td>Availability of parks &amp; recreational/ natural areas (70.9%)</td>
<td>Availability of parks &amp; recreational/ natural areas (65.9%)</td>
<td>Availability of parks &amp; recreational/ natural areas (63.4%)</td>
</tr>
<tr>
<td>Clean environment (49.5%)</td>
<td>Clean environment (35.1%)</td>
<td>Strong sense of community &amp; community engagement (42.6%)</td>
<td>Strong sense of community &amp; community engagement (39%)</td>
<td>Clean environment (46.7%)</td>
</tr>
<tr>
<td>Strong sense of community &amp; community engagement (40.5%)</td>
<td>Transportation options (31.5%)</td>
<td>Clean environment (38.5%)</td>
<td>Clean environment (35.5%)</td>
<td>Strong sense of community &amp; community engagement (33.9%)</td>
</tr>
</tbody>
</table>
### By Age:

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Availability of parks &amp; recreational/natural areas</th>
<th>Transportation options</th>
<th>Clean environment</th>
<th>Access to affordable, healthy food</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>58.4%</td>
<td>45.8%</td>
<td>43.7%</td>
<td></td>
</tr>
<tr>
<td>26-39</td>
<td>74.5%</td>
<td>39.7%</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>40-54</td>
<td>70.5%</td>
<td>36.7%</td>
<td>33.5%</td>
<td></td>
</tr>
<tr>
<td>55-64</td>
<td>64.4%</td>
<td>39.8%</td>
<td>33.5%</td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>53.8%</td>
<td>41.2%</td>
<td>35.8%</td>
<td></td>
</tr>
<tr>
<td>75-84</td>
<td>53.8%</td>
<td>41.2%</td>
<td>35.8%</td>
<td></td>
</tr>
</tbody>
</table>

### By Education:

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Availability of parks &amp; recreational/natural areas</th>
<th>Transportation options</th>
<th>Clean environment</th>
<th>Strong sense of community &amp; community engagement</th>
<th>Access to affordable, healthy food</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School Diploma</td>
<td>56.6%</td>
<td>37.7%</td>
<td>34%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>High School Diploma/GED</td>
<td>51.8%</td>
<td>37.6%</td>
<td>34%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Some College, No Degree</td>
<td>62.6%</td>
<td>39%</td>
<td>39%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Associate/Technical Degree</td>
<td>63.4%</td>
<td>42.6%</td>
<td>41%</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>Bachelor's Degree</td>
<td>73.3%</td>
<td>39.4%</td>
<td>40%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Advanced Degree</td>
<td>58.5%</td>
<td>35.8%</td>
<td>35.8%</td>
<td>38.4%</td>
<td></td>
</tr>
</tbody>
</table>

### By Income:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Availability of parks &amp; recreational/natural areas</th>
<th>Transportation options</th>
<th>Clean environment</th>
<th>Strong sense of community &amp; community engagement</th>
<th>Access to affordable, healthy food</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $20,000</td>
<td>54.7%</td>
<td>45.1%</td>
<td>34.9%</td>
<td>32.8%</td>
<td></td>
</tr>
<tr>
<td>$20,000-$29,999</td>
<td>69.7%</td>
<td>39.2%</td>
<td>32.8%</td>
<td>38.9%</td>
<td></td>
</tr>
<tr>
<td>$30,000-$49,999</td>
<td>72.4%</td>
<td>41.9%</td>
<td>38.9%</td>
<td>40.1%</td>
<td></td>
</tr>
<tr>
<td>Over $50,000</td>
<td>71.7%</td>
<td>41.9%</td>
<td>40.1%</td>
<td>40.1%</td>
<td></td>
</tr>
</tbody>
</table>
CTSA: APPENDIX B

Survey Population and Lane County Population

The following charts compare the survey population with the Lane County Population (Census 2013 5-Year Estimates). When compared to the Lane County population (U.S. Census 2013 5-Year Estimates), the survey population is generally younger, higher educated, more racially and ethnically diverse, and more likely to be a woman than the general population. All regions of the county are represented, although residents are slightly more likely to be from districts 3 & 4 (North and South Eugene) and West Lane is underrepresented. It is important to note that a fair comparison of income could not be completed as it was unclear if the respondents were providing information about their own income or their total household income.
### Educational Attainment

The chart shows the percentage of the adult population with different levels of educational attainment, as compared between Census and Survey data.

<table>
<thead>
<tr>
<th>Educational Attainment</th>
<th>Census</th>
<th>Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school diploma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school diploma/GED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some college, Associate/technical degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelors degree or higher</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Race

The chart shows the percentage of the adult population classified under different race categories, as compared between Census and Survey data.

<table>
<thead>
<tr>
<th>Race</th>
<th>Census</th>
<th>Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>90.4%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>3.4%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Asian</td>
<td>2.6%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Other</td>
<td>2.0%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Native American</td>
<td>1.0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>African-American/Black</td>
<td>0.9%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>0.2%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

### Hispanic Ethnicity

The chart shows the percentage of the adult population classified under Hispanic ethnicity, as compared between Census and Survey data.

<table>
<thead>
<tr>
<th>Hispanic Ethnicity</th>
<th>Census</th>
<th>Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>8.0%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>
PARTICIPATING FOCUS GROUPS

- Alliance for Healthy Families
- Be Your Best Cottage Grove
- Centro de fe Community Church
- CHIP Equity Workgroup
- CHIP Mental Health & Addictions Workgroup
- CHIP Obesity Prevention Workgroup
- CHIP Tobacco Prevention Workgroup
- Community Resource Network
- Community Advisory Council
- Cornerstone Community Housing Residents
- Department of Human Services Staff
- Downtown Languages, Centro Latino Americano, Huerto de la Familia Clients
- Early Childhood Mental Health Team
- Early Learning Stakeholders
- Early Learning Alliance Pediatric Advisory Group
- Emerging Leaders
- Eugene Springfield Prevention Council
- FOOD for Lane County Programs & Services Staff
- HIV Alliance Clients
- Housing and Policy Board
- LGBTQ+ Community Members
- Lane Independent Living Alliance Staff and Clients
- Mental Health Advisory Council/Local Drug & Alcohol Committee
- Mental Health Promotion Steering Committee
- Mohawk-McKenzie Grange 747
- NAACP - Back to School Success
- Oakridge Kiwanis
- Upper Willamette Community Development Corporation
- Patient & Family Advisory Council
- PeaceHealth Health & Wellness Committee
- Pearl Buck Center Parents
- Planned Parenthood REV Youth Action Council
- Public Safety Coordinating Council – Adult Committee Work Plan Workgroup
- Public Safety Coordinating Council – Juvenile Committee
- Rural Advisory Council
- Safety Net Committee
- South Lane Family Resource Center
- St. Vinny's Night Shelter Families
- Stand for Children
- Trillium Staff
- United Way of Lane County Staff
- University of Oregon Graduate Students
- University of Oregon Undergraduate Students
- United Way Human Service Providers
- Veneta Community Members
- Walterville Community Members
Executive Summary

The Community Health Status Assessment (CHSA) provides quantitative information on community health conditions and answers the following questions:
- How healthy is the community?
- What does the health status of the community look like?

A subcommittee with experience in data collection and analysis worked together and identified data that would best represent the health status of Lane County, Oregon. Each member of the assessment team was assigned to gather data for a section of the core health indicators. Similar to other areas, the Lane County region has unique issues that contribute to health conditions which are not present in every community in the United States. Therefore, focus was placed on identifying local indicators and health issues. When possible, county level data was used to compare against state and national data and was analyzed by race/ethnicity, sex, and age to offer insight into health disparities that affect specific demographic subgroups in the community.

Overall, Lane County is a moderately healthy community with well-educated and active residents. The 2015 County Health Rankings and Roadmaps rank Lane County 16th out of 34 counties in Oregon for overall health outcomes (length and quality of life) and 9th for health factors (health behaviors, clinical care, social and economic factors, and physical environment). Although good health outcomes and behaviors are prominent in Lane County, there are still gaps to be addressed. In Lane County, as in the rest of the nation, health status and quality of life are intimately tied to a number of social and environmental factors including income, poverty, race/ethnicity, education level, geographic location, and employment status.
KEY FINDINGS

The key findings below summarize data from surveys, birth and death records, and other available sources of data about the health of Lane County.

**People (Demographic Characteristics)**

**Growth:**
With a population of 353,382, Lane County is the 4th most populous county in Oregon. The Eugene-Springfield metropolitan area contains over 60% of the county’s population, and outside of the metro area, Lane County is largely rural and unincorporated. The county’s population is growing (almost 10% from 2000 to 2013) at a slightly slower rate than Oregon as a whole.

**Aging:**
When compared to the total Oregon population, Lane County has a higher percent of the population falling between the ages of 18-24 due to the number of local colleges and universities. The county’s over-65 age group is larger than Oregon, and several rural communities have significantly older populations than the county as a whole. Finally, the under-18 age group is decreasing slightly, while Oregon is seeing a slight increase.

**Race/Ethnicity:**
While still predominately white, Lane County is becoming increasingly diverse. Hispanics are the largest and fastest growing ethnic group in the county: from 2000 to 2013 there has been an 81% increase.

**Language:**
The predominant language spoken at home in Lane County is English. In 2013, 8.9% of the Lane County population age 5 and older spoke a language other than English at home, compared with 14.8% of the Oregon population.

**Veterans:**
Similar to the state, approximately 11% of Lane County’s population 18 years or older are veterans.

**Disabled:**
Approximately 15% of the county’s population has a disability (hearing, vision, cognitive, ambulatory, self-care), slightly more than the state.

**Medicaid Demographics:**
The Affordable Care Act greatly expanded eligibility criteria for Medicaid. Lane County’s Medicaid population has increased dramatically in recent years, from approximately 49,677 members (December 2013) to 90,606 (February 2015). The majority of this increase was in the adult population; the bulk of the members are now adults.

**Social and Economic Characteristics**

**Employment:**
Lane County’s unemployment rate is currently similar to the state rate. Lane County in recent years has had an unemployment rate somewhat higher than the national and state level. While unemployment reached a high in 2009 during the recent recession, the rates are currently on the decline. Overall, African-Americans, Latinos, youth and adults with less than a high school diploma are more likely to be unemployed.
Income:
The median income of all households in Lane County consistently lags behind Oregon and the United States. There is also a notable disparity of income between white households and households of other races.

Poverty
Approximately 20% of the population lives below the federal poverty level, compared to 16% of Oregonians. Almost 22% of Lane County’s total population is receiving Supplemental Assistance Nutrition Program (SNAP) benefits. The percentage of students eligible for the Free and Reduced Lunch Program in Lane County is 52.2% - higher than in Oregon (50.79%). The percent of eligible students varies greatly across districts, with a low of 38% in Eugene and a high of 78% in Mapleton.

Education:
Oregon has the 4th worst four-year high school graduation rate in the nation, with Lane County continuously falling below the state average. Lane County’s 2014 rate was 69.4% with disparities evident in minority populations, disabled, economically disadvantaged, and in certain school districts. In contrast, a high percentage of the population is enrolled in college or graduate school.

Early Childhood Development:
Lane County Kindergarten assessment scores are strong and similar to Oregon scores.

Housing:
In Lane County, 41% of households are cost burdened (paying more than 30% of their income for housing), slightly higher than Oregon. Students may make up a large portion of this percentage. Without means of support other than educational and family assistance, students increase the number of households in Lane County living in poverty.

Homelessness:
The Point-In-Time Count is a snapshot of the number of sheltered and unsheltered individuals during a specified 24-hour period and is an estimate of the number of individuals who are homeless on any given day. In 2015, 1,473 were counted, lower than the previous year. After Multnomah County, Lane County has the largest homeless population in the state. Almost 5% of K-12 students in the county are homeless, higher than the state’s 3.3%.

Family and Community Structure (Quality of Life and Social Connectedness):
Lane County and Oregon have strong community participation in the forms of voter registration, volunteerism, and involvement in social, civic, sports, and/or religious groups. Most youth are in school and/or working.

Abuse/Neglect and Violent Crime:
The violent crime rate and child abuse/neglect rate in Lane County are both higher than Oregon.

Healthy Environments
Housing Safety and Quality:
About 60% of homes in Lane County were built prior to 1979, the year when lead paint was banned from use in homes.

Air Quality
Air quality in Lane County has improved slightly over the past decade, a trend which is consistent with Oregon overall. While the number of days during the year in which air quality measurements exceeded national standards peaked at 37 days in 2005, it declined to 2 days in 2010, before increasing to around 16 days in 2014.
Soil and water quality:
Water and soil quality is generally rated well, however only the City of Florence provides fluoridated water. Overall, the vast majority (99.8%) of residents had access to safe drinking water in 2015, and Lane County fared slightly better than the state average.

Access to goods and services:
Access to parks and open space is relatively high in Lane County, but does vary by neighborhood in the metro area. Public transit is readily available in the metro area, but is limited or lacking in outlying and rural areas. Tobacco, alcohol and firearm retailers are easy to access in most incorporated areas of Lane County. Fast food is similarly accessible, while access to full service grocers and farm stands varies throughout the county and “food deserts” do exist both in the metro area and in outlying communities. In 2010, an estimated 39% of Lane County residents lived within close proximity to a full service grocer or a farm stand. In general, children in Lane County have better access to childcare and preschool opportunities than other children throughout Oregon. Alcohol is readily accessible in Lane County and is more accessible than tobacco, lottery and firearms combined. Retailers of alcohol for off-site use are 3 times more common than tobacco and lottery retailers.

Health System (Public Health, Medical and Human Services)
Insurance Access and Affordability:
The percent of the population without health insurance has declined dramatically since implementation of the Affordable Care Act. Currently about 6% of the population is without health insurance. Prior to implementation of the ACA, cost prevented approximately 15% of adults from seeing a provider when needed.

System capacity:
When compared to Oregon overall, Lane County has fewer physicians relative to the overall population. In 2013 there was approximately 1 provider for every 1,180 people in the county. As of Mid-Year 2015, 69% of Medicaid enrollees in Lane County were assigned to Primary Care Providers practicing out of recognized Patient Centered Primary Care Homes (PCPCH). This is up from just over 60% in 2014, due to Medicaid expansion. Additionally, Lane County has a high ratio of mental health providers to residents compared to Oregon overall, and ranks in the top 90% of all counties nationally. Lane County Public Health is staffed with about half of the FTE of similarly sized health departments nationally and funded at $34 per capita, substantially lower than the national benchmark of $43.

Preventative Health Services
Use of preventative screening and health services is generally lower in Lane County than in Oregon overall. Dental care utilization is comparable to the state overall.

Healthy Living (Health Behaviors)
Alcohol, tobacco and drug use
Tobacco use has declined over the past decade, yet it remains the leading preventable cause of death and tobacco use is higher in Lane County than in Oregon overall. Adult binge drinking is also higher, while binge drinking and alcohol use in general in youth has declined and remains comparable or lower in Lane County. Prescription drug abuse is similar in Lane County and Oregon overall. Illicit drug use and marijuana use is also comparable to the state overall, but higher than national rates.

Physical Activity and Nutrition
More adults meet guidelines for physical activity and fruit and vegetable consumption than the state overall, however only about 1 in 4 do so. Lane County youth are about as likely to meet physical activity guidelines, but are slightly less likely to consume fruits and vegetables than Oregon youth overall.
Sexual Activity in Youth
Rates of sexual activity in youth is higher in Lane County 8th graders than in Oregon, yet youth who had sexual intercourse are more likely to use a condom and contraception, and are slightly less likely to use alcohol or drugs at the time of intercourse.

Birth, death, Illness and Injury
Life expectancy has continued to rise in Lane County and is comparable to the state overall.

Pregnancies and Prenatal Care:
Overall, birth rates have declined over the last decade. Similarly, births to teen aged mothers have also declined. The percent of women who receive prenatal care in the first trimester has declined slightly, but remains around 80%.

Births
Infant mortality rates are generally higher in Lane County than the state average and have increased slowly over the past decade, while preterm births have declined in recent years.

Chronic Diseases:
Chronic diseases and accidents remain the leading causes of death in Lane County, led by cancer and heart disease. Deaths from the most common cancers (lung, prostate, breast cancer) and heart disease have steadily declined, most likely due to decreasing overall tobacco use; however tobacco use remains the leading preventable cause of death. Rates of obesity, asthma, high blood pressure, and high blood cholesterol are higher in Lane County than in Oregon, while heart disease and cancers occur at rates similar to or slightly lower than the state overall.

Injury:
Motor vehicle accident deaths have steadily declined; however suicide rates have slowly increased over the last decade in Lane County and in Oregon and suicides are more common than vehicle accidents between the ages of 15-44 years of age. Alcohol induced deaths have also increased. Drug poisonings have declined in recent years, but are higher than they were a decade ago. Gun related deaths in youth are higher in Lane County than in Oregon overall.

Infectious Diseases
Sexually Transmitted Diseases (Chlamydia, Gonorrhea, Syphilis) have steadily risen over the last decade, and rate has accelerated in the past 5 years.
Chapter 1 – People (Demographic Characteristics)

Population

Lane County covers 4,722 square miles and extends from the Pacific Ocean in the west to the Cascade mountain range in the east. Lane County is the fourth most populated county in Oregon with a population of 353,382 in 2013 with a population density of 77.6 persons/square mile, according to the American Community Survey. Outside of the Eugene-Springfield metro area, Lane County is largely rural and unincorporated. The large geographic expanse of the county creates disparities in access to health and human services.

There are twelve incorporated cities in Lane County: Coburg, Cottage Grove, Creswell, Dunes City, Eugene, Florence, Junction City, Lowell, Oakridge, Springfield, Veneta, and Westfir. Eugene is the largest city in the county with a 2013 population of about 157,318 residents, nearly 45% of the county’s population. The Eugene-Springfield metro area contains over 60% of the county’s population and is the third largest Metropolitan Statistical Area in Oregon.

**Population by Incorporated Cities, in Lane County, Oregon 2009-2013**

<table>
<thead>
<tr>
<th>City</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eugene</td>
<td>157,318</td>
</tr>
<tr>
<td>Springfield</td>
<td>59,692</td>
</tr>
<tr>
<td>Cottage Grove</td>
<td>9,734</td>
</tr>
<tr>
<td>Florence</td>
<td>8,463</td>
</tr>
<tr>
<td>Junction City</td>
<td>5,505</td>
</tr>
<tr>
<td>Creswell</td>
<td>5,204</td>
</tr>
<tr>
<td>Veneta</td>
<td>4,580</td>
</tr>
<tr>
<td>Oakridge</td>
<td>3,210</td>
</tr>
<tr>
<td>Dunes City</td>
<td>1,337</td>
</tr>
<tr>
<td>Coburg</td>
<td>1,008</td>
</tr>
<tr>
<td>Lowell</td>
<td>961</td>
</tr>
<tr>
<td>Westfir</td>
<td>280</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, American Community Survey.

Reedsport, Oregon is located in Douglas County on the central Oregon coast and is 87 miles southwest of Eugene, OR and had 4,130 residents (97% urban, 3% rural) in 2013.
Growth

From 2000 to 2013, there was a 9.4% increase in the total population of Lane County, which is a slightly slower growth rate than the state.

*Population in Lane County, Oregon*

![Population in Lane County, Oregon](chart.png)

*Source: US Census Bureau; US Census Bureau, American Community Survey.*

Age

In Lane County in 2013, 13.1% of the population was between the ages of 18-24, as compared to 9.4% of the state’s population.

*Population by Age Group and Incorporated City in Lane County, Oregon, 2009-2013*

![Population by Age Group and Incorporated City in Lane County, Oregon, 2009-2013](chart.png)

*Source: US Census Bureau, American Community Survey.*

In Lane County, the under-18 age group decreased slightly (by 6.5%) between 2000 and 2013, while the state of Oregon, as a whole, saw a slight increase.

Based on 2013 data, a higher percentage of the Lane County’s population is age 65 and older than in Oregon or the nation. Several rural communities have significantly older populations than the metro areas: Florence (38.8%), Dunes City (35.5%) and Oakridge (28.4%). This finding has significant implications for overall health and the need for health care services.
**Sex**

Similar to state and national population rates, approximately half of the Lane County population is male and half is female.

**Race and Ethnicity**

In 2013, 88.8% of the population in Lane County was white, in contrast to 85.2% in Oregon. While Lane County as a whole is predominantly white, several communities have much larger populations of Latino/Hispanic residents. Junction City (9.1%) and Springfield (12.3%) have the largest Latino/Hispanic populations. The Springfield and Eugene metro area, along with several communities in South Lane County, are projected to continue this trend of an increasing Latino/Hispanic population. Latinos/Hispanics are the largest and fastest growing minority group in the County: from 2000 to 2013, there was an 81.3% increase.
Language Spoken

The predominant language spoken at home in Lane County is English. Households that are linguistically isolated may have difficulty accessing services that are available to fluent English speakers. This language barrier may prevent such households from receiving transportation, medical, and social services, as well as limit employment and schooling opportunities. In cases of national or local emergency, linguistically isolated households may not receive important notifications.

In 2013, 8.9% of the Lane County population age 5 and older spoke a language other than English at home, compared with 14.8% of the Oregon population. In Lane County, of the 29,855 individuals that speak a language other than English at home, 33.9% speak English less than “very well”. An inability to speak English well, in a community where services are often only offered in English, exposes places in the system where there are barriers to healthcare, social service access, provider communications, employment, education, and health literacy/education.
Primary Language Spoken at Home in Lane County, Oregon, 2009-2013

% of Population

Lane County | Oregon | USA

Speak English Only | Speak a language other than English

Source: US Census Bureau, American Community Survey.

Language Spoken at Home Other Than English in Lane County, Oregon, 2009-2013

Number of Households

Spanish | Other Indo-European languages | Asian and Pacific Islander languages | Other languages

Source: US Census Bureau, American Community Survey.
Disability Status

People with a disability may have difficulties performing activities due to a physical, mental, or emotional condition. The extent to which a person is limited by a disability is heavily dependent on the social and physical environment in which he or she lives. Without sufficient accommodations, people with disabilities may have difficulties living independently or fulfilling work responsibilities. Several federal agencies use information on the size, distribution, and needs of the disabled population in order to develop policies, distribute funds, and develop programs for individuals with disabilities.

In 2013, 14.8% of the county’s population had a disability (hearing, vision, cognitive, ambulatory, self-care), compared to 13.8% of the state.

Veteran Status

In 2013, 11% of the Lane County population was made up of veterans.

Medicaid Demographics

Medicaid is a social health care program for families and individuals with low income and limited resources. Free or low-cost health care coverage is available to people who meet requirements for income, residency, and other factors. Oregonians may also qualify based on age and disability status. Adults and children who qualify will be enrolled in the Oregon Health Plan (OHP), Oregon’s Medicaid program. The Patient Protection and Affordable Care Act significantly expanded both eligibility for and federal funding of Medicaid.
POPULATION AND GROWTH
A single Coordinated Care Organization, Trillium Community Health Plan, is responsible for all Medicaid coverage in Lane County. The Medicaid population has seen dramatic increases recently, from approximately 49,677 Medicaid members in December 2013 to 90,606 Medicaid physical health members in 2015. This expansion largely consisted of adults, who now outnumber children enrolled in Medicaid.

AGE
The minor population (≤17) has grown more slowly than other age groups.

SEX
Medicaid currently has slightly more female members than male.

Medicaid Enrollment in Lane County, Oregon

Medicaid Population by Age in Lane County, Oregon, 2015

Medicaid Population by Sex in Lane County, Oregon, 2015

Source: Trillium Demographics Report 2015.
**Race/Ethnicity**
The vast majority of Medicaid members are white (non-Hispanic). Adult Medicaid members, particularly older adults, are disproportionately likely to be white rather than other ethnicities, while child Medicaid members are disproportionately likely to be Latino/Hispanic. American Indians/Alaskan Natives are slightly younger than the white population, but compare similarly to Medicaid as a whole.

**Medicaid Population by Race/Ethnicity, in Lane County, Oregon, 2015**

- White (Non-Hispanic): 73.3%
- Hispanic: 12.6%
- Asian/Pacific Islander: 9.6%
- Black: 0.1%
- Other Race or Ethnicity: 1.2%

*Source: Trillium Demographics Report. 2015.*

**Location**
About 75% of Medicaid members live in metro Eugene or Springfield area.

**Medicaid Population by Location, in Lane County, Oregon, 2015**

- Eugene: 48.3%
- Springfield: 26.4%
- W Lane County: 7.9%
- NW Lane County: 8.6%
- S Lane County: 3.5%
- SE Lane County: 1.5%
- E Lane County: 3.8%

*Source: Trillium Demographics Report. 2015.*

**Language**
English (81.8%) is by far the dominant language among Medicaid members.
Chapter 2 – Social and Economic Characteristics

The social determinants of health include the conditions in which people are born, grow, live, work and age; and significantly influence the health status of individuals and communities. Socioeconomic factors such as income, poverty, food security, and education are strongly correlated to health outcomes.

Understanding how a community compares to surrounding areas in terms of key social indicators such as educational attainment and crime rates, as well as understanding the comparative economic status of a community, is necessary to determine the types of community health programs needed.

**Income**

Median household income is the most widely used measure of income and is a good predictor of household income because it is less impacted by the income highs and lows. It divides the income distribution into two equal parts, one-half falling below and one-half above the median (middle). Median income can affect the ability of a household to have access to affordable housing, health care, higher education opportunities, and food. Median household income reflects the relative affluence and prosperity of an area. Areas with higher median household incomes are likely to have more educated residents and lower unemployment rates. Higher employment rates lead to better access to healthcare and better health outcomes, since many families get their health insurance through their employer.

The median income of all Lane County households consistently lags as compared to the state of Oregon as whole and the rest of the United States. In 2013, the median household income of all households in Lane County was $42,931, compared to Oregon ($50,229) and the United States ($53,046).

![Median Household Income in Lane County, Oregon](image)

*Source: US Census Bureau, American Community Survey & US Census*

There are significant income differences across the incorporated cities in Lane County. In 2013, Coburg had the highest median household income and Florence had the lowest median household income.
There are also income disparities between white households and households of other races and ethnicities. This is seen not only in Lane County, but also at the state level. In 2013 in Lane County, Native Hawaiians had the highest median household income and Asians had the lowest median household income.

Source: US Census Bureau, American Community Survey.
Poverty

Poverty is associated with poor health. Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. The poverty guidelines are often referred to as the Federal Poverty Level (FPL) and are used to determine financial eligibility for certain programs. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Poverty is associated with lower quality schools and decreased business survival. Without adequate income, individuals living in poverty may not be able to afford necessary expenses, such as rent or mortgage, utility bills, medical and dental care, and food.

In Lane County the poverty rate is historically slightly higher than both the state as a whole and the nation, with several communities experiencing significantly higher rates of poverty. In 2013, 20% of Lane County residents were living below the federal poverty level, compared with 16.2% of Oregonians.

Source: US Census Bureau, American Community Survey.
Racial and ethnic minority groups, rural residents, women, and children are also more likely to live in poverty as compared to the rest of the population.

**Population Living Below the Federal Poverty Level, By Race, in Lane County, Oregon 2009-2013**

Source: US Census Bureau, American Community Survey.

**Population Living Below the Poverty the Federal Poverty Levey By Ethnicity, in Lane County, Oregon, 2009-2013**

Source: US Census Bureau, American Community Survey.
In 2013 in Lane County, Oakridge had the largest percent of population living below the Federal Poverty Level, and Creswell had the smallest.

**ALICE (Asset Limited, Income Constrained, Employed)**

ALICE (an acronym that stands for Asset Limited, Income Constrained, Employed) households are households that earn more than the federal poverty level, but less than the basic cost of living for the county where they are located. Combined, the number of poverty and ALICE households equals the total population struggling to afford basic needs in a given area. The ALICE threshold is the average level of income that a household needs to afford the basics, defined by the Household Survival Budget. The Household Survival Budget calculates the actual costs of basic necessities (housing, child care, food, health care, and transportation). This bare-minimum Household Survival Budget does not allow for any savings, leaving a household vulnerable to unexpected expenses. In 2013, Lane County’s Household Survival Budget was $18,300 for a single adult and $54,516 for a family of four.

In Lane County in 2013, 43% of households fell below the ALICE Threshold, compared with 38% of Oregon households.

**Population Living Below the Federal Poverty Level**

*By City, in Lane County, Oregon, 2009-2013*

![Population Living Below the Federal Poverty Level](chart)

*Source: US Census Bureau, American Community Survey.*

**Oregon Households Living Below the ALICE Threshold, 2013**

![Oregon Households Living Below the ALICE Threshold, 2013](chart)

*Source: U.S. Department of Housing and Urban Development (HUD), U.S. Department of Agriculture (USDA), Bureau of Labor Statistics (BLS), Internal Revenue Service (IRS) and state Treasury, and ChildCare Aware, 2013; American Community Survey, 1 year estimate.*
Food Insecurity

The U.S. Department of Agriculture (USDA) defines food security as “access by all people at all times to enough food for an active, healthy life.” Food insecurity is an economic and social indicator of the health of a community. Food insecurity is associated with numerous chronic health problems and mental health issues in adults. Food insecurity is usually related to insufficient resources for food purchases, with the majority of food insecure households relying on a more narrow range of foods or acquiring food through private and public assistance programs. Poverty and unemployment are predictors of food insecurity.

In 2013, Lane County’s food insecurity rate of 16.5% was higher than Oregon’s 15.8%.

The Supplemental Nutrition Assistance Program (SNAP), previously called the Food Stamp Program, is a federal-assistance program that provides low-income families with electronic benefit transfers (EBTs) that can be used to purchase food. The purpose of the program is to assist low-income households in obtaining adequate and nutritious diets. The number of individuals enrolled in SNAP, has increased in recent years. It is estimated that 21.6% of Lane County’s total population were receiving SNAP benefits in 2013.


The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. The Free Lunch Program (FLP) under the NSLP provides nutritionally balanced lunches to children at no cost. Families who meet the income eligibility requirements or who receive SNAP benefits can apply through their children’s schools to receive free meals. The Free Lunch Program ensures that students who may not otherwise have access to a nutritious meal are fed during the school day.

The number of school children eligible for the Free or Reduced Lunch Program is a strong indicator of childhood and family poverty within a community. During the 2014-2015 school year, more than half of children (52.2%) in Lane County were eligible for free or reduced price school lunches, slightly higher than Oregon’s 50.8%. In addition, districts vary significantly across the county: ranging from 37.8% (Eugene) to 78.5% (Mapleton).
Students Eligible for Free and Reduced Lunch in Lane County, Oregon

Source: Department of Education.

Students Eligible for Free and Reduced Lunch by School District in Lane County, Oregon, 2014-2015 School Year

Source: Department of Education.
Education

Education is strongly tied to health outcomes and quality of life. High school graduates are more likely to possess the basic skills required to function in an increasingly complicated job market and society. Graduation rates are also an important indicator of the performance of the educational system.

In previous years, Oregon used a measurement called Average Freshman Graduation Rate for on-time high school graduation, which reported a higher high school graduation rate than the newer Adjusted Cohort Graduation Rate measurement. Over the past few years, there has been a shift from the Average Freshman Graduation Rate by states towards the Adjusted Cohort Graduation Rate. The Department of Education has not updated the Average Freshman Graduation Rate since 2012, so it is impossible to continue to use this indicator. While both indicators are concerned with the percentage of freshmen who graduate high school in four years, the Adjusted Cohort Graduation Rate is thought to be a more precise indicator because it accounts for the transfer of high school students into and out of the school during the year. The difference and discrepancy between the two measurements can explain much of Oregon’s recent decline in the education rankings.

Oregon has the 4th worst four-year high school graduation rate in the nation, with Lane County currently falling below the state average. With a high school four-year cohort graduation of 69.4% for the 2013-2014 school year, Lane County has consistently lower rates than Oregon (72%) and the nation (81%).

High School Graduation Rate in Lane County, Oregon (4-Year Cohort)

Source: Department of Education.
Racial and ethnic minority groups, disabled, economically disadvantaged, males, and rural students have disproportionately lower high school graduation rates.

Source: Department of Education.

Districts vary significantly across the region in high school graduation rates.

Source: Department of Education.
For many, having a bachelor’s degree is the ticket to a better life. The college experience develops cognitive skills and allows learning about a wide range of subjects, people, cultures, and communities. Adults with a college degree are less likely to live in poverty and having a degree is often the prerequisite for a higher-paying job.

A high percentage of Lane County’s population is enrolled in college or graduate school. In 2013, 36% of those living in Lane County ages 25 and older had an Associate Degrees or higher. 52% of adults in Lane County ages 18-25 were enrolled in college or graduate school. In 2013 for the population age 25 and older with earnings, median individual income ranged from $19,917 (less than high school graduate) to $47,350 (graduate or professional degree).


Early Childhood Development

In 2013, Oregon launched a new annual statewide Kindergarten Assessment, replacing the kindergarten survey that was suspended in 2009. The Oregon Kindergarten Assessment was created to get a clearer picture of early learning experiences across the state, and to provide a snapshot for educators of the skills children are coming to kindergarten with: the early literacy and early math skills, as well as interpersonal and self-regulation skills. There remains a great deal of inequity in the types of experiences children have before entering school. The Oregon Kindergarten Assessment is essential to understanding, and ultimately closing, the divide for the most underserved early learners. The Kindergarten Assessment is used to figure out what sort of preschool and Pre-K programs students attend – and which communities need more preschools that will teach the skills that are necessary to be successful in the kindergarten classroom – both academic and social.
The 2013-2014 Kindergarten Assessment average scores in Lane County were similar to Oregon scores.

![Kindergarten Assessment Score in Lane County, Oregon, 2013-2014](image)

Source: Oregon Department of Education

**Employment**

The unemployment rate is a key indicator of the local economy. A high rate of unemployment has personal and societal effects. During periods of unemployment, individuals are likely to feel severe economic strain and stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer.

The economic recession of the mid/late-2000s caused significant unemployment in Lane County and contributed to the decline in services provided by municipalities, government agencies, and non-profit organizations. Lane County traditionally has an unemployment rate somewhat higher than the national and state level. In 2014, Lane County’s unemployment rate of 7.1% was similar to the state rate. While unemployment is slowly improving, many families in Lane County continue to experience economic distress. Overall, black/African-Americans, Hispanics, youth and adults with less than a high school diploma are more likely to be unemployed in Lane County.

![Unemployment Rate in Lane County, Oregon](image)

Source: U.S. Bureau of Labor Statistics
The availability of safe and affordable housing can serve as an indicator of the overall social, economic, health, and demographic picture of the community. Spending a high percentage of household income on rent can create financial hardship, especially for lower-income renters. With a limited income, paying a high rent may not leave enough money for other expenses, such as food, transportation and medical. Moreover, high rent reduces the proportion of income a household can allocate to savings each month.

It is important to look at the amount of income spent on housing for Lane County residents. The U.S. Department of Housing and Urban Development (HUD) considers families who spend more than 30% of their income on housing as “cost burdened.” In 2013, 40.4% of households in Lane County (38.5% in Oregon) were cost-burdened.

In 2013, the median gross rent in Lane County was $841 (Oregon’s was $875). Lane County is home to multiple colleges which impact the community in many ways, one of which is housing. Eugene has seen many large new “luxury” apartment complexes, mostly catering to the student population, built in the last several years. Students add to the demand for housing. This often leaves those lacking additional financial support without affordable and sometimes safe housing.

Safe and affordable housing is an essential component of healthy communities, and the effects of housing problems are widespread. In areas where housing costs are high, low-income residents may be forced into substandard living conditions with an increased exposure to mold and mildew growth, pest infestation, and lead or other environmental hazards.

In 2013, 41% of occupied housing units in Lane County had at least one substandard condition.

Source: US Census Bureau, American Community Survey.

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Homelessness is a significant issue in several Lane County communities. An annual count of homeless individuals (both sheltered and unsheltered) enumerates thousands of unhoused individuals in Lane County. The primary community level indicator of homelessness in Lane County is the number of homeless individuals represented during the Point-In-Time Count. The Point-In-Time Count is a snapshot of the number of sheltered and unsheltered individuals during a specified 24-hour period and offers a baseline to quantify the number of individuals who are homeless on any given day. However, the transient nature of homeless individuals brings about challenges in obtaining an accurate count of the population and in assessing individual needs. The 2015 Lane County one-night homeless count was 1,473 individuals.

In the 2013-2014 school year, 4.8% of Lane County K-12 students were homeless, compared to 3.3% of Oregon students. Oregon data also indicate disparities in student homelessness based on race/ethnicity.

Source: Lane County Human Services Commission; Oregon Housing and Community Services

Source: U.S. Department of Education.
Family and Community Structure

When people feel safe within their communities, their children do better in the classroom and adults are better able to establish the links and connections for a cohesive social network. Social capital is the networks of relationships among people who live and work in a particular community. It plays an important role in expanding people’s opportunities and improving their health. Community participation and social capital is often measured by voter registration, volunteerism, and involvement in social, civic, sports, and/or religious groups.

In 2013, a low number of county youth (11.9%) were not in school and not working, lower than the state as a whole’s 14.8%. 40.3% of Oregonians are involved in social, civic, sports and/or religious groups. Oregon has a high volunteer rate of 31.7%. A high level of voter turnout indicates that citizens are involved in and interested in who represents them in the political system. In 2013, 57.9% of residents in Lane County were registered to vote, higher than the Oregon's rate of 55.5%.

Abuse/Neglect and Violent Crime

A violent crime is a crime in which the offender uses or threatens to use violent force upon the victim. Violent crimes can include homicide, rape, robbery, and assault. In 2012, Lane County had a higher violent crime rate (262.3 out of 100,000) than Oregon (242.9). Both the state of Oregon and Lane County had a homicide rate of 3 out of 100,000 people.

Source: National Center for Health Statistics.
Intimate partner violence (IPV) can affect health in many ways. The longer the violence goes on, the more serious the effects. Many victims suffer physical injuries; some are minor, others are more serious and can cause death or disability. Not all injuries are physical. IPV can also cause emotional harm. IPV is linked to harmful health behaviors as well.

The extent of sexual and intimate partner violence is often difficult to grasp in a community because of the lack of reporting by the abused partner for a variety of reasons. In 2014 there were 7,744 Lane County calls made to Oregon Sexual and Domestic Violence Program, compared to the 6,038 reported in 2013. In 2014, the child abuse/neglect rate in Lane County was 14.3 per 1,000 children, higher than Oregon’s rate of 11.6 per 1,000 children.

![Child Abuse/Neglect Rate in Lane County, Oregon 2014](image)

Source: Department of Human Services.
Access to Goods and Services

Access to Full Service Grocers, Farmers Markets, and Farm Stands

There are strong correlations between the density of grocery stores in a neighborhood and the nutrition and diet of its residents. The availability and affordability of healthy and varied food options in the community increase the likelihood that residents will have a balanced and nutritious diet. Farmers markets often emphasize good nutrition and support consumers to cook healthier meals and maintain good eating habits. Low-income and underserved areas often have limited numbers of stores that sell healthy foods, especially high-quality fruits and vegetables. People living farther away from grocery stores are less likely to access healthy food options on a regular basis and thus more likely to consume foods which are readily available at convenience stores and fast food outlets. Moreover, rural communities often have a high number of convenience stores, where healthy and fresh foods are less available than in larger, retail food markets. A diet comprised of nutritious foods, in combination with an active lifestyle, can reduce the incidence of heart disease, cancer and diabetes and is essential to maintain a healthy body weight and prevent obesity.

Residents of Lane County have slightly better access to Supermarkets or Grocery Stores when compared to the state of Oregon as a whole. In 2010, an estimated 39% of Lane County residents lived within close proximity to a full service grocer or a farm stand.

Percent of Population with Low Access to a Supermarket or Grocery Store in Lane County, OR, 2010

Source: USDA Food Environments Atlas (Data released July 2015)

Fast Food and Convenience Store Density

A lack of access to healthy foods is often a significant barrier to healthy eating habits. Fast food outlets are more common in low-income neighborhoods and studies suggest that they strongly contribute to the high incidence of obesity and obesity-related health problems in these communities. Fast food is often high in fat and calories and lacking in recommended nutrients. Frequent consumption of these foods and an insufficient consumption of fresh fruits and vegetables increase the risks being overweight and/or obese. Individuals who are overweight or obese are at increased risk for serious health conditions, including coronary heart disease, type-2 diabetes, multiple cancers, hypertension, stroke, premature death and other chronic conditions.
In Lane County, access to convenience stores and fast-food restaurants is slightly higher than the state average. In 2012, there was slightly less than 1 fast food restaurant per 1,000 people and 1 convenience store for every 2,500 residents. More than half of residents (57%) live in close proximity to a fast food restaurants or convenience stores.

**Number of Fast-food Restaurants & Convenience Stores per 1,000 population in Lane County, OR**

![Graph showing number of fast-food restaurants and convenience stores per 1,000 population in Lane County, OR, from 2007 to 2012.](image)

Source: USDA Food Environments Atlas (Data released July 2015)

**Childcare and Preschool Access**

Quality, affordable child care increases the income opportunity for working parents and early learning opportunities for children; these opportunities can promote optimal early childhood development and school readiness for children, thus setting the stage for success throughout a child’s school years. In general, children in Lane County have better access to childcare and preschool opportunities than other children throughout Oregon. There are roughly 13 licensed childcare facilities for every 1,000 children under the age of 5 in Lane County.

**Number of licensed childcare facilities/preschools per 1,000 children under 5 years old in Lane County, OR, 2015**

![Bar chart showing number of licensed childcare facilities/preschools per 1,000 children under 5 years old in Lane County, OR, 2015.](image)

Source: Oregon Department of Human Services; Oregon Health Authority Office of Forecasting, Research and Analysis
ACCESS TO PARKS AND OPEN SPACE
Proximity to safe exercise opportunities, such as parks and recreations facilities, tends to increase the likelihood of physical activity. Parks create physical spaces for people to socialize and connect. Trees and green spaces also remove air pollution, and make neighborhoods more livable. Regular physical activity has a wide array of health benefits.

Overall, Lane County offers excellent access to parks, opens spaces, and outdoor recreational opportunities. Residents tend to have good access regardless of race or ethnicity. Nearly 2 out of 3 residents live close to a park or outdoor recreation site. There are 57 acres of parks and open space available per 1,000 residents, or roughly an area the size of a tennis court for every resident.

Percent of Population Living Within Half a Mile of a Park by Race/Ethnicity in Lane County, OR, 2010

Source: Centers for Disease Control and Prevention Environmental Public Health Tracking, 2016

TOBACCO, ALCOHOL, LOTTERY, AND FIREARMS RETAIL DENSITY
Access to alcohol, tobacco, other drugs and lottery, due to retail/social access and decreased price, increases the likelihood of both youth and adult use. This adds to the risk of addiction related health outcomes and behavioral health concerns.

Alcohol is readily accessible in Lane County and is more accessible than tobacco, lottery and firearms combined. Retailers of alcohol for off-site use are 3 times more common than tobacco and lottery retailers. Still tobacco, lottery and firearms are accessible in the Eugene/Springfield metro region. For every 1,000 residents, there is one lottery and one tobacco outlet. For every 2,000 residents there is one firearm dealer. Youth who have increased access to firearms are more likely to develop behavioral health issues such as delinquency and violence and reducing access to lethal means is an important strategy for suicide prevention.
**Transportation**

**Vehicle Availability**

Vehicle ownership is directly related to the ability to get to where a person needs to go. In general, people living in a household without a car make fewer than journeys compared to those with a car. This limits their access to essential local services such as supermarkets, post offices, doctors’ offices and hospitals.

In Lane County, 8.3% of households have no vehicle available, which is slightly higher than the state average.

**Percent of Households with No Vehicle Available in Lane County, OR, 2009-2013**

**Workers Who Drive Alone to Work**

Driving alone to work consumes more fuel and resources than other modes of transportation, such as carpooling, public transportation, biking and walking. Driving alone also increases traffic congestion, especially in areas of greater population density.

71% of Workers in Lane County drive alone to work which is slightly lower than the state as a whole’s average.

![Percent of Workers 16 Years and Over Driving Alone to Work in Lane County, OR, 2009-2013](image)

*Source: American Community Survey 2009-2013.*

**Workers Commuting by Public Transportation**

Public transportation offers mobility to U.S. residents, particularly people without cars. Transit can help bridge the spatial divide between people and jobs, services, and training opportunities. Public transportation is also beneficial because it reduces fuel consumption, minimizes air pollution, and relieves traffic congestion.

Commuting by public transit is relatively low in Lane County, with only 3 out of every 100 workers doing so. On average, workers throughout the state of Oregon are slightly more likely to commute by Public Transit than in Lane County alone.

![Percent of Workers 16 Years and Over Commuting to Work by Public Transportation in Lane County, OR, 2009-2013](image)

*Source: American Community Survey 2009-2013.*
AIR QUALITY

Poor air quality is linked to premature death, cancer, and long-term damage to respiratory and cardiovascular systems. Air pollution is a leading environmental threat to human health. Particles in the air like dust, dirt, soot, and smoke are one kind of air pollution called particulate matter. Fine particulate matter that is less than 2.5 micrometers in diameter, or PM2.5, is so small that it cannot be seen in the air. Breathing in PM2.5 may cause breathing problems, make asthma symptoms or some heart conditions worse, and lead to low birth weight.

The national standard for annual PM2.5 levels is 15.0 µg/m³. When PM2.5 levels are above 15, this means that air quality is more likely to affect your health.

Air quality in Lane County has improved slightly over the past decade, a trend which is consistent with Oregon overall. Measures of small particles in the air declined slightly and then stabilized in recent years. Similarly, while the percent of the year (number of days during the year) in which air quality measurements exceeded national standards peaked at 10.1% (37 days) in 2005, it declined to 0.6% (2 days) in 2010, before increasing to around 5% (16 days) in 2014. This recent upward trend is due, in large part, to increasing temperature and draught related to climate change, which is resulting in more and larger forest fires.

Mean Annual Ambient Particulate Matter 2.5 (PM 2.5) Concentration (µg/m³) in Lane County, OR (based on Continuous Spatial Surfaces Algorithm)

Source: CDC WONDER, 2013.
Traffic-related air pollution is a major cause of unhealthy air quality, especially in urban areas, and many health problems have been linked to traffic-related air pollution exposure. The closer your home or school is to a major highway, the more likely you and your family are to be exposed to traffic-related air pollution.

Residents in Lane County are 42% more likely to live near a highway than residents in other parts of Oregon; on average. 5.8% of houses in Lane County are located near a highway compared to 4.1% of houses throughout Oregon. On the other hand, public elementary schools are 31% less likely to be located near a highway in Lane County than in other parts of Oregon.
**ACCESS TO SAFE DRINKING WATER**

Access to safe drinking water is essential to human health. Public drinking water systems are required to monitor approximately 90 contaminants and indicators regulated by the Environmental Protection Agency. A health-based violation occurs when a contaminant exceeds its Maximum Contamination Limit (MCL)—the highest amount allowed in drinking water—or when water is not treated properly. Limiting the levels of microorganisms, chemicals, and other contaminants in a community’s public water supply reduces residents’ risk of waterborne diseases, cancer, and other adverse outcomes.

During 2015, approximately 600 Lane County residents were served by 8 community water systems which failed to meet one or more health based standards. Overall, the vast majority (99.8%) of residents had access to safe drinking water, and Lane County fared slightly better than the state average. The larger water systems that serve the majority of the state population generally meet safe, clean drinking water standards.

(Source: Oregon Health Authority, Drinking Water Data Online)

**Percent of Population Meeting All Health Based Standards**

*in Lane County, OR, 2015*

<table>
<thead>
<tr>
<th>% of Population</th>
<th>Lane</th>
<th>Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td>99.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>98.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Oregon Health Authority, Drinking Water Data Online)

**Percent of Community Water Systems Meeting All Health Based Standards**

*in Lane County, OR, 2015*

<table>
<thead>
<tr>
<th>% of Community Water Systems</th>
<th>Lane</th>
<th>Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td>88.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>86.7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Oregon Health Authority, Drinking Water Data Online)
**FLUORIDATION**

Fluoridation of water is an important intervention to ensure optimal dental health in the community, particularly of children. Oregon has the third lowest amount of fluoridation in community water systems, a fact that continues to negatively impact the dental health of all Oregonians. Despite evidence that water fluoridation is safe and prevents tooth decay, Oregon ranks 48th among U.S. states by proportion of public water systems that are fluoridated. This diminishes the dental health of all Oregonians.

Florence remains the only community water system in Lane County which provides fluoridated water to its residents. As a result only 3 out of every 100 residents have access to fluoridated water. This is substantially lower than the rest of Oregon, where about 1 in 5 people receive fluoridated water.

**Percent of Population Served by Community Water Systems Who Receive Fluoridated Water in Lane County, OR**

![Graph showing the percentage of the population served by community water systems who receive fluoridated water in Lane County, OR, compared to Oregon. The graph indicates a decrease from 2006 to 2014.]

*Source: Centers for Disease Control and Prevention, Water Fluoridation Statistics 2014; Oregon Health Authority, Drinking Water Data Online, 2016.*

**RADON**

Radon is a radioactive gas formed from the natural decay of uranium, which is found in varying concentrations in most rock and soil. Humans can be exposed to radon gas as it migrates through soil into the air and concentrates in enclosed spaces. It is the second leading cause of lung cancer after smoking, and the primary cause of lung cancer in non-smokers. When smokers are exposed to radon, their risks are magnified. Northwest Oregon, including the Columbia Gorge and Willamette River Valley, tends to be the area of greatest known concern for radon exposure in Oregon.

Positive tests for radon are about 3 times higher in Lane County than the average for the state of Oregon. Thirty percent of households tested in Lane County are positive for radon, with most of the positive tests being concentrated in the Willamette Valley.
Housing Conditions

Age of Homes
Living environments, including housing and institutional settings, can support health. Quality housing is associated with positive physical and mental well-being. How homes are designed, constructed, and maintained, their physical characteristics, and the presence or absence of safety devices (like fire extinguishers) have many effects on injury, illness, and mental health. Children living in housing built before 1950 are at elevated risk for lead poisoning due to the use of lead paint in older housing. Risks due to aging homes tend to be lower in Oregon than the rest of the nation. Most homes in Lane County and in Oregon were built after 1950. Only about 15% of homes in Lane County were built before 1950, and roughly half of the local housing stock was built between 1950 and 1979.

Percent of Homes Built by Time Period
in Lane County, OR, 2009-2013

Source: American Community Survey, 2009-2013
Restaurant and Pool Inspections

Restaurant Inspections
Foodborne illnesses are a preventable and underreported public health problem. These illnesses are a burden on public health and contribute significantly to the cost of health care. Safer food is linked to healthier and longer lives and less costly health care, as well as a more resilient food industry. Prevention activities and collaborative efforts by the food industry, regulatory and public health agencies, and consumers are needed to reduce foodborne illness in the United States. To keep Oregonians healthy while dining out, the Oregon Public Health Division Foodborne Illness Prevention Program has adopted the 2009 FDA Food Code, which is based on the latest science regarding food safety practices. The Foodborne Illness Prevention Program works in partnership with local health departments, the food service industry, and the public to reduce or eliminate the known causes of foodborne illness. The program provides technical assistance, training, and education, coordinates rulemaking, and oversees the field inspection system and the Food Handler Card program. Restaurants in Lane County and in Oregon tend to comply well with food handling safety standards. More than 99% of all restaurants consistently receive passing grades upon inspection.

Percent of Restaurants that Passed Inspection in Lane County, OR

Source: Oregon Health Authority, Oregon Licensed Facility Statistics Report

Pool Inspections
A vital step in assuring the safety of a residential pool or spa is to have it inspected by a trained and qualified inspector. Properly maintained facilities reduce the risk of drownings, submersion injuries and entrapments. Trained pool and spa professionals evaluate water quality, safety equipment and the physical conditions of facilities. Ensuring that pools and spas are adequately maintained and well-designed also reduces the chances of germs being spread and of injury or drowning. The number of pools and spas closed due to poor water quality or other issues varies dramatically by year. Since 2007, less than 10% of pools or spas have been closed. Lane County pools have performed slightly better than the state average, yet were closed at a rate comparable to the state average in 2014.
Percent of Pools or Spas Closed in Lane County, OR

Source: Oregon Health Authority, Oregon Licensed Facility Statistics Report
Chapter 4 – Health System (Public Health, Medical [and Human Services])

The Affordable Care Act and subsequent health care reform changed the landscape of healthcare and health insurance in Lane County. The Patient Protection and Affordable Care Act significantly expanded both eligibility for and federal funding of Medicaid and the impact of Medicaid expansion has been significant. Because the number of uninsured individuals was cut in half, it is likely that much of the following data will change in the upcoming years; however updated estimates are not yet available, so we are reporting on the most recently available data.

Health Insurance Status

Uninsured
Lack of health insurance coverage is a significant barrier to accessing needed health care. People with health insurance and access to needed healthcare are more likely to have better health throughout their life.

Based on 2012 data, an estimated 21% of adults and 7% of children were reported to be uninsured in Lane County, mirroring state averages. Comparable data from 2014 shows significant reduction in uninsured rates in Lane County, largely due to Medicaid expansion the same year. In 2014, 12% of adults and 4% of children in Oregon were reported to be uninsured. A study conducted by the Oregon Health Authority and Oregon Health & Science University estimated that only 6% of all residents remained without health insurance in Lane County; the statewide average declined to 5.6% in the same time frame.

Uninsured By Age in Lane County, Oregon:

<table>
<thead>
<tr>
<th>Report Area</th>
<th># Uninsured Adults (18-64yrs)</th>
<th>% Uninsured Adults (18-64yrs)</th>
<th># Uninsured Children (0-18yrs)</th>
<th>% Uninsured Children (0-18yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lane County (2012)*</td>
<td>47,484</td>
<td>21%</td>
<td>4,754</td>
<td>7%</td>
</tr>
<tr>
<td>Oregon (2012)*</td>
<td>NA</td>
<td>21%</td>
<td>NA</td>
<td>7%</td>
</tr>
<tr>
<td>Oregon (2014)^</td>
<td>NA</td>
<td>12%</td>
<td>NA</td>
<td>4%</td>
</tr>
</tbody>
</table>

*County Health Rankings Data; ^Kaiser Family Foundation Data

Medicaid
Medicaid is a social health care program for families and individuals with low income and limited resources. Free or low-cost health care coverage is available to people who meet requirements for income, residency, age, disability, and other factors. Oregonians may also qualify based on age and disability status. Adults and children who qualify may be enrolled in the Oregon Health Plan (OHP), Oregon’s Medicaid program.

The Patient Protection and Affordable Care Act significantly expanded both eligibility for and federal funding of Medicaid. The impact of Medicaid expansion has been significant. As of 2015, an estimated 25% of adults and nearly 50% of children in Lane County have Medicaid coverage. With Medicaid coverage, cost is removed as a barrier to health care services.
Medicaid Coverage By Age in Lane County, Oregon:

<table>
<thead>
<tr>
<th>Report Area</th>
<th># Adults 18-64</th>
<th># Medicaid Adults (18-64yrs)</th>
<th>% Total County Population (18-64yrs)</th>
<th># Children 0-17</th>
<th># Medicaid Children (0-18yrs)</th>
<th>% Total County Population (0-18yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lane County (2015)</td>
<td>229,064</td>
<td>57,631</td>
<td>25%</td>
<td>69,054</td>
<td>33,592</td>
<td>49%</td>
</tr>
</tbody>
</table>

Source: Trillium Demographics Report, 2015

MEDICARE

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

In 2014, 19.5% of the population in Lane County and 17.9% in Oregon had Medicare coverage.

Percent of Population with Medicare Coverage in Lane County, OR, 2014

![Graph showing percent of population with Medicare coverage in Lane County and Oregon.]

Source: American Community Survey (ACS), 2014.

Health Care Costs and Affordability

Adults Who Could Not Afford a Doctor

Barriers to comprehensive clinical care, such as high costs and delays in appointment scheduling can result in unmet health needs and increased system costs from avoidable emergency room visits and hospitalizations. Out-of-pocket medical expenses in the United States can be extremely high and people without health insurance are more likely to forego care, including preventative checkups and screenings. When they do seek care, the uninsured are more likely to be sicker and require treatment that is more complex and costly.

In 2012, 15.1% of Lane County adults (18+ years old) say they were unable to see a doctor when needed in the past 12 months because they could not afford it. This is similar to the 15.6% of U.S. adults who did not see a doctor because of cost. Because the number of uninsured was cut in half, it is likely that those who were unable to see a doctor due to cost has declined significantly; however updated estimates are not yet available.
HEALTHCARE COSTS

Compared to other states, Oregon Medicare spending rates rank in the lowest ten nationally. Within Oregon, Lane County ranks 16th in terms of average reimbursements per Medicare enrollee. After being adjusted for demographic and regional factors, the key driver for this indicator is the volume of services delivered.

Medicare Spending per Enrollee in Lane County, Oregon:

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Health Care Costs (Price-adjusted*)</th>
<th>Medicare reimbursements per enrollee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lane County</td>
<td>$7,082</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>$7,204</td>
<td></td>
</tr>
</tbody>
</table>

* Adjusted for demographic and regional factors.

Preventable Hospitalizations

Preventable Hospital Stays refers to hospital care for medical conditions that can be treated in an outpatient setting. This index includes conditions such as chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, diabetes, and dehydration. The measure represents the rate of hospitalization for these conditions per 1,000 fee-for-service Medicare enrollees and is age-adjusted. Lane County has a much better rate than Oregon overall and ranks in the top 10th percentile nationally. This is a strong indicator of quality primary care and outpatient services.

The following table indicates the number of hospital stays for outpatient-care sensitive conditions per 1,000 Medicare enrollees in 2012. Lane County had a lower rate of preventable hospital stays than Oregon.

Number of Hospital Stays for Ambulatory-Care Sensitive Conditions per 1,000 Medicare Enrollees in Lane County, Oregon:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lane County</th>
<th>Oregon</th>
<th>Top Nationally</th>
<th>Performers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventable Hospital Stays</td>
<td>30</td>
<td>35</td>
<td>38</td>
<td></td>
</tr>
</tbody>
</table>

Preventative Health Care

**Breast Cancer Screening**
Breast cancer is the second most common type of cancer among women in the United States. Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women.

One indicator of Mammography Screening levels is the percentage of female fee-for-service Medicare enrollees age 67-69 that had at least one mammogram over a two-year period. 63% of Lane County and 61% of Oregon female Medicare enrollees ages 67-69 received mammography screening in 2012. Data based upon national survey data suggests that mammogram screening may be slightly higher. According to the Behavioral Risk Factor Surveillance System Survey, about three out of every four women age 50-74 had a mammogram within the past two years.

**Percentage of Female Medicare Enrollees Age 67-69 that had at least one Mammogram over a two-year period in Lane County, Oregon:**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lane County</th>
<th>Oregon</th>
<th>Top Nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography Screening</td>
<td>63%</td>
<td>61%</td>
<td>71%</td>
</tr>
</tbody>
</table>


**Cervical Cancer Screening**
Cervical cancer is a common cancer that has a very high cure rate when detected and treated early. The Pap test, also known as a Pap smear, checks for changes in the cells of the cervix that can be early signs of cervical cancer.
In Lane County, the percent of women 21-65 years old with an intact cervix who had a pap smear within the past three years decreased between 2006 and 2011. Based on 2010-2013 data, 76.3% of Lane County women 21-65 years old with an intact cervix had a pap smear within the past three years.

**Percent of Women 21-65 Years Old with an Intact Cervix Who had a Pap Smear within the Past 3 Years in Lane County, OR (age-adjusted)**

(Note: A new statistical method was used to produce estimates of adult health in Oregon counties starting in the 2010-2013 period. Because of this change, 2010-2013 data should not be compared with previous years; previous trends may not necessarily be consistent with 2010-2013 data).

**COLORECTAL CANCER SCREENING**

Colorectal cancer is one of the most commonly diagnosed cancers in the United States, and is the second leading cancer killer in the U.S. Colorectal cancer screening helps prevent deaths from colorectal cancer.

In 2014, 60% of the Lane County population 50-75 years old was current on colorectal cancer screening, similar to the 61% of all Oregonians.

**Percent of Population 50-75 Years Old Who Are Current on Colorectal Cancer Screening in Lane County, OR, 2014**

Source: Behavioral Risk Factor Surveillance System (BRFSS), 2014
**Alcohol and Drug Misuse Screening**

Excessive alcohol use is a leading cause of preventable death. These deaths are due to health effects from drinking too much over time such as breast cancer, liver disease, and heart disease; and health effects from consuming a large amount of alcohol in a short period of time such as violence, alcohol poisoning, and motor vehicle crashes. Drug overdose deaths are the leading cause of injury death. Drug-induced deaths include all deaths for which drugs are the underlying cause, including deaths attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use.

Because of the consequences of alcohol and drug misuse, screening for alcohol and/or drug misuse is critical to the prevention of or early intervention in addiction. For those at risk of developing a serious problem with drinking or drugs, the identification of early warning signs can be enough to change negative drinking or drug use habits. For others, these assessments are important first steps toward treatment of and recovery from addiction.

Among Trillium Medicaid members, 8.8% of members ages 12 and older received screening by mid-year 2015 (the most recent estimate available), a figure that has nearly tripled since 2013.

**Percentage of Trillium Members (ages 12 and older) Provided Appropriate Screening and Intervention for Alcohol or Other Substance Abuse**

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013 Performance</th>
<th>Trillium</th>
<th>2014 Performance</th>
<th>Trillium Mid-Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and drug misuse screening (SBIRT)</td>
<td>3%</td>
<td>7.8%</td>
<td>8.8%</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Trillium, 2013-2015*

**Developmental Screening**

Well-child visits allow doctors and nurses to have regular contact with children; this helps to monitor the child's health and development through periodic developmental screening. Developmental screening assesses basic skills progression or delays.

Among Trillium members, developmental screening in the first 3 years of life has increased from 28.3% in 2013 to 57.1% by mid-year 2015 (the most recent estimates available).

**Percentage of Children Served by Trillium Who Received Developmental Screening in the First 36 Months of Life**

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013 Performance</th>
<th>Trillium</th>
<th>2014 Performance</th>
<th>Trillium Mid-Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental screening</td>
<td>28.3%</td>
<td>45%</td>
<td>57.1%</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Trillium, 2013-2015*

**Adolescent Well Care Visits**

Adolescence is a time of dramatic physical, cognitive, social, and emotional change. Because of the rapid development occurring during this period, many physical and mental health conditions, substance use disorders, and health risk behaviors first emerge during adolescence. Yet well-care visit rates decline as children enter adolescence. Regular preventive care visits for adolescents provide opportunities for early identification and appropriate management and intervention for conditions and behaviors that, if not addressed, can become serious and persist into adulthood.
This measure is used to assess the percentage of adolescents 12 to 21 years of age who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year. Nearly 30% of adolescents served by Trillium had well-child visits in 2015 (mid-year), an improvement of approximately 10% over 2013.

**Percentage of Adolescents (ages 12-21) Served by Trillium Who Had at Least One Well-Care Visit in the Past Year.**

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013 Trillium Performance</th>
<th>2014 Trillium Performance</th>
<th>Trillium Mid-Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent well care visits</td>
<td>26.80%</td>
<td>28.7%</td>
<td>29.5%</td>
</tr>
</tbody>
</table>

*Source: Trillium, 2013-2015*

**Diabetes Monitoring**

Diabetic control monitoring is the percentage of diabetic fee-for-service Medicare patients ages 65-75 whose blood sugar control was monitored in the past year using a test of their glycated hemoglobin (HbA1c) levels. Regular HbA1c monitoring among diabetic patients is considered the standard of care. It helps assess the management of diabetes over the long term by providing an estimate of how well a patient has managed his or her diabetes over the past two to three months. When hyperglycemia is addressed and controlled, complications from diabetes can be delayed or prevented.

Diabetes Control Monitoring is the percentage of diabetic fee-for-service Medicare patients ages 65-75 that received HbA1c monitoring in 2012. Diabetic monitoring rates for Lane County are below both state and national rates.

**Percentage of Diabetic Medicare Enrollees Ages 65-75 that Received HbA1c Monitoring in Lane County, Oregon, 2012**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lane County</th>
<th>Oregon</th>
<th>Top Performers Nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic monitoring</td>
<td>85%</td>
<td>86%</td>
<td>90%</td>
</tr>
</tbody>
</table>

*Data retrieved from County Health Rankings, 2015. Data Source: Dartmouth Atlas of Health Care, 2012*

**Oral Health Promotion**

Oral health has been shown to impact overall health and well-being. Dental sealants act as a barrier to prevent cavities and are usually applied to the chewing surfaces of the back teeth (premolars and molars) where decay occurs most often.

Among Trillium members, the percentage of children ages 6-14 who received dental sealants has increased and was 14.2% by mid-year 2015.

**Percentage of Children Ages 6-14 Who Received Dental Sealants among Trillium Members**

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013 Trillium Performance</th>
<th>2014 Trillium Performance</th>
<th>Trillium Mid-Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental sealants for permanent</td>
<td>N/A</td>
<td>10.8%</td>
<td>14.2%</td>
</tr>
<tr>
<td>children</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Trillium, 2013-2015*
CERVICAL CANCER PREVENTION

HPV vaccines can prevent HPV. Human Papilloma Virus (HPV) is the most common sexually transmitted infection in the U.S. There are many different types of HPV and some types can cause health problems such as genital warts and cancers. Most of the time HPV has no symptoms so people do not know they have it.

Similar to the overall rate in Oregon, in 2015 in Lane County 63.7% of female adolescents had one to three doses of HPV vaccine and 35.2% had three doses. The rates increased slightly from 2014 to 2015.

Percent of Female Adolescents Who Had One or More Doses of HPV Vaccine in Lane County, OR

![Graph showing the percentage of female adolescents who had one or more doses of HPV vaccine in Lane County, OR. The graph includes data for 2014 and 2015.]

Source: Oregon ALERT Immunization Information System (ALERT IIS), 2014-2015

FAMILY PLANNING

The availability of family planning services allows individuals to plan for desired birth spacing and family size, and contributes to improved health outcomes for infants, children, women, and families.

For individuals who are sexually active and do not want to become pregnant or cause a pregnancy, correct and consistent contraceptive use is highly effective at preventing unintended pregnancy. In 2012, 46% of women in need of publically funded contraceptive services obtained family planning services in Lane County.

Percent of Women in Need of Publicly Funded Contraceptive Services Served by Family Planning Services in Lane County, OR, 2012

![Graph showing the percentage of women in need of publically funded contraceptive services who were served by family planning services in Lane County, OR, in 2012.]

Source: Oregon Health Authority Public Health Division, Reproductive Health Program
**Prenatal Care**

Early prenatal care (i.e. care in the first trimester of a pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development.

Four out of every five pregnant women served by Trillium received timely prenatal care in 2014.

**Percentage of Pregnant Women who are Trillium Members Who Received a Prenatal Care Visit Within the First Trimester or within 42 Days of Enrollment in Medicaid**

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013 Performance</th>
<th>2014 Performance</th>
<th>Trillium Mid-Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness of prenatal care</td>
<td>56%</td>
<td>79.7%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Source: Trillium, 2013-2015*

**Medical Care System Capacity**

The following sections illustrate several key indicators for gauging the effectiveness of the health care system in Lane County.

**Access to Care**

People without a regular source of health care are less likely to get routine checkups and screenings. Maintaining regular contact with a health care provider may be especially difficult for low-income people, who are less likely to have health insurance.

Among Trillium members, perceptions of access to care worsened slightly from 2013 to 2014, from 84.2% to 82.2%; however overall satisfaction with care improved slightly from 84.2% in 2013 to 86.2% in 2014.

**Perceptions of Access to Care and Satisfaction with Care among Trillium Members.**

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013 Performance</th>
<th>2014 Performance</th>
<th>Trillium Mid-Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHPS composite: Access to care</td>
<td>84.7%</td>
<td>82.2%</td>
<td>N/A</td>
</tr>
<tr>
<td>CAHPS composite: Satisfaction with care</td>
<td>84.2%</td>
<td>86.2%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Source: Trillium, 2013-2015*

**Availability of Primary Care**

Access to primary care providers increases the likelihood that community members will have routine checkups and screenings. Moreover, those with access to primary care are more likely to know where to go for treatment in acute situations.

When compared to Oregon overall, Lane County has fewer physicians relative to the overall population. In 2013 there was approximately 1 provider for every 1,180 people in the county.
ENROLLMENT IN PRIMARY CARE PATIENT CENTERED HOME
A Patient-Centered Primary Care Home is a health care clinic that has been recognized for their commitment to patient-centered care. Key initiatives throughout the county focus on ensuring access to high quality health, wellness, and preventive services.

As of Mid-Year 2015, 69% of Medicaid enrollees in Lane County were assigned to Primary Care Providers practicing out of recognized Patient Centered Primary Care Homes (PCPCH). This is up from just over 60% in 2014, due to Medicaid expansion. Since that time, there have been multiple new access points created, including two new Lane County Community Health Center locations.

Percentage of Trillium Members Who Were Enrolled in a Recognized Patient-Centered Primary care Home (PCPH)

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013 Trillium Performance</th>
<th>2014 Trillium Performance</th>
<th>Trillium Mid-Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Centered Primary Care Home enrollment</td>
<td>85.3%</td>
<td>60.7%</td>
<td>69%</td>
</tr>
</tbody>
</table>

Source: Trillium, 2013-2015

PRIMARY CARE BY COMMUNITY HEALTH CENTERS
Community health centers are community-based and patient-directed organizations that serve populations with limited access to health care. Community Health Centers provide high quality preventive and primary health care to patients regardless of their ability to pay. Overall, Community Health Centers emphasize coordinated primary and preventive services or a “medical home” that promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities and other underserved populations.

In 2014, 8.4% of the Lane County population was provided primary care by Community Health Centers, similar to Oregon’s 9%. The population served has increased about 6% since 2012.
Nursing Workforce

A registered nurse (RN) is a nurse who has graduated from a nursing program and has met the requirements outlined by a country, state, province or similar licensing body in order to obtain a nursing license. A licensed practical nurse (LPN) is a nurse who cares for people who are sick, injured, convalescent, or disabled. LPNs work under the direction of registered nurses or physicians.

In 2015, there were 8.1 Lane County RNs and 0.9 LPNs per 1,000 people, similar to Oregon’s overall rates.

Mental Health Provider Workforce

As the mental health parity aspects of the Affordable Care Act create increased coverage for mental health services, increased workforce shortages have been anticipated.

The chart below provides the ratio of the county population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care. Lane County has a high ratio of mental health providers to residents compared to Oregon overall, and ranks in the top 90% of all counties nationally. There is one mental health provider for every 160 people living in Lane County. Among Trillium members, timely follow-up care after hospitalization for mental illness declined slightly in 2015. Seven out of every ten members who had been hospitalized received follow-up care in 2015.

Ratio of Population to Mental Health Providers in Lane County, Oregon, 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lane County</th>
<th>Oregon</th>
<th>Top Nationally Performers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Providers</td>
<td>160:1</td>
<td>270:1</td>
<td>370:1</td>
</tr>
</tbody>
</table>

### Percent of Trillium Members who Received Follow-up Care After Hospitalization for Mental Illness

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013 Trillium Performance</th>
<th>2014 Trillium Performance</th>
<th>Trillium Mid-Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow up after hospitalization for mental illness</td>
<td>69.9%</td>
<td>77%</td>
<td>71.1%</td>
</tr>
</tbody>
</table>

*Source: Trillium, 2013-2015*

### Dental Care Workforce

Untreated dental disease can lead to serious health effects including pain, infection, and tooth loss. Although lack of sufficient providers is only one barrier to accessing oral health care, much of the country suffers from shortages. People living in areas with low rates of dentists may have difficulty accessing the dental care they need.

In 2014, Lane County had fewer dentists relative to the population than the state of Oregon overall, one dentist per 1,480 residents.

#### Ratio of Population to Dentists in Lane County, Oregon, 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lane County</th>
<th>Oregon</th>
<th>Top Nationally Performers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentists</td>
<td>1,480:1</td>
<td>1,330:1</td>
<td>1,340:1</td>
</tr>
</tbody>
</table>

*Data retrieved from County Health Rankings, 2015. Data Source: Area Health Resource*

In Lane County, 64.1% of adults had a dental care visit in the past year, based on 2010-2013 data. This was slightly lower than Oregon’s 66%. About 75% of Lane County 8th and 11th graders had seen a dentist in the past year.

#### Percent of Adults Who Had a Dental Care Visit in the Past Year in Lane County, OR, 2010-2013 (age-adjusted)

*Source: Behavioral Risk Factor Surveillance System (BRFSS), 2013*
HOSPITAL CAPACITY

Hospital beds include inpatient beds available in public, private, general, and specialized hospitals and rehabilitation centers. The following are statistics on the number of acute care hospital beds available per 1,000 residents.

In 2012 in Lane County, there were 1.4 acute care hospital beds per 1,000 population, less than Oregon’s overall average of 2 beds per 1,000 population.

Number of Acute Care Hospital Beds per 1,000 Population in Lane County, OR, 2012
**Emergency Care Use**

Emergency departments are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to lower costs and improve the health care experience for patients.

**Rate of Patient Visits among Trillium Members to an Emergency Department per 1,000 Member Months**

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013 Performance</th>
<th>Trillium Mid-Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory care: Emergency department utilization</td>
<td>51.3/1000 member months</td>
<td>51.4/1000 member months</td>
</tr>
</tbody>
</table>

Source: Trillium, 2013-2015

**Nursing Home and Long Term Care Capacity**

Long-term care services include a broad range of services that meet the needs of frail, older people and other adults with functional limitations. Assisted living and other residential settings represent a critical component of the long-term services and supports system for older adults who cannot live alone, but do not require the skilled care provided by nursing homes.

In 2013, there were 15.3 licensed assisted living facility units per 1,000 people 65 years and older in Lane County, significantly lower than the 21.6 available on average in Oregon.

**Number of Licensed Assisted Living Facility Units per 1,000 Population 65 Years and Older in Lane County, OR**

Source: Oregon Department of Human Services - Seniors and People with Disabilities Home and Community-Based Capacity Report, 2009-2013
In 2013, there were 21.1 licensed residential care facility beds per 1,000 people 65 years and older in Lane County, higher than the 17.2 on average in Oregon.

**Number of Licensed Residential Care Facility Beds per 1,000 Population 65 Years and Older in Lane County, OR**

![Graph showing the number of licensed residential care facility beds per 1,000 population 65 years and older in Lane County, OR, from 2009 to 2013. The graph compares the number of beds in Lane County to those in Oregon.](image)

*Source: Oregon Department of Human Services - Seniors and People with Disabilities Home and Community-Based Capacity Report, 2009-2013*

**Public Health System Capacity**

**Public Health**

For the purposes of this measure, the public health system refers to “activities undertaken within the formal structure of government and the associated efforts of private and voluntary organizations and individuals” (IOM, 1988).

In Lane County, the local health department FTE per 10,000 people was 2.1 in 2015.

**Local Health Department FTE per 10,000 Population in Lane County, OR, 2015**

![Graph showing the local health department FTE per 10,000 population in Lane County, OR, in 2015.](image)

*Source: Lane County Public Health*
In Lane County, the local health department expenditures per person was 34 dollars in 2015, significantly lower than the U.S. benchmark of 43 dollars.

Local Health Department Expenditures per Person in Lane County, OR, 2015

Source: Lane County Public Health & National Association of County & City Health Officials (NACCHO) National Profile of Local Health Departments, 2015
Chapter 5 – Healthy Living (Health Behaviors)

Food and Nutrition

It is essential to eat a fresh, healthy and balanced diet in order to maintain a healthy weight and prevent chronic disease. Consuming healthy foods and beverages is associated with lower risk of overweight and obesity and lower rates of numerous chronic diseases. There are risk factors for many chronic diseases. Despite the benefits, many people still do not eat the recommended levels of fruits and vegetables.

In 2013, only one in four Lane County adults consumed five or more servings of fruits and vegetables per day, a proportion that has not changed significantly over time.

Consumption of 5 or More Fruits or Vegetables Per Day by Adults in Lane County, Oregon, 2010-2013

Source: Behavioral Risk Factor Surveillance System

Produce consumption for adolescents is much the same as for adults. One in four Lane County 8th graders and one in five 11th graders consumed five or more servings a day of fruits and vegetables in 2013, slightly below the statewide rates.

Youth Consumption of 5 or More Servings of Fruits or Vegetables Per Day in Lane County, Oregon

Source: Oregon Healthy Teens Survey
Sugar-sweetened beverages are the largest source of added sugar in the American diet. Sugar-sweetened beverage consumption is associated with overweight and obesity in adults and children.

Fortunately, Lane County has experienced a decrease in soda consumption among adolescents over time, mirroring a trend seen on the statewide level. In 2006, more than one out of every four 8th graders and 11th graders in Lane County consumed at least one soda per day. In 2013 those rates were down to just over one in every ten.

**Percent of Youth Consuming 1 or More Sodas Per Day in Lane County, Oregon**

![Bar chart showing soda consumption rates in Lane County compared to Oregon](chart.png)

Source: Oregon Healthy Teens Survey

**Physical Activity**

Regular physical activity can improve health and quality of life in people of all ages. Active adults reduce their risk of many serious health conditions including obesity, heart disease, diabetes, colon cancer, and high blood pressure. In addition, physical activity reduces the symptoms of anxiety and depression, improves mood and feelings of well-being, and promotes healthy sleep patterns. In addition to reducing the risk of multiple chronic diseases, physical activity helps maintain healthy bones, muscles, joints, and helps to control weight, develop lean muscle, and reduce body fat.

In 2013, fewer than 25% of adults in Lane County met the CDC guidelines for physical activity, which include both strengthening activities as well as aerobic exercise.
Inactivity during childhood and adolescence increases the likelihood of being inactive as an adult. Participation in all types of physical activity declines drastically with both age and grade in school.

In 2013, just over half of Lane County 11\textsuperscript{th} graders and roughly 60\% of 8\textsuperscript{th} graders met physical activity guidelines.

![Percent of Adults that Met CDC Guidelines for Physical Activity in Lane County, Oregon, 2010-2013](chart)

Source: Behavioral Risk Factor Surveillance System

![Percent of Students Meeting Physical Activity Recommendations in Lane County, Oregon](chart)

Source: Oregon Healthy Teens Survey
**Alcohol, Tobacco, and Drug Use**

**Alcohol Use**
Binge drinking alcohol is a significant risk factor for injury, violence, substance abuse and alcoholism. Binge drinking is defined as five or more drinks for men and four or more drinks for women, on one occasion. Binge drinking is associated with:
- Unintentional injuries (car crashes, falls, burns, drowning).
- Intentional injuries (sexual assault, domestic violence, firearm injuries).
- Sexually transmitted diseases.
- Unintended pregnancies.
- Alcohol poisoning.
- Children born with Fetal Alcohol Spectrum Disorders.

In 2013 adult binge drinking in Lane County was slightly higher than the state average with 19.3% of Lane County adults reporting binge drinking (in the past month) compared to 17.7% statewide.

**Percent of Adults Who Participated in Binge Drinking Within the Past Month in Lane County, Oregon 2010-2013**

<table>
<thead>
<tr>
<th>Year</th>
<th>Oregon</th>
<th>Lane</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-2013</td>
<td>17.7%</td>
<td>19.3%</td>
</tr>
</tbody>
</table>

*Source: Behavioral Risk Factor Surveillance System*

Underage drinking is: alcohol consumption by anyone under the age of 21. Teens that have their first drink before age 15 are four times more likely to become alcohol dependent at some point in their lives than those that wait until they are 21 to drink (the rate of alcohol dependence drops the closer they get to 21).

In 2013 in Lane County, 27.2% of 11th graders and 15.5% of 8th graders used alcohol in the last 30 days, both lower than the state as a whole.
The most recent data (2013) indicates a 5% decrease in the percent of state and county 8th graders who participated in binge drinking (past 30 days) since 2004. The rate for binge drinking for 11th graders in Lane County has remained relatively steady at approximately 27%, but recent data suggest a decrease for this adolescent age group as well. As of 2013, the binge drinking rate for 11th graders was 17.7% statewide and 13.5% in Lane County.

Source: Oregon Healthy Teens Survey

Percent of Youth Who Participated in Binge Drinking in the Past 30 Days in Lane County, Oregon
Tobacco use is another major health concern for Lane County. Tobacco use is the single most preventable cause of death and disease in the United States and Oregon. It kills more than 7,000 Oregonians annually, and costs the state $2.5 billion in health care costs and lost productivity due to premature death.

Adult smoking in Lane County has followed a similar trend to that seen statewide with a slight, gradual, decrease between 2005 and 2010. This was followed by a sharper increase starting in 2011 and continuing up to the most recent available data. As of 2013, 21.6% of adults in Lane County currently smoke compared to 19% statewide.

![Percent of Adults who Currently Smoke in Lane County, Oregon, 2010-2013](chart)

*Source: Behavioral Risk Factor Surveillance System*

Youth cigarette usage rates are much lower than adult usage rates both state and county wide. The rates also follow a noticeably different trend. Rates for 8th grade smokers remained relatively stable between 2004 and 2008; however, the most recent data suggests a noticeable decrease. Just 6.3% of Lane County 8th graders smoked (in the past 30 days) in 2013, and only 4.1% statewide. The rates also remained relatively stable for 11th graders statewide, while Lane County 11th grade rates experienced a decline following 2004, before beginning a steady increase from 2005 to 2008. Fortunately, the most recent data suggests that both statewide and countywide smoking rates for 11th graders have decreased noticeably to 9.4% statewide and just 6.3% in Lane County. While the most recent data suggests that statewide smoking remains a greater concern for 11th graders than for 8th graders, within Lane County the rates for 8th and 11th graders are now identical.
Electronic cigarettes (also called e-cigarettes or electronic nicotine delivery systems) are battery-operated devices designed to deliver nicotine, with flavorings and other chemicals, to users in vapor instead of smoke. E-Cigarettes are increasingly popular among adolescents.

In 2013, 3.9% of Lane County 11th graders used e-cigarettes in the past 30 days, less than the 5.2% of Oregon 11th graders. 2.5% of Lane County 8th graders used e-cigarettes, more than the 1.8% of Oregon 8th graders.

Source: Oregon Healthy Teens Survey
**Drug Use**

In addition to alcohol and tobacco use, other substance abuse also has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. Drug use is also a concern for the youth population.

Non-medical prescription pain reliever use for adults at least 26 years old in Lane County have remained relatively stable since 2004 and close to the statewide average. Rates for adults 18-25 year olds have been noticeably higher and less stable over time, with relatively similar state and countywide trends. However, a sharp increase starting in 2006 resulted in identical rates of 15.6% for both Lane County and the state as a whole. In 2012 the rate of non-medical prescription pain reliever use for adults 18-25 years old remained similar for both the state- and county-wide: approximately 14.5%, significantly higher than the 4.5% rate for those 26 and older.

Illicit drug usage in adults has followed a similar trend to non-medical prescription pain reliever usage over time, with the rates for 18-25 year olds both noticeably higher and less stable than the corresponding rates for adults aged 26 and older. As of 2012, 9% of adults 18-25 in Lane County and 9.8% of adults 18-25 statewide reported illicit drug usage (in past 30 days) compared to only 3.3% of adults aged 26 and older both state and county-wide.

*Source: National Survey on Drug Use and Health*
In general, at both the state and county level, marijuana usage is higher for 11th graders than for 8th graders. From 2004 through 2008, marijuana usage in Lane County for 11th graders was higher than the statewide rate. However, the most recent data indicates that while the statewide rate has increased slightly to 20.9%, there has been a decrease for Lane County to 18.6% in 11th grade use.
Deaths associated with both prescription and non-prescription opioids (e.g. heroin) are among the leading causes of injury death in Oregon. Adolescent opiate usage, unlike marijuana usage, has remained relatively similar between both 8th and 11th graders over time. The most recent data suggest rates have decreased with most notable difference for Lane County 11th graders. Rates for Oregon 8th graders, Lane County 8th graders, and Oregon eleventh graders clustered around 0.9%; rates for Lane County eleventh graders were lower, at 0.2%.

As of 2013, youth prescription drug use without doctor’s orders was higher for 11th graders than 8th graders both statewide and within Lane County. Additionally, Lane County’s rates were slightly higher than the statewide rates for both groups with 4.9% of 8th graders and 6.9% of 11th graders reporting usage in the past 30 days compared to the statewide rates of 3.9% and 6.4% respectively.
**Problem Gambling**

Problem gambling in adolescents is associated with many of the same mental and behavioral health outcomes associated with problem gambling in adults. Problem gambling can have negative health consequences not only for the adolescent, but also for his/her loved ones and society as a whole.

The rate of problem gambling in Lane County is similar to statewide rates with 8th graders having a higher prevalence than 11th graders. In 2013 25.6% of 8th graders and 20.4% of 11th graders reported gambling in the past 30 days compared to the statewide rates 26% and 22.3% for 8th and 11th graders respectively.

**Percent of Youth Who Participated in Gambling in the Last 30 Days in Lane County, Oregon, 2013**

![Bar Chart showing the percentage of students who participated in gambling in the last 30 days in Lane County, Oregon, 2013.

**Injury Prevention**

Motor vehicle crash deaths are a leading cause of injury mortality in Oregon. Crashes also cause millions of serious injuries in the U.S. every year. Seat belts reduce the risk of being killed or seriously injured in a crash.

Statewide, in 2014 97.8% of drivers and front seat passengers wore seatbelts. This rate has remained consistent overtime, increasing just 2.5% since 2007. While, ideally, this rate should be 100%, it is still better than the national rate of 87% (up 5% since 2007.)
Sexual Behavior

Responsible sexual behavior reduces unintended pregnancies and sexually transmitted diseases.

In 2013 approximately 70% of 8th graders statewide and in Lane County reported condom use the last time they had sexual intercourse. Of 11th graders, around 65% in Lane County reported using condoms the last time they had sexual intercourse, slightly higher than the statewide rate of approximately 64%.

Source: Oregon Healthy Teens Survey
While condoms are one of the most commonly known methods of pregnancy prevention, they certainly are not the only method. Other contraceptive methods include male and female sterilization, intrauterine devices (IUD) and contraceptive implants, hormonal pills, patches, rings, and shots, sponges/diaphragms, spermicide and withdrawal.

In 2013, 93% of Lane County 8th graders and 91.9% of 11th graders used a condom the last time they had sexual intercourse. This is higher than Oregon’s 81.4% of 8th graders and 83.5% of 11th graders.

Percent of Youth That Used a Method to Prevent Pregnancy the Last Time They Had Sexual Intercourse in Lane County, Oregon

Alcohol and drug use both impair judgement and can lead to poor decision making or even an inability to knowingly consent to sex. The most recent data (2013) suggest that rates of 8th and 11th graders reporting use of alcohol/drugs the last time they had sexual intercourse are decreasing. Oregon’s rates are at their lowest with reported usage rates for 8th graders at 21.1% and 11th graders at 16.8%. The rate for Lane County 11th graders is also at its lowest at just 12.4%. However, while the rate for Lane County 8th graders decreased to 22.3%, it was 10 percentage points higher than the 2005 rate.

Source: Oregon Healthy Teens Survey

Alcohol and drug use both impair judgement and can lead to poor decision making or even an inability to knowingly consent to sex. The most recent data (2013) suggest that rates of 8th and 11th graders reporting use of alcohol/drugs the last time they had sexual intercourse are decreasing. Oregon’s rates are at their lowest with reported usage rates for 8th graders at 21.1% and 11th graders at 16.8%. The rate for Lane County 11th graders is also at its lowest at just 12.4%. However, while the rate for Lane County 8th graders decreased to 22.3%, it was 10 percentage points higher than the 2005 rate.
The only 100% effective way to prevent unintended pregnancies and sexually transmitted infections is to abstain from sex completely. In 2013, 11th grade rates of adolescents reporting they had intercourse were relatively unchanged (approximately 45% for Oregon and 46% for Lane County compared to 2007-2008 data; however, the 8th grade rates decreased to their lowest rates yet at approximately 11% for Oregon and 14% Lane County.

Source: Oregon Healthy Teens Survey
**Overall Health Status**

**Life Expectancy**
Life expectancy is a good measure of a population's longevity and general health. It is highly dependent on infant mortality rates and all-cause death rates. Although the overall average life expectancy at birth has been steadily increasing in the U.S., there are great variations in life expectancy between racial and ethnic groups.

Comparable to the state overall, the life expectancy for Lane County males was approximately 77 years in 2013. The life expectancy for Lane County females in 2013 was approximately 81 years.

Source: Oregon Center for Health Statistics
**Premature Death**

Premature death is made up of the number of years of potential life lost before age 75. Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person dying at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost to a county’s years of potential life lost (YPLL).

In 2013, the Lane County YPLL was higher among males (8,066 per 100,000 years) than females (5,904 per 100,000).

![Years of Potential Life Lost, Relative to Age 75, by Sex, in Lane County, OR, 2013](image)

*Source: Oregon Center for Health Statistics*

**Poor Physical Health Days**

Overall health depends on both physical and mental well-being. In addition to measuring how long people live, it is also important to include data that maps the quality of people’s health. Measuring health-related quality of life helps characterize the burden of disabilities and chronic diseases within a population. Reported days of poor physical health is a reliable estimate of recent quality of health.

The graph below is based on survey responses to the question: “Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?” In 2012 Lane County adults reported that their physical health was not good for an average of 4.1 days compared to Oregon adults at 3.7 days, both of which have increased slightly over five years.
The Oregon Healthy Teens Survey includes questions relating to students' physical, mental and emotional health, including connections to the school and community, as well as unmet needs. Higher academic test scores are strongly associated with students' reporting of caring relationships at school and meaningful participation in the community. Students who report receiving higher school grades also report better physical and emotional health. Students reporting mostly A and B grades were less likely to report various health risk factors than students with grades of C or lower. Students with D and F grades were the most likely to report health risk factors.

In 2013, 90.8% of Lane County 8th graders and 88.7% of 11th graders reported their physical health as being good, very good, or excellent—similar to Oregon's respective 90.2% and 88.4%.
**Poor Mental Health Days**

Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good represents an important facet of health-related quality of life.

The graph below is based on survey responses to the question: “Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” In 2012, Lane County adults reported having an average of 4 poor mental health days compared to 3.3 for Oregon adults, both of which have increased slightly over five years.

*Average # of Days Adults Report that Their Mental Health Was Not Good, in Lane County, OR (age adjusted)*

![Graph showing average days of poor mental health for Lane County and Oregon from 2008 to 2012.](chart)

*Source: Behavioral Risk Factor Surveillance System*

In 2013, 81.2% of Lane County 8th graders and 82.6% of 11th graders reported their mental health as being good, very good, or excellent, similar to Oregon’s respective 83.6% and 79.7%.

*Percent of Youth Experiencing Good Mental Health, in Lane County, OR*

![Chart showing percent of students experiencing good mental health from 2007-2008 to 2013.](chart)

*Source: Oregon Healthy Teens Survey*
Births and Birth Outcomes

A healthy pregnancy and healthy status at birth set the stage for subsequent child development and well-being.

Fertility

Tracking trends in fertility rates is essential in planning for the current and future needs of multiple generations. The fertility rate measures the number of live births occurring per 1,000 women between the ages of 15 and 44 in a particular calendar year.

In 2013, Lane County’s total fertility rate for women age 15 to 44 was 49.1 per 1,000. The total fertility rate in Lane County has declined 2008. Fertility rates are the highest for Latino/Hispanic women in Lane County.

Prenatal Care

Looking at the maternal and child health of a community is one of the most important ways to monitor the health of infants and children, one of the most vulnerable populations. Prenatal visits are important for the health of both infant and mother. Health care providers can educate mothers on important health issues such as their diet and nutrition, exercise, immunizations, weight gain, and abstaining from drugs and alcohol. Health care professionals also have an opportunity to instruct expecting parents on nutrition for their newborn, the benefits of breastfeeding, and injury and illness prevention, as well as monitoring for health-compromising conditions, and helping them prepare for the new emotional challenges of caring for an infant.

In 2013, 77% of mothers in Lane County began prenatal care in the 1st trimester, and 4.5% waited until the 3rd trimester. In Oregon, 77.8% of mothers in Lane County began prenatal care in the 1st trimester, and 3.6% waited until the 3rd trimester.

Source: Oregon Center for Health Statistics

Hispanic mothers are more likely than white mothers to receive either late or no prenatal care.

Source: Oregon Center for Health Statistics

Percent of Births Where the Mother Received Prenatal Care by Trimester, in Lane County, OR

Source: Oregon Center for Health Statistics

Percent of Births Where Prenatal Care Was Initiated the First Trimester by Hispanic Ethnicity, Lane County, Oregon

Source: Oregon Center for Health Statistics
LOW BIRTH WEIGHTS

Babies born with a low birth weight are more likely than babies of normal weight to require specialized medical care, and often must stay in the intensive care unit. Low birth weight is often associated with premature birth.

In Lane County and the state as a whole, low birth weight rates have increased since 1999. In 2013, Lane County’s low birth weight rate was 7.4%, compared to the state as a whole's rate of 6.3%.

**Percent of Births Where the Child Weighed Less than 2500 grams, in Lane County, OR**

![Graph showing the percent of births where the child weighed less than 2500 grams from 2007 to 2012 for Oregon and Lane County.]

*Source: Oregon Center for Health Statistics*

Birth weight rates vary by race/ethnicity. In Lane County in 2013, Asian Non-Hispanic women had the highest low birth rate, and Hispanic women had the lowest rate.

**Low Birth Weight Births, By Race/Ethnicity, in Lane County, OR, 2011-2013**

![Bar chart showing low birth weight births by race/ethnicity in Lane County, OR, 2011-2013.]

*Source: Oregon Center for Health Statistics*

* Suppressed; Statistically Unreliable
Birth weight rates also vary by the educational attainment level of the mother. In Lane County in 2013, women with high school or less than high school education had the highest low birth rate, and women with a college education had the lowest rate.

**Low Birth Weight by Education, in Lane County, OR, 2013**

Birth weight rates also vary by the age of the mother. In Lane County in 2013, women aged 20-24 had the highest low birth rate, and women aged 25-29 had the lowest rate.

**Low Birth Weight, by Age Group in Lane County, OR 2011-2013**

*The data for Oregon and Lane County 10-14 years old and Lane County 45-49 years old is suppressed because it is statistically unreliable.*

*Source: Oregon Center for Health Statistics*
**Preterm Births**

Preterm birth is the birth of an infant before 37 weeks of pregnancy. Infants born preterm are at increased risk for a number of health problems and are likely to require specialized medical care, and oftentimes must stay in intensive care nurseries. While there have been many medical advances enabling premature infants to survive, there is still risk of infant death or long-term disability.

Generally, Lane County’s preterm birth rate is higher (8.1% in 2013) than the state as a whole’s (7.6%).

**Percent of Births Born Preterm in Lane County, OR**

![Graph showing the percent of births born preterm in Lane County, OR, from 1999 to 2013.](image)

*Oregon*  *Lane County*

Source: Oregon Center for Health Statistics

Preterm birth rates vary by race/ethnicity. In Lane County in 2013, American Indian/Alaska Native Non-Hispanic women had the highest preterm birth rate, and Pacific Islander Non-Hispanic women had the lowest rate.

**PreTerm Birth, By Race/Ethnicity in Lane County, OR, 2011-2013**

![Graph showing preterm birth rates by race/ethnicity in Lane County, OR, from 2011 to 2013.](image)

*Oregon*  *Lane County*  

* Suppressed; Statistically Unreliable

Source: Oregon Center for Health Statistics
Preterm birth rates also vary by the educational attainment level of the mother. In Lane County in 2013, women with some college had the highest preterm birth rate, and women with less than high school had the lowest rate.

**Teen Births**

In Oregon, the teen (age 15-19) birth rate has been on the decline, and Lane County has had a consistently lower rate than the state as a whole. In 2013, Lane County’s teen birth rate was 17 per 1,000, compared to the state rate of 21.6.

---

**Source:** Oregon Center for Health Statistics, 2008-2013
Teen birth rates vary by the race/ethnicity of the mother. In Lane County in 2013, White Non-Hispanic women had the lowest teen birth rate, and Hispanic women had the highest rate.

**Teen (age 15-19) Birth Rate by Race/Ethnicity in Lane County, OR, 2009-2013**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Oregon</th>
<th>Lane County</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native NH*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian NH*</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Black NH*</td>
<td>36</td>
<td>24</td>
</tr>
<tr>
<td>Hispanic</td>
<td>33</td>
<td>22</td>
</tr>
<tr>
<td>Pacific Islander NH*</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Two or More Races NH</td>
<td>52</td>
<td>27</td>
</tr>
<tr>
<td>White NH</td>
<td>42</td>
<td>19</td>
</tr>
</tbody>
</table>

*Suppressed; statistically unreliable

**Source: Oregon Center for Health Statistics**

**SMOKING DURING PREGNANCY**

Women who smoke during pregnancy increase their risk of complications, including low infant birth weight. Infants and children exposed to secondhand smoke are at increased risk of sudden infant death syndrome, acute lower respiratory infections, ear infections, and asthma attacks.

Lane County has a higher percentage of pregnant women who smoke (13.8% in 2013) compared to the state the state rate (10.2% in 2013).

**Percent of Women who Smoked at While Pregnant in Lane County, OR**

**Source: Oregon Center for Health Statistics**
**Chronic Diseases and Conditions**

Chronic diseases and accidents remain the leading causes of death in Lane County, led by cancer and heart disease. Deaths from the most common cancers (lung, prostate, breast cancer) and heart disease have steadily declined. However, tobacco use remains the leading preventable cause of death.

Rates of obesity, asthma, high blood pressure, and high blood cholesterol are higher in Lane County than in the state as a whole, while heart disease and cancers occur at rates similar to or slightly lower than the state overall.

**ALZHEIMER’S**

Alzheimer’s disease is the most common form of dementia among the population over 65 years old, accounting for 50 to 80 percent of dementia cases. It is a progressive and irreversible disease where memory and cognitive abilities are slowly destroyed, making it impossible to carry out even simple, daily tasks.

In 2012 9.3% of the 65 and older population in Lane County had Alzheimer’s which is lower than the national average of 10.3%.

![Prevalence of Alzheimer's in Older Adults 65+ in Lane County, OR, 2012](image)

*Source: Community Health Status Indicators referencing Medicare Chronic Conditions Report, Center of Medicare and Medicaid Services*

**ASTHMA**

Asthma is a chronic inflammatory disorder of the airways, characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath.

In 2013, 11.7% of adults in Lane County had asthma, compared to 10.4% in the state.
In 2013, 16.1% of 8th graders and 12.7% of 11th graders in Lane County had asthma, compared to the state rates of 12.6% and 11.5% respectively.

Source: Behavioral Risk Factor Surveillance System

Source: Oregon Healthy Teens Survey
STROKE

A stroke occurs when a clot severely blocks the blood supply to the brain or when a blood vessel bursts, resulting in bleeding into or around the brain. When either happens, brain cells begin to die and brain damage can occur. Abilities controlled by the affected area of the brain cannot function, which may result in an inability to control limbs on one side of the body, inability to understand or formulate speech, or the inability to see out of one eye.

In Lane County and across Oregon, prevalence of stroke has stayed consistent over time. In 2013 the prevalence of stroke in adults was 2.4% compared to 2.5% of the entire state’s adults.

RESPIRATORY DISEASES

Chronic Obstructive Pulmonary Disease, or COPD, is a condition that restricts airflow into the lungs, making it difficult to breathe. COPD is most commonly a mix of chronic bronchitis and emphysema, and usually results from tobacco use, although it can also be a result of pollutants in the air, genetic factors, and respiratory infections.

In 2013 the prevalence of adults with chronic obstructive pulmonary disease was 6.1% in Lane County, which is slightly higher than the state rate of 5.7%.
**HIGH BLOOD PRESSURE**

Hypertension, also known as high blood pressure, is a significant increase in the blood pressure in the arteries. Hypertension is the leading cause of stroke and a major cause of heart attacks.

Lane County has a higher prevalence over time of adults with high blood pressure when compared to the state of Oregon as a whole. In 2013, 33.5% of the Lane County adult population had high blood pressure, while the state as a whole's adult population was 31.8%.

![Prevalence of High Blood Pressure in Adults in Lane County, OR, 2010-2013](image)

*Source: Behavioral Risk Factor Surveillance System*

**DIABETES**

Diabetes mellitus is a group of diseases marked by high levels of blood glucose, also called blood sugar, resulting from defects in insulin production, insulin action, or both. Diabetes lowers life expectancy, increases the risk of heart disease, and is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The prevalence of adults with diabetes in Lane County has increased over time, but has remained slightly lower than that of the state as a whole. In 2013 the prevalence of diabetes in adults was 7.4%, lower than the state as a whole at 8.2%.

![Prevalence of Diabetes in Adults in Lane County, OR 2010-2013](image)

*Source: Behavioral Risk Factor Surveillance System*
OBESITY

The percentage of overweight and obese adults is an indicator of the overall health and lifestyle of a community. Being overweight or obese affects quality of life and puts individuals at risk for developing many diseases such as heart disease, stroke, diabetes, and cancer.

The prevalence of adults with obesity in Lane County has increased over time, and is higher than the rate of obesity in all Oregon adults. In 2013, the percent of obese Lane County adults was 27%, higher than the state as a whole at 25.9%.

Source: Behavioral Risk Factor Surveillance System

The prevalence of obesity in youth has increased over time in Lane County. In 2013, the prevalence of obesity for Lane County 11th graders was 13.2%, and 10.1% for 8th graders.

Source: Oregon Healthy Teens
Deaths

Oregon Center for Health Statistics provides county level information on all deaths of Lane County residents, including leading causes by age group. Comparable to the state as a whole, Lane County’s leading causes of death are: cancer, heart disease, respiratory disease, accidental, and stroke. Chronic disease and accidents remain among the leading causes of death in Lane County, while tobacco use, obesity, physical inactivity and alcohol use remain the leading preventable causes.

Leading Causes of Death in Lane County, OR 2013
(age adjusted)

Source: Oregon Center for Health Statistics, 2013

Leading Causes of Death by Age Group, Lane County 2013

<table>
<thead>
<tr>
<th></th>
<th>All Ages</th>
<th>&lt;1</th>
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<th>15 to 24</th>
<th>25 to 44</th>
<th>45 to 64</th>
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<td>166</td>
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<td>Accidents (unintentional injuries)</td>
<td>Accidents (unintentional injuries)</td>
<td>Cancer</td>
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<tr>
<td></td>
<td>Congenital malformations, deformations, chromosomal abnormalities</td>
<td>135</td>
<td>128</td>
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<td>*</td>
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<td>*</td>
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<tr>
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<td>Heart Disease</td>
<td>*</td>
<td>*</td>
<td>Intentional Self-Harm (suicide)</td>
<td>Intentional Self-Harm (suicide)</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>#3</td>
<td>Respiratory Diseases</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>Cancer</td>
<td>Accidents (unintentional injuries)</td>
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<tr>
<td>#4</td>
<td>Accidents (unintentional injuries)</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>Alcohol-Induced Deaths</td>
<td>Alcohol-Induced Deaths</td>
<td>Alzheimer’s Disease</td>
</tr>
<tr>
<td>#5</td>
<td>Stroke</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>Heart Disease</td>
<td>Intentional Self-Harm (suicide)</td>
<td>Stroke</td>
</tr>
</tbody>
</table>

*Suppressed; statistically unreliable.
Source: Oregon Center for Health Statistics
INFANT MORTALITY
Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy. In 2013 the infant death rate of Lane County was notably higher at 6.52 per 100,000 compared to the state’s infant death rate of 4.99 per 100,000.

![Infant Death Rate in Lane County, OR](image)

*May be statistically unreliable; interpret with caution.

Source: Oregon Center for Health Statistics, 1999-2013

CANCER
Cancer is a leading cause of death in the United States, the state of Oregon, and Lane County. The National Cancer Institute (NCI) defines cancer as a term used to describe diseases in which abnormal cells divide without control and are able to invade other tissues. According to the NCI, lung, colon and rectal, breast, pancreatic, and prostate cancers lead to the greatest number of annual deaths.

LUNG CANCER
According to the American Lung Association, more people die from lung cancer annually than any other type of cancer; exceeding the total deaths caused by breast cancer, colorectal cancer, and prostate cancer combined. The greatest risk factor for lung cancer is duration and quantity of smoking.

Lung cancer mortality rates have decreased in Lane County over the past decade. In 2013, the total lung cancer mortality rate in Lane County was 46.1 per 100,000, slightly higher than the state as a whole’s rate of 42.
Breast cancer is the most common type of cancer among women other than skin cancer. Breast cancer forms in tissues of the breast, usually the ducts (tubes that carry milk to the nipple) and lobules (glands that make milk). According to American Cancer Society, 1 out of 8 women in the United States will be diagnosed in her lifetime.

The breast cancer mortality rates for the state and Lane County have decreased over time. In 2013 the breast cancer mortality rate for Lane County was 16.5 per 100,000 compared to the state rate of 19.9 per 100,000.
**Cervical Cancer**

Cervical cancer forms in tissues of the cervix and is slow-growing. Cervical cancer is almost always caused by the human papillomavirus (HPV), which is transmitted through sexual contact. According to American Cancer Society, 1 out of 147 women in the United States will be diagnosed in her lifetime. Early cervical cancer can be cured by removing or destroying the pre-cancerous or cancerous tissue. Thus, early detection is very important and the Centers for Disease Control and Prevention highly recommend screenings with regular Pap tests.

In 2013, Lane County’s cervical cancer mortality rate was 2.5 per 100,000 women, higher than the state rate of 1.8.

**Deaths from Cervical Cancer, Lane County, OR**

![Chart showing deaths from cervical cancer from 1993-2013](chart.jpg)

*Source: Oregon Center for Health Statistics*

**Colorectal Cancer**

Colorectal cancer—cancer of the colon or rectum—is a leading cause of cancer-related deaths in the United States. The Centers for Disease Control and Prevention estimates that if all adults aged 50 or older had regular screening tests for colon cancer, as many as 60% of the deaths from colorectal cancer could be prevented. While 90% of colorectal cancer cases occur in adults aged 50 or older, it is essential for individuals with risk factors (those with a family history of colorectal cancer, inflammatory bowel disease, or heavy alcohol use) to seek regular screening earlier.

In 2013, Lane County’s total colorectal cancer mortality rate was 14.6 per 100,000, similar to the state rate of 14.4.
Prostate Cancer

The prostate is a gland found only in males, and is located below the bladder and in front of the rectum. Prostate cancer is a leading cause of cancer death among men. According to the American Cancer Society, about 1 in 7 men will be diagnosed with prostate cancer, and about 1 in 36 will die from it. The two greatest risk factors for prostate cancer are age and race; with men over the age of 65 and men of African descent possessing the highest incidence rates of prostate cancer in the U.S.

Prostate cancer deaths have been decreasing over the past decade in Lane County and the state. In 2013 the mortality rate for prostate cancer in Lane County was 14.4 per 100,000 men, lower than the state rate at 19.4 per 100,000.
**MELANOMA**

Skin cancer is the most common form of cancer in the United States. Melanoma, the third most common skin cancer, is most dangerous and causes the most deaths. The majority of skin cancer are caused by exposure to ultraviolet (UV) light.

The melanoma mortality rate is consistently higher for males than females in Lane County and the state. In 2013 Lane County’s total melanoma mortality rate was 2.9 per 100,000, compared to the state’s 3.3.

**Deaths from Melanoma Cancer, Lane County, OR**

![Deaths from Melanoma Cancer, Lane County, OR](image)

Source: Oregon Center for Health Statistics

**ORAL CANCER**

Oral cancer is a largely preventable type of cancer that affects the mouth and/or part of the throat. Most oral cancers are related to tobacco use, alcohol use, or both.

Oral cancer mortality is higher among males than females across Lane County and Oregon as a whole. In 2013 the total oral cancer mortality rate for the state was 3.31 per 100,000, compared to 3.98 for Lane County.

**Oral Cancers Deaths in Lane County, OR**

![Oral Cancers Deaths in Lane County, OR](image)

Source: Oregon Center for Health Statistics
**Alzheimer’s Disease Mortality**
In Lane County the Alzheimer’s mortality rate is consistently higher among females than males. In 2013 the Alzheimer’s mortality rate for Lane County females was 34.5 per 100,000 compared to Lane County males at 29.6.

**Deaths from Alzheimer's Disease, Lane County, OR**
(age-adjusted)

![Graph showing Alzheimer's mortality rates from 1999 to 2013 for males and females.](image)

*Source: Oregon Center for Health Statistics, 1999-2013*

**Respiratory Disease**
In Lane County the rate of respiratory disease mortality remains consistent over time. In 2013 the rate of mortality for females was 45.7 per 100,000 compared with males at 43.9.

**Respiratory Disease Deaths in Lane County, OR**
(age-adjusted)

![Graph showing respiratory disease mortality rates from 1999 to 2013 for males and females.](image)

*Source: Oregon Center for Health Statistics*
HEART DISEASE MORTALITY
Heart disease is a term that encompasses a variety of different diseases affecting the heart. The most common type in the United States is coronary artery disease, which can cause heart attack, angina, heart failure, and arrhythmias. There are many modifiable risk factors for atherosclerosis including tobacco smoking, obesity, sedentary lifestyle, and high levels of low-density lipoprotein in blood serum.

Over time heart disease mortality has decreased in Lane County, but still remains the second leading cause of death in the state and Lane County. In 2013, Lane County male heart disease mortality rate was 163.4 per 100,000 compared with, Lane County females at 98.9.

RENAL DISEASE MORTALITY
The primary function of the kidneys is to remove waste and excess water from the body. Chronic kidney disease (CKD), also known as chronic renal disease, is a progressive loss of this function over time. The primary causes of CKD are diabetes and high blood pressure. As kidney disease progresses it can lead to kidney failure, which requires dialysis or a kidney transplant. Renal disease mortality rates have decreased slightly over time and were 7.7 per 100,000 people in 2013.
**STROKE MORTALITY**

Stroke mortality is the fifth leading cause of death in Lane County and is a leading cause of long-term disability. Stroke mortality has been declining since the early 20th century. In 2013, Lane County the stroke rate death rate was 35 per 100,000.

**Diabetes Mortality**

In Lane County in 2013, the diabetes mortality rate was notably higher for males at 28.5 per 100,000 than for females at 17.7.
**Influenza/Pneumonia Mortality**

Influenza and pneumonia are a leading cause of death. The two diseases are traditionally reported together because pneumonia is frequently a complication of influenza. The number of influenza deaths can fluctuate considerably from one year to the next as influenza can be caused by more virulent virus strains in some years than others as the viruses constantly mutate. Influenza vaccination is suggested for all individuals six months and older, but influenza and pneumonia vaccinations are especially recommended for persons most at risk, including the elderly, the very young, and the immunocompromised.

In 2013 the influenza/pneumonia mortality rate per 100,000 was similar for both sexes: 10.7 for females and 11 for males in Lane County.

![Influenza/Pneumonia Deaths in Lane County, OR](image)

**Source:** Oregon Center for Health Statistics, 1999-2013

**Drug Overdose Deaths**

Drug overdose deaths are the leading cause of injury death. The death rate due to drug overdose across the state of Oregon has increased over the last two decades. Drug overdose deaths may be accidental, intentional, or of undetermined intent. Drug-induced deaths include all deaths for which drugs are the underlying cause, including deaths attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use. A drug includes illicit or street drugs (e.g., heroin or cocaine), as well as legal prescription drugs and over-the-counter drugs. Alcohol is not included in this definition.

In Lane County, drug induced deaths have declined since 2009, but are higher than they were a decade ago, and increased from 2012 to 2013. In 2013, the rate of drug induced deaths in Lane County was 17.81 per 100,000, higher than the rate of the state at 13 per 100,000.
Excessive alcohol use is a leading cause of preventable death. Deaths can occur from drinking too much over time; breast cancer, liver disease, and heart disease; and from consuming a large amount of alcohol in a short period of time; violence, alcohol poisoning, and motor vehicle crashes.

Alcohol-induced deaths have increased in Lane County over the past decade. Lane County has higher rates of alcohol-induced mortality than the state. Lane County males have higher rates of alcohol-induced mortality than females with male rates of 23.2 per 100,000, and females rates of 14.2.
Lane County has chronic liver disease mortality rates that are notably higher than the state, and rising. In 2013 in Lane County, the rate of chronic liver disease in females was 12.2 per 100,000 and males had a rate of 20 compared to the state with female rates at 7.7 per 100,000 and male rates at 16.

![Chronic Liver Disease Deaths in Lane County, OR](image)

**Source:** Oregon Center for Health Statistics

Nearly one-third of all traffic-related deaths in the United States are caused by alcohol-impaired crashes.

Over time the motor vehicle mortality rate for both, the state, and Lane County, has decreased. In 2013 the total motor vehicle mortality rate is Lane County was slightly higher at 8.8 per 100,000 compared to 8 at the state level.

![Motor Vehicle Crash Related Deaths in Lane County, Oregon](image)

**Source:** Oregon Center for Health Statistics
**Tobacco Linked Mortality**

Tobacco is the leading cause of preventable death in the United States, Oregon, and Lane County. Smoking causes many diseases and negatively affecting the health of smokers in general. The major causes of excess mortality among smokers are diseases related to smoking, including cancer and respiratory and vascular disease.

Although tobacco linked mortality rates have been on the decline in Oregon, including Lane County, in 2013 Lane County females had a tobacco linked mortality rate of 132.4 per 100,000 compared with Lane County males at 219.9.

**Tobacco Linked Deaths in Lane County, Oregon**

(age adjusted)

![Tobacco Linked Deaths in Lane County, Oregon](image)

*Source: Oregon Center for Health Statistics*

Notably, tobacco linked mortality rates vary significantly by race/ethnicity. In Lane County in 2013, American Indian/Alaska Native Non-Hispanics had the highest tobacco linked death rate, and Hispanics had the lowest rate.

**Tobacco Linked Deaths by Race Ethnicity**

**in Lane County, Oregon, 2009-2013**

(age adjusted)

![Tobacco Linked Deaths by Race Ethnicity](image)

*Source: Oregon Center for Health Statistics*

* Lane Asian NH & Pacific Islander NH suppressed; statistically unreliable.
**GUN RELATED DEATHS**
The United States has the highest rate of gun-related injuries among developed countries. Youth are disproportionately affected by firearm violence.

Gun-related deaths in youth are higher in Lane County than in the state overall.

**Youth Gun Related Deaths in Lane County, 2004-2013**

(age adjusted)

<table>
<thead>
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<th></th>
<th>Rate per 100,000</th>
</tr>
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<tr>
<td>Oregon</td>
<td>1.4</td>
</tr>
<tr>
<td>Lane County*</td>
<td>1.9</td>
</tr>
</tbody>
</table>

* May be statistically unreliable; interpret with caution.

*Source: Oregon Center for Health Statistics, 2013*

**SUICIDE MORTALITY**
Suicide, a death resulting from the intentional use of force against oneself, is one of Lane County’s most persistent yet largely preventable public health problems. Suicide rates in Lane County have been consistently higher than the U.S. for the past 30 years. Suicide affects survivors and entire communities, and the effects are devastating and long lasting. It is one of the most persistent public health concerns for our state and county.

Suicide rates have slowly increased over the last decade in both Lane County and in the state as a whole and are one of the five leading causes of death for people in Lane County aged 10-54 years. More people between the ages of 15-44 die from suicide than motor vehicle accidents. Compared to Oregon, in 2013 the deaths from suicide rate in Lane County was slightly higher at 19.6 per 100,000 compared to 16.8 at the state level. This translates into more than one person dying from suicide in Lane County every week. In 2013 Lane County females had a deaths from suicide rate of 7.9 per 100,000 compared with Lane County males at 31.7.
**ACCIDENT MORTALITY**

Accidents (unintentional injuries) are a leading cause of death for people in Lane County of all ages, regardless of gender, race, or economic status. Major categories of unintentional injuries include motor-vehicle collisions, poisonings, and falls.

Accident mortality in Lane County has increased over time. Most notably in 2013 the accident mortality for Lane County females was 44.4 per 100,000 compared to 29.6 for the state. Lane County males have seen a decrease in accident mortality over time: the 2013 rate was 50.1 for both Lane County and the state.
**Work-Related Injury Mortality**

Although employment can contribute positively to a worker's physical and psychological health, each year many workers are fatally injured at work.

Work-related injury mortality has decreased over time in Oregon as a whole, and in Lane County. In 2013 Lane County’s total rate for work related injury mortality was 0.85 per 100,000 compared to 0.89 in the state.

![Deaths due to Work Related Injuries, Lane County, OR](chart)

*Source: Oregon Center for Health Statistics, 1999-2013*

**Infectious Diseases**

**Animal/Vector Borne Diseases**

Lyme disease is caused by bacteria called *Borrelia burgdorferi* and is transmitted to humans through the bite of infected blacklegged ticks. If left untreated, infection can spread to joints, the heart, and the nervous system. Most cases of Lyme disease can be treated successfully with a few weeks of antibiotics.

Lane County’s Lyme disease rate is lower when compared to the state as a whole. In 2013 the rate for Lane County was 0.8 per 100,000 and 1.1 per 100,000 across the state.
West Nile virus (WNV) is most commonly transmitted to humans by mosquitoes. There are no medications to treat or vaccines to prevent WNV infection. Fortunately, most people infected with WNV will have no symptoms. About 1 in 5 people who are infected will develop a fever with other symptoms. Less than 1% of infected people develop a serious, sometimes fatal, neurologic illness.

The rate of West Nile Virus has remained low in Lane County. Fewer than 5 cases have been diagnosed in the county over the past 10 years. In 2013 there were 16 reported cases of West Nile Virus in the state.

**ENTERIC DISEASE**

Foodborne illness (sometimes called "foodborne disease," "foodborne infection," or "food poisoning) is a common, costly—yet preventable—public health problem.

In 2013 the Lane County rate for food and waterborne disease illness was 46.6 per 100,000, which was lower than the 55.41 per 100,000 state rate.
Norovirus is a very contagious virus that can be transmitted from an infected person, contaminated food or water, or by touching contaminated surfaces.

In 2013 Lane County had nine norovirus outbreaks.

Salmonella is a bacterial disease that affects the intestinal tract and causes foodborne illnesses. In 2013 the rate of salmonella infection was 9.46 per 100,000, slightly lower than the state rate of 9.72.
HIV AND AIDS

HIV is a virus spread through body fluids that attacks the body’s immune system, specifically the CD4 cells which are often called T cells. Over time, HIV can destroy so many of these cells that the body can’t fight off infections and disease. These special cells help the immune system fight off infections. Untreated, HIV reduces the number of CD4 cells (T cells) in the body. This damage to the immune system makes it harder and harder for the body to fight off infections and other diseases. Opportunistic infections or cancers take advantage of a very weak immune system and signal that the person has AIDS.

The HIV case rate in Lane County has stayed consistently lower than the state. In 2013 the case rate of HIV in Lane County was 3.7 per 100,000 while the rate in the state was 6.5 per 100,000.

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STI) are a significant health problem in Oregon and Lane County. These infections pose a threat to an individual’s immediate and long term health and well-being. They can lead to severe reproductive health complications such as infertility and ectopic pregnancy. Gonorrhea is a sexually transmitted infection that can infect both men and women. It can cause infections in the genitals, rectum, and throat. It is a very common infection, especially among young people ages 15-24 years.

In both the state of Oregon as a whole and Lane County the rates for gonorrhea in males and females have increased dramatically since 2011. Lane County males have a higher rate of gonorrhea at 75.7 per 100,000 when compared with males at the state level, 62.4 per 100,000.
In Lane County the rate for gonorrhea in 15-19 year olds has increased over time and is much higher than the total population, especially for Lane County females. In 2013 the rate for 15-19 year old Lane County males was 62.4 per 100,000 while the rate for 15-19 year old Lane County females was 99.1 per 100,000.

Chlamydia, the most frequently reported bacterial sexually transmitted disease in the United States, is caused by the bacterium, *Chlamydia trachomatis*. Although symptoms of chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia also can cause discharge from the penis of an
infected man. Under-reporting of chlamydia is substantial because most people with chlamydia are not aware of their infections and do not seek testing.

Over time the chlamydia rates for both males and females in Lane County, and across the state have increased significantly over time. Lane County females have a significantly higher rate of chlamydia when compared to Lane County males. In 2013 the chlamydia rate for Lane County females was 507.7 per 100,000 while the Lane County male’s rate was 212.1 per 100,000.

Chlamydia Cases in Lane County, Oregon
(age-adjusted)

In Lane County the chlamydia rate for 15-19 year olds has increased over time, and is significantly higher for Lane County females. In 2013 the rate for 15-19 year old Lane County females was 2,366 per 100,000 while the rate for 15-19 year old Lane County males was 360 per 100,000.

Chlamydia in 15-19 Year Olds
in Lane County, Oregon
(age-adjusted)

Source: HIV/STD/TB Prevention Program, Center for Public Health Practice, Public Health Division, Oregon Health Authority
*Treponema pallidum* (syphilis) is an STI that can cause long-term complications if not treated correctly. You can get syphilis by direct contact with a syphilis sore during vaginal, anal, or oral sex. Syphilis can also be spread from an infected mother to her unborn baby.

Over time the rate of early stage syphilis cases has increased dramatically for both Lane County and Oregon. In 2013 the rate of early stage syphilis cases was 2.2 per 100,000 which was a dramatic increase from 0.7 per 100,000 in 2008. In the state as a whole, the early stage syphilis case rate of 2013 was 5.8 per 100,000 which is an increase from 1.4 per 100,000 in 2008.

![Syphilis Cases (Early Stage) in Lane County, Oregon](image)

### Tuberculosis

Tuberculosis (TB) is caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually infect the lungs, but TB bacteria can attack any part of the body including the kidney, spine, and brain. If not treated properly, TB can be fatal.

Over time the tuberculosis rate in Lane County and Oregon has decreased. In 2013 the rate of tuberculosis was 0.7 per 100,000 which is lower than the state rate of 1.7 per 100,000.
IMMUNIZATIONS AND VACCINE PREVENTABLE DISEASES

In our mobile society, many people travel to and from other countries, where many vaccine-preventable diseases remain relatively common. Without vaccines, epidemics of preventable diseases could return. There are record or near record low levels of vaccine-preventable childhood diseases in the United States, but that does not mean they have disappeared completely. It is important that children, especially infants and young children receive recommended immunizations on time.

Influenza is a contagious disease caused by the influenza virus. It can lead to pneumonia and can be dangerous for people with heart or breathing conditions. Infection with influenza can cause high fever, diarrhea, and seizures in children. The seasonal influenza vaccine can prevent serious illness and death. The Centers for Disease Control and Prevention recommends annual vaccinations to prevent the spread of influenza.

Between 2005 and 2011, the influenza vaccination rate decreased for the 65 or older population in Lane County from 73.6% to 64.1%.
Pneumonia is an infection of the lungs that can cause mild to severe illness in people of all ages. It is the leading cause of death in children younger than five years of age worldwide. However, these infections can often be prevented with vaccines and can usually be treated.

In Lane County the pneumonia vaccination rate for adults 65 or older in Lane County has stayed consistent between 2005 and 2011.

Source: Behavioral Risk Factor Surveillance System
Meningococcal disease is caused by the bacterium *Neisseria meningitidis*. About 1 out of 10 people have this type of bacteria in the back of their nose and throat with no signs or symptoms of disease; this is called being 'a carrier'. But sometimes *Neisseria meningitidis* bacteria can invade the body causing certain illnesses, which are known as meningococcal disease.

In 2013 the rate of meningococcal disease cases in Lane County was 1.1 per 100,000 which is higher than the state rate at 0.6 per 100,000.

The Human Papillomavirus (HPV) is a group of more than 150 related viruses. Each HPV virus in this large group is given a number which is called its HPV type. HPV is named for the warts (papillomas) some HPV types can cause. Some other HPV types can lead to cancer, especially cervical cancer. There are vaccines that can prevent infection with the most common types of HPV.

The rate for female adolescent HPV vaccination in Lane County is comparable to that of Oregon. In 2015, the percent of Lane County female adolescents who received one or more doses of HPV vaccine was 63.7% and Oregon was 64.3%.
Measles can be prevented with the MMR (measles, mumps, and rubella) vaccine. In Lane County, 91.9% of adolescents received two or more MMR vaccinations in 2015.

Tetanus, diphtheria, and pertussis are very serious diseases. **Tetanus** is rare in the United States today. It causes painful muscle tightening and stiffness, usually all over the body. **Diphtheria** is also rare in the United States today. It can cause a thick coating to form in the back of the throat. The Tdap vaccine can protect us from these diseases, and, Tdap vaccine given to pregnant women can protect newborn babies against pertussis.

In 2015, the percent of adolescents receiving Tdap vaccine in Lane County was 92.1%, slightly lower than the 92.7% in the state as a whole.
The seasonal flu vaccine protects against the influenza viruses that research indicates will be most common during the upcoming season.

In 2015, the percent of adolescents receiving seasonal flu vaccine in Lane County was 24.3%, lower than the 36% in 2013.

Meningococcal vaccines help protect against all three serogroups of meningococcal disease that are most commonly seen in the United States (serogroups B, C and Y), but they will not prevent all cases.

In 2015, the percent of adolescents receiving meningococcal vaccine in Lane County was 70.3%, compared to the 2013 rate of 65%.
Pertussis (Whooping Cough) causes severe coughing spells, which can cause difficulty breathing, vomiting, and disturbed sleep.

The pertussis rate in Lane County is significantly higher than that of Oregon. In 2013 the rate of pertussis in Lane County was 39.8 per 100,000 while the state as a whole’s total rate was 14.2 per 100,000.

Source: Acute & Communicable Disease Prevention Program, Center for Public Health Practice, Public Health Division, Oregon Health Authority
HEPATITIS

“Hepatitis” means inflammation of the liver. Heavy alcohol use, toxins, some medications, and certain medical conditions can cause hepatitis. However, hepatitis is most often caused by a virus. In the United States, the most common types of viral hepatitis are hepatitis A, B, and C.

Hepatitis A is a contagious liver disease that results from infection with the hepatitis A virus. It can range in severity from a mild illness lasting a few weeks to a severe illness lasting several months. Hepatitis A is usually spread when a person ingests fecal matter from contact with objects, food, or drinks contaminated by the feces, or stool, of an infected person. It can be prevented with a vaccine. Lane County’s hepatitis A rate decreased significantly in the total population from 2010 to 2013. In 2013 the hepatitis A rate for both Lane County and the state as a whole was 0.4 per 100,000.

Hepatitis B is a contagious liver disease that ranges in severity from a mild illness lasting a few weeks to a serious, lifelong illness. It results from infection with the Hepatitis B virus, spread through sexual contact. Hepatitis B can be either “acute” or “chronic.” Acute hepatitis B virus infection is a short-term illness that occurs within the first 6 months after someone is exposed to the hepatitis B virus. Acute infection can — but does not always — lead to chronic infection. This can also be prevented with a vaccine, usually combined with hepatitis A.

Lane County’s acute hepatitis B rate decreased significantly from 2010 to 2013. In 2013 the rate of acute hepatitis B in Lane County was 0.89 per 100,000 which is similar to the rate in Oregon, 0.8 per 100,000.

Source: Acute & Communicable Disease Prevention Program, Center for Public Health Practice, Public Health Division, Oregon Health Authority

* Data may be statistically unreliable; interpret with caution
Chronic Hepatitis B virus infection is a long-term illness that occurs when the hepatitis B virus remains in a person’s body; it can lead to liver cancer or cirrhosis that may require liver transplant.

In 2013, Lane County males, at 10.59 per 100,000, had a higher rate of hepatitis B cases than females. Lane County’s total rate in 2013 was 8.6 per 100,000.

* Data for 2010-2013 may be statistically unreliable; interpret with caution.

Source: Acute & Communicable Disease Prevention Program, Center for Public Health Practice, Public Health Division, Oregon Health Authority
Hepatitis C is a contagious liver disease that ranges in severity from a mild illness lasting a few weeks to a serious, lifelong illness that attacks the liver. It results from infection with the Hepatitis C virus (HCV), which is spread through contact with the blood of an infected person, usually by sharing needles for illegal drug injection. Hepatitis C can be either “acute” or “chronic.” Acute hepatitis C virus infection is a short-term illness that occurs within the first 6 months after someone is exposed to the Hepatitis C virus. For most people, acute infection leads to chronic infection. As with hepatitis B, chronic infection can lead to liver cancer or cirrhosis that may require liver transplant. There is no vaccination protecting against hepatitis C.

In 2013 the rate of acute hepatitis C in Lane County was 1.2 per 100,000, higher than the rate in Oregon, 0.7 per 100,000.

![Acute Hepatitis C Cases in Lane County, Oregon](chart)

Source: Acute & Communicable Disease Prevention Program, Center for Public Health Practice, Public Health Division, Oregon Health Authority

Chronic hepatitis C virus infection is a long-term illness that occurs when the hepatitis C virus remains in a person’s body. Hepatitis C virus infection can last a lifetime and lead to serious liver problems, including cirrhosis (scarring of the liver) or liver cancer.

As you can see on the chart below, the chronic Hepatitis C rate in Lane County has decreased over time. In 2013, Lane County males had the highest rate of chronic Hepatitis C at 125.2 per 100,000 while Lane County females had a rate of 98.7 per 100,000.
Oral Health

The health of the mouth and surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Oral and craniofacial diseases and conditions include: dental caries (tooth decay); periodontal (gum) diseases; cleft lip and palate; oral and facial pain; and oral and pharyngeal (mouth and throat) cancers. Given these serious health consequences, it is important to maintain good oral health. Professional dental care helps to maintain the overall health of the teeth and mouth, and provides for early detection of pre-cancerous or cancerous lesions.

The percent of 8th and 11th graders in Lane County who have ever had a cavity has remained very similar to the state's rate since 2004. In 2013, 69.7% of Lane County 8th graders and 74% of 11th graders had ever had a cavity.
In 2012, the percent of Lane County adults aged 65+ who have lost all their natural teeth due to tooth decay or gum disease was crudely estimated to be 14.8%, similar to the state’s rate.

Source: Oregon Healthy Teens Survey
Source: Behavioral Risk Factor Surveillance System

In 2012 in Lane County, approximately 41.2% of adults had had any permanent teeth extracted.

Source: Behavioral Risk Factor Surveillance System
EXECUTIVE SUMMARY

The Forces of Change Assessment (FOCA) is a component of the Community Health Needs Assessment. The purpose of Forces of Change Assessment (FOCA) is to identify the trends, factors, and events that are likely to influence community health and quality of life, or impact the work of the local public health system in the Lane County region.

The Forces of Change brainstorming session focused on the following questions:
- What has occurred recently or may occur in the foreseeable future that may affect our local public health system or the health of our community?
- What are the trends occurring that will have an impact?
- What forces are occurring locally? Regionally? Nationally? Globally?
- What opportunities will be created for improving our public health system or the health of our community?
- What barriers exist in improving our public health system or the health of our community?

For the purpose of the Forces of Change exercise, forces include trends, events and factors:
- Trends: Patterns over time
- Events: One time occurrences
- Factors: Discrete elements or attributes of a community

The findings from the Forces of Change Assessment will ensure that the strategic issues identified later in the CHNA process are relevant to the changing environment and that the developed action plans are responsive to potential threats and opportunities.

Key Findings

Through the assessment process, the following health-impacting forces of change were identified:

- Collaboration
- Access to primary care
- Funding for healthcare
- Affordable Care Act (ACA)
- Care delivery system
- Technology in healthcare
- Dental
- Public Health workforce
- Political and leadership changes
- Economy
- Education funding
- Healthy schools
- Environment
- Community infrastructure
- Affordable housing
- Poverty
- Rural
- Changing demographics
- Behavioral/mental health
- Health behaviors
- Communicable disease

Across the identified forces of change, common reoccurring threats and opportunities emerged:

**Threats:**
- The impact of poverty and economic shifts overwhelming the systems of: education, employment, and affordable housing
- Shortages of resources and funding shifts
- Increased costs
- System capacity and issue overload

**Opportunities:**
- Access to healthcare
- Health integration
- Collaboration, coordination, and innovation
- Emerging technology
- Focus on prevention
PROCESS

As one component of the 2015 Community Health Needs Assessment, community leaders from across the region convened on May 13, 2015 for the collaborative Forces of Change Assessment. The assessment objectives were to determine forces affecting the health of the community and local health system and to identify the associated threats and opportunities.

Facilitated by Karen Gaffney from Lane County Health and Human Services, the brainstorming session comprised of leaders representing 22 organizations from diverse sectors including local government, healthcare and public health, education, and social services. Utilizing a customization of the snow card technique, participants compiled a broad inventory of forces – events, trends, and factors – that are or will be influencing the health and quality of life of the community and the local public health system. Ideas spanned local, regional, national, and global concerns as well as community based issues.

Through the process, of the 21 named categories, eight of the most common key categories were selected for further in-session examination: 1) collaboration; 2) access to primary care; 3) Affordable Care Act; 4) technology in healthcare; 5) political and leadership changes; 6) economy; 7) rural; and 8) changing demographics. Small groups then discussed and recorded the potential threats and opportunities that could be generated by these forces of change. The planning committee later identified the threats and opportunities for the remaining 13 categories.

RESULTS

This report details the comprehensive findings from the May 2015 Forces of Change Assessment. The analysis of themes produced 21 categories of forces (trends, events, and factors) and associated potential threats and opportunities.

Collaboration

The Lane County region has a strong history of collaboration with community partners becoming increasingly interested in collective impact. In addition, there is a growing demand to provide culturally and linguistically appropriate and relevant services. With this increase in local, regional, and national collaboration comes both obstacles and opportunities.

Threats posed:
- Threats to individual organizations: relevance, revenue streams, and loss of identify
- Leadership changes threatening old partnerships
- Leadership at high levels does not reflect the diversity in our community
- Lag in results, inability to prioritize, and collaboration fatigue
- Lack of a universally accepted vision

Opportunities created:
- Development of non-traditional partnerships and coalitions with new strategies for managing cross sector collaboration and leadership
- Collaboration with multicultural organizations, local colleges and universities, and utilizing students as resources for impacts of change
- Better understanding of health integration and mobilizing the entire community to impact health
- Maximize use of resources and efforts; collaborative processes for sharing and analyzing data
Access to Primary Care

Adequate and easy access to local primary care, including the limited linguistic access to healthcare, is a growing issue impacting healthcare providers, individuals, and the overall community health status. As a result of the Affordable Care Act, there is an increasing gap between primary care supply and demand.

**Threats posed:**
- Limited skilled labor and lack of clinicians/physicians in Lane County; high cost to recruit and retain skilled physicians and staff
- High turnover due to burnout
- Phone interpretation is not always a culturally appropriate practice
- Increased bureaucracy

**Opportunities created:**
- New nurse practitioner (NP) and physician assistant (PA) programs locally and medical team expansion with PAs, NPs, and extended team members
- Increased need for more medical interpreters could result in job growth
- Rural health initiatives, loan forgiveness programs, and reimbursement programs
- Expansion in interdisciplinary services provision
- Nontraditional access points; group visits; TeleMed
- Improved staff and doctor disabled competency trainings
- Improved treatment of the mentally challenged through care and provider training
- Financing to patients (e.g. PeaceHealth’s use of HealthFirst Financial)

Funding for Healthcare

Numerous concerns exist over the trend of decreased federal and state funding for healthcare, Coordinated Care Organizations (CCOs), preventative care, and governmental public health.

**Threats posed:**
- Partners’ ability to collaborate and share resources will decrease, unraveling commitment to current efforts
- Transformation efforts and health gains could stall/fall short or new issues will not be tackled; system breaks down
- Decreased reimbursement levels will reduce access to care
- Fewer services available for people who are low income

**Opportunities created:**
- Strengthen local partnerships and identify local resources
- Strategies can be more tailored because there will not be outside funding requirements attached
- Pressure will demand improved efficiencies and focus on most effective interventions

Affordable Care Act (ACA)

The ACA is the largest health care legislation since Medicaid and Medicare were passed and will drastically change the way healthcare is delivered and received. There are issues regarding the legislation’s public perception and how individuals may not understand how to navigate their newly acquired insurance. Additionally, there is a resulting influx of demand on providers and in the post ACA healthcare marketplace.
Threats posed:
- Confusion with consumers and providers
- Shortage of providers
- Negative impact on the delivery system and provider satisfaction/engagement
- Increased regulations increasing costs
- Lack of economic stability and volatility of market

Opportunities created:
- Collaboration and innovation: broadening health care to include more than just medical care
- Economies of scale
- $2 billion prevention and public health fund will enable reach to upstream issues to advance prevention
- Educating households on tax credits to support affordability and stabilize cost
- CCO incentive metrics

Care Delivery System

The impact of the current care delivery system and its high costs and variations in care delivery are significant local concerns. On a positive note, there are strong safety net providers in Lane County. Also locally, the imminent sale of Trillium to Centene is a significant force that could have an impact on the community.

Threats posed:
- Change in ownership of PeaceHealth or McKenzie Willamette could change the focus on community health
- Cost escalation due to inefficiencies, government regulations and administrative burden, and designer drugs and treatments
- Aging and increasingly ill population further stresses the delivery system

Opportunities created:
- Develop community-wide practice standards and protocols for treatment
- Strengthen safety net coalition by networking and providing infrastructure support
- Advocate for payment reform shifts
- Improve care coordination capacity and leverage community health workers (CHW), Patient Navigators and Peer Support Specialists
- Enhance training and support for patient-centered medical home (PCMH) workforce
- Improve community wide information service directory, 211

Technology in Healthcare

Rapidly evolving technology and access to information are significant trends impacting healthcare delivery and outreach, health sector operating budgets, and personal health and fitness monitoring. The key Electronic Medical Records Mandate in ACA will result in an increased importance of cost-benefit analysis to maximize the return on technology spending.

Threats posed:
- Inaccessible to certain populations (i.e. elderly, homeless, and low income)
- Confidentiality, privacy concerns, and data breaches
- Financial costs associated with new technology, training, implementation, and infrastructure improvements
- Providers and individuals may be resistant to change
- Lack of personalization of care
Opportunities created:
- Accessible to the younger generations; efficient way to reach more people
- Collaborative processes for sharing and analyzing data
- Emergence and integration of self-health monitoring technology
- Electronic health records, shared electronic medical system, health information exchange, Telehealth, telecommuting, mobile/kiosk health care units, patient portals

Dental

The lack of unified focus on oral health within medicine, inadequate local dental care access (including restorative), lack of coordination in care delivery, and low oral hygiene knowledge and instructions are major local dental factors affecting the local public health system and community.

Threats posed:
- Increased cost for delayed care
- State budget shortfall and resulting cut in Medicaid adult dental
- Ongoing anti-fluoride propaganda

Opportunities created:
- Link with Early Learning Alliance initiatives
- Tele-dentistry to serve rural areas
- Great focus on oral health with a new State Dental Director to lead efforts

Public Health Workforce

The local public health authority was reported as being very engaged, with positive leadership, training, and cross-disciplinary capabilities.

Threats posed:
- New requirements might divert energy or focus away from current priorities and traditional services; funds may be insufficient
- Could create more disconnect between the clinical care system and public health, or between different types of public health services
- Could create more scrutiny or bureaucracy from the state that would limit local control

Opportunities created:
- Sufficient funding for core public health functions
- Increased effectiveness for Public Health interventions, resulting in decreased costs and pressure on the clinical care system
- More focus on prevention and population health strategies
- Higher awareness about the role of public health and more local investment

Political and Leadership Changes

Participants pointed to the impact of upcoming state and national elections of a new governor and president. Additional concerns surround the forces of political and leadership change: leadership transitions in key organizations and institutions, uncertain governmental public health structure, increased regulations and mandates, federal and state healthcare policy, Rivlin-Ryan, and the Public Health Modernization Bill.

Threats posed:
- Problems growing with no long-term vision on solutions
- Transition in leadership and stagnation with change
- Loss of institutional memory
- Translation of policy to practice; Continuity of policy priorities
- Rising costs

**Opportunities created:**
- Innovation and positive change; longer-term perspectives and investments
- Oregon Task Force on future of public health
- Tobacco Master Settlement Agreement monies given for health improvement (CHNA, CHIP, Prevention efforts)
- Payment reform through legislation/policy leadership

**Economy**

Local economic concerns include personal and family financial security, the challenge of recruiting and retaining quality employees, the lack of economic opportunity in rural communities leading to high poverty rates, stagnant wages, Oregon budget issues, and high medical bills. Noted economic factors of encouragement included the recent economic development, increase of good jobs and decrease in unemployment rate. Also of concern is the predicted 2019 recession.

**Threats posed:**
- Poverty (hot spots, generational, etc.); cost of living; income inequality/inequity
- Education: increased cost and declining funds
- Employment: increased job outsources, lack of qualified employees, livable wage jobs, declining benefits offered by employers, unequal opportunities
- Legislative limits
- Rates of incarceration

**Opportunities created:**
- New growing and sustainable industries; job growth
- Economic growth environment – push health agenda now!
- Minimum wage increases
- Education as critical to economic stability
- Reduction in "silos" at state level

**Education Funding**

The state funding challenges, current low funding for education, and the privatization of education are significant concerns. Optimistically, there is an increased focus, especially locally, on investing in early childhood and the related impact on long-term public health outcomes. A particular example is the newly launched Lane Early Learning Alliance.

**Threats posed:**
- Lack of tax base to adequately fund education
- Need for additional revenue not to spread resources thinner
- Competition for funding between early childhood, K-12, and higher education
- Shortage of skilled labor in needed trades
- Oregon’s outcomes for education could continue to slip below national averages, impacting our economic and social future

**Opportunities created:**
- Going upstream and the future impacts on educational career, long term health and lifespan
- Community awareness and action to create political will
- Professionalism of early education field building momentum for higher quality care
- Leveraging resources and momentum around a P-20 continuum
Healthy Schools

Numerous healthy school forces include the great school nutrition programs, increased funding for Farm to School, new 2017 PE instructional time mandates, behavioral health education, and programs for kids to engage in healthy lifestyles. Noteworthy concerns include the lack of mental health supports and nurses in schools, increasing number of homeless students, and dramatic rise of children with life threatening illnesses. Also highlighted is the necessity of strong school support and infrastructure for Safe Routes to School.

Threats posed:
- High burnout rate among school nurses; rapid turnover of staff
- Untreated mental health issues at early stages due to limited/stigmatized access
- Education funding cuts and state regulations impacting school based health center’s (SBHC) capacity
- Negative impacts of technology, such as children being more sedentary
- PE mandate remains unfunded and eventually not implemented

Opportunities created:
- Mental wellness, healthy lifestyles, and prosocial behaviors are the norm
- Easier access to non-stigmatizing behavioral health services
- Awareness of physical literacy and movement being incorporated into classroom learning; setting the stage for healthy behaviors reduces obesity rates
- Utilizing schools to share information and connect with entire families
- Potential created for SBHCs to become PCPCH
- State funds to allow SBHCs to stay open with quality staffing and care

Environment

As a physical determinant of health, there is a great need to protect and improve the environment. The recent challenges surrounding climate change and the potential for a cataclysmic event highlight the importance of community emergency preparedness.

Threats posed:
- Lack of common language and understanding
- Extreme weather conditions, increased energy and water resources, and adverse impact on agriculture
- Lack of cohesive community wide disaster plan

Opportunities created:
- Public policy
- Education and awareness; creation of a community wide disaster plan
- Support the Community Organizations Active in Disasters (COAD)
- Utilization of 211 to support infrastructure

Community Infrastructure

There is a great community need to protect and improve upon community planning and design, transportation (especially outside the metro area), parks and recreation, disabled considerations and access to facilities, and housing as they serve as both social and physical determinants of health.

Threats posed:
- Provincialism
- Unavailable low income housing and high cost of housing relative to income
• Unsafe parks
• Lack of rural public transportation

**Opportunities created:**
• Regional community planning and collaboration
• Collaboration with city planners and other officials to improve roadway safety, expand parks and recreational venues
• Community gardens, safe parks, and access to food

### Affordable Housing

Unease exists regarding the local patterns reinforcing the growing housing stability issues. These issues result from the increasing housing costs, declining incomes, loss of affordable and safe housing options, and decrease in state funding for housing programs.

**Threats posed:**
• Disparity between housing costs and income earned
• Shortage of housing for those with mental health issues, which increases homelessness and medical needs
• Lack of emergency shelter impacts emergency room services
• Housing application fees
• Low housing vacancy rates pushes up prices and keeps people out of market

**Opportunities created:**
• Lane County Poverty and Homeless board developing strategic plan for individuals that overlap multiple systems; collaboration to address issues
• Re-entry for ex-offenders
• DHS Child Welfare (CW) Strengthening, Preserving and Reunifying Families (SPRF)
  Housing for homeless families to maintain children with families
• Beds for homeless; coordinated entry and database
• Behavioral/physical health integration
• Emerald Village; Housing First

### Poverty

Economic factors in the areas of education, employment, housing, and access to health care have caused a local increase in poverty and income disparity. Specific regional trends and factors include the decreasing median salary, more people with limited incomes surviving on social security or disability benefits, and a continued lack of economic opportunity in rural areas of the county.

**Threats posed:**
• Lane County has the third highest poverty rate of the counties in the state, which creates greater demand for health and other social services
• Dependency on system support
• Disparity in the cost of living and wages is especially impactful on the growing elderly and disabled population and young families
• Competition for low income employment with students limits access to labor market
• High cost of child care can lead to placement of children into unhealthy environments

**Opportunities created:**
• Program for job seekers (Worksource Lane, Prosperity Centers, JOBS Program)
• Employment rate increases
•
- Lane Workforce Partnership (LWP) convening sector strategy, education, and economic groups
- Established tax aid sites
- Food distribution system
- Access to health care

**Rural**

Outside of the Eugene-Springfield metro area, much of the region consists of rural populations. Concerns surround the continued lack of local rural economic opportunity, the impacts of climate change, and the challenge to find and identify people left out of coverage and the resources to serve them.

*Threats posed:*
- Isolation and detachment
- Fewer opportunities for employment, healthcare access, quality early childhood education and childcare, funding, transportation, public safety, drug abuse/addiction treatment, and other services
- Receive the first funding cuts and are slower to recover
- Most new clinics/points of healthcare access continue to be built in the metro areas of Lane County

*Opportunities created:*
- Lessons learned from CCO work; RAC/CAC of Trillium
- Integration health related supports for stability
- Recruitment and incentives (loan forgivingness)
- Connect patients to existing resources
- Telehealth

**Changing Demographics**

With the Baby Boomer generation retiring, the population is rapidly aging. The population is also growing and becoming increasingly diverse, with the Latino population growing faster than other ethnic groups. There is also an increase in immigration and migration, as well as an increase in undocumented individuals. This continued population growth has potential to surpass current infrastructure capabilities. In addition, there is concern regarding the changing family structure trend toward smaller households, more single parents, and more families dispersed.

*Threats posed:*
- Shortage of resources and access to healthcare and public services
- Lack of cultural competency in medical community
- Increase in job competition and housing costs
- High numbers in retirement leading to more government debt, resulting in an increase in taxes
- Increasing gaps in socioeconomic status groups

*Opportunities created:*
- Changing focus on upstream population (i.e. early education)
- Public health programs to serve diverse range of needs
- Address disparity in workforce and generational workplace transitions
- Technology to provide access and language translation
- Access points to reach different populations
- Improved conditions for deaf, poor vision to blind, and elderly population
Behavioral/Mental Health

There is a growing need for behavioral and mental healthcare, and concerns over the limited access to existing services (especially for rural residents and ethnic minorities) and a lack of support in schools. Adverse Childhood Experiences (ACEs) and the county’s high substance and alcohol abuse rates are significant issues. Integration of drug and alcohol treatment with mental and physical healthcare and a focus on early intervention are becoming more imperative.

**Threats posed:**
- Community norms support alcohol industry and marijuana legalization
- Addiction and poor health caused by substance use
- Youth mental health issues untreated; increased youth suicides, self-harm, substance use; risky behaviors; sexual activity
- ACEs; trauma and PTSD; emotional instability
- Decreased need for specialty care
- Provider shortage (especially bilingual and multicultural) and inadequacies

**Opportunities created:**
- Develop systems to recruit, hire, support, and train diverse providers
- Workforce development in social services
- Integrated care, clinics, and services for adolescents and adults
- Trauma informed care
- Tobacco cessation programs
- Screening, Brief Intervention, Referral to Treatment (SBIRT) in PCP clinics; SUDS treatment; detox; methadone/suboxone and ORT; medications for addiction

Health Behaviors

The upward trend of childhood and adult obesity, increase in electronic cigarette use, health impacts of limited time and money, and lack of individual ownership over health are community concerns. On a statewide level, the passage of Measure 91 legalizing the recreational use of cannabis is a recent event to have a future impact. Encouragingly, the community is embodying an increasingly positive culture of wellness.

**Threats posed:**
- Burden of health impacts of legalized marijuana
- Loss of momentum for public health efforts with budget changes or lack of community engagement
- Healthy community venues threatened by funding shifts
- Food deserts expand
- Big business resources for advertising and policy influence increase
- New technology that further decreases need for activity

**Opportunities created:**
- Local and organic food movement; nutrition awareness; outdoor recreation
- Partnerships to create healthy workforces and grow consumer education programs
- School-based programs to improve health behavior choices and provide physical education in schools; expand summer activity opportunities for children
- Use of advertising to more effectively promote healthy choices
- Advocate for policies to limit tobacco and cannabis smoke exposure
- Expand data systems and leverage technology
Communicable Disease

The increase in unimmunized children and certain STDs in the region is of high concern. In addition, the recent University of Oregon meningitis outbreak and other emerging infectious diseases that have then potential to overwhelm current systems are issues to the health system.

**Threats posed:**
- Increased death, disease, and other long-term health impacts from largely preventable illnesses
- Disease burden and outbreak response costs to health delivery system, social services, public health, and other institutions; diversion of strategic bandwidth
- Lost workforce productivity

**Opportunities created:**
- Underscore community interconnectedness
- Create new partnerships to strengthen community response
- Increase public awareness about the importance of public health, prevention strategies, and early detection
Local Public Health System Assessment

EXECUTIVE SUMMARY

The Local Public Health System Assessment (LPHSA) is one of four assessments completed as part of the 2015 Community Health Needs Assessment. The LPHSA was conducted with local public health system leaders from the local government, hospitals, other health care organizations, health insurers, research institutions, safety net, and social service organizations. The assessment focused on the delivery of the 10 Essential Public Health Services by the local public health system (LPHS), which includes all “public, private, and voluntary entities that contribute to the delivery of the essential health services within a jurisdiction.” Through the process, the following questions were answered:

- What are the components, activities, competencies, and capacities of our public health system?
- How well are the 10 Essential Public Health Services being provided in our system?

Overall, the LPHSA:

- Improved organizational and community communication and collaboration
- Educated participants about the local public health system composition, functions, and standards, as well as their organization’s role within the system
- Strengthened the diverse network of partners within the LPHS
- Identified strengths and weaknesses to guide data driven quality improvement efforts
- Provided a baseline measure of performance to track future progress

The findings from this assessment create a snapshot of activities being performed by the local public health system and will guide a system-wide infrastructure and performance improvement process. Improvements in the areas discussed will help the LPHS enhance its collective performance and effectiveness as a system to better serve the community and to ensure greater health and quality of life for all residents. The strengths that surfaced throughout the assessment, including robust inter-agency relationships and established collaborative efforts, can be leveraged to help partners across the LPHS come together to collectively advance system-wide improvements.

Key Themes

The assessment was an honest and critical look at the LPHS. Throughout the discussions, the following themes emerged relating to system strengths, weaknesses, and opportunities for improvement.

Strengths

- Successful organizational collaborations and community partnerships to mobilize and strategize.
- The involvement of community organizations in service delivery.
- Solid interest and support for strengthening the local public health system.
- A strong infrastructure exists for investigating and responding to public health threats and emergencies.

Weaknesses

- Local organizations are often unaware or unclear about their role in the public health system.
- The general public’s lack of awareness and understanding regarding the local public health system.
- There is an insufficient degree of communication, which creates the perception of organizational silos.
- Limited capacity and infrastructure for research across the entire LPHS.

Opportunities for Improvement

- Bolster communication, coordination of efforts, and execution of action plans across the LPHS.
- Leverage the use of technology to better connect and communicate with our community.
- Strengthen the system for sharing data and conducting public health research to enhance decision making and implementing strategies that improve population health.
The Centers for Disease Control and Prevention’s 10 Essential Public Health Services:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Using the 10 Essential Public Health Services as a framework, a total of 30 Model Standards (2-4 Model Standards per Essential Service) describe an optimally performing local public health system. Each Model Standard is followed by questions that serve as measures of performance. The Performance Measures related to each Essential Service describe an optimal level of performance and capacity to which the LPHS should aspire.

For the assessment, participants in were led in a facilitated discussion and scoring of the Model Standards. Participants responded to the Performance Measure questions using the activity levels listed in Table 1 below.

Using the responses to all of the performance measure questions, a scoring process generated a score for each Model Standard, Essential Service, and finally the overall score.

Table 1: Summary of Performance Measure Response Options

<table>
<thead>
<tr>
<th>Performance Measure Response Options</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 in 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 in the question is met.</td>
</tr>
<tr>
<td>Minimal Activity (1-25%)</td>
<td>Greater than 0% but no more than 25% of the activity described in the question is met.</td>
</tr>
<tr>
<td>No Activity (0%)</td>
<td>0% or absolutely no activity</td>
</tr>
</tbody>
</table>
PROCESS

As part of the 2015 Community Health Needs Assessment, a Local Public Health System Assessment was conducted using the National Public Health Performance Standards Program (NPHPSP) local instrument to measure how well system partners provide public health services. The objectives were:

- To determine the components, activities, competencies, and capacity of the LPHS.
- To determine how well the Essential Public Health Services are being provided in the community.

On September 9, 2015 from 7am-11:30am at Pacific Source, a broad set of local public health system partners convened to participate in the assessment. The session comprised of 27 leaders representing the following organizations:

- Board of County Commissioners
- Board of Health
- Cascade Health Solutions
- City of Eugene, Recreation
- Cornerstone Community Housing
- HIV Alliance
- Kaiser Permanente
- Lane County 211 Info
- Lane County Health and Human Services
- McKenzie-Willamette
- Oregon Medical Group
- Oregon Research Institute
- PeaceHealth Sacred Heart Medical Center
- PeaceHealth Peace Harbor Medical Center
- South Lane Mental Health
- Trillium Community Health Plans
- Trillium Consumer Advisory Counsel
- United Way of Lane County
- Volunteers in Medicine
- Willamette Family

As part of the introduction to the assessment, participants were familiarized with the local public health system, 10 Essential Public Health Services (EPHS), LPHS assessment, and performance measures. Participants then broke into four workgroups to complete each of the following four 40-minute sessions:

- EPHS 1 and 2
- EPHS 3, 4, and 5
- EPHS 6 and 7
- EPHS 8, 9, and 10

During each session, participants were led through a review of the Essential Service and Model Standards of Performance, individual scoring, and a group discussion of how the LPHS was perceived to meet performance expectations in each area. Each individual rater scored the perceived community activity in each Essential Service’s Model Standards as no activity, minimal activity, moderate activity, significant activity, or optimal activity. The ensuing facilitated discussion aimed to identify system strengths, weaknesses, and areas of improvement opportunities. Upon completion of the four sessions, the four workgroups reported highlights to the larger group to summarize and conclude the session.

After completing the assessment, the LPHSA subcommittee reconvened to debrief the assessment meeting, analyze participant results, and identify major themes. The 100% Health Executive Committee then met to review and approve the report, complete the priority questionnaire, and discuss the priority ratings.
LIMITATIONS

There are a number of limitations to the assessment results due to wide variations in the breadth and knowledge of participants, and differences in interpretation of the questions. When evaluating the 10 Essential Public Health System results, each person’s rankings reflect his or her own different experiences and perspectives, and the responses to the questions involve an element of subjectivity. In some instances, for example, LPHSA participants indicated that they did not know or were unaware of a particular action. A “don’t know/not aware” response was not included in the calculations of averages for the performance scores.

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 the results are limited to guiding an overall public health infrastructure and performance improvement process for the LPHS as determined by organizations involved in the assessment.

ASSESSMENT RESULTS: SCORES

Throughout the LPHSA, many participants agreed that the Lane County region lacks a coordinating body that integrates the essential services across the LPHS. Therefore, participants found it difficult to respond to certain assessment questions, as language in the assessment tool often presumed that the LPHS actually functions as a cohesive system.

Based upon the responses provided in the assessment, a score was calculated for each of the 10 Essential Services (ES). The score of each Essential Service can be interpreted as the degree in which the local public health system meets the performance standards for each Essential Service. Scores can range from a minimum value of 0% (no activity performed compared to the standard) to a maximum value of 100% (all activity performed compared to the standard). The data created establishes the foundation upon which we may set priorities for performance improvement and identify specific quality improvement projects.

Overall Scores for Each Essential Public Health Service

Figure 1 displays the average score for each Essential Service, along with an overall average assessment score. Examination of these scores immediately gives a sense of the LPHS’s greatest strengths and weaknesses. The black bars identify the range of reported performance score responses within each ES.

**Figure 1: Summary of Average Essential Public Health Service Performance Score**

<table>
<thead>
<tr>
<th>Essential Service</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES 1: Monitor Health Status</td>
<td>50.3</td>
</tr>
<tr>
<td>ES 2: Diagnose and Investigate</td>
<td>48.6</td>
</tr>
<tr>
<td>ES 3: Educate/Empower</td>
<td>60.4</td>
</tr>
<tr>
<td>ES 4: Mobilize Partnerships</td>
<td>38.9</td>
</tr>
<tr>
<td>ES 5: Develop Policies/Plans</td>
<td>55.2</td>
</tr>
<tr>
<td>ES 6: Enforce Laws</td>
<td>52.1</td>
</tr>
<tr>
<td>ES 7: Link to Health Services</td>
<td>57.1</td>
</tr>
<tr>
<td>ES 8: Assure Workforce</td>
<td>53.1</td>
</tr>
<tr>
<td>ES 9: Evaluate Services</td>
<td>57.8</td>
</tr>
<tr>
<td>ES 10: Research/Innovations</td>
<td>47.9</td>
</tr>
<tr>
<td>Average Overall Score</td>
<td>31.9</td>
</tr>
</tbody>
</table>

Legend:
- 1 - 25%: Minimal
- 26 - 50%: Moderate
- 51 - 75%: Significant
- 76 - 100%: Optimal
Performance Scores by Essential Public Health Service for Each Model Standard

Table 2 displays the average performance score for each of the Model Standards within each Essential Service. The performance score at the Essential Service level is a calculated average of the respective Model Standard scores within that Essential Service. This level of analysis enables the identification of 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</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES 1: Monitor Health Status</td>
<td>48.6</td>
</tr>
<tr>
<td>1.1 Community Health Assessment</td>
<td>66.7</td>
</tr>
<tr>
<td>1.2 Current Technology</td>
<td>41.7</td>
</tr>
<tr>
<td>1.3 Registries</td>
<td>37.5</td>
</tr>
<tr>
<td>ES 2: Diagnose and Investigate</td>
<td>60.4</td>
</tr>
<tr>
<td>2.1 Identification/Surveillance</td>
<td>58.3</td>
</tr>
<tr>
<td>2.2 Emergency Response</td>
<td>66.7</td>
</tr>
<tr>
<td>2.3 Laboratories</td>
<td>56.3</td>
</tr>
<tr>
<td>ES 3: Educate/Empower</td>
<td>38.9</td>
</tr>
<tr>
<td>3.1 Health Education/Promotion</td>
<td>41.7</td>
</tr>
<tr>
<td>3.2 Health Communication</td>
<td>25.0</td>
</tr>
<tr>
<td>3.3 Risk Communication</td>
<td>50.0</td>
</tr>
<tr>
<td>ES 4: Mobilize Partnerships</td>
<td>55.2</td>
</tr>
<tr>
<td>4.1 Constituency Development</td>
<td>43.8</td>
</tr>
<tr>
<td>4.2 Community Partnerships</td>
<td>66.7</td>
</tr>
<tr>
<td>ES 5: Develop Policies/Plans</td>
<td>52.1</td>
</tr>
<tr>
<td>5.1 Governmental Presence</td>
<td>33.3</td>
</tr>
<tr>
<td>5.2 Policy Development</td>
<td>50.0</td>
</tr>
<tr>
<td>5.3 CHIP/Strategic Planning</td>
<td>66.7</td>
</tr>
<tr>
<td>5.4 Emergency Plan</td>
<td>58.3</td>
</tr>
<tr>
<td>ES 6: Enforce Laws</td>
<td>57.1</td>
</tr>
<tr>
<td>6.1 Review Laws</td>
<td>56.3</td>
</tr>
<tr>
<td>6.2 Improve Laws</td>
<td>50.0</td>
</tr>
<tr>
<td>6.3 Enforce Laws</td>
<td>65.0</td>
</tr>
<tr>
<td>ES 7: Link to Health Services</td>
<td>53.1</td>
</tr>
<tr>
<td>7.1 Personal Health Service Needs</td>
<td>56.3</td>
</tr>
<tr>
<td>7.2 Assure Linkage</td>
<td>50.0</td>
</tr>
<tr>
<td>ES 8: Assure Workforce</td>
<td>57.8</td>
</tr>
<tr>
<td>8.1 Workforce Assessment</td>
<td>50.0</td>
</tr>
<tr>
<td>8.2 Workforce Standards</td>
<td>75.0</td>
</tr>
<tr>
<td>8.3 Continuing Education</td>
<td>50.0</td>
</tr>
<tr>
<td>8.4 Leadership Development</td>
<td>56.3</td>
</tr>
<tr>
<td>ES 9: Evaluate Services</td>
<td>47.9</td>
</tr>
<tr>
<td>9.1 Evaluation of Population Health</td>
<td>43.8</td>
</tr>
<tr>
<td>9.2 Evaluation of Personal Health</td>
<td>50.0</td>
</tr>
<tr>
<td>9.3 Evaluation of LPHS</td>
<td>50.0</td>
</tr>
<tr>
<td>ES 10: Research/Innovations</td>
<td>31.9</td>
</tr>
<tr>
<td>10.1 Foster Innovation</td>
<td>37.5</td>
</tr>
<tr>
<td>10.2 Academic Linkages</td>
<td>33.3</td>
</tr>
<tr>
<td>10.3 Research Capacity</td>
<td>25.0</td>
</tr>
</tbody>
</table>

**Average Overall Score** 50.3  **Median Score** 52.6

Optimal Activity (76-100%)
Significant Activity (51-75%)
Moderate Activity (26-50%)
Minimal Activity (1-25%)
No Activity (0%)
Performance Relative to Optimal Activity

Figures 2 and 3 display the proportion of performance measures that met specified thresholds of achievement for performance standards. The five threshold levels of achievement used in scoring these measures are shown in the Figure 1. For example, measures receiving a composite score of 51-75% were classified as meeting performance standards at the significant level.

Figure 2: Percentage of the System’s Essential Services Scores that Fall Within the Five Activity Categories. This chart provides a high level snapshot of the information found in Figure 1, summarizing the composite performance measures for all 10 Essential Services.

Figure 3: Percentage of the System’s Model Standard Scores that Fall Within the Five Activity Categories. This chart provides a high level snapshot of the information found in Table 2, summarizing the composite measures for all 30 Model Standards.
ASSESSMENT RESULTS: DISCUSSION

Through discussions of the local public health system (LPHS), participants identified the following system strengths, weaknesses, and opportunities of the 10 Essential Public Health Services (EPHS).

EPHS 1  Monitor Health Status to Identify Community Health Problems
   1.1 Population-Based Community Health Assessment (CHA)
   1.2 Current Technology to Manage and Communicate Population Health Data
   1.3 Maintaining Population Health Registries

Strengths
- The community is committed to conducting a CHNA every three years and aims to engage a broad representation of community members and partners in the process.

Weaknesses
- While there is more awareness of the CHNA, the average person has minimal knowledge or involvement in it.
- In addition to the large lag time of data, it is difficult to integrate data between systems and organizations.
- Limited work is being done in maintaining population health registries.

Opportunities for Improvement
- Continue to engage the public in the CHNA and throughout the three years of the CHIP.
- Gain support for and participation in population survey efforts, including the Healthy Teen Survey.
- Leverage technology to develop more active strategies for sharing and using data, continually update information, and create a dashboard of data points for the CHNA and CHIP.

EPHS 2  Diagnose and Investigate Health Problems and Health Hazards
   2.1 Identifying and Monitoring Health Threats
   2.2 Investigating and Responding to Public Health Threats and Emergencies
   2.3 Laboratory Support for Investigating Health Threats

Strengths
- Robust preparedness plans are in place for public health threats/events within and among organizations.
- Coordinated collaborations have created a strong infrastructure for investigating and responding to public health threats and emergencies.
- While most are unaware of the lab support for investigating health threats, local laboratory services are strong.

Weaknesses
- While we do really well at identifying and monitoring acute health threats, emerging health issues are more difficult. There is a need to have community conversations to figure out how to address the bigger picture challenges.

Opportunities for Improvement
- Serve as a community voice of what is a danger, take a greater advocacy role in the community, and extend the health action network to get alerts out to a broader network of providers.
- Use information technology to leverage how this essential service is provided to the community.
- Develop relationships with state public health to further support the diagnosis and investigation of health problems and hazards in our community.
EPHS 3  Inform, Educate, and Empower People about Health Issues

3.1 Health Education and Promotion
3.2 Health Communication
3.3 Risk Communication

Strengths
• Strong cross-sector collaboration with a strong spirit of partnership to educate and promote health.
• Emergency communications plans for each stage of an emergency allow for the effective dissemination of information; an appropriate amount of resources are available for a rapid emergency communication response.

Weaknesses
• Due to the silo effect, there is inadequate communication of health education and issues across sectors and institutions of the LPHS, as well as with the general public.

Opportunities for Improvement
• Utilize collaborations to integrate substance abuse and mental health into primary care.
• Increase efforts around equity and diversity; work to understand the populations and appropriate communication vehicles.
• Develop health communication plans, build relations with different media providers, and identify and train spokespersons on public health issues.

EPHS 4  Mobilize Community Partnerships to Identify and Solve Health Problems

4.1 Constituency Development
4.2 Community Partnerships

Strengths
• The Lane County region strongly supports community involvement and establishing community partnerships to address health problems.

Weaknesses
• Despite the culture of collaboration, the LPHS does not have a formalized process or coordinating entity to mobilize community partnerships or to communicate accomplishments.

Opportunities for Improvement
• Designate a communication hub, create forums, and innovatively utilize social media for communication of health issues.
• System collaboration to maintain, promote, and further develop a directory of community organizations.
EPHS 5  Develop Policies and Plans That Support Individual and Community Health Efforts

5.1 Governmental Presence at the Local Level
5.2 Public Health Policy Development
5.3 Community Health Improvement Process and Strategic Planning
5.4 Planning for Public Health Emergencies

Strengths
- Significant levels of system activity in the community health improvement process, strategic planning, and planning for public health emergencies.

Weaknesses
- LPHS institutions and agencies engage in a significant level of planning activities, but this work is not coordinated across the LPHS.
- Limited funding for the local public health system.

Opportunities for Improvement
- Effort needs to be better coordinated and communicated with other agencies and policymakers, and the information should be translated and more widely disseminated to support community actions.

EPHS 6  Enforce Laws and Regulations That Protect Health and Ensure Safety

6.1 Reviewing and Evaluating Laws, Regulations, and Ordinances
6.2 Involvement in Improving Laws, Regulations, and Ordinances
6.3 Enforcing Laws, Regulations, and Ordinances

Strengths
- The public is very engaged in local issues and policy.

Weaknesses
- Most are unaware of work being done related to enforcing, reviewing, or evaluating laws, regulations, or ordinances. The general opinion is that such work feels “opaque.” The assumption is that the work is being done, but few are aware of what, or how well it is being done, or how effective the policies are in improving health.

Opportunities for Improvement
- There is opportunity for mobilizing and galvanizing advocacy and non-governmental agencies to advance local policy. Such agencies are open and willing to assist in advancing public health laws and regulations.
EPHS 7  Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable

7.1  Identifying Personal Health Service Needs of Populations
7.2  Ensuring People are Linked to Personal Health Services

**Strengths**
- Most people now have health insurance due to the Affordable Care Act.
- There are many available social and human services.

**Weaknesses**
- Because of transportation issues, limited providers, and the complexity of the system, there are still healthcare access issues and specific populations remain uninsured or underinsured.

**Opportunities for Improvement**
- Our region has many social and human services available, however accessing services and working in the system remains fractured. There is a need to improve coordination and assist individuals in finding and accessing services and improving coordination between medical and social, and human services.

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EPHS 8  Assure a Competent Public Health and Personal Healthcare Workforce

8.1  Workforce Assessment, Planning, and Development
8.2  Public Health Workforce Standards
8.3  Life-Long Learning through Continuing Education, Training, and Mentoring
8.4  Public Health Leadership Development

**Strengths**
- Many organizations conduct workforce assessments.

**Weaknesses**
- There is no integrated, systems-wide approach to workforce assessment, development, and training that serves all LPHS members.
- Labor shortages across the region have led to a shortage of providers and other trained and skilled staff.

**Opportunities for Improvement**
- While the confident assumption is that there is significant activity within public health workforce standards, the actual activity is closer to minimal or moderate activity, leaving room for improvement.
- Coordinate workforce recruitment efforts and leverage resources.
**EPHS 9  Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services**

9.1 Evaluating Population-Based Health Services  
9.2 Evaluating Personal Health Services  
9.3 Evaluating the Local Public Health System

**Strengths**
- Community partners and members are often involved with these assessments, and their input and feedback are solicited as part of program evaluation.
- Strong interest and commitment to regularly evaluating the local public health system.

**Weaknesses**
- Coordinating strategic planning and evaluating effectiveness across all LPHS members is limited.
- Inadequate activity in translating data into information and monitoring outcomes.

**Opportunities for Improvement**
- Maintain a feedback loop (strategic planning resulting in specific implementation of actions) and use data to improve services.
- Effectively use information technology for the purposes of collecting, storing, and evaluating data.

**EPHS 10  Research for New Insights and Innovative Solutions to Health Problems**

10.1 Fostering Innovation  
10.2 Linking with Institutions of Higher Learning and/or Research  
10.3 Capacity to Initiate or Participate in Research

**Strengths**
- Lane County's LPHS is at an advantage in that it has access to first class research institutions (ORI, OSLC, and UO) and researchers.

**Weaknesses**
- Inadequate communication and coordination between research and the other LPHS partners.
- Minimal level of activity in the capacity to initiate or participate in research.

**Opportunities for Improvement**
- Research efforts – and the outcomes of that research – could be better leveraged and coordinated across the LPHS to the benefit of the community’s health.
- Share best practices outside of silos and implement innovative interventions when possible.
**Priority of Model Standards Questionnaire**

As recommended by the MAPP framework, the 100% Health Steering Committee used a nominal group technique to respond to the LPHSA Priority Questionnaire. Each attending member was asked to rank the Essential Services individually (low, medium, or high priority), and then weighed averages were tallied for each Essential Service. Prioritizing the Essential Services will help the local public health system identify areas for improvement or where resources could be realigned.

Based on the priority given to each of the 10 Essential Services by the Steering Committee, each service was assigned to one of four quadrants. The four quadrants, which are based on how the performance of each Essential Service compares with the priority rating, should provide guidance in considering areas for attention and next steps for improvement.

| Quadrant A | (High Priority and Low Performance) – These activities may need increased attention. |
| Quadrant B | (High Priority and High Performance) – These activities are being done well, and it is important to maintain efforts. |
| Quadrant C | (Low Priority and High Performance) – These activities are being done well; consideration may be given to reducing effort in these areas. |
| Quadrant D | (Low Priority and Low Performance) – These activities could be improved, but are of low priority. They may need little or no attention at this time. |

Table 3 below displays average priority ratings (on a scale of 1-10, with 10 being the highest priority) and performance scores for the Essential Services, arranged under the four quadrants. By considering the appropriateness of the match between the importance ratings and current performance scores and also by reflecting back on the previous qualitative data, potential priority areas can be identified for future action planning.

**Table 3. Essential Services by Priority and Performance Score**

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Essential Service</th>
<th>Performance Score (%)</th>
<th>Priority Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quadrant A</td>
<td>ES 1: Monitor Health Status</td>
<td>48.6</td>
<td>7.1</td>
</tr>
<tr>
<td>Quadrant A</td>
<td>ES 3: Educate/Empower</td>
<td>39.8</td>
<td>6.4</td>
</tr>
<tr>
<td>Quadrant B</td>
<td>ES 2: Diagnose and Investigate</td>
<td>60.4</td>
<td>7.6</td>
</tr>
<tr>
<td>Quadrant B</td>
<td>ES 4: Mobilize Partnerships</td>
<td>55.2</td>
<td>6.0</td>
</tr>
<tr>
<td>Quadrant B</td>
<td>ES 6: Enforce Laws</td>
<td>57.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Quadrant B</td>
<td>ES 7: Link to Health Services</td>
<td>53.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Quadrant C</td>
<td>ES 5: Develop Policies/Plans</td>
<td>52.1</td>
<td>5.3</td>
</tr>
<tr>
<td>Quadrant C</td>
<td>ES 8: Assure Workforce</td>
<td>57.8</td>
<td>5.6</td>
</tr>
<tr>
<td>Quadrant D</td>
<td>ES 9: Evaluate Services</td>
<td>47.9</td>
<td>3.8</td>
</tr>
<tr>
<td>Quadrant D</td>
<td>ES 10: Research/Innovations</td>
<td>31.9</td>
<td>4.5</td>
</tr>
</tbody>
</table>
Figure 4: Summary of Essential Public Health Service Model Standard Scores and Priority Ratings

- **EPHS 1 - Monitor Health Status**
- **EPHS 2 – Diagnose & Investigate**
- **EPHS 3 – Educate/Empower**
- **EPHS 4 – Mobilize Partnerships**
- **EPHS 5 – Develop Policies/Plans**
- **EPHS 6 – Enforce Laws**
EXECUTIVE SUMMARY

Upon completion of the four assessments, the next step of the Community Health Needs Assessment (CHNA) process is to use the findings to identify strategic issues: the fourth phase of the MAPP (Mobilizing for Action through Planning and Partnerships) Process. Strategic issues are fundamental policy choices or critical challenges that must be addressed in order for our community to achieve its vision. Strategic issues are the foundation upon which the Community Health Improvement Plan (CHIP) strategies will be developed.

Strategic issues build on the results of all of the previous phases. When addressing strategic issues, our community is being proactive in positioning ourselves for the future, rather than simply reacting to problems. In this phase, strategic issues emerge by examining the challenges and opportunities identified in the four MAPP Assessments and evaluating how they will affect the community's achievement of the vision. Completing phase four answers the following questions:

- What issues are critical to the success of the local public health system?
- What fundamental policy choices or critical challenges must be addressed in order for the community to achieve its vision?

Lane County's strategic issues were identified by implementing the steps outlined by the MAPP framework. Phase Four was conducted between December 2015 and March 2016, during which time meetings occurred to review assessment data, identify overarching strategic issues, and prioritize the strategic issues. Following a multi-site community input event — the following two strategic issues were selected and approved to be the foundation for the 2016-2019 Community Health Improvement Plan:

- How can we promote access to economic and social opportunities necessary to live a healthy life? Social and economic opportunities create a better life: high quality education, secure jobs with good wages, and housing that is both safe and affordable. These support a strong community and healthy people.
- How can we promote healthy behaviors and engage the community in healthy living? Healthy actions and choices lead to good health. To create good health, we must make the healthy choice the easy choice. We can support individuals and the community to take positive actions that support a lifetime of healthy living.

The community event marked the end of the 2015-2016 Lane County Regional Community Health Needs Assessment and the beginning of the development of the 2016-2019 Lane County Regional Community Health Improvement Plan.
PROCESS

The CHNA Core Team took the lead role in determining the method for completing the ‘Identify Strategic Issues’ phase and worked together to answer the following questions:

- How will we present data from all four MAPP Assessments to our local public health system partners and community members?
- How will we ensure our local public health system partners and community members can fully comprehend results from the four assessments?
- How will we facilitate a process to help the local public health system partners and community members identify strategic issues that are informed by all four assessments?
- How will we prioritize our strategic issues?
- How will we ensure everyone is aware of our strategic issues?

The Core Team was tasked with first compiling the results of the assessments. Subsequently, the Core Team, CHIP Workgroups, and Steering Committee would review the themes and brainstorm strategic issues. The Steering Committee would prioritize the strategic issues based on identified criteria to narrow down the list. The narrowed list of strategic issues would then be presented to the community during a public event, along with the results of the Community Health Needs Assessment, for a final vote.

The detailed steps below outline the process of completing the ‘Identify Strategic Issues’ phase of Lane County’s Community Health Needs Assessment.

Identifying Criteria

A diverse set of criteria were considered to be used in the priority selection process for community health initiatives. The following criteria were identified to be used by the Steering Committee in prioritizing the strategic issues for community health improvement: size, seriousness, trends, intervention, feasibility, value, consequences of inaction, and social determinant/root cause. Explanations of each criterion can be found in the Appendix (A).

Rather than using equity as a priority selection criteria or a separate strategic issue, it was decided that equity would be used as a lens throughout the ensure process. Equity will be infused within all of the strategic issues contained in the CHIP. A key element to successfully achieving our vision of a healthy community will be to address all social, economic and environmental factors that provide everyone in the region an opportunity to live a healthy life. In every decision we make and strategy we implement, we will consider equity and the impact on all, especially those in underserved demographic groups and protected classes. We will intentionally promote an equity agenda through the entire community health improvement strategic planning and implementation process. By doing so, we can work on addressing the underlying factors that have led to consistently poorer health outcomes for historically marginalized groups.
Weighting Criteria

Each Steering Committee member involved in the criteria selection process assigned a relative importance (high, moderate, or low) to each identified criterion. Adding up all responses, a weighted score was calculated for each criterion. Discussion will follow to ensure consensus of final criterion importance. This system allowed for flexibility and an accurately weighted score. The weighting of each criterion can be found in the Appendix (A).

Review of Assessment Data

This process began with a review of the key findings from the four assessments, which was compiled and summarized by a subcommittee. These key findings, along with challenges and opportunities from each assessment, were presented to the CHNA Core Team, CHIP Workgroups, and Steering Committee during December meetings. In addition to the full reports, a written assessment summary report was provided and the key findings were captured on large colored post-it notes. The notes were then displayed on a “sticky wall” and grouped by assessment. Members were asked to consider the findings both individually and collectively in an effort to identify predominant and cross-cutting issues.

Brainstorm Potential Strategic Issues

After review of the assessment findings, the CHNA Core Team, CHIP Workgroups, and Steering Committee were given an opportunity to share their ideas for strategic issues during brainstorming discussions. These subsequent discussions aimed to explore the stories unfolding from the four assessments.

After identifying the underlying themes that affect the community, the themes were rephrased as strategic issues. Strategic issues are written as questions that need to be answered in order for a community to achieve its vision. When developing the strategic issues, it was ensured that all four assessments informed the question to be answered. The strategic issues are broad, which allows for the development of innovative, strategic activities as opposed to relying on the status quo, familiar, or easy activities. The broad strategic issues will help align the overall community’s strategic plan with the missions and interests of individual local public health system partners.

In three additional meetings, CHNA Core Team members reviewed the brainstormed discussions and information from previous meetings with the goal of determining which issues were essential to achieve our vision of a healthy community. Strategic issues were closely reviewed and collapsed into four common groups/themes, classified as “buckets”: Socioeconomics, Healthy Behaviors, Environment, and Healthy System. Each of the preliminary issues was reviewed in turn and discussion centered on how each reflected the community and partnership’s vision and captured the findings of its four analyses.
The CHNA Core Team reconvened on December 10th to further explore cross-cutting themes and collapse potential strategic issues further. From this meeting, nine strategic issues were formed and new wording was incorporated to better reflect the scope of the partnership’s thinking. The Core Team then looked to find supporting evidence for each issue from across each of the four assessments. Issues with little or no supporting data were eliminated. The CHNA Core Team reconvened again on December 17th to review the nine narrowed brainstormed strategic issues, along with each one’s clarifying statements, rationale/assessment support, and potential focus areas. Following additional brainstorming, discussion, and wordsmithing, related questions were further clustered and grouped resulting in seven proposed issues to be presented to the Steering Committee on January 13, 2016 for prioritization:

A. How can we promote access to economic and social opportunities necessary to live a healthy life?
   - Potential impact areas: employment, education, housing, finances, transportation

B. How can we promote healthy behaviors and engage the community in embracing healthy living?
   - Potential impact areas: nutrition, physical activity, no substance use/abuse, sexual behaviors, stress management

C. How can we increase our knowledge and capacity to promote a culture of mental wellness?
   - Potential impact areas: awareness and stigma reduction, promotion, prevention, treatment, addictions

D. How can we create a community and environment which provides access, opportunities and encouragement for healthy lifestyles?
   - Potential impact areas: access to healthy food, access to recreation/physical activity, bikeability/walkability, public transportation

E. How can we promote a safe and inclusive community?
   - Potential impact areas: community programs and activities/sense of community, violence prevention, civil rights

F. How can we strengthen collaboration, coordination, and navigation of resources and services?
   - Potential impact areas: health literacy, connecting people to resources, appropriate services

G. How can we support access to an integrated system of coordinated care that is appropriate, preventative and patient-centered?
   - Potential impact areas: access to care, preventative services, access to healthcare for un/under-insured, healthcare affordability, appropriate care and providers)
Prioritize Strategic Issues

Prioritization is a key step in the community health improvement process that serves as a natural transition from focusing on the findings of the Community Health Needs Assessment (CHNA) to developing a Community Health Improvement Plan (CHIP). Prioritization will help our community focus on key issues in order to maximize impact and use our resources as efficiently as possible to achieve the greatest impact on health.

Through prioritization, the Steering Committee narrowed the list of seven strategic issues down to five strategic issues. During a subsequent county-wide community event, attendees voted on two final strategic issues.

Steering Committee Prioritization

Based on input from the CHNA Core Team, the Steering Committee, and the CHIP Workgroups, seven strategic issues were presented to the Steering Committee on January 13, 2016 for prioritization. The method used for this process was a consensus criteria method: a combination of using a prioritization matrix (weighted voting and ranking) along with group discussion. The Steering Committee came to consensus on a rating for each potential strategic issue with regards to each identified criterion.

The prioritization matrix is a quantitative tool that objectively ranks specific health problems based off the identified criteria and weights. A final weighted score for each strategic issue option will be calculated. The higher the weighted score, the higher the priority will be assigned to the strategic issue. The prioritization matrix which illustrates the criteria scores of the seven strategic issues can be found in the Appendix (B). The strategic issues that ranked in the top five were presented to the community for a final vote.

Community Prioritization

On February 10, 2016 a multi-site community event titled Live Healthy Lane: Defining Our Future, was held to share the results of the Community Health Needs Assessment and help develop the 2016-2019 Community Health Improvement Plan.

In total, 257 community members participated across the three sites: Eugene, Florence, and Cottage Grove. ASL and Spanish interpretation were provided for the event. The event was also live-streamed and watched by 31 computers. 9 people submitted voting input online.

The Live Healthy Lane event was a great demonstration of people and organizations coming together to make our community healthier. What unites us is our commitment to making better health an opportunity for all people in Lane County.
The event’s agenda items included:

- Official Welcome
- Steering Committee Recognition
- Background of CHNA and the MAPP Process
- 2013-2016 CHIP Accomplishments
- Participant Recognition
- CHNA Results – Visioning Session and Four Assessments
- Identified Strategic Issues
- Break and Questions/Answers
- Strategic Issue Voting
- Next Steps and Commitments
- Closing Remarks and Thank You

After hearing the results from the Community Health Needs Assessment, event participants voted (using electronic voters and voting slips) on five strategic issues to identify the priorities for our collaborative work going forward. The following five strategic issues were presented to the community for a vote:

A. **Promote access to economic and social opportunities necessary to live a healthy life:**
   Social and economic opportunities create a better life: high quality education, secure jobs with good wages, and housing that is both safe and affordable. These support a strong community and healthy people.
   - Potential impact areas: employment, finances, education, housing, transportation

B. **Increase our knowledge and capacity to promote a culture of mental wellness:**
   Mental health includes emotional, psychological, and social well-being. We can promote good mental health from the start of life until its end. By embracing a culture of mental wellness, people will live longer and happier lives.
   - Potential impact areas: reduce mental health stigma, build awareness, support wellness, prevent and treat illness

C. **Support access to an integrated system of coordinated care that is appropriate, preventative and patient-centered:**
   Leaders across countless organizations can bring their skills to the table and work together to improve health. An integrated system makes quality, affordable, and culturally appropriate services possible and accessible. It supports a community where its members can be healthy and thriving.
   - Potential impact areas: access to care, preventative services, cost of care, appropriate care, attracting providers

D. **Promote an inclusive community that is safe for all:**
   Community belonging is important to everyone’s physical and mental health, happiness and well-being. All deserve to feel safe, welcomed, and free from discrimination and stigma. By building a strong sense of community we can better work together towards common goals.
   - Potential impact areas: community programs and activities, violence prevention, civil and social rights, community preparedness and resilience

E. **Promote healthy behaviors and engage the community in healthy living:**
   Healthy actions and choices lead to good health. To create good health, we must make the healthy choice the easy choice. We can support individuals and the community to take positive actions that support a lifetime of healthy living.
   - Potential impact areas: nutrition, physical activity, reduce substance abuse, sexual behaviors, stress management
VOTING RESULTS

After presenting the results of the Community Health Needs Assessment and the five identified strategic issues, event participants were instructed to select one strategic issue for each of the following voting questions:

1. Which issue is most important to achieve our vision of a healthy community?
2. Over the next three years, where can we make the biggest difference?
3. Which issue are you most passionate about working on?

Each question was equally weighted, and the results of the voting across the three sites, along with online voting responses, revealed two prioritized strategic issues, which will be the foundation for Lane County’s 2016-2019 Community Health Improvement Plan. As we make progress in these areas, we firmly believe we will improve population health, well-being, and equity.

- Promote access to economic and social opportunities necessary to live a healthy life.
- Promote healthy behaviors and engage the community in healthy living.

The voting results totals across all questions are illustrated in the graph below. Graphs of the voting results for each question can be found in the Appendix (C).

CHNA assessment support for each strategic issue can be found in the Appendix (D).
Next Steps

Following the announcement of the two prioritized strategic issues, participants were informed of the next steps and invited to be a part of the next phase as we continue to work together to make the region a healthier place for all: developing and implementing a community health roadmap for how to get from where we are to where we want to go. Over the next few months, the focus of the work will be on formulating goals and strategies to address the strategic issues. From there, we will move from planning to action.

Since there are no “one size fits all” blueprints for success, it will be vital for our community build on strengths, leverage available resources, and respond to unique needs. To do so, we will need to harness the collective power of leaders, partners, and community members. It is through the strength of each of us, the resources, and talents we bring, that we can create a stronger, healthier community. Successfully addressing the two strategic issues requires resources, effort, innovations and most importantly, strong participation across the county and sectors. We can make the most different in the health of our community by using a collective impact approach, where organizations from different sectors agree to solve a specific social problem using a common agenda, aligning their efforts, and using common measures of success. Ultimately, we can only achieve a culture of health when our public health, social services, and health care systems are working hand in hand. We know that when these systems are integrated intentionally that we see improvements in health and quality of life.

To make an impact, we need the partnership, the passion, and the promise of community members and organizations. Event participants were invited to join United Way, Lane County Public Health, PeaceHealth, and Trillium in this effort. To identify the interest in helping move this work forward event participants were asked to fill out a commitment card, which were then collected. Participants encouraged to follow along on our website: www.livehealthylane.org, where we will present the summary findings of the Community Health Needs Assessment, what we are currently doing/the progress, and keep it up to date with information about how people can get involved in making our community a healthier place for all.

Dissemination of Phase Four Results

The two strategic issues were shared with everyone who participated in the MAPP process and the community at large through online and in-person sharing. In disseminating results, people new to the process have the opportunity to learn more and get involved in the action cycle. The later phases of the MAPP process involve formulating goals and strategies, and narrowing the strategic issues into strategic actionable steps. In sharing the results of phase four and subsequent phases, it is emphasized that while two strategic issues were selected to be the focus of the Community Health Improvement Plan, all areas are interconnected and will be impacted by the work.

Evaluation

Phase four was evaluated with a survey of event participants and Core Team members. Survey questions focused on the process used to identify the issues. Evaluation results were shared with the Core Team for planning purposes and to ensure continuous improvement.
Summary

The 2015-2016 Lane County Region Community Health Needs Assessment is the product of 15 months of collaboration between United Way, Lane County, PeaceHealth, and Trillium, along with our partners and engaging the communities we serve. The findings outlined in this document are only the first step to improving the health of our community. The prioritized strategic issues will form the foundation for the 2016-2019 Lane County Regional Community Health Improvement Plan (CHIP): a collaborative action-oriented plan intended to make a measurable impact on the health of our community. The CHIP Report will be released Summer 2016 and implementation will begin Fall 2016.

Community engagement is the most critical component of the Community Health Needs Assessment process. We are thankful to the thousands of community members and hundreds of organizations across the region who shared their time and expertise by attending the Community Health Visioning Session, the Live Healthy Lane: Defining Our Future event, participating in a focus group or key informant interview, or completing the Community Health Survey. This health improvement planning process has only been possible because of the amazing participation from hundreds of local organizations and thousands of community members. Thank you!

Contact

If you would like to be added to our list of Live Healthy Lane partners to receive information about CHIP convenings and periodic updates, or if you or your organization would like to become involved in the Community Health Improvement Plan, please contact us.

Web: www.LiveHealthyLane.org
Email: hamrhein@unitedwaylane.org
Phone: 541-741-6000 x122

Working together to create a caring community where all people can live a healthier life!
Acknowledgements

Thousands of community members and hundreds of organizations representing public, private and nonprofit groups participated in the 2015-2016 Community Health Needs Assessment. The entire list of participating organizations can be found on the following page. Their time, dedication and efforts are greatly appreciated. The following is a list of key contributors:

100% Health Community Coalition Executive Committee

- Rick Kincade, MD
  - Community Health Centers of Lane County
- Marian Blankenship
  - PacificSource Health Plans
- Cheryl Boyum
  - Cascade Health Solutions
- Rachel Burdon
  - Kaiser Permanente
- Michelle Cady
  - Cornerstone Community Housing
- Chad Campbell
  - McKenzie-Willamette Medical Center
- Jim Connolly
  - Trillium Community Health Plan
- Noreen J. Dunnells
  - United Way of Lane County
- Karen Gaffney
  - Lane County Health & Human Services
- Lisa Gardner
  - Planned Parenthood of Southwestern Oregon
- Alicia Hays
  - Lane County Health & Human Services
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  - Volunteers in Medicine
  - 100% Health Safety Net Committee
- Cris Noah
  - Oregon Medical Group
- Paul Wagner
  - RN Sacred Heart Medical Center
  - Willamette Family
- Tom Wheeler
  - South Lane Mental Health
- Trevor Whitbread
  - Centro Latino Americano
- Rick Yecny
  - PeaceHealth Peace Harbor Medical Center

CHNA/CHIP Core Team

- Heather Amrhein
  - United Way of Lane County
- Dan Casares
  - PeaceHealth
- Shannon Conley
  - Trillium Community Health Plan
- Tara DaVee
  - Trillium Community Advisory Council
- Noreen Dunnells
  - United Way of Lane County
- Leah Edelman
  - Lane County Health and Human Services
- Karen Gaffney
  - Lane County Health and Human Services
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  - United Way of Lane County
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  - Lane County Health and Human Services
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- Rick Yecny
  - Trillium Rural Advisory Council
Thank you to everyone who participated in the 2015-2016 Community Health Needs Assessment!

**Health System**
- Advantage Dental
- Bethel Health Center
- Cascade Health Solutions
- Community Health Centers of Lane County
- Cottage Grove Physical Therapy
- Emergency Veterinary Hospital
- Eugene Health Centers
- Healing Spirit Integrative Health Center
- Health Care For ALL Oregon
- Health Security Preparedness and Response
- Hope Family Health Clinic
- Kaiser Permanente
- Lane Community College Health Clinic
- Lane County Maternal and Child Health Programs
- Lane County Health and Human Services
- McKenzie Surgery Center
- McKenzie-Willamette Medical Center
- Occupy Medical
- Oregon Health Authority
- Oregon Heart and Vascular Rehab Program
- Oregon Home Care Commission
- Oregon Imaging Center
- Oregon Medical Group
- Oregon Research Institute
- PacificSource Health Plans
- PeaceHealth
- Planned Parenthood of Southwestern Oregon
- Rural Oregon Accessible Medicine
- Simard Chiropractic
- Slocum Center for Orthopedics & Sports Medicine
- Taylored Benefits
- Trillium Community Health Plan
- University of Oregon Health Center
- Volunteers in Medicine
- White Bird Clinic
- Willamette Dental Group

**Behavioral and Mental Health**
- Center for Family Development
- Direction Service
- HIV Alliance
- Lane County Behavioral Health
- Laurel Hill Center
- Lifestyle Changes
- Looking Glass Community Services
- National Alliance on Mental Illness (NAMI) of Lane County
- Options Counseling and Family Services
- Oregon Family Support Network
- Oregon Research Behavioral Intervention Strategies
- Serenity Lane
- Siuslaw Area Partnership to Prevent Substance Abuse
- Solutions Therapy, Consulting and Training
- South Lane Mental Health
- Trauma Healing Project
- Willamette Family Inc.

**Government**
- Board of County Commissioners
- City of Creswell
- City of Eugene
- City of Eugene Adaptive Recreation
- City of Eugene Planning & Development Department
- City of Eugene Public Works
- City of Eugene Senior Services
- City of Eugene: Recreation Services
- City of Florence
- City of Oakridge
- City of Springfield
- City of Veneta
- Community Health Centers of Lane County
- Congressman Peter DeFazio
- Department of Human Services
- Eugene City Council
- Lane Council of Governments
- Lane County Behavioral Health
- Lane County Government
- Lane County Health & Human Services
- Lane County Maternal and Child Health Programs
- Lane County Public Health
- Lane County Public Works
- Oregon Health Authority
- Oregon State Legislature
- Oregon's 4th Congressional District
- US Forest Services, Willamette National Forest

**Foundations & Philanthropy**
- AmeriCorps VISTA
- Children's Institute
- Slocum Research and Education Foundation
- Taubert Foundation
- United Way of Lane County
**Human Services and Community Organizations**

211 Info  
90by30  
A Community Together  
Alliance for Healthy Families  
Bethel Family Center  
Brattain House Community Family Center  
Centro Latino Americano  
City of Eugene Adaptive Recreation  
City of Eugene Senior Services  
City of Eugene: Recreation Services  
Coaching Parents  
Cottage Grove Family Resource Center  
Court Appointed Special Advocates (CASA)  
CrossFit Kin  
Daisy CHAIN Mothering  
Department of Human Services  
Downtown Languages  
Eugene Civic Alliance  
Eugene Family YMCA  
Eugene Public Library  
Family Forward Oregon  
Family Relief Nursery  
Fern Ridge Community Dinner  
FOOD for Lane County  
Goodwill Industries of Lane and South Coast Counties  
HealthFirst Financial  
Healthy Moves  
Hearing Loss Association of America  
Huerto de la Familia  
Institute for Patient- and Family-Centered Care  
Kids’ FIRST Center  
Lane County Commission for the Advancement of Human Rights  
Lane Independent Living Alliance (LILA)  
Lane Workforce Partnership  
League of United Latin American Citizens  
Marcola Family Resource Center  
Mohawk-McKenzie Grange  
NAACP - Eugene/Springfield Oregon  
Oakridge Family Resource Center  
Oakridge Kiwanis Club  
Ophelia’s Place  
Oregonians for Gambling Awareness Organization  
Parent Partnership Comprehensive Programs  
Parenting Now!  
Pearl Buck Center  
Pilas! Family Literacy Program  
Planned Parenthood REVolution  
Relief Nursery  
School Garden Project of Lane County  
Senior and Disability Services  
ShelterCare  
South Lane Family Resource Center  
Sponsors  
Springfield Public Library  
St. Vincent de Paul  
St. Vincent de Paul’s Night Shelter Program  
Stand For Children  
Sustainable Cottage Grove  
United Way of Lane County  
Walterville Grange  
Willamalane Park and Recreation District  
Willamette Farm and Food Coalition  
WomenSpace  
Youth MOVE Oregon

**Education**

4J Eugene School District  
Bethel School District  
Creswell School District  
Early Childhood CARES  
Early Learning Alliance  
Head Start of Lane County  
Junction City School District  
Lane Community College  
Lane Community College Health Professions Division  
Northwest Christian University  
Northwest Youth Corps  
Oregon Health and Science University  
Oregon State University Extension  
Sioux Falls School District  
South Lane School District  
Springfield Public Schools  
University of Oregon  
Wilagillespie Elementary School

**Housing**

Cornerstone Community Housing  
Housing and Community Services Agency (HACSA)  
Housing Policy Board  
Lane County Land Use Planning & Zoning  
Springfield/Eugene Habitat for Humanity  
Viridian Management  
Windermere

**Transportation**

City of Eugene Transportation Options  
Eugene and Springfield Safe Routes to School  
Lane Transit District (LTD)

**Economic Development**

Lane County Economic Development  
Neighborhood Economic Development Corporation  
Upper Willamette Community Development Corporation  
WorkSource Lane

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BUSINESSES
Banner Bank
Cross Cultural Now
Dean/Ross Associates
Emerald Aquatics
Eugene Water and Electric Board
Hawes Financial Group
Hershner Hunter
Lourdes Sanchez Attorneys at Law
Moss Adams LLP
Ninkasi Brewing Company
Pacific Continental Bank
Royal Caribbean Cruises Ltd
Sapient Private Wealth Management
Smith and Associates
US Bank

MEDIA
Rick Dancer Media Services
KEZI 9 News
KLCC
KMTR
Register Guard

CRIMINAL JUSTICE AND PUBLIC SAFETY/EMERGENCY SERVICES
Eugene Police Department
Eugene Springfield Fire Department
Johnson Johnson & Schaller, PC
Juvenile Recovery and Progress Court
Lane County Circuit Court
Lane County District Attorney's Office
Lane County Legal Aid & Advocacy Center
Lane County Sheriff's Office
Lane County Youth Services
Oregon Department of Corrections
Public Defender Services of Lane County Inc.
Springfield Police Department
US District Court, District of Oregon

FAITH
Centro de fe Community Church
Community Service Center
Discover the Power of Choice
First Christian Church
Power House Worship Center

COALITIONS & COMMITTEES
100% Health Community Coalition
100% Health Safety Net Committee
Be Your Best Cottage Grove
Bicycle and Pedestrian Advisory Committee
CHIP Equity Workgroup
CHIP Mental Health and Addictions Workgroup
CHIP Obesity Prevention Workgroup
CHIP Tobacco Prevention Workgroup
Coalition of Local Health Offices
Community Resource Network
DHS District 5 Advisory Committee
Early Childhood Mental Health Team
Early Learning Alliance
Early Learning Alliance Pediatric Advisory Group
Early Learning Stakeholders
Eugene Springfield Prevention Coalition
Family Resource Center Managers
Lane County Mental Health Promotion Steering Committee
Lane Equity Coalition
Mental Health Advisory/Local Alcohol and Drug Planning Committee
Patient and Family Advisory Council
PeaceHealth Health and Wellness Committee
Pediatric Advisory Group
Public Safety Coordinating Council - Adult Committee
Public Safety Coordinating Council - Youth Committee
Trillium Community Advisory Council
Trillium Rural Advisory Council
United Way Emerging Leaders
United Way Human Service Providers Forum

LANE COUNTY AND REEDSPORT COMMUNITY MEMBERS AND CONSUMERS
Glossary

10 Essential Public Health Services
The 10 Essential Public Health Services, developed by representatives from federal agencies and national organizations, describe what public health seeks to accomplish and how it will carry out its basic responsibilities. The list of 10 services defines the practice of public health. These services include:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Access/Access to Care
This is the extent to which a public health service is readily available to the community’s individuals in need, including the capacity of the agency to provide service in a way that honors the social and cultural characteristics of the community. It also focuses on agency efforts to reduce barriers to service utilization. “Access to care” refers to access in a medical setting.

Action Cycle
During Phase Six, Action Cycle, the community implements and evaluates action plans to meet goals, address strategic issues, and achieve the community’s vision.

Behavioral Risk Factors
Risk factors in this category include behaviors that are believed to cause, or to be contributing factors to most accidents, injuries, disease, and death during youth and adolescence as well as significant morbidity and mortality in later life. The Behavioral Risk Factor Surveillance System includes the indicators tobacco use, illegal drug use, binge drinking, nutrition, obesity, exercise, sedentary lifestyle, seatbelt use, child safety seat use, bicycle helmet use, condom use, pap smear screening, and mammography screening.

Chronic Diseases
These are diseases of long duration, generally slow progression, and can be multisymptomatic. Examples include heart disease, stroke, cancer, arthritis, chronic respiratory diseases, and diabetes.

Community
Broad community participation is vital to a successful MAPP process. Activities for each phase include specific consideration of ways to gain broader community member participation. This will ensure that the community’s input is a driving factor.

Community Assets
Contributions made by individuals, citizen associations, and local institutions that individually or collectively build the community’s capacity to assure the health, well-being, and quality of life for the community and all its members.
Community Health Improvement Plan (CHIP)
A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. A community health improvement plan is critical for developing policies and defining actions to target efforts that promote health. It defines the vision for the health of the community through a collaborative process and addresses the gamut of strengths, weaknesses, challenges, and opportunities that exist in the community to improve the health status of that community.

Community Health Needs Assessment (CHNA)
A Community Health Assessment engages community members and local public health system partners to collect and analyze health-related data from many sources. Critical tasks are accomplished through the Community Health Needs Assessment: informs community decision-making; prioritizes health problems; and assists in the development and implementation of community health improvement plans.

Community Member
This is anyone who works, learns, lives, and plays in the Lane County, Oregon and Reedsport community.

Consumer
This is anyone who is the recipient of services or commodities.

Death, Illness, and Injury
Health status in a community is measured in terms of mortality (rates of death within a population) and morbidity (rates of the incidence and prevalence of disease). Mortality may be represented by crude rates or age-adjusted rates; by degree of premature death (Years of Productive Life Lost); and by cause (disease—cancer and non-cancer or injury—intentional, unintentional). Morbidity may be represented by age-adjusted incidence of cancer and chronic disease.

Demographic Characteristics
Demographic characteristics of a jurisdiction include measures of total population as well as percent of total population by age group, gender, race and ethnicity, where these populations and sub-populations are located, and the rate of change in population density over time, due to births, deaths, and migration patterns.

Environmental Health Indicators
The physical environment directly impacts health and quality of life. Clean air, water, and safely prepared food are essential to physical health. Exposure to environmental substances, such as lead or hazardous waste, increases risk for preventable disease. Unintentional home, workplace, or recreational injuries affect all age groups and may result in premature disability or mortality.

Evidence-based
Supported by the current peer-reviewed scientific literature.

Formulate Goals and Strategies
In Phase Five, Formulate Goals and Strategies, goals that the community wants to achieve are identified that relate to the strategic issues. Strategies are then identified to be implemented.

Four MAPP Assessments
During Phase Three, Four MAPP Assessments, qualitative and quantitative data are gathered to provide a comprehensive picture of health in the community.

Goals
Goals are broad, long-term aims that define the desired result associated with identified strategic issues.
Health

This is a dynamic state of complete physical, mental, spiritual, and social wellbeing and not merely the absence of disease or infirmity.

Health Disparity

Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by people who have historically made vulnerable by policies set by local, state, and Federal institutions. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), gender identity, or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.

Health Equity

Health equity is the realization by all people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally, and entails focused and ongoing societal efforts to address avoidable inequalities by ensuring the conditions for optimal health for all groups, particularly for those who have experienced historical or contemporary injustices or socioeconomic disadvantage.

Health Inequity

Health inequities are differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.

Health Resource Availability

Factors associated with health system capacity, which may include both the number of licensed and credentialed health personnel and the physical capacity of health facilities. In addition, it includes measures of access, utilization, and cost and quality of health care and prevention services.

Health Risk

This is a condition of humans that can be represented in terms of measurable health status or quality-of-life indicators.

Health Status

This is the current state of a given population using various indices, including morbidity, mortality, and available health resources.

Identify Strategic Issues

In Phase Four, Identify Strategic Issues, the data are analyzed to uncover the underlying themes that need to be addressed in order for a community to achieve its vision.

Incidence

This is the measure of the frequency with which new cases of illness, injury, or other health condition occur among a population during a specified period.

Indicator

This is a measure of health status or health outcome such as the number of people who contract a respiratory disease or the number of people who die from a particular chronic disease. Measures/data that describe community conditions (e.g., poverty rate, homelessness rate, number of food stamp recipients, life expectancy at birth, heart disease mortality rate) currently and over time.

Infectious Disease

A disease caused by the entrance into the body of a living organism (e.g., Bacteria, protozoans, fungi, or viruses). An infectious disease may, or may not, be transmissible from person to person, animal to person, or insect to person.
**Injury**
Any damage to the body due to acute exposure to amounts of thermal, mechanical (kinetic or potential), electrical, or chemical energy that exceed the individual’s tolerance for such energy, or to the absence of such essentials as heat or oxygen. This includes intentional injuries (e.g., homicide, suicide) as well as unintentional injuries, regardless of where they occur, the activity that was taking place when the injurious event happened, or the object that was involved in the energy transfer.

**Local Public Health System**
This is the collection of public, private and voluntary entities, as well as individuals and informal associations, that contribute to the public’s health within a jurisdiction.

**Steering Committee**
This is the group that gives the MAPP process direction. The Steering Committee serves in a similar function as a board of directors and is representative of the local public health system.

**Strategies**
Strategies are patterns of action, decisions, and policies that guide a local public health system toward a vision or goal.

**Strategic Planning**
Strategic planning is continuous and systematic process whereby an organization or coalition makes decisions about its future, develops the necessary procedures and operations to achieve that future, and determines how success is to be measured.

**Maternal and Child Health**
This is a set of programs and policies focusing on birth data and outcomes as well as mortality data for infants and children. Because maternal care is correlated with birth outcomes, measures of maternal access to, or utilization of, care is included. One of the most significant areas for monitoring and comparison relates to the health of a vulnerable population: infants and children. Births to teen mothers are a critical indicator of increased risk for both mother and child.

**Mobilizing for Action through Planning and Partnerships (MAPP)**
This is a community-wide strategic planning process for improving public health.

**National Association of County and City Health Officials (NACCHO)**
NACCHO’s vision is health, equity, and security for all people in their communities through public health policies and services. NACCHO’s mission is to be a leader, partner, catalyst, and voice for local health departments in order to ensure the conditions that promote health and equity, combat disease, and improve the quality and length of all lives.

**National Public Health Performance Standards (NPHPS)**
The NPHPS is designed to measure public health practices at the state and local levels. Three NPHPS instruments exist to measure local, state, and government provision of the 10 Essential Public Health Services, respectively. The local instrument, referred to as the local public health system assessment in Mobilizing for Action through Planning and Partnerships (MAPP), evaluates the capacity of local public health systems to deliver the 10 Essential Public Health Services. The NPHPS Local Instrument is the instrument used to complete the Local Public Health System Assessment in MAPP.

**Public Health**
This is the science and the art of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of the individual in principles of personal hygiene; the organization of medical and nursing service for the early diagnosis and treatment of disease; and the development of the
social machinery to ensure to every individual in the community a standard of living adequate for the maintenance of health.

**Quality of Life**
While some dimensions of quality of life can be quantified using indicators that research has shown to be related to determinants of health and community wellbeing, other valid dimensions of quality of life include the perceptions of community residents about aspects of their neighborhoods and communities that either enhance or diminish their quality of life.

**Social and Mental Health**
This data represents social and mental factors and conditions, which directly or indirectly influence overall health status and individual and community quality of life.

**Social Determinants of Health**
Social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. They include the social environment, physical environment, and health services.

**Socioeconomic Characteristics**
Socioeconomic characteristics include measures that have been shown to affect health status, such as income, education, and employment, and the proportion of the population represented by various levels of these variables.

**Stakeholders**
All persons, agencies, and organizations with an investment or “stake” in the health of the community and the local public health system. This broad definition includes persons and organizations that benefit from and/or participate in the delivery of services that promote the public’s health and overall wellbeing.

**Strategic Issue**
Strategic issues are those fundamental policy choices or critical challenges that must be addressed for a community to achieve its vision.

**Strategic Plan**
This is a plan resulting from a deliberate decision-making process that defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward.

**Sub-committee**
For several phases of MAPP, especially the Four MAPP Assessments, subcommittees are designated to oversee the work. The sub-committees include representation from the Core Team and other individuals with specific expertise, skills, or knowledge.

**Visioning**
During Phase Two, Visioning, those who work, learn, live, and play in the MAPP community (Lane County, Oregon) create a common understanding of what it would like to achieve. The community decides the vision, which is the focus of the MAPP process.
Working together to create a caring community
where all people can live a healthier life
Health

“A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”
– World Health Organization

Healthy Community

“One that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.”
– World Health Organization
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Dear Community Partner,

I am pleased to present the 2016-2019 Community Health Improvement Plan. This plan is the product of a collaborative effort by community members, the 100% Health Community Coalition Executive Committee (serving as the Steering Committee), United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, and Trillium Community Health Plan. In order to collaboratively develop this Community Health Improvement Plan, an extensive Community Health Needs Assessment and Community Health Improvement Planning process was conducted over the last 15 months (March 2015-June 2016). Please see the companion document, the 2015-2016 Community Health Needs Assessment, for further details on the process and data collected.

This Community Health Improvement Plan was designed to mobilize critical areas where collaborative action is needed to improve health and well-being. The plan illustrates where our community will work together over the next three years to improve the mental, physical and social health and overall well-being of our community.

One of our region’s greatest assets is our people: we are passionate about our community, committed to improvement, and determined to see the vision of health become a reality. The drive, diligence, and support from the community made planning and completing this improvement plan possible. Thank you for all of your ongoing contributions and support for this remarkable community health improvement process.

Our challenges are great, but so is our community. We invite you to use this plan to help inform and enhance your knowledge of the work currently underway to improve community health. We also encourage you to review the priorities and goals, reflect on the suggested strategies, and consider how you can participate in this effort. By working together, we can create a caring community where all people can live a healthier life. We look forward to embarking on this journey together.

Sincerely,

Rick Kincade, MD
Chair, 100% Health Community Coalition
Executive Summary

We all want our community to be a healthy place to live and learn, work and play. Our region has a strong foundation for a healthy community; it is built around abundant natural resources, has a history of collaboration across organizations, hardworking residents, caring neighborhoods, and innovative opportunities. While we are proud of these assets, we recognize there are still barriers to overcome.

The 2016-2019 Community Health Improvement Plan (CHIP) is the product of a 15-month long community health improvement planning process led by the Live Healthy Lane partnership – United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, Trillium Community Health Plan and many community partners. The purpose of this process has been to develop a health improvement plan that partners from different sectors (e.g. health, education, housing, transportation) can use as a framework to improve the health of our community over the next three years. This plan contains strategies intended to make measurable improvements in two areas that the community voted to make our priority: social and economic opportunities and healthy behaviors.

The CHIP is informed by the 2015-2016 Community Health Needs Assessment (CHNA), a report describing the health status of people in our community and the conditions that contribute to health. It also integrates significant input received from community members and stakeholders. The report is available online at: www.LiveHealthyLane.org.

The purpose of the assessment and health improvement effort is to reduce health disparities, promote health equity and improve overall population health. There are education and economic implications for poor health and addressing these issues successfully requires resources, effort, innovations and most importantly, participation from the entire community. The CHIP provides a common vision and shared approach for local partners to build strategic partnerships as we work toward creating a healthy and vibrant community.

To date, this community-driven process has engaged over 2,500 individuals and 200 organizations. By continuing to work together, we can create a caring community where everyone can have the opportunity to live a healthier life.
Overview of Our Region

For the purposes of this 2016-2019 Community Health Improvement Plan, our community’s region includes Lane County and Reedsport, Oregon.

Reedsport, Oregon is located in Douglas County on the central Oregon coast and is 87 miles southwest of Eugene, Oregon and has 4,090 residents (97% urban, 3% rural).

Extending from the Pacific Ocean to the Cascade mountain range, Lane County is a vibrant mix of communities and people. Lane County is the fourth most populous county in Oregon, with a population just over 350,000 residents. The Eugene-Springfield area contains over 60% of the county’s population and is the third-largest Metropolitan Statistical Area in Oregon. Outside of the metro area, Lane County is largely rural and unincorporated. The concentrated population, yet large geographic area of the county creates disparities in access to health and human services, as well as resources.

The 2016 County Health Rankings and Roadmaps rank Lane County 12th out of 36 counties in Oregon for overall health outcomes (length of life and quality of life) and 9th for health factors (health behaviors, clinical care, social and economic factors, and physical environment). Our region is a moderately healthy community with well-educated and active residents. The population is increasing, living longer, and becoming more diverse. Although good health outcomes and behaviors are prominent, there are still gaps to be addressed. Disparities exist between racial, geographic, and socioeconomic groups. For some issues, the gap is markedly wide.
Vision Statement

**Live Healthy Lane:** Working together to create a caring community where all people can live a healthier life.

Community Values

- **Compassion** – We are creating a community where all people are treated with dignity and respect.
- **Equity** – We believe everyone should have the opportunity to live a healthy life.
- **Inclusion** – We strive to embrace our differences and treat the whole person.
- **Collaboration** – We have committed our collective resources to innovation, coordination, and integration of services.
Goals & Strategies

Goals

Increase economic and social opportunities that promote healthy behaviors. Increase healthy behaviors to improve health and well-being.

Strategies

- Support economic development through investing in workforce strategies that provide sustainable family wage jobs in our communities.
- Encourage a range of safe and affordable housing opportunities, including the development of integrated and supportive housing.
- Assure availability of affordable healthy food and beverages in every community.
- Strengthen cross-sector collaborations and align resource to improve the physical, behavioral, and oral health and well-being of our communities.
- Encourage organizations across multiple sectors to integrate health criteria into decision making, as appropriate.
- Encourage the implementation of programs to promote positive early childhood development and safe/nurturing environments.
- Support the implementation of evidence-based preventive screening and referral policies and services by physical, behavioral, and oral healthcare and social service providers.
Equity Considerations

Equity Value Statement:
*We believe everyone should have the opportunity to live a healthy life.*

When making decisions, problem solving and taking action, it is important for us to consider equity and the impact on everyone in in our community, especially those in underserved demographic groups and protected classes.

**Health Equity** - Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." - Centers for Disease Control and Prevention.

**Health Disparities** - “Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by” people who have historically made vulnerable by policies set by local, state, and Federal institutions. "Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), gender identity, or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.” - Centers for Disease Control and Prevention

**Social Determinants** - “Social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices.” - World Health Organization

This community health improvement effort offers providers, planners, decision makers, policy makers, funders, and community leaders an opportunity to intentionally apply an equity framework into collective action and impact. A key element to successfully addressing the prioritized strategic issues will be to address all social, economic and environmental factors that provide everyone in our region an opportunity to live a healthy life. In order to fully realize health equity, all factors contributing to health must be addressed. Therefore, the Community Health Improvement Plan will use an equity lens to identify those factors that may have significant impacts on each priority area. An equity lens process is an intentional method for identifying and addressing health inequities by making more informed decisions to move toward the goal of achieving health equity. By adhering to such a framework, we can work on addressing the underlying factors that have led to consistently poorer health outcomes for disadvantaged groups.

Formed from the 2013-2016 Community Health Improvement Plan’s Equity Workgroup, the Lane Equity Coalition Steering Committee will help ensure equitable implementation of the 2016-2019 Community Health Improvement Plan and monitor its progress toward improving health equity.
What Makes Us Healthy?

Risk factors that influence health such as age, genetics and race cannot be changed; these risk factors determine about 30% of an individual's health. The other 70% of risk factors that influence health are factors such as social and economic conditions, health behaviors, clinical care, and the physical environment, that can be changed through individual actions, policy changes or environmental modification. These two types of risk factors interact over the lifespan to influence an individual's overall health.

Research demonstrates that social and economic conditions contribute to the largest percentage of our health status, followed by health behaviors, clinical care, and the physical environment. Social and economic conditions encompass community safety, education, employment and income. Health behaviors include alcohol and drug use, diet and exercise, tobacco use, and sexual activity. Clinical care comprises access to health insurance and a consistent source of quality care that will meet the needs of the people. Lastly, the physical environment covers housing, air quality, and transportation.

Social Determinants of Health

A person's health is determined largely by social and economic factors, rather than by the health care he or she receives. This “social determinants of health” model explains why certain segments of the population experience better health outcomes, while for other populations, external factors in their lives make health difficult to achieve. Parts of our community experience significantly worse health than others. Narrowing the health disparities, and improving overall population health, requires solutions to address the social determinants of poor health. Understanding how these factors influence health is critical for developing the best strategies to address them.

The conditions in which we live, work, study, and play all influence health; achieving healthy communities will require the active engagement of many sectors. Working toward better health is not just the job of the individual, but the job of the community and organizations as well. Community and organizational support will ensure that residents who decide to live healthier will have the support and encouragement needed to be successful.

“The biggest obstacle to making fundamental societal changes is often not a shortage of funds but lack of political will; the health sector is well positioned to build the support and develop the partnerships required for change.”

- Dr. Thomas Frieden, CDC Director
Planning Process

This Community Health Improvement Plan (CHIP) is the culmination of a community health improvement planning process that began with a Community Health Needs Assessment (CHNA), a comprehensive report of the state of health in our region. This CHIP was derived from CHNA findings of the health needs, conditions, and disparities between populations and regions in our community.

The process followed the Mobilizing for Action through Planning and Partnerships (MAPP) framework, a community-driven strategic planning model for improving community health. Developed by the National Association of County and City Health Officials (NACCHO), MAPP outlines the framework to conduct a CHNA and CHIP.

MAPP is made up of four assessments that are the foundation of the planning process, and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action.

Organize for Success and Partner Development
The assembly of the Live Healthy Lane partnership completed PHASE ONE of the process in the spring of 2015. United Way of Lane County, Lane County Public Health, Trillium Community Health Plan, and PeaceHealth collaborated with members of the local public health system to form the organizational structure for the MAPP process. To develop a plan for improved community health and help sustain implementation efforts, the assessment and planning process engaged community members and local public health system partners through the following avenues:

- Steering Committee: provided guidance and direction for CHNA and CHIP.
- Core Team: conducted the CHNA, implement the CHIP, and will provide the overall management of the process.
- CHIP Action Teams: developed and will implement CHIP action plans.
- Additionally, community members and local public health system partners provided input and direction throughout the process.

Visioning
PHASE TWO: The visioning phase was a community-based process where more than 135 people from across the region participated in a multi-site simulcast community brainstorming session on June 25, 2015. The community vision and values that were selected are:

*Working together to create a caring community where all people can live a healthier life.*

*Compassion • Equity • Inclusion • Collaboration*
Four MAPP Assessments

**PHASE THREE:** The four MAPP assessments included for the collection of quantitative and qualitative data. These data offered critical insights into the challenges and opportunities for our community. Phase Three was conducted from May through December 2015.

- *The Community Health Status Assessment* provided quantitative information on the community’s health. To complete this assessment, a subcommittee was formed to focus on identifying and analyzing key issues from over 200 broad indicators.
- *The Community Themes and Strengths Assessment* gathered the thoughts, opinions, and perceptions of thousands of community members and consumers in order to understand which issues are important to the community. Three methods of data collection were utilized: 2,295 surveys were gathered, 50 focus groups conducted (with 500 participants), and 53 key informants were interviewed.
- *The Local Public Health System Assessment* evaluated the components, activities, competencies, and capacities of our local public health system and how well the 10 Essential Services of Public Health are being provided. To complete this assessment, members of the local public health system met to assess the system’s performance.
- *The Forces of Change Assessment* identified the trends, factors, and events that were likely to influence community health and quality of life, or impact the work of the local public health system. To complete this assessment, the Core Team and Steering Committee worked together to form a comprehensive picture of the region’s strengths, weaknesses, opportunities, and threats.

Identify Strategic Issues

**PHASE FOUR:** Strategic issues are critical challenges to be addressed, as well as significant opportunities to be leveraged, in order for a community to achieve its vision. Phase Four was conducted between December 2015 and February 2016, concluding with a multi-site community event to present the CHNA findings and vote on the strategic issues. While many areas are significant, identifying priority areas creates opportunities for collective impact. Two strategic issues were prioritized by over 260 people in our community to mark the end of the CHNA and form the foundation for the CHIP. The 2015-2016 CHNA report is available online at [www.LiveHealthyLane.org](http://www.LiveHealthyLane.org).

Formulate Goals and Strategies

**PHASE FIVE:** This phase involved the formation of goals related to each strategic issue and identifying strategies for achieving each goal. Phase Five was conducted between February and April 2016, during which time meetings were held with the Core Team, Steering Committee, previous CHIP Workgroups, and stakeholders to evaluate potential strategies on various criteria (potential for cross-sector collaboration, health and equity impact, alignment with current work, available resources, and community support). In April 2016, the Steering Committee approved two goals and seven strategies for the 2016-2019 CHIP.

Action Cycle

**PHASE SIX:** The action cycle is a continuous cycle of planning, implementation, and evaluation that seeks to move the needle on key health priorities over the course of the three year plan. Implementation of Phase Six began in April 2016 with the identification of objectives and the development of this CHIP report. The action cycle will continue through 2019.
Strategic Direction

In collaboration with community members, consumers, and stakeholders, two strategic issues and goals were identified to guide actions toward demonstrably improving health and well-being in our community. The multi-level, multi-sectoral strategic approach demonstrates that the CHIP is a bold effort to harness the collective impact of our region’s communities and local public health system partners.

Strategic Issues

- How can we promote access to economic and social opportunities necessary to live a healthy life?
- How can we promote healthy behaviors and engage the community in healthy living?

Goals

- Increase economic and social opportunities that promote healthy behaviors.
- Increase healthy behaviors to improve health and well-being.

Creating a healthy community requires action within and across sectors, because progress in one area will advance progress in another. To achieve lasting change, our community cannot continue doing more of the same. We must embrace a more integrated, comprehensive approach to health. This new perspective on health must become an essential part of our community, achieved by weaving together the threads of physical, mental, economic and social well-being.

These priorities were chosen based on which accomplishments would offer the greatest improvements in lifelong health, advance health equity, and promote equal access to conditions that allow people to be healthy. This plan outlines seven strategies intended to serve as the roadmap to addressing these areas and advancing toward our vision of a healthy community.
Economic and Social Opportunities

Health starts in our homes, schools, workplaces, neighborhoods, and communities. Good health is far more than the absence of illness; social and economic opportunities strongly affect the ability to lead healthy lives. Health status and quality of life are intimately tied to numerous factors including income, poverty, race/ethnicity, education level, geographic location, and employment status. Unfortunately, too many in our community still do not have access to equal choices and opportunities that enable them to pursue healthy behaviors. By working to positively influence social and economic conditions that support changes in behavior, we can improve health in ways that can be sustained over time. Improving the conditions in which we live, learn, work, and play takes a unified approach to create a healthier community.

The “Economic and Social Opportunities” priority highlights the need for improving the conditions in which we live, learn, work, and play in order to create a healthier community.

Healthy Behaviors

To create positive health outcomes, we must foster individual and community actions that promote good health from the start of life until its end. Community leaders, individuals, and representatives from healthcare, businesses, government and education must forge powerful partnerships and must support the desire of people to live healthier lives and engage in healthy behaviors. Personal choice and responsibility play a key role in attaining and maintaining health. Daily practices like eating a healthy diet, getting regular exercise, refraining from risky behaviors, and managing stress is linked to reduced negative health conditions such as heart disease, diabetes, and cancer. However, the choices people make depend on the choices they are given. The healthy choice is not always the “easy” choice – particularly for our community’s more vulnerable residents – as was repeatedly voiced by community members and consumers throughout the CHNA/CHIP development process. Socioeconomic factors – such as whether people can afford to buy nutritious foods and safely engage in exercise in their neighborhoods – and environmental factors – such as whether healthy food options are locally available – impact an individual’s health behaviors. By empowering the community to embrace healthy behaviors, individual and overall health outcomes will be positively impacted.

The “Healthy Behaviors” priority strives to demonstrate the link between health behaviors and chronic disease and to help our region create environments that make healthy choices the easy choices.

“It is so important to address the social determinants of health: poverty, access, education, and housing, which are root causes of so many chronic diseases.”
– Community Member

“We have to make the healthy choice the easy choice!”
- Community Member
Statement of Need

As part of the 2015-2016 Community Health Needs Assessment (CHNA), assessments were conducted to capture comprehensive snapshot of the current community health condition of our region, including the specific health needs and opportunities. Please view the full report online at www.LiveHealthyLane.org for the detailed findings and data citations.

As voiced by the community and supported by publically available data, our community is, overall, a moderately healthy and safe community. Our population is increasing, living longer, and becoming more diverse. Our community strengths include our availability of parks and recreational areas, strong collaboration and sense of community, public awareness of the social determinants of health, local healthy food, clean environment, increased access to health care coverage, and healthy living as a value. Collaborative partnerships and community engagement are strong and should serve as the foundation for planning and implementing initiatives to improve health.

Although good health outcomes and behaviors are prominent in our region, there are still gaps to be addressed. Disparities were identified between racial, geographic, and socioeconomic groups. The overarching theme of the CHNA data reflects a community divided between a high quality of life and limited resources for those in need. Not everyone in our region has the opportunity to be healthy and thriving. Some communities, for example, have great access to affordable grocery stores, public transit, health and human services, and other resources that benefit health and wellness. Other communities – often low-income and/or rural – are closer to fast food and alcohol retail outlets, freeways, industrial pollutants, and other factors that contribute to high rates of disease, death, injury, and violence.

Employment and Income
Creating conditions for economic growth adds to the health and vitality of a community. Investing in sustainable local businesses has many community benefits, including economic development (provides new jobs and keeps money in the local economy), environmental sustainability, and food security.

Community members who completed the survey identified good jobs and a healthy economy to be the third most important factor in creating a healthy community. Higher employment rates lead to better access to healthcare and better health outcomes. Lane County’s current unemployment rate of 6.9% is similar to the state rate (U.S. Bureau of Labor Statistics, 2014). Overall, black/African-Americans, Latinos, youth and adults with less than a high school diploma are more likely to be unemployed. Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, and lead to an increase in unhealthy behaviors.

Income can affect the ability of a household to have access to quality housing and childcare, health care, higher education opportunities, and nutritious food. Areas with higher median household incomes are likely to have more educated residents and lower unemployment rates. As income increases, so does life expectancy.
The median income of all Lane County households consistently lags when compared to the state of Oregon as whole and the rest of the United States. In 2013, the median household income of all households in Lane County was $42,931 (ACS, 2013).

Far too many people in Lane County live in poverty. Approximately 20% of residents live below poverty level, which is more than the state as a whole and the nation (ACS, 2013). Poverty can result in negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. Key informants who were interviewed mentioned poverty as a critical health and quality of life issues in our region. Income and poverty disparities are evident between racial, geographic, and socioeconomic groups.

ALICE (an acronym that stands for Asset Limited, Income Constrained, Employed) households are households that earn more than the federal poverty level, but less than the basic cost of living for the county where they are located. Combined, the number of poverty and ALICE households equals the total population struggling to afford basic needs in a given area. In Lane County in 2013, 43% of households fell below the ALICE Threshold, compared with 38% of Oregon households (ALICE, 2013). Community members and stakeholders participating in focus groups highlighted the lack of family wage jobs in our region.

“I think having a livable wage takes so much stress off people, so then they are able to live a healthy life and make healthy choices.”
– CHNA Focus Group Participant

“The cost of adequate housing in relation to wages here is very difficult.”
– CHNA Focus Group Participant

**Housing**

The availability of safe and affordable housing can serve as an indicator of the overall social, economic, health, and demographic state of the community. Spending a high percentage of household income on housing can create financial hardship, especially for renters with lower income. With a limited income, paying a high rent may not leave enough money for other expenses, such as food, transportation and medical care.
In Lane County, 40.4% of our households are cost burdened, meaning they pay more than 30% of their income for housing (ACS, 2014). Surveyed community members identified the lack of affordable housing and poverty in the top five problems that impact health in the community. Focus group participants and key informants highlighted the vital importance of affordable, quality, and safe housing, especially with integrated services, to provide the foundation for community members to be healthy and thriving.

**Food Security**

Far too many of residents in our community struggle with access to healthy nutritious foods and food security. The USDA defines food insecurity as “limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.” When it’s hard for people to access nutritious food it becomes difficult to prevent and manage chronic diseases like diabetes or other diet related diseases.

Lane County’s food insecurity rate of 16.5% is higher than Oregon as a whole’s 15.2% (Mind the Meal Gap, 2014). Almost 22% of Lane County’s total population receives financial supports through the Supplemental Nutrition Assistance Program (SNAP) and ½ of all students are eligible for the Free and Reduced Lunch Program in Lane County (SNAP, 2012; Department of Education, 2015). Community residents echoed the need for increased accessibility to affordable healthy foods in survey responses, focus groups, and key informant interviews.

“We need to step out of the food box, and we need more focus on jobs, job training, and more long term access to food.”

— CHNA Focus Group Participant
Food and Nutrition
It is essential to eat a fresh, healthy and balanced diet in order to maintain a healthy weight and prevent chronic disease. Consuming healthy foods and beverages is associated with lower risk of overweight and obesity and lower rates of numerous chronic diseases. Due to a combination of behavioral, social, economic, and environmental factors, many people do not eat the recommended levels of fruits and vegetables.

Only one in four Lane County adults and youth (8th and 11th graders) consume the recommended five or more servings of fruits and vegetables per day, a proportion that has not changed significantly over time (Oregon Behavioral Risk Factor Survey, 2013; Oregon Healthy Teens Survey, 2013).

The availability and affordability of healthy and varied food options in a community increase the likelihood that residents will have a balanced and nutritious diet. Unfortunately, fast food is accessible across Lane County, while access to full service grocers and farm stands varies throughout the county and “food deserts” exist both in metro and rural areas. The USDA defines food deserts as “parts of the country vapid of fresh fruit, vegetables, and other healthful whole foods, usually found in impoverished areas. This is largely due to a lack of grocery stores, farmers’ markets, and healthy food providers.”

In 2010, an estimated 39% of Lane County residents lived within close proximity to a full service grocer or a farm stand (USDA, 2010). While residents of Lane County have slightly better access to supermarkets or grocery stores when compared to the state of Oregon as a whole, there are huge disparities across the county. Low-income and underserved areas in Lane County have limited numbers of stores that sell healthy foods, especially fresh fruits and vegetables. Rural communities have a high number of convenience stores, where healthy and fresh foods are less available than in larger, retail food markets. Public transit is readily available in the metro area, but is limited or lacking in outlying and rural areas, creating more of a barrier to accessing healthy foods.

Early Childhood Development
Community members and stakeholders identified positive early childhood development as one of the key indicators of creating a healthy and thriving community. Experiences in early childhood are extremely important for a child’s healthy development and lifelong learning. How a child develops during this time affects future

“We need better early education so kids have the best possible chance of doing well later in school and in life.”
– CHNA Focus Group Participant
cognitive, social, emotional, language, and physical development, which in turn influences school readiness and later success in life. Failure to mitigate adverse early childhood experiences, such as poverty, abuse, or neglect, can impair healthy brain development, increasing social costs by exposing children to greater risk of academic failure and physical and mental health problems (Drotar, 1992).

Early education greatly influences health by improving access to more opportunities for secure employment and housing, better living conditions, and opportunities to live a healthy lifestyle. Oregon has the 4th worst four-year high school graduation rate in the nation, with Lane County continuously falling below the state average. In 2014, only 7 out of every 10 students had graduated from high school in four years (Dept. of Education, 2014).

**Tobacco, Alcohol, and Drug Use**
Alcohol, tobacco use, and drug use issues are concerns in our region that impact many lives. Community members who were surveyed and key leaders who were interviewed identified drug and alcohol abuse issues as having a big impact on health in the community.

Tobacco use remains the leading preventable cause of death. With nearly one out of every five people smoking, tobacco use is higher in Lane County than in Oregon overall (BRFFS, 2013). The burden of tobacco use falls hardest on lower-income residents. Tobacco use kills approximately two people a day in Lane County. Tobacco use causes lung cancer, cardiovascular disease and chronic obstructive pulmonary disorder, as well as increases the chances that a person will develop asthma, arthritis, diabetes, stroke, and various cancers, and worsens the ability to manage existing chronic diseases.

Binge drinking alcoholic beverages is associated with greater risk for injury, violence, substance abuse and alcoholism. Adult binge drinking has trended upward for more than a decade and has remained consistently higher in Lane County than the state average. One in five adults report binge drinking in the past month. Likewise, alcohol induced deaths have also continued to increase. 74 people in Lane County died from causes directly attributable to alcohol use and an estimated 90 or so more people died from alcohol related causes including chronic diseases, injury and other (Oregon Center for Health Statistics, 2013).

Despite regulation by federal and state agencies, misuse, abuse, addiction and overdose of prescription drugs continues to occur in Lane County. Drug poisonings after a period of decline in end of the 2000’s is on the rise again, and is 1.5 times higher than it was a decade ago (OCHS, 2013). On average, one person died from a drug poisoning each week in Lane County last year, more than half of those deaths were from Opioids. Opioids such as heroin and prescription pain medications are the leading contributor to drug-induced deaths.
Mental Health
According to the World Health Organization, mental health is defined as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” Focus group participants and key informants identified mental health as a critical health and quality of life issue affecting our community. Suicides and severe depression have devastating long-lasting impacts on Lane County communities at rates far higher than much of the nation. Suicide rates have slowly increased over the last decade in Lane County and in the state as a whole and suicide is one of the five leading causes of death for people in Lane County aged 10-54 years. More than one person dies from suicide in Lane County every week (Oregon Center for Health Statistics, 2013).

Sexually Transmitted Infections
Sexually transmitted infections are a significant health problem in Lane County. These infections pose a threat to an individual’s immediate and long term health and well-being. They can lead to severe reproductive health complications such infertility and ectopic pregnancy. Rates of some sexually transmitted infections are the highest they’ve been in 15 years. Sexually Transmitted Infections such as Chlamydia, Gonorrhea, and Syphilis have steadily risen and more than doubled over the last decade, and rate has accelerated in the past 5 years, roughly half of all infections occur among young people age 15-24 years of age (OR Office of Disease Prevention and Epidemiology, 2000-13).

Preventive Care
Preventative screenings and other services are essential for both children and adults in preventing illness, promoting wellness, and fostering vibrant communities. Use of preventative screening and health services is generally lower in Lane County than in Oregon overall.

“We need to make mental health services more accessible.”
– CHNA Survey Respondent

“Prevention is the key to a healthier community.”
– CHNA Kev Informant
Well-child visits allow doctors and nurses to have regular contact with children; this helps to monitor the child’s health and development through periodic developmental screening. Among children served by Trillium who received developmental screening in the first 36 months of life, 57.1% completed developmental screening during the first six months of 2015, compared to 28.3% in 2013 and 45% in 2014. Nearly 30% of adolescents served by Trillium had well-child visits in 2015 (mid-year), an approximate 10% improvement over 2013.

Screening for alcohol and drug misuse is critical to the prevention of or early intervention in addiction. Among Trillium Medicaid members, alcohol and drug screening has nearly tripled since 2013 and was completed for 8.8% of members ages 12 and older during the first six months of 2015, compared to 3% in 2013.

Oral health has been shown to impact overall health and well-being. Professional dental care helps to maintain the overall health of the teeth and mouth, and provides for early detection of pre-cancerous or cancerous lesions. People living in areas with low rates of dentists, such as our rural communities, have more difficulty accessing the dental care they need. In Lane County, 64.1% of adults had a dental care visit in the past year, based on 2010-2013 data. This was slightly lower than Oregon’s 66% (BRFSS, 2013). About 75% of Lane County 8th and 11th graders had seen a dentist in the past year (Oregon Healthy Teens Survey, 2013).

Access to Care
Community members and stakeholders indicated that it is necessary to increase the availability of integrated primary care and behavioral health services, including School Based Health Centers. While we have greatly expanded the availability of health insurance, having health insurance is most effective when it also facilitates access to a consistent source of care. Access to a consistent healthcare provider results in increased use of preventive services, better health (physical, behavioral, oral) outcomes, reduced health disparities, and lower health care expenditures.

As of Mid-Year 2015, 69% of Medicaid enrollees in Lane County were assigned to Primary Care Providers practicing out of recognized Patient Centered Primary Care Homes (PCPCH). This is up from just over 60% in 2014, due to Medicaid expansion. (Trillium Report, 2014, 15).

Access varies greatly throughout the county and some rural areas have the highest unmet need in the state. Lane County is ranked in the middle as far as the number physicians are available to the population overall, 80% or more of local physicians are concentrated in Eugene/Springfield. Communities in the Coastal Range and foothills and along the Highway 58 corridor have some of the highest unmet needs in the state. Surveyed community members identified the lack of access to physical, mental, and oral as the third biggest problem impacting the health in our community and that there is a shortage of health and social services, especially in rural communities and for vulnerable populations (i.e. rural, racial and ethnic minorities, homeless, LGBQT+, children and families, seniors, etc.).
Collaboration, Coordination, and Navigation

Our health is determined in part by the resources and supports available in our homes, neighborhoods, and communities. Community members stressed that the current system remains too difficult to navigate for many people. There is a need to improve communication between organizations and the public about available resources, and improve access to appropriate services for vulnerable populations. Many in Lane County – ranging from low-income persons to non-native English speakers seeking culturally responsive care in their primary language – struggle to get the services they need to be healthy and well. Community members and stakeholders identified services for vulnerable populations as one of the highest priorities for the community and its members to be healthy and thriving. Residents appreciate the organizations that provide critical services and resources in Lane County. However, there are still not enough health and social services to meet the growing needs of Lane County’s most vulnerable populations. When community members are linked with appropriate services, complex health and socioeconomic factors can be better addressed.

“We need more culturally and linguistically appropriate health care and human services.”
– CHNA Focus Group Participant

Community Assets

- Successful organizational collaborations and community partnerships.
- Social connectedness and community involvement.
- Community awareness of the social determinants of health and the broad perspective of health.
- An increased focus on prevention.
- The involvement of community organizations in service delivery.
- Solid interest and support for strengthening the local public health system.
- Healthy environments and recreational opportunities.
- Increased access to healthcare coverage.

“There is a lot of collaboration between organizations and community members in our community.”
- CHNA Focus Group Participant
Action Framework

This CHIP Action Framework reflects our vision of health and well-being as the sum of many parts, and our belief that combining these components is essential to improving population health and motivating community change. This framework demonstrates the interdependence of factors affecting health and is intended to focus efforts and mobilize an integrated course of action.

**VISION**
Working together to create a caring community where all people can live a healthier life.
Equity – Collaboration – Inclusion - Compassion

**ASSESSMENTS**
Community Health Status • Community Themes & Strengths • Forces of Change • Local Public Health System

**STRATEGIC ISSUE:**
How can we promote access to economic and social opportunities necessary to live a healthy life?

**STRATEGIC ISSUE:**
How can we promote healthy behaviors and engage the community in healthy living?

**GOALS:**
- Increase economic and social opportunities that promote healthy behaviors
- Increase healthy behaviors to improve health and well-being

**HEALTH OUTCOMES**
Improved Population Health, Well Being and Equity; Reduced, Managed Chronic Disease

We know it will take many partners to improve the health of Lane County, and it is our hope that this CHIP will help join individuals, organizations, and communities together to create a healthier place for everyone. As we make progress with the strategic issues outline in this CHIP, we believe Lane County will approach an outcome of improved population health, well-being and health equity. Achieving this will require sectors of the community to come together in new ways.
Strategies and Objectives

Strategies
Decades of research and practice have built an evidence base that point to effective approaches to improve the health of our community. Improving socioeconomic factors (e.g., poverty, education) and providing healthful environments (e.g., designing communities to promote access to healthy food) reinforce health across the community. Broad-based changes that benefit everyone should be supplemented by clinical services that meet individual health needs (e.g., mental health screening). Through health promotion, education, and counseling, we can provide people with the knowledge, tools, and options they need to make healthy choices.

The strategies and objectives described in this CHIP are based on information gathered from interviews and surveys conducted with key stakeholders and content experts, case study and evidence-based research, and local quantitative and qualitative data. These implementation strategies and objectives were selected based on their feasibility within the focus areas and their potential for adoption by the project partners and community.

This CHIP outlines seven multi-level, multi-sectoral, evidence-based strategies designed to improve the health and wellness of our community. The five-tier pyramid, shown on the following page, illustrates the impact of different types of strategies that will be implemented. The strategies addressing the socioeconomic factors that affect health make up the top of the pyramid. They have the greatest potential to affect health because they reach the entire population by making health resources readily available, ensuring the health care system is equipped to address health needs, and enacting policy that makes the healthy choice the default choice for the entire population. The strategies in the bottom two tiers of the pyramid commonly occur in a healthcare or social service setting. These interventions are essential to protect and improve an individual’s health, but they typically have a lesser impact on the entire population’s ability to achieve optimal health. Together, the strategies weave the web to help support community members in leading healthier lives.

Measuring Progress
The strategies are accompanied by a mix of measurable objectives, which were selected to illustrate progress and spark dialogue about the factors that influence and improve health. While the objectives set measurable targets for our region as a whole, it is critical that the activities and tactics carried out ultimately lead to a reduction of disparities. Historically underserved and disproportionately impacted communities will be prioritized when resource decisions are being made and when strategies are being designed.

The performance measures that have been identified have the evidence base necessary to lead to improved health and well-being. The measures are not meant to delineate every indicator of population health, but rather to represent key elements of possible change. These indicators will be used to measure progress toward creating a healthy community and to plan and implement future efforts. Key indicators will be reported for the overall population and by subgroups as data becomes available. Indicators and targets are drawn from existing measurement efforts. As data sources and metrics are developed or enhanced, key measures/indicators and targets will be updated.
GOALS
Increase economic and social opportunities that promote healthy behaviors.
Increase healthy behaviors to improve health and well-being.

STRATEGIES

- Support economic development by investing in workforce strategies that provide sustainable family wage jobs.
- Encourage a range of safe and affordable housing opportunities, including the development of integrated and supportive housing.
- Assure availability of affordable healthy food and beverages in every community.
- Strengthen cross-sector collaborations and align resources to improve the physical, behavioral, and oral health and well-being of our communities.
- Encourage organizations across multiple sectors to integrate health criteria into decision making, as appropriate.
- Encourage the implementation of programs to promote positive early childhood development and safe/nurturing environments.
- Support the implementation of evidence-based preventive screening and referral policies and services by physical, behavioral, and oral healthcare and social service providers.

*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*
Community Health Improvement Plan

**Strategic Issues**

- How can we promote access to economic and social opportunities necessary to live a healthy life?
- How can we promote healthy behaviors and engage the community in healthy living?

**Goals**

- Increase economic and social opportunities that promote healthy behaviors.
- Increase healthy behaviors to improve health and well-being.

**Equity Focus**

Ensure that activities are prioritized to positively impact underserved demographic groups and reduce health disparities. When making decisions, problem solving and taking action, it is important for us to consider equity and the impact on everyone in our community, especially those in underserved demographic groups.

**Long-term Outcomes**

<table>
<thead>
<tr>
<th>Improved:</th>
<th>Reduced:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mental/behavioral health</td>
<td>• Food insecurity</td>
</tr>
<tr>
<td>• Physical health</td>
<td>• Poverty</td>
</tr>
<tr>
<td>• Oral health</td>
<td>• Chronic disease</td>
</tr>
<tr>
<td>• Living wage jobs</td>
<td>• Preventable death and disease</td>
</tr>
<tr>
<td>• High school graduation rate</td>
<td>• Obesity and obesity-related disease</td>
</tr>
<tr>
<td>• Affordable housing</td>
<td>• Adverse Childhood Experiences</td>
</tr>
</tbody>
</table>

• Substance abuse
• Tobacco use and tobacco-related disease
• Suicide and depression
• Health disparities
INITIATIVE #1: SOCIAL AND ECONOMIC OPPORTUNITIES

STRATEGIES:

- Support economic development through investing in workforce strategies that provide sustainable family wage jobs in our communities.
- Encourage a range of safe and affordable housing opportunities, including the development of integrated and supportive housing.
- Promote availability of affordable healthy food and beverages in every community.

JUSTIFICATION

Investing in workforce strategies that support sustainable local businesses has many community benefits, including economic development (by providing new jobs and keeping money in the local economy), environmental sustainability, and food security. Specifically, the growth and re-localization of the food system has health, social, economic, and environmental impacts.

Safe and affordable housing serves as a platform for positive health, education and economic outcomes and is a crucial base in supporting resilient neighborhoods. Service-enriched housing helps the most vulnerable members of our communities to live a healthier life in a more stable environment.

As our community seeks to grow a more sustainable and equitable economy with healthy residents, ensuring that healthy food is accessible to all is crucial. Without access to healthy foods, a nutritious diet and good health are out of reach. Likewise, without grocery stores and other fresh food retailers, communities are also missing the commercial vitality that makes neighborhoods livable and helps local economies thrive.

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>PERFORMANCE MEASURE</th>
<th>BASELINE</th>
<th>2019 TARGET</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the percent of families with living wage jobs</td>
<td>Percent of families with incomes below the living wage</td>
<td>46% (2010-2014)</td>
<td>44%</td>
<td>ACS; MIT Living Wage Calculator</td>
</tr>
<tr>
<td>Increase the median household income</td>
<td>Median household income</td>
<td>$42,931 (2008-2013)</td>
<td>$43,779</td>
<td>ACS</td>
</tr>
<tr>
<td>Decrease the proportion of low-income households that spend more than 30% on housing</td>
<td>Proportion of cost burdened low-income households (household income less-than or equal to 30% Housing Urban Development Area Median Family Income)</td>
<td>76% (2012)</td>
<td>75%</td>
<td>Comprehensive Housing Affordability Strategy data</td>
</tr>
<tr>
<td>OBJECTIVES</td>
<td>PERFORMANCE MEASURE</td>
<td>BASELINE</td>
<td>2019 TARGET</td>
<td>DATA SOURCE</td>
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<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
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<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Increase the number of supportive housing units (integrating behavioral</td>
<td>Number of supportive housing units</td>
<td>537</td>
<td>553</td>
<td>HUD CoC Housing Inventory County Reports</td>
</tr>
<tr>
<td>health and primary care services)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the number of services (e.g. nutrition, employment/ training,</td>
<td>Number of services provided in supportive housing units</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>physical activity, screening/ healthcare) provided in supportive housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>units</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the percent of our collective food budget that is spent on foods</td>
<td>Proportion of school district's food budget spent on local foods</td>
<td>29.6%</td>
<td>36%</td>
<td>USDA Farm to School Census</td>
</tr>
<tr>
<td>grown, raised, and processed in our communities</td>
<td></td>
<td>(2013-2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of producers participating in farm direct marketing (farms selling</td>
<td>22.9%</td>
<td>23.6%</td>
<td>USDA Census of Agriculture</td>
</tr>
<tr>
<td></td>
<td>directly to the consumer)</td>
<td>(2012)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of total agricultural sales that are farm direct marketing sales</td>
<td>4.0%</td>
<td>4.5%</td>
<td>Oregon Dept. of Ag.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2012)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the proportion of the population that lives within close</td>
<td>Percent of population within close proximity to healthy food retail outlets</td>
<td>38.6%</td>
<td>39.8%</td>
<td>Lane County Health Mapping</td>
</tr>
<tr>
<td>proximity to healthy food retail outlet</td>
<td></td>
<td>(2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of low income (income below poverty threshold) population with low access</td>
<td>29%</td>
<td>28%</td>
<td>USDA Food Environment Atlas</td>
</tr>
<tr>
<td></td>
<td>to a supermarket, supercenter, or large grocery store. (&gt;1 mile urban, &gt;10 mile</td>
<td>(2010) [4.9% of total population; 17,141 people]</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>rural)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Farmers' markets/1,000 population</td>
<td>0.045</td>
<td>0.05</td>
<td>USDA Food Environment Atlas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2013) [count=16 markets]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the proportion of adults and youth that consume at least five</td>
<td>Percent of youth and adults who consume at least five servings of fruits/ veggies</td>
<td>8th</td>
<td>8th</td>
<td>Oregon Healthy Teens Survey; BRFFS</td>
</tr>
<tr>
<td>fruits/veggies per day</td>
<td>per day</td>
<td>22.7%</td>
<td>23.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>11th</td>
<td>19.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>17.8%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adults:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>23.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2013)</td>
<td></td>
<td></td>
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</table>

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INITIATIVE #2: HEALTHY BEHAVIORS

STRATEGIES:

- Encourage the implementation of programs to promote positive early childhood development and safe/nurturing environments.
- Support the implementation of evidence-based preventive screening and referral policies and services by physical, behavioral, and oral healthcare and social service providers.

JUSTIFICATION

Experiences in early childhood are extremely important for a child's healthy cognitive, social, emotional and physical development. Failure to prevent early adverse childhood experiences, such as poverty, abuse, or neglect, can impair healthy brain development, increasing social costs by exposing children to greater risk of academic failure and physical and mental health problems. Communities can promote positive early childhood development and safe/nurturing environments by making a variety of services and programs available.

Preventive screening and services can help improve the health of infants, children, and adults and promote healthy behaviors. By encouraging patients to take advantage of appropriate preventive services, diseases can be found early, when treatment works best.

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>PERFORMANCE MEASURE</th>
<th>BASELINE</th>
<th>2019 TARGET</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the proportion of children who are ready for school in the following domains of healthy development: social-emotional development, approaches to learning, language, and cognitive development</td>
<td>Kindergarten Assessment average scores (self-regulation and interpersonal skills)</td>
<td>Self-Reg: 3.5/5 Interpersonal Skills: 3.9/5 (2015-2016)</td>
<td>Self-Reg: 3.7 Interpersonal Skills: 4.0</td>
<td>Oregon Dept. of Education</td>
</tr>
<tr>
<td>Increase the availability of integrated primary care and behavioral health services, including School Based Health Centers (SBHCs)</td>
<td>Number of Tier 2 and 3 Primary Care Patient Centered Medical Homes (PCPCH)</td>
<td>30 Tier 3 PCPCH (based on Q3 2016 PCPCH data)</td>
<td>33</td>
<td>Trillium</td>
</tr>
<tr>
<td></td>
<td>Percentage of Medicaid members enrolled in a recognized PCPCH</td>
<td>82.4% (2015 performance)</td>
<td>90%</td>
<td>Trillium</td>
</tr>
<tr>
<td>OBJECTIVES</td>
<td>PERFORMANCE MEASURE</td>
<td>BASELINE</td>
<td>2019 TARGET</td>
<td>DATA SOURCE</td>
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<td>-------------</td>
</tr>
<tr>
<td></td>
<td>Utilization of School Based Health Centers</td>
<td>TBD</td>
<td>TBD</td>
<td>National Census of School Based Health Centers and OHA Public Health SBHC Program</td>
</tr>
<tr>
<td></td>
<td>Percent of SBHCs that are integrated</td>
<td>TBD</td>
<td>TBD</td>
<td>National Census of School Based Health Centers and OHA Public Health SBHC Program</td>
</tr>
<tr>
<td></td>
<td>Increase the number of individuals who receive screenings/ referrals/ services (e.g. developmental, SBIRT, well-care, oral care, tobacco cessation, mental health/suicide, BMI, food security, reproductive sexual health)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of children served by Trillium who receive developmental screening in the first 36 months of life</td>
<td>67.2% (2015)</td>
<td>73%</td>
<td>Trillium; Oregon Health Authority</td>
</tr>
<tr>
<td></td>
<td>Percent of Trillium members (ages 12 and older) who had appropriate screening and intervention for alcohol or other substance abuse (SBIRT)</td>
<td>12.7% (2015)</td>
<td>12.7%</td>
<td>Trillium; Oregon Health Authority</td>
</tr>
<tr>
<td></td>
<td>Percent of Trillium members (ages 12 and older) who had depression screening (PHQ9 or PHQ2)</td>
<td>23.5% (2015)</td>
<td>25%</td>
<td>Trillium; Oregon Health Authority</td>
</tr>
<tr>
<td></td>
<td>Percent of adolescents (ages 12-21) served by Trillium who had at least one well-care visit in the past year</td>
<td>37.8% (2015)</td>
<td>41.5%</td>
<td>Trillium; Oregon Health Authority</td>
</tr>
<tr>
<td></td>
<td>Percent of population who had a dental care visit in the last year</td>
<td>8th Graders: 74% 11th Graders: 72.7% Adults: 64.1% (2013)</td>
<td>8th Graders: 76.2% 11th Graders: 74.8% Adults: 65.3%</td>
<td>Oregon Healthy Teens Survey; BRFSS</td>
</tr>
<tr>
<td>OBJECTIVES</td>
<td>PERFORMANCE MEASURE</td>
<td>BASELINE</td>
<td>2019 TARGET</td>
<td>DATA SOURCE</td>
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<td>---------------------------------------------------------------------------</td>
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<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Percentage of adult Trillium member tobacco users advised to quit by their doctor</td>
<td>51.3% (2014)</td>
<td>56.4%</td>
<td></td>
<td>Trillium; Oregon Health Authority</td>
</tr>
<tr>
<td>Effective contraceptive use percentage among Trillium women members at risk of unintended pregnancy</td>
<td>36.6% (2015)</td>
<td>42.2%</td>
<td></td>
<td>Trillium; Oregon Health Authority</td>
</tr>
</tbody>
</table>
INITIATIVE #3: COLLABORATIVE INFRASTRUCTURE

STRATEGIES:

- Strengthen cross-sector collaborations and align resources to improve the physical, behavioral, and oral health and well-being of our communities.
- Encourage organizations across multiple sectors to integrate health criteria into decision making, as appropriate.

JUSTIFICATION

Creating a healthy community is a team effort and calls for mobilizing effective partnerships in order to identify and solve health problems. Collaboration across sectors such as education, business, transportation, and community development can play an essential role in the process. Cross-sector collaborations and aligning resources have the power to directly influence our community’s health.

A ‘Health in All Policies’ approach infuses health considerations and criteria into policy, planning, and program decisions. It also encourages collaboration with partners outside of the health care sector.

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>PERFORMANCE MEASURE</th>
<th>BASELINE</th>
<th>2019 TARGET</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the number of entities across a range of sectors contributing (e.g. staff, financial, other resources) to the CHIP</td>
<td>Number of hours and dollars contributed to the CHIP</td>
<td>Orgs that contributed to the 2013-2016 CHIP (Steering Committee or Workgroup): 31 (2016)</td>
<td>Orgs that contribute to the 2016-2019 CHIP: 50</td>
<td>Internal; Annual CHIP Survey</td>
</tr>
<tr>
<td>Increase the dollars to support common agenda goals</td>
<td>Dollars supporting common agenda goals: - External grants that align with the CHIP - Leveraged grants - Funds made available for community projects - Partner expenditures on CHIP initiatives</td>
<td>TBD</td>
<td>TBD</td>
<td>Internal; Annual CHIP Survey</td>
</tr>
<tr>
<td>OBJECTIVES</td>
<td>PERFORMANCE MEASURE</td>
<td>BASELINE</td>
<td>2019 TARGET</td>
<td>DATA SOURCE</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>-------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Establish a shared measurement system for the CHIP</td>
<td>Creation of a CHIP shared measurement system</td>
<td>0 (2016)</td>
<td>1</td>
<td>Internal</td>
</tr>
<tr>
<td>Improve the performance of the local public health system in delivering the ten Essential Public Health Services</td>
<td>Essential Public Health Services (EPHS) and Model Standards Scores</td>
<td>Average overall performance score: 50.3%</td>
<td>Average score: 55.6%</td>
<td>National Public Health Perf Standards Program: Local Public Health System Asses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EPHS #4: 61%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EPHS #4: 61%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the number of organizations across a range of sectors that formally adopt a “health in all policies” approach to decision making</td>
<td>Number of organizations that have a formally adopted “health in all policies” approach to decision making</td>
<td>1 (2016)</td>
<td>6 orgs across 3 sectors</td>
<td>Annual CHIP Survey</td>
</tr>
<tr>
<td>Increase the number of policies that support tobacco- and smoke-free environments and address the main drivers of youth tobacco use</td>
<td>Number of tobacco- and smoke-free environments</td>
<td>48 (2016)</td>
<td>53</td>
<td>Lane County Public Health</td>
</tr>
<tr>
<td></td>
<td>Number of policies that address the main drivers of youth tobacco use</td>
<td>56 (2016)</td>
<td>61</td>
<td>Lane County Public Health</td>
</tr>
</tbody>
</table>
Alignment

During the community health improvement planning process, the need for greater alignment of efforts was determined to be necessary in order to have the greatest impact on health. As such, this plan defines “alignment” as shared priorities, partnerships, and collaborative effort to reach goals. Alignment brings together a number of intersecting initiatives, all of which share common aims.

Based on the review of local public health data, it was determined that there are more similarities than differences in the health of our residents and that of the rest of the state. For this reason, and in order to align efforts at the state and local level to increase impact, the Live Healthy Lane team has worked to align our CHIP’s priorities and strategies with the Oregon State Health Improvement Plan, Healthy People 2020, and National Prevention Strategy. We would like to thank these health improvement planning teams for their leadership in this work.

The chart below demonstrates the alignment of the 2016-2019 Lane County Regional Community Health Improvement Plan strategies with local, state, and national health improvement priorities.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Local Plans</th>
<th>Oregon State Health Improvement Plan</th>
<th>Healthy People 2020</th>
<th>National Prevention Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support economic development through investing in workforce strategies that provide sustainable family wage jobs in our communities.</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Encourage a range of safe and affordable housing opportunities, including the development of integrated and supportive housing.</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assure availability of affordable healthy food and beverages in every community.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Strengthen cross-sector collaborations and align resource to improve the physical, behavioral, and oral health and well-being of our communities.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Encourage organizations across multiple sectors to integrate health criteria into decision making, as appropriate.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Encourage the implementation of programs to promote positive early childhood development and safe/nurturing environments.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Support the implementation of evidence-based preventive screening and referral policies and services by physical, behavioral, and oral healthcare and social service providers.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Next Steps

To oversee the CHIP’s implementation process, the Live Healthy Lane partnership will develop an implementation plan. The plan will be developed in collaboration with community members, consumers, and stakeholders and will outline the activities and a timeline to accomplish the goals in the CHIP. United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, and Trillium Community Health Plan will take the lead on implementing and tracking progress. The 100% Health Executive Committee will serve as the Steering Committee for the Community Health Improvement Plan and provide guidance and direction for its implementation. Along with the collaboration of community stakeholders, the four partnering organizations will:

- Track and evaluate progress made implementing the strategies.
- Periodically review the plan and propose changes when greater impact can be achieved by modifying approaches.
- Help form strategic new partnerships to carry out the CHIP.
- Create connections between this plan and other key plans and initiatives that have similar goals.

A key initial step in the implementation plan will be to identify partners with whom to collaborate in each of the plan’s priority areas. CHIP Action Teams focusing on particular initiatives will be established to complete more in-depth planning and to ensure successful implementation of strategies. Action Team members will have significant expertise on a specific issue and will include a mix of community partners and staff. When needed and as recommended, additional Task Forces will be established.

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing for the desired future, and a clear evaluation of whether the efforts are making a difference. The health of the community is ever changing, as are the priorities of its members. In response to the changing needs of the community, action plans will be annually reviewed and will be updated as needed to meet current needs and trends. This will allow us to track progress, celebrate achievements and change course when desired outcomes are not being met. We will produce an annual report, beginning in 2017.

While participating in the CHIP’s development, current and new partners demonstrated a great deal of enthusiasm for collaborating with United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, and Trillium Community Health Plan. This enthusiasm relates not only to the important goals outlined in the CHIP, but also to the spirit of partnership that is required to work together across sectors to improve the health and well-being of the community. We acknowledge that we cannot begin to do this work alone and we invite you to join us. We invite you to visit the Live Healthy Lane website at www.LiveHealthyLane.org to view updates about the work and learn more about participating.

Lastly, it is important to note that the CHIP priorities are not the only priorities that United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, and Trillium Community Health Plan will pursue. While each organization’s internal strategic plans contain key activities and programs that will be implemented to help achieve the CHIP goals, they also include many other important projects and priorities.
Summary

This Community Health Improvement Plan is the product of 15 months of collaboration between United Way of Lane County, Lane County Public Health, PeaceHealth Oregon West, and Trillium Community Health Plan, along with our partners and the communities we serve. The strategies and objectives outlined in this document are only the beginning stages of improving the health of the region. The community’s health is ever changing, as are the priorities of its members. In response to the changing needs, action plans will be annually reviewed and will be updated as needed to meet current needs and trends. We will produce an annual report, beginning in 2017, to share any successes or challenges we have encountered.

Community and organizational engagement is the most critical component of the community health improvement planning process. We are thankful to the thousands of community members and hundreds of organizations across our region who shared their time and expertise by attending the Community Health Visioning Session, the Live Healthy Lane: Defining Our Future event, participating in a focus groups, key informant interviews, completing the Community Health Survey, or evaluating potential strategies and otherwise providing input on the plan development. This health improvement planning process has only been possible because of the amazing participation from local organizations and the community. Thank you!

How Can You Help Improve Community Health?

Community health improvement is not a static process. We promote a cross-sector approach to community health planning and are therefore looking for a variety of agencies interested in partnering across the region to help develop recommendations, implement programs, and evaluate efforts. If you, or your organization, are one of the missing partners in the Lane County Regional CHIP please contact us to get more information about how you can help support our efforts to improve community health. We look forward to working together to create a caring community where all people can live a healthier life!

CONTACT
Web: www.LiveHealthyLane.org
Email: hamrhein@unitedwaylane.org
Phone: 541-741-6000.122
Acknowledgements

Thousands of community members and hundreds of organizations representing public, private and nonprofit groups contributed to the 2015/2016 Community Health Needs Assessment and development of the 2016-2019 Community Health Improvement Plan. The complete list of contributors can be found on Page 36. Their time, dedication and efforts are greatly appreciated. The following is a list of key contributors:

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Cascade Health Solutions

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Kaiser Permanente

Michelle Cady  
Cornerstone Community Housing

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McKenzie-Willamette Medical Center

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Trillium Community Health Plan

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Volunteers in Medicine

100% Health Safety Net Committee

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Oregon Medical Group

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RN Sacred Heart Medical Center

Willamette Family

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South Lane Mental Health

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Centro Latino Americano

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PeaceHealth Peace Harbor Medical Center

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PeaceHealth

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Trillium Community Health Plan

Jocelyn Warren  
Lane County Health and Human Services

Rick Yecny  
Trillium Rural Advisory Council
Thank you to all who participated in the 2015-2016 Community Health Needs Assessment and helped develop the 2016-2019 Community Health Improvement Plan. Thank you!

**HEALTH SYSTEM**
- Advantage Dental
- Bethel Health Center
- Cascade Health Solutions
- Community Health Centers of Lane County
- Cottage Grove Physical Therapy
- Emergency Veterinary Hospital
- Eugene Health Centers
- Healing Spirit Integrative Health Center
- Health Care For ALL Oregon
- Health Security Preparedness and Response
- Hope Family Health Clinic
- Kaiser Permanente
- Lane Community College Health Clinic
- Lane County Maternal and Child Health Programs
- Lane County Health and Human Services
- McKenzie Surgery Center
- McKenzie-Willamette Medical Center
- Occupy Medical
- Oregon Health Authority
- Oregon Heart and Vascular Rehab Program
- Oregon Home Care Commission
- Oregon Imaging Center
- Oregon Medical Group
- Oregon Research Institute
- PacificSource Health Plans
- PeaceHealth
- Planned Parenthood of Southwestern Oregon
- Rural Oregon Accessible Medicine
- Simard Chiropractic
- Slocum Center for Orthopedics & Sports Medicine
- Taylored Benefits
- Trillium Community Health Plan
- University of Oregon Health Center
- Volunteers in Medicine
- White Bird Clinic
- Willamette Dental Group

**BEHAVIORAL AND MENTAL HEALTH**
- Center for Family Development
- Direction Service
- HIV Alliance
- Lane County Behavioral Health
- Laurel Hill Center
- Lifestyle Changes
- Looking Glass Community Services
- National Alliance on Mental Illness (NAMI) of Lane County
- Options Counseling and Family Services
- Oregon Family Support Network
- Oregon Research Behavioral Intervention Strategies
- Serenity Lane
- Siuslaw Area Partnership to Prevent Substance Abuse
- Solutions Therapy, Consulting and Training
- South Lane Mental Health
- Trauma Healing Project
- Willamette Family Inc.

**GOVERNMENT**
- Board of County Commissioners
- City of Creswell
- City of Eugene
- City of Eugene Adaptive Recreation
- City of Eugene Planning & Development Department
- City of Eugene Public Works
- City of Eugene Senior Services
- City of Eugene: Recreation Services
- City of Florence
- City of Oakridge
- City of Springfield
- City of Veneta
- Community Health Centers of Lane County
- Congressman Peter DeFazio
- Department of Human Services
- Eugene City Council
- Lane Council of Governments (LCOG)
- Lane County Behavioral Health
- Lane County Government
- Lane County Health & Human Services
- Lane County Maternal and Child Health Programs
- Lane County Public Health
- Lane County Public Works
- Oregon Health Authority
- Oregon State Legislature
- Oregon's 4th Congressional District
- US Forest Services, Willamette National Forest
HUMAN SERVICES AND COMMUNITY ORGANIZATIONS
211 Info
90by30
A Community Together
Bethel Family Center
Brattain House Community Family Center
Centro Latino Americano
City of Eugene Adaptive Recreation
City of Eugene Senior Services
City of Eugene: Recreation Services
Coaching Parents
Cottage Grove Family Resource Center
Court Appointed Special Advocates (CASA)
CrossCultural Now
CrossFit Kin
Daisy CHAIN Mothering
Department of Human Services
Downtown Languages
Eugene Civic Alliance
Eugene Family YMCA
Eugene Public Library
Family Forward Oregon
Family Relief Nursery
Fern Ridge Community Dinner
FOOD for Lane County
Goodwill Industries
HealthFirst Financial
Healthy Moves
Hearing Loss Association of America
Huerto de la Familia
Institute for Patient- and Family-Centered Care
Kids’ FIRST Center
Lane County Commission for the Advancement of Human Rights
Lane Independent Living Alliance (LILA)
Lane Workforce Partnership
League of United Latin American Citizens
Marcola Family Resource Center
Mohawk-McKenzie Grange
NAACP - Eugene/Springfield Oregon
Oakridge Family Resource Center
Oakridge Kiwanis Club
Ophelia’s Place
Oregon Food Bank
Oregonians for Gambling Awareness Organization
Parent Partnership Comprehensive Programs
Parenting Now!
Pearl Buck Center
Pilas! Family Literacy Program
Planned Parenthood REVolution
Relief Nursery
School Garden Project of Lane County
Senior and Disability Services
ShelterCare
South Lane Family Resource Center
Sponsors
Springfield Public Library
St. Vincent de Paul
Stand For Children
Sustainable Cottage Grove
United Way of Lane County
Walterville Grange
Willamalane Park and Recreation District
Willamette Farm and Food Coalition
WomenSpace
Youth MOVE Oregon
EDUCATION
4J Eugene School District
Bethel School District
Creswell School District
Early Childhood CARES
Early Learning Alliance
Head Start of Lane County
Junction City School District
Lane Community College
Lane Community College Health Professions Division
Northwest Christian University
Northwest Youth Corps
Oregon Health and Science University
Oregon State University Extension
Siuslaw School District
South Lane School District
Springfield Public Schools
University of Oregon
Wilagillespie Elementary School
HOUSING
Cornerstone Community Housing
Housing and Community Services Agency (HACSA)
Housing Policy Board
Lane County Land Use Planning & Zoning
Oregon Housing and Community Services
Oregon Housing Alliance
Springfield/Eugene Habitat for Humanity
Viridian Management
Windermere
TRANSPORTATION
City of Eugene Transportation Options
Eugene and Springfield Safe Routes to School
Lane Transit District (LTD)
ECONOMIC DEVELOPMENT
Eugene Chamber of Commerce
Lane County Economic Development
Lane Workforce Partnership
Neighborhood Economic Development Corp. (NEDCO)
Upper Willamette Community Development Corporation
WorkSource Lane
FOUNDATIONS & PHILANTHROPY
AmeriCorps VISTA
Children’s Institute
Oregon Community Foundation
Slocum Research and Education Foundation
Taubert Foundation
United Way of Lane County
BUSINESSES
Banner Bank
Cross Cultural Now
Dean/Ross Associates
Emerald Aquatics
Eugene Water and Electric Board
Hawes Financial Group
Hershner Hunter
Lourdes Sanchez Attorneys at Law
Lunar Logic
Moss Adams LLP
Ninkasi Brewing Company
Pacific Continental Bank
Royal Caribbean Cruises Ltd
Sapient Private Wealth Management
Smith and Associates
US Bank

MEDIA
Rick Dancer Media Services
KEZI 9 News
KLCC
KMTR

CRIMINAL JUSTICE AND PUBLIC SAFETY/EMERGENCY SERVICES
Eugene Police Department
Eugene Springfield Fire Department
Johnson Johnson & Schaller, PC
Juvenile Recovery and Progress Court
Lane County Circuit Court
Lane County District Attorney's Office
Lane County Legal Aid & Advocacy Center
Lane County Sheriff's Office
Lane County Youth Services
Oregon Department of Corrections
Public Defender Services of Lane County Inc.
Springfield Police Department
US District Court, District of Oregon

FAITH
Centro de fe Community Church
Community Service Center
Discover the Power of Choice
First Christian Church
Power House Worship Center

COALITIONS & COMMITTEES
100% Health Community Coalition
100% Health Safety Net Committee
Alliance for Healthy Families
Be Your Best Cottage Grove
Bicycle and Pedestrian Advisory Committee
CHIP Equity Workgroup
CHIP Mental Health and Addictions Workgroup
CHIP Obesity Prevention Workgroup
CHIP Tobacco Prevention Workgroup
Coalition of Local Health Offices
Community Resource Network
DHS District 5 Advisory Committee
Early Childhood Mental Health Team
Early Learning Alliance
Early Learning Alliance Pediatric Advisory Group
Early Learning Stakeholders
Eugene Springfield Prevention Coalition
Family Resource Center Managers
Lane County Mental Health Promotion Steering Committee
Lane Equity Coalition
Mental Health Advisory/Local Alcohol and Drug Planning Committee
Patient and Family Advisory Council
PeaceHealth Health and Wellness Committee
Pediatric Advisory Group
Public Safety Coordinating Council - Adult Committee
Public Safety Coordinating Council - Youth Committee
Trillium Community Advisory Council
Trillium Rural Advisory Council
United Way Emerging Leaders
United Way Human Service Providers Forum

LANE COUNTY AND REEDSPORT COMMUNITY MEMBERS AND CONSUMERS
Glossary

10 ESSENTIAL PUBLIC HEALTH SERVICES
The 10 Essential Public Health Services, developed by representatives from federal agencies and national organizations, describe what public health seeks to accomplish and how it will carry out its basic responsibilities. The list of 10 services defines the practice of public health:
1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

ACCESS/ACCESS TO CARE
This is the extent to which a public health service is readily available to the community’s individuals in need, including the capacity of the agency to provide service in a way that honors the social and cultural characteristics of the community. It also focuses on agency efforts to reduce barriers to service utilization. “Access to care” refers to access in a medical setting.

ACCOUNTABILITY
Accountability is an obligation or willingness to be assessed on the basis of appropriate measures of actions and outcomes with regard to the achievement of workgroup/program/organization or policy purposes.

ACTION CYCLE
During Phase Six, Action Cycle, the community implements and evaluates action plans to meet goals, address strategic issues, and achieve the community’s vision.

BEHAVIORAL RISK FACTORS
Risk factors in this category include behaviors that are believed to cause, or to be contributing factors to most accidents, injuries, disease, and death during youth and adolescence as well as significant morbidity and mortality in later life.

CHRONIC DISEASES
These are diseases of long duration, generally slow progression, and can be multisymptomatic.

COMMUNITY
Broad community participation is vital to a successful MAPP process. Activities for each phase include specific consideration of ways to gain broader community member participation. This will ensure that the community’s input is a driving factor. For this CHIP, ‘community’ refers to all those who live, learn, work, or play in Lane County, Oregon and Reedsport, Oregon.
COMMUNITY ASSETS
Contributions made by individuals, citizen associations, and local institutions that individually or collectively build the community’s capacity to assure the health, well-being, and quality of life for the community and all its members.

COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)
A community health improvement plan is a three-year, systematic effort to address public health problems on the basis of the results of community health needs assessment activities and the community health improvement process.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)
A Community Health Assessment engages community members and local public health system partners to collect and analyze health-related data from many sources.

COMMUNITY MEMBER
This is anyone who works, learns, lives, or plays in Lane County, Oregon or Reedsport, Oregon.

CONSUMER
This is anyone who is the recipient of services or commodities.

DEMOGRAPHIC CHARACTERISTICS
Demographic characteristics of a jurisdiction include measures of total population as well as percent of total population by age group, gender, race and ethnicity, where these populations and sub-populations are located, and the rate of change in population density over time, due to births, deaths, and migration patterns.

ENVIRONMENTAL HEALTH INDICATORS
The physical environment directly impacts health and quality of life. Clean air, water, and safely prepared food are essential to physical health.

EVIDENCE-BASED
Supported by the current peer-reviewed scientific literature.

FORMULATE GOALS AND STRATEGIES
In Phase Five, Formulate Goals and Strategies, goals that the community wants to achieve are identified that relate to the strategic issues. Strategies are then identified to be implemented.

FOUR MAPP ASSESSMENTS
During Phase Three, Four MAPP Assessments, qualitative and quantitative data are gathered to provide a comprehensive picture of health in the community.

GOALS
Goals are broad, long-term aims that define the desired result associated with identified strategic issues.

HEALTH
This is a dynamic state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity.
HEALTH DISPARITY
Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by people who have historically made vulnerable by policies set by local, state, and Federal institutions. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), gender identity, or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.

HEALTH EQUITY
Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

HEALTH INEQUITY
Health inequities are differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.

HEALTH RISK
This is a condition of humans that can be represented in terms of measurable health status or quality-of-life indicators.

HEALTH STATUS
This is the current state of a given population using various indices, including morbidity, mortality, and available health resources.

IDENTIFY STRATEGIC ISSUES
In Phase Four, Identify Strategic Issues, the data are analyzed to uncover the underlying themes that need to be addressed in order for a community to achieve its vision.

INCIDENCE
This is the measure of the frequency with which new cases of illness, injury, or other health condition occur among a population during a specified period.

INDICATOR
This is a measure of health status or health outcome such as the number of people who contract a respiratory disease or the number of people who die from a particular chronic disease. Measures/data that describe community conditions (e.g., poverty rate, homelessness rate, number of food stamp recipients, life expectancy at birth, heart disease mortality rate) currently and over time.

INTERVENTION
An intervention is an action intended to improve a specific public health issue.

LOCAL PUBLIC HEALTH SYSTEM
This is the collection of public, private and voluntary entities, as well as individuals and informal associations, that contribute to the public’s health within a jurisdiction.
OBJECTIVES
An objective is a measurable target that describes specific end results that a service or program is expected to accomplish within a given time period. Objectives are time-bound and quantifiable or verifiable. They are action-oriented and focus on results. They help you track progress toward achieving your goals and carrying out your mission.

STAKEHOLDER
A stakeholder is anybody who can affect or is affected by an organization, strategy or project. Stakeholders can be internal or external.

STEERING COMMITTEE
This is the group that gives the MAPP process direction. The Steering Committee serves in a similar function as a board of directors and is representative of the local public health system. For this CHIP, the Steering Committee is the 100% Health Community Coalition Executive Committee.

STRATEGIES
Strategies are patterns of action, decisions, and policies that guide a local public health system toward a vision or goal.

STRATEGIC PLANNING
Strategic planning is a continuous and systematic process whereby an organization or coalition makes decisions about its future, develops the necessary procedures and operations to achieve that future, and determines how success is to be measured.

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)
This is a community-wide strategic planning process for improving public health.

NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS (NACCHO)
NACCHO’s vision is health, equity, and security for all people in their communities through public health policies and services. NACCHO’s mission is to be a leader, partner, catalyst, and voice for local health departments in order to ensure the conditions that promote health and equity, combat disease, and improve the quality and length of all lives.

OUTCOME
Outcome means a change, or lack of change, in the health of a defined population that is related to a public health intervention. A health status outcome is a change, or lack of change, in physical or mental status.

PERFORMANCE MEASURE
A performance measure is the specific quantitative representation of a capacity, process, or outcome deemed relevant to the assessment of performance.

PUBLIC HEALTH
This is the science and the art of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of the individual in principles of personal hygiene; the organization of medical and nursing service for the early diagnosis and treatment of disease; and the development of the social machinery to ensure to every individual in the community a standard of living adequate for the maintenance of health.
QUALITY OF LIFE
While some dimensions of quality of life can be quantified using indicators that research has shown to be related to determinants of health and community wellbeing, other valid dimensions of quality of life include the perceptions of community residents about aspects of their neighborhoods and communities that either enhance or diminish their quality of life.

SOCIAL DETERMINANTS OF HEALTH
Social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. They include the social environment, physical environment, and health services.

SOCIOECONOMIC CHARACTERISTICS
Socioeconomic characteristics include measures that have been shown to affect health status, such as income, education, and employment, and the proportion of the population represented by various levels of these variables.

STAKEHOLDERS
All persons, agencies, and organizations with an investment or “stake” in the health of the community and the local public health system. This broad definition includes persons and organizations that benefit from and/or participate in the delivery of services that promote the public’s health and overall wellbeing.

STRATEGIC ISSUE
Strategic issues are those fundamental policy choices or critical challenges that must be addressed for a community to achieve its vision.

STRATEGIC PLAN
This is a plan resulting from a deliberate decision-making process that defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward.

VISIONING
During Phase Two, Visioning, those who work, learn, live, and play in the MAPP community (Lane County, Oregon) create a common understanding of what it would like to achieve. The community decides the vision, which is the focus of the MAPP process.
<table>
<thead>
<tr>
<th><strong>Trillium Community Advisory Council (CAC) Charter</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE</strong></td>
</tr>
</tbody>
</table>
| **DATE CHARTERED** | Authorizing Charter: July 9, 2012  
Revision/Approval: June 2017 |
| **TIMELINE** | This is a standing/ongoing Council.  
The Charter will be reviewed annually in January by the CAC members. Any amendments will be brought first to the Trillium Community Health Plan Executive Committee (EC) for approval with final approval by the CCO Governing Board. |
| **MEETING FREQUENCY** | The CAC meets face-to-face at least every three months, and more frequently as needed.  
When necessary, members may participate remotely. Standing sub-committees or ad hoc work groups will meet as directed. |
| **SPONSOR** | Trillium Community Health Plan Governing Board. |
| **PURPOSE** | Engage Trillium Community Health Plan Members and the community as a whole to advise and make recommendations to the Governing Board on the strategic direction of the organization, ensure that Trillium remains responsive to consumer and community health needs, and advise on the design and priorities of Trillium in achieving the Triple Aim.  
Provide a link back to community members to aid in achieving the goals of the Triple Aim, with a focus on Trillium’s effectiveness in providing quality services that are accessible to all members. |
| **OVERSIGHT** | The CAC roles and responsibilities include:  
• Identifying and advocating for preventive care practices to be utilized by Trillium  
• Representing Trillium in a community-wide, collaborative Community Health Assessment and Community Health Improvement Plan  
• Publish an annual report on the progress of the community health improvement plan  
• In collaboration with the larger community effort, adopt the Community Health Improvement Plan to serve as a health blueprint for Trillium's strategic efforts, and develop recommendations for innovative, evidence-based initiatives  
• Work to assess and then make recommendations on how best to address issues related to health disparities, including linkages between medical and non-medical services, in conjunction with the Clinical Advisory Panel  
• Provide advice on strategies to effectively engage the community in transforming health care |
| **SCOPE** | All communities within the Eugene/Springfield area. |
| **OPERATING PRINCIPLES** | All members adhere to established team agreements/ground rules. CAC meetings are open to the public.  
The CAC will clarify its decision-making model prior to all decisions.  
To the best extent possible and where feasible, the CAC will seek input from other Trillium committees (such as the Clinical Advisory Panel, the Compensation Advisory Committee, the Finance Committee and the Rural Advisory Council) on proposals it is considering. This is to seek a broader perspective and is not intended as a requirement for approval from such committees prior to presenting to the Board. Likewise, the CAC will provide input to other committees regarding the impact of proposals under consideration on consumers and the community  
Recommendations will be presented to the Board for final approval prior to implementation. Fifty-one (51)% of CAC members constitutes a quorum. A quorum can act. All CAC members are voting members.  
Standing sub-committees will be established for:  
• Community Health Assessment & Community Health Improvement Plan  
• Health Disparities |
The Community Advisory Council is staffed with appropriate management and analytic services representation. The CAC will charter additional subgroups as well as convene ad hoc "project teams" as needed.

When conflicts arise, the members will discuss and resolve the conflict with the CAC Chair, with the support of staff. If unable to resolve, the CCO CEO will resolve the difference in the best interests of the Trillium Community Health Plan.

| CHAIR AND VICE CHAIR | The CAC will review a slate of nominees for Chair, from which it will select a Chairperson and Vice Chairperson. Both the CAC Chair and the CAC Vice Chair will hold their positions for a 2-year term. They may be nominated for reappointment for one additional term. The CAC Chair will represent the CAC in all matters. The CAC Chair is accountable for:  
| | • Convening and leading meetings  
| | • Developing, prioritizing and approving meeting agendas  
| | • Ensuring engagement of CAC members  
| | • Facilitating conflicts among CAC members  
| | • Providing leadership to CAC members  
| | • Ensuring regular communication to CAC members regarding decisions made by other groups that impact this CAC  
| | • Working with staff to provide monthly reports and recommendations to the Governing Board on behalf of the CAC  
| | • Oversight and facilitate establishment of CAC sub-committees and the CAC member who chairs them  
| The CAC Vice Chair is accountable for:  
| • Partnering with the CAC Chair to achieve the duties listed above.  
| • Covering the duties of the Chair in his/her absence |

| CAC REPRESENTATIVES TO THE TRILLIUM BOARD | The CAC shall appoint two CAC members to represent the Council on the governing board of Trillium Community Health Plans. One of the representatives shall be a consumer member of the CAC, and the other a non-consumer, community leader member of the CAC. These representatives shall be full voting member of the Board of Directors and are responsible for ensuring good two-way communication between the CAC and the governing board regarding CAC activities and recommendations, as well as assisting the governing board in its work to communicate with the larger Lane County community. |

| MEMBER ACCOUNTABILITY | Each council member is responsible for fully and actively participating on the team in order to achieve the goals of the team as described in this Charter—accepting his/her responsibilities diligently and carrying his/her share of the team's work.  
| • The members should define and advocate for innovation  
| • The members should act as a liaison for the community and for their individual groups  
| • The members should look for avenues to transform care  
| • The members should have commitment to the community and the CCO |

| CAC MEMBERSHIP | The CAC will be appointed in accordance with ORS 414.625, including the requirement that a majority of CAC members be consumers. This means that more than half of the CAC members must be Oregon Health Plan (OHP) members or parents of children enrolled on OHP at time of appointment to the CAC. |
The CAC includes 20 members, including:

- Rural OHP Members (representing West Lane, South Lane, and East Lane)
- At-large OHP Members
- OHP Members representing other community advisory groups and commissions
- Lane County representatives of Health & Human Services divisions linked to healthcare transformation (not subject to term limits)
- Other health and human services system partners
- A community leader from outside the healthcare system
- A representative with research and evaluation expertise
- A representative with marketing/public relations/media expertise
- A representative appointed by the Clinical Advisory Panel (not subject to term limits)

**SELECTION PROCESS**

The CAC and staff will work together to publicly announce vacancies on the CAC and solicit applications for membership. A committee of equal representation from Lane County and from the Trillium Board of Directors will interview applicants and select individuals to serve on the CAC. Recommendations for appointments will be made to the Trillium Board of Directors, who will make final approval.

**TERMS**

The following seats are not subject to term limits:

- Lane County representatives of Health & Human Services divisions linked to healthcare transformation
- A representative appointed by the Clinical Advisory Panel.

All other council members serve a term of 2 years and will not serve more than 3 consecutive terms. Council members that have termed out of membership may continue attending meetings as a non-voting community member and reapply for membership after one year, if interested. Terms will be staggered to provide for both turnover and continuity in committee membership.

**Annual Recruitment**

The CAC Chair is responsible for ensuring CAC member vacancies are announced in April.

The nominating and selection process takes place in May, with new member recommendations presented to the Governing Board in June. The selection process is concluded in June to ensure new members effective start date is July 1.

**Special Circumstances**

1. In the event a recruitment effort does not result in any new member applications the terms of current members may be extended for the length of one term
2. In the event a member cannot complete their term the Committee Chair may initiate a recruitment to fill the vacant slot. Once a replacement is chosen, they will serve until the original member’s term is complete. At that time, if the replacement wishes to continue as a member and is in good standing with the Committee, they may be appointed to the Committee. The partial term served shall not count towards their term limit.

**MONITORING EFFECTIVENESS**

The CAC will submit monthly written reports to the Board of Directors related to the Council's work plan, progress and recommendations. Annually, the CAC will publish a report to the community regarding the Community Health Improvement Plan and progress in meeting the goals outlined in the plan.
SCOPE: Trillium Community Health Plan (Plan) Medical Management, Behavioral Health, Dental and Member Service departments.

PURPOSE: To outline covered benefits and services offered to Trillium members.

POLICY:
1. Trillium, at a minimum, provides benefits and services that are covered services and benefits as defined by the Trillium contract and the State’s Medicaid Policies, Billing Instructions, Member Handbook, and Provider Manuals, as applicable. All services must be reasonable and medically necessary for the diagnosis or treatment of an illness or injury. Preventive care and certain screening tests are also covered under the benefit plan.

2. Trillium does not require Prior Authorization for Emergency Services nor limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

3. Trillium provides an after-hours call-in system to Triage Urgent Care and Emergency Service calls, consistent with OAR 410-141-3140.

4. Trillium does not deny services based on moral or religious grounds.

5. Medically necessary services are furnished in an amount, duration, and scope that are no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-service Medicaid, unless otherwise specifically excluded under the Contract.

6. Trillium permits out of network Indian Health Care Provider’s (IHCPs) to refer a CCO-enrolled Indian to a network provider for covered services as required by 42 CFR 438.14(b)(6).

7. Trillium provides to members all dental covered services within the scope of the member’s benefit package of dental services, in accordance with OAR Chapter 410 Division 141 applicable to Dental Care Organization’s (DCOs) and with the terms of the CCO contract.
8. Trillium provides staff training regarding the delivery of covered services, applicable administrative rules, and Trillium’s administrative policies.

9. Trillium requires prior authorization and/or certification of specific covered benefits and services as outlined in the Prior Authorization List.

10. Contractor is responsible for Covered Services for Fully Dual Eligible Medicare and Medicaid Members. Contractor shall pay for Covered Services for Members who are Fully Dual Eligible in accordance with applicable contractual requirements that include CMS and OHA.

11. An individual becomes a Member as of the date of enrollment with Trillium, on which date, Trillium will provide all covered services applicable to their member benefit package. If a person becomes a Member on the same day they are admitted to the hospital or, for children and adolescents admitted to Psychiatric Residential Treatment Services (PRTS), Trillium is responsible for said services.

PROCEDURE:
I. Covered Benefits and Services

1. Trillium provides, at a minimum:

   1.1. Those Covered Services that are Medically Appropriate and are described as funded Condition/Treatment Pairs on the Health Evidence Review Commission (HERC) Prioritized List of Health Services.

   1.2. Trillium may not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition, subject to the Prioritized List of Health Services.

   1.2.1. Before denying treatment for a condition that is below the funding line of the Prioritized List of Health Services, the Plan shall review any submitted documentation of a disability or co-morbid condition to determine whether the member has a funded condition/treatment pair that would entitle member to treatment.
1.3. Trillium notifies the Oregon Health Authority Transplant Coordinator of all transplant Prior Authorizations. Trillium uses the same limits and criteria for transplants as those established in the Transplant Services Rules, OAR Chapter 410 Division 124.

1.3.1. Trillium is prohibited from paying for organ transplants unless the State Plan, Section 1903(i), provides and Trillium follows written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Members.

1.4. Diagnostic services that are necessary and reasonable to diagnose the presenting condition, regardless of whether or not the final diagnosis is covered.

1.5. Treatment, including ancillary services, which is included in or supports the condition/treatment pairs that are above the funding line on the Prioritized List of Health Services.

1.6. Preventive services, which are those services promoting physical, oral and mental health or reducing the risk of disease or illness. Services include, but are not limited to, periodic medical examinations based on age, gender and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors.

1.7. Coverage for any hospital length of stay for labor/delivery will not be restricted to less than 48 hours following a normal vaginal birth or less than 96 hours following a cesarean section. An exception to the minimum length of stay may be made by the physician in consultation with the mother, which must be documented in the clinical record.

1.8. Emergency Services

1.8.1. Trillium covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with Trillium, as provided for in OAR 410-141-3140.

1.8.2. Trillium covers and pays for services to treat a member with an emergency medical or dental condition, including cases in which the absence of immediate
1.8.3. Trillium covers and pays for post stabilization services as provided for in OAR 410-141-3140 and 42 CFR 438.114. Trillium is financially responsible for post stabilization services obtained within or outside the provider network that are pre-approved by a participating provider or other contractor representative as specified in 42 CFR 438.114©(1)(ii)(B). Trillium limits charges to members for post stabilization services to an amount no greater than what the provider would charge the member for the services obtained within the provider network.

1.8.4. Trillium covers post stabilization services administered to maintain, improve, or resolve the member’s stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within Trillium’s network, when Trillium could not be contacted for pre-approval, or did not respond to a request for pre-approval within one hour.

1.8.4.1. Trillium covers post-stabilization services it has not pre-approved until the member is discharged, consistent with the requirements of 42 CFR 438.114.

1.8.5. Trillium will cover and pay for subsequent screening and treatment needed to diagnose the specific condition, or to stabilize the member. The treating provider is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

1.8.6. Trillium will not deny coverage of emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care provider of the member’s screening and treatment within 10 days of presentation for emergency services as specified in 42 CFR 438.114(c)(1)(ii).

1.8.7. Trillium will cover and pay for treatment obtained when a representation of the plan instructs the member to seek emergency services as specified in 42 CFR 438.114.

1.9. If Trillium is unable to provide necessary covered services, including physical health, behavioral health (which includes mental health and substance use disorders), and dental services which are culturally and linguistically and medically appropriate to a particular
member within our provider panel, Trillium will adequately and timely cover these services out of network for the member, for as long as Trillium is unable to provide them. Non-participating providers must coordinate with Trillium with respect to payment. Trillium ensures the cost to the member is no greater than it would be if the services were provided within the provider panel.

1.10. Trillium provides female members with direct access to women’s health specialists within the provider network for covered services necessary to provide women’s routine and preventive health care services. This is in addition to the member’s designated PCP if the designated PCP is not a women’s health specialist.

1.11. Trillium may cover and reimburse inpatient psychiatric services, but not including substance use disorder treatment, at an Institution for Mental Diseases, as defined in 42 CFR 435.1010, provided: (i) the facility is a hospital providing inpatient psychiatric services; and (ii) the length of stay is no more than 15 days during the period of the monthly Capitation Payment. The provision of inpatient psychiatric treatment in an IMD must meet the requirements for in lieu of services at §438.3(e)(2)(i) through (iii). Trillium must offer the Member the option to access the state plan services in accordance with OAR 410-141-3160 (10).

Limits may apply based on member benefit package:

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### Policy and Procedure

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- 2J.2 Trillium MC Transplant Workflow
- CC.UM.18 Transplant Service Authorizations Policy & Procedure
- CC.UM.18.07 Identification and Communication of Transplant Related Services Work Process
- CC.UM.03.03 Coordination Between HP and NurseWise
**DEFINITIONS:**

**Co-morbid Condition:** A condition that is funded on the Prioritized List of Health Services that will be improved if a non-funded condition is treated. If a co-morbid condition exists, approval for treatment of a non-funded condition will be reviewed by clinical staff without regard to its non-funded status.

**Covered Services:** Those medically necessary health care services provided to members, the payment or indemnification of which is covered under the State contract.

**Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to pregnant women, the health of the woman or unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

**Emergency Medical Services:** Covered inpatient and outpatient services furnished by a qualified provider, that are needed to evaluate or stabilize an emergency medical condition found to exist using prudent layperson standard.

**Medically Appropriate:** The Plan shall be responsible for providing covered services sufficient in amount, duration, and scope to reasonably achieve their purpose, which includes (1) the prevention, diagnosis and treatment of health impairments; (2) the ability to achieve age-appropriate growth and development; and (3) the ability to attain, maintain or regain functional capacity. Medically appropriate services are provided in accordance with accepted standard of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting. Services may be limited by medical necessity. Criteria used for medically appropriate determinations with respect to benefit package for physical health, behavioral health and oral health will be made available to any member, potential member or participating provider, upon request.

**Member:** An individual becomes a Member as of the date of enrollment with the Plan, on which date, the Plan will provide all covered services applicable to their member benefit package. If a person becomes a Member on the same day they are admitted to the hospital or, for children and adolescents admitted to Psychiatric Residential Treatment Services (PRTS), the Plan is responsible for said services.

**Post Stabilization Services:** Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.
**Policy and Procedure**

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<tr>
<td>5/10/2016</td>
<td>OR.MM.159</td>
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**Revision Log**

<table>
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<th>Revision</th>
<th>Date</th>
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<tbody>
<tr>
<td>Established this NEW Policy and Procedure to be in compliance with State of Oregon Medicaid contract.</td>
<td>5/2016</td>
</tr>
<tr>
<td>Annual Review. No updates required.</td>
<td>6/2017</td>
</tr>
<tr>
<td>Inserted Para 1.2: Trillium may not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition, subject to the Prioritized List of Health Services. Required for CCO contract Exhibit B- Statement of Work 2. Provision of Covered Service and Megarule 438.210(3)(ii)</td>
<td>7/6/2017</td>
</tr>
<tr>
<td>Addition to Policy Section Per 2018 CCO Contract: Trillium permit’s out of network IHCPs to refer a CCO-enrolled Indian to a network provider for covered services as required by 42 CFR 438.14(b)(6). Update of CCO/OHP Contract Sections under “References”. OAR list verified. Trillium does not require Prior Authorization for Emergency Services nor limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Addition per CCO/OHP 2018 contract: Trillium provides an after-hours call-in system to Triage Urgent Care and Emergency Service calls, consistent with OAR 410-141-3140.</td>
<td>1/23/2018</td>
</tr>
<tr>
<td>Added numbers to paragraphs under “Policy” section for clarity in citing. Addition of paragraph 11 under Policy section to meet CCO/OHP 2018 Contract B.3.6. Enrollment and Disenrollment. Note: Para 11 is same language as in “Member” Definition section.</td>
<td>2/22/2018</td>
</tr>
<tr>
<td>Added procedure section 1.8: Emergency Services. Added language in CCO Contract section B.2.4.a with the addition of subsections 1.8.2, 1.8.4.1, 1.8.5, 1.8.6, and 1.8.7. Updated references section to include these areas of the CCO contract and 42 CFR 438.411. Included Behavioral Health and Dental to scope statement.</td>
<td>4/03/2018</td>
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<tr>
<td>Annual Review. No changes.</td>
<td>12/10/2018</td>
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**Policy and Procedure Approval**

The electronic approval is retained in Compliance 360
### POLICY AND PROCEDURE

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<th>DEPARTMENT:</th>
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Director of Department: Approval on file

Vice President of Department: Approval on file
POLICY AND PROCEDURE

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<tr>
<td>Operations- Claims</td>
<td>Medicaid Enrollment Practices</td>
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SCOPE: Medicaid Enrollment

PURPOSE: To provide compliance with State and Federal enrollment requirements and to provide services beginning on the date an individual becomes a member.

POLICY: Medicaid line of business:

1. Enrollment for the Medicaid line of business follows the open-enrollment guidelines which provide enrollment opportunity at all times.
2. Trillium’s enrollment and disenrollment practices do not discriminate on the basis of sex, sexual orientation, gender identity, and disability, or any factor including, but not limited to, the following and does not request disenrollment of any member for the following reasons:
   2.1.1 Medical condition, mental condition, or physical illness.
   2.1.2 An adverse change in health.
   2.1.3 Diminished physical, intellectual, developmental or mental capacity.
   2.1.4 Claims experience.
   2.1.5 Receipt of health care.
   2.1.6 Medical history.
   2.1.7 Genetic information.
   2.1.8 Evidence of insurability, including conditions arising out of acts of domestic violence.
   2.1.9 Disability.
   2.1.10 Race and ethnicity.
   2.1.11 Gender, gender identity and sexual orientation.
   2.1.12 Financial status.
   2.1.13 Uncooperative or disruptive behavior resulting from the member’s special needs, a disability or any condition that is a direct result of their disability.
3. Trillium will not use any policy or practice that has the effect of discriminating on the basis of:
   - Race
   - Color, or national origin
• Sex
• Sexual orientation
• Gender Identity
• Or disability

PROCEDURE:
1. Trillium ensures that all covered services are available, accessible, and payable at the time the member become eligible and throughout the time the member is eligible under the plan.
   1.1 For persons enrolled on the same day as admitted to a hospital or psychiatric residential treatment center, services are covered
   1.2 Any discrepancy in enrollment is validated against the State MMIS system
2. Trillium is no longer responsible for providing service at the time of member’s disenrollment or termination from the plan.
   2.1 Except in the case of an inpatient stay for which the plan was responsible at the time of admit.
3. If at any time it is discovered that disenrollment occurred due to an illegal act by member or provider, the information would be reported to OHA office of Payment Accuracy and Recovery.
4. Reconciliation of the OHA 834 monthly enrollment transaction file is completed each month against the Health Information System.
   4.1 Finding are documented on the Enrollment Reconciliation Certification form and submitted to the OHA Enrollment Reconciliation Coordinator within 14 days of receipt of the monthly 834 enrollment transaction file.
   4.2 Discrepancies, if found are corrected prior to receipt of the next monthly enrollment transaction file.
5. Trillium will verify eligibility for fully dual eligible members via the State MMIS Web portal.
**DEFINITIONS:** Define terms used in the P&P

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<tr>
<td>Added #5. To policy</td>
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<td>Revised #2 to include sex, sexual orientation, gender identity, and disability. Revised #2.1.11 to include gender identity and sexual orientation. Added #3.</td>
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<td>Annual review, no changes</td>
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**POLICY AND PROCEDURE APPROVAL**

The electronic approval is retained in Compliance 360

Director of Department: Approval on file

Vice President of Department: Approval on file
POLICY AND PROCEDURE

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<th>DEPARTMENT:</th>
<th>DOCUMENT NAME:</th>
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<tr>
<td>Compliance</td>
<td>Notification of Member Rights and Responsibilities</td>
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<td>ALL</td>
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SCOPE: All Workforce, Contracted Providers, Practitioners and their Workforce.

PURPOSE: Methods used to ensure members of Trillium are aware of their rights and responsibilities, information is provided regarding Member Rights and Responsibilities several times during their enrollment.

POLICY: To provide Member Rights and Responsibilities information to all Trillium workforce members, all contracted providers, practitioners and their staff members.

PROCEDURE:

1. Trillium members receive a Member Handbook or Evidence of Coverage, which includes the Trillium Member Rights and Responsibilities Statement, upon initial enrollment, annually during their enrollment with Trillium and upon request any time during their enrollment.

2. Trillium workforce members are trained on Member Rights and Responsibilities during new employee orientation. In addition, workforce training of the Member Rights and Responsibilities Statement is conducted annually.

3. To ensure Trillium providers, practitioners and their staff have a clear understanding of Trillium Member Rights and Responsibilities, providers and practitioners receive the Trillium Member Rights and Responsibilities Statement in the provider manual upon initial contract finalization, annual contract renewal and upon request.

4. Trillium posts the Trillium Member Rights and Responsibilities Statement and the Trillium Member Rights and Responsibilities Policy on our Member and Provider websites. Information regarding how to find the Rights and Responsibilities Statement on the website is provided to members in the annual National Committee for Quality Assurance (NCQA) member newsletter and providers in the provider manual.

REFERENCES

List Federal regulations, state contract reference or other related P&Ps

| 42 CFR | 438.100 |
| NCQA   | RR 1: A Rights and Responsibilities Statement |
| OR.COMP.140 | RR 1: B Distribution of Rights Statement |
| OAR    | 410-141-0320 |
# TRILLIUM COMMUNITY HEALTH PLAN
## RESPONSE TO RFA OHA #4690-19 – CCO 2.0
### ATTACHMENT 10 – NOTIFICATION OF MEMBER RIGHTS AND RESPONSIBILITIES POLICY AND PROCEDURE

## POLICY AND PROCEDURE

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### Related Materials

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<tr>
<th>Trillium Exchange Member Rights and Responsibilities Statement</th>
<th>Trillium Exchange Member Website</th>
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<tr>
<td>Trillium Medicaid Member Rights and Responsibilities Statement</td>
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<tr>
<td>Trillium Medicare Member Rights and Responsibilities Statement</td>
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### ATTACHMENTS:

- Medicare Member Rights and Responsibility Statement
- Trillium Exchange Member Rights and Responsibility Statement
- Medicaid Member Rights and Responsibility Statement

### DEFINITIONS: Define terms used in the P&P

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Member</td>
<td>A person insured or otherwise provided coverage by Trillium. For purpose of this procedure, a reference to member means a member, member’s representative, or representation of a deceased member’s estate.</td>
</tr>
<tr>
<td>Practitioner</td>
<td>A professional who provides healthcare services. Practitioners are usually licensed as required by law (e.g., Physicians, Optometrists, Physician Assistants, Advanced Practice Nurses, Certified Nurse Anesthetists, Certified Nurse Midwives, Podiatrists, Chiropractors, Physical Therapists, Psychologists).</td>
</tr>
<tr>
<td>Provider</td>
<td>An institution or organization that provides services for health plan members (e.g., hospitals, home health agencies, laboratories, durable medical equipment vendors, long-term care facilities).</td>
</tr>
<tr>
<td>Vendor</td>
<td>An individual or entity that supplies goods or services.</td>
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</table>

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Attachment 10
2

Attachment 10
16
**REVISION LOG**

<table>
<thead>
<tr>
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**POLICY AND PROCEDURE APPROVAL**

The electronic approval is retained in Compliance 360

Director of Department: Approval on file

Vice President of Department: Approval on file
SCOPE: Staff supporting the members of the CCO and the Medicaid program.

PURPOSE: To define the policy and process followed in development and dissemination of the Medicaid Member Handbook.

POLICY: Trillium develops, maintains and provides the CCO member handbook in accordance with the Medicaid contract with the Oregon Health Authority (OHA), and the Oregon Administrative Rules.

Member handbooks incorporate all of the requirements as outlined in Exhibit J of the Medicaid contract. Member handbooks are developed by Trillium that meet the Flesch-Kincaid standard and are available in the prevalent languages in Lane and Douglas County. In compliance with the Americans with Disabilities Act Trillium provides the handbook and all written materials in alternate formats of communication including, Braille, large print, audiotape, electronic format and can be provided by oral presentation. All members and potential members are made aware of the availability of alternative formats.

Trillium reviews and updates the handbook annually, and when material changes in benefits occur. All handbook changes are submitted by Trillium to the DMAP Materials Coordinator for approval.

Member handbooks are mailed within 14 days of receiving OHA enrollment files for all new members (including those that are Fully Dual Eligible), and for those re-enrolling in the plan after 6 months of disenrollment. Handbooks are available in print, on the website and can be sent electronically based on member preference. On an annual basis Trillium will notify members of their right to request a handbook.

Notices of any Material Change in benefits and provider access will be provided to members 30 days prior to the intended effective date, or as soon as possible if the participating provider has not given Trillium sufficient notice to meet the 30 day notice requirement.
POLICY AND PROCEDURE

DEPARTMENT: Marketing

DOCUMENT NAME: CCO Member Handbook

PAGE: 2 of 4

REPLACES DOCUMENT:

APPROVED DATE: 02/26/2016

RETIRED:

EFFECTIVE DATE: 02/26/2016

REVIEWED/REVISED: 02/26/2016; 12/06/2016

PRODUCT TYPE: Medicaid

REFERENCE NUMBER: OR.MRKT.101

PROCEDURE:

1. Annually, the Medicaid Product Lead routes an electronic copy of the current Trillium OHP Member Handbook to appropriate Trillium Medicaid departments for review and update. Those departments include:
   1.1. Compliance
   1.2. Medical Management
   1.3. Operations
   1.4. Provider Affairs
   1.5. Quality Management
   1.6. Trillium Behavioral Health

2. Staff within each department will review the handbook and make revisions using “Track Changes” as needed.

3. Proposed updates and changes are reviewed and accepted as necessary (highlighting changes in yellow as they are made). Upon completion of edits and highlighting, the documents proposed updates in a separate document and re-routes Member Handbook, proposed updates are documented, and an ECAR is sent to each department for review of revisions and approval signatures.

   3.1. Step 3 is repeated until all departments have signed approvals and no additional edits are necessary.

4. Upon receipt of approval signatures, the Compliance Coordinator forward the updated/highlighted Member Handbook, proposed updates document and ECAR to Document Coordinator.

5. The Document Coordinator submits Member Handbook and proposed updates document to Department of Medical Assistance Programs (DMAP) reviewer for final review and approval.

   5.1. Following review by DMAP changes are made as requested
   5.2. Upon notification of DMAP approval, Compliance Coordinator:

       5.2.1. Notes approval date on the Handbook;
5.2.2. Archives Member Handbook and ECAR form in Glossary files; and,
5.2.3. Forwards approved Member Handbook to the Medicaid Product Lead

6. Preparation for posting to the website and printing
   6.1. The Compliance Coordinator sends the approved Member Handbook to the
   Marketing Department for print and upload to the Trillium website;
   6.2. Translation formats are determined for Lane and Douglas County by the Compliance
   Coordinator
   6.3. Completes an ECAR for each alternate format/non-English translation needed;
   6.4. Forwards ECAR to the Medicaid Program Director for approval signature;
   6.5. Forwards completed ECAR to Compliance Coordinator for submission to translation
   service; and,
   6.6. Develops Large Print handbook.
7. Upon completion of translation or formatting, the Compliance Coordinator sends
   translated/reformatted Member Handbooks to the Compliance Coordinator.
8. The Compliance Coordinator sends revised handbook English, non-English, and alternative
   formats to Marketing.
9. Marketing sends Member handbooks to print and to Graphics/Web Designer for upload to
   the Trillium website.
10. Final Member Handbooks are mailed out to members as needed.

REFERENCES:
Oregon Health Authority Medicaid – Trillium Contract
Exhibit J Oregon Health Authority Medicaid Contract
OAR 410-141-3300
OAR 410-141-3280
42 CFR 438.10
42 CFR 438.10 (g)
42 CFR 438.10(f)(6)
42 CFR 438.10(f)(4)
POLICY AND PROCEDURE

DEPARTMENT: Marketing
DOCUMENT NAME: CCO Member Handbook
PAGE: 4 of 4
REPLACES DOCUMENT:

APPROVED DATE: 02/26/2016
RETIRED:
EFFECTIVE DATE: 02/26/2016
REVIEWED/REVISED: 02/26/2016; 12/06/2016
PRODUCT TYPE: Medicaid
REFERENCE NUMBER: OR.MRKT.101

42 CFR 438.10(f)(6)

ATTACHMENTS: List attachments

DEFINITIONS:
- CCO: Coordinated Care Organization
- OHA: Oregon Health Authority
- Alternative Format: Any format other than the standard written format, including large print, audio, Braille and other formats as identified.
- Non-English Format: Format requiring language translation by translation service provider
- External Communication Approval Request Process (ECAR): The formal process for obtaining internal review and approval of documents sent to members, which utilizes the ECAR form.

REVISION LOG

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POLICY AND PROCEDURE APPROVAL

The electronic approval is retained in Compliance 360

Director of Department: Approval on file

Vice President of Department: Approval on file
SCOPE: Managers and Trillium Provider Website

PURPOSE: Neither Trillium Community Health Plan (Trillium) nor any of its contracted providers will deny, limit, or condition the coverage or furnishing of benefits to Trillium members on the basis of any factor related or not related to health status.

POLICY: Guidance to assure Trillium and Trillium's contracted providers do not deny, limit, or condition the coverage or furnishing of benefits to Trillium members on the basis of any factor related or not related to health status.

1. Trillium and Trillium's contracted providers do not deny, limit, or condition the coverage or furnishing of benefits to Trillium members on the basis of any factor related or not related to health status including, but not limited to:
   1.1. Medical condition, mental condition, or physical illness
   1.2. Claims experience
   1.3. Receipt of health care
   1.4. Medical history
   1.5. Genetic information
   1.6. Evidence of insurability, including conditions arising out of acts of domestic violence
   1.7. Mental or Physical Disability
   1.8. Race, color, ethnicity or national origin
   1.9. Ancestry
   1.10. Age
   1.11. Gender
   1.12. Religion
   1.13. Source of payment
   1.14. Sexual orientation or marital status
   1.15. Any other characteristic or classification deemed protected under state or federal law
   1.16. Trillium Illegal Drug Use

2. Trillium provides employees with training in cultural competency,

3. Trillium ensures member access to interpreter services.
4. Trillium monitors and investigates member complaints and concerns involving discriminatory practices.

4.1. Should an investigation find wrongdoing, the contracted provider or employee will be subject to sanctions, up to and including termination of employment or contract, in accordance with Trillium’s policies and procedures.

5. Trillium requires that contracted providers convey information about treatment options (including the option of no treatment) in a culturally competent manner.

6. Contracted providers must ensure that individuals with disabilities have opportunities for effective communication throughout the health system when making decisions regarding treatment options.

Trillium communicates no less than yearly, its commitment to equal access to health care and services through the member handbook, the website and member-specific communications.

**REFERENCES** List Federal regulations, state contract reference or other related P&Ps

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<td>Code Of Federal Regulations – 42 Public Health</td>
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**Related Materials**

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<td>Interpreter Services Policy</td>
<td>SharePoint P&amp;P Central Database</td>
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<td>Mass Communication Translation/Alternative Format Policy</td>
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<td>Advance Directive Policy</td>
<td>SharePoint P&amp;P Central Database</td>
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**ATTACHMENTS:** List attachments

**DEFINITIONS:** Define terms used in the P&P

| Contracted Providers | Doctors or Surgeons; other provider types, for example, Dentists and Oral Surgeons, Optometrists, Physician |
Assistants, and Advanced Practice Nurses, Certified Nurse Anesthetists and Certified Nurse Midwives, Podiatrists, Chiropractors, Physical Therapists; or facilities such as hospitals, home health agencies, laboratories, DME vendors, long-term care facilities contracted by Trillium.

**REVISION LOG**

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**POLICY AND PROCEDURE APPROVAL**

The electronic approval is retained in Archer
RFA Community Engagement Plan Tables

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

| All applicants must complete this full table. Applicants may add rows as needed. |
|---|---|---|---|
| **Part 1a.** 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. | **Part 1b.** 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. | **Part 1b.** Describe why each listed agency, organization and individual was included. | **Part 1b.** Describe how Applicant plans to develop, maintain or strengthen relationships with each stakeholder and maintain a presence within the community. |
| **OHP consumers (list in first column below)** | **Trillium Board of Directors (BOD) Consumer Members** | • Caitlyn Hatteras, Cornerstone Community Housing (Consumer Advocate) • Tara DaVee, Community Health Worker (Consumer) | Trillium takes a grassroots approach to engaging the community via Trillium’s extensive committee structure including the Community Advisory Council (CAC), Rural Advisory Council (RAC), Clinical Advisory Panel (CAP), Compensation Advisory Committee, and the Finance Advisory Committee. We are also To support a regionally-focused governance structure as we expand our Service Area, we plan to establish an additional Regional BOD in Clackamas, Multnomah, and Washington Counties (Tri-County Region). Under this structure, both Regional BODs will report to the Trillium Governing Board, comprised of representatives from Regional BODs and other CCO committees, to support local |
Trillium Community Advisory Council (CAC) Consumer and Consumer Advocate Members: Current Service Area

- Advantage Dental (Consumer Advocate): Cindy Shirtcliffe
- City of Eugene (Consumer Advocate): Stephanie Jennings
- Community Health Centers of Lane County (Consumer Advocate): Rick Kincade
- Consumer: Drake Ewbank
- Consumer: John Rolling- Thunder
- Consumer: Michelle Thurston
- Consumer: Shara Brittain
- Consumer: Silverio Mogart
- Consumer Advocate: Cindy Williams
- Cornerstone Community Housing (Consumer): Caitlyn Hatteras
- Department of Human Services District 5 (Consumer Advocate): John Radich
- FOOD for Lane County (Consumer): Dana Baxter
- HACSA Commissioner, Florence (Consumer Advocate): Charene Reavis
- HeadStart Program (Consumer Advocate): Val Haynes
- Home Health Care (Consumer): Rebecca Henson
- Lane County Developmental

Through representation on the CAC, the organizations, agencies, and individuals included offer diverse input on how to best serve the communities in our Service Area.

Trillium plans to establish an additional CAC in the Tri-County Region (Multnomah, Clackamas, and Washington Counties). Through the efforts of our Community Development Team, we have been outreaching to and engaging with providers, organizations, and individuals who serve as key community members and who may be considered to serve on the CAC. Trillium will also engage with the other CCOs in our proposed Service Area to coordinate on CAC recruitment activities. We will strengthen tribal consumer and consumer advocate representation through a separate Tribal Advisory Council. We will establish a Health Equity Council inclusive of our Health Equity Officer, health equity professionals, and community stakeholders invested in equity and healthcare.
### Trillium Rural Advisory Committee (RAC) Consumer and Consumer Advocate Members: Current Service Area

- Court Appointed Special Advocates – CASA (Consumer Advocate): Heather Murphy
- Consumer: Connie Hoffman
- Consumer: John Bauman
- Consumer: Michelle Thurston
- HACSA Commissioner, Florence (Consumer Advocate): Charene Reavis
- McKenzie Family Resource Center (Consumer Advocate): Robin Roberts
- Lane County Prevention (Consumer): Leah Edelman

Through representation on the RAC, the organizations, agencies, and individuals included offer diverse input on how to best serve the rural communities in our Service Area.

Beginning in April 2019, Trillium will expand the RAC into Reedsport and grow the community, tribal, and consumer participation through incentive packages for those who serve on the RAC. Trillium will consider establishing an additional RAC in the Tri-County Region to meet the needs of the communities in our proposed Service Area.

### Trillium Tribal Advisory Council Consumer and Consumer Advocate Members: Current and Proposed Service Area

- Coquille Tribe (Consumer): Trudy Simpson
- Native American Rehabilitation Association of the Northwest (NARA NW) (Consumer Advocate): Jackie Mercer
- Siletz Tribe (Consumer Advocate): Kaye Stainbrook

Through representation on the Tribal Advisory Council, the organizations, agencies, and individuals included offer diverse input on how to best serve Tribal communities in our Service Area.

In 2019 Trillium established the Tribal Advisory Council and will be targeting to include five members as part of the council.

### Community-based organizations that address disparities and SDOH-HE (list in first column below)

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Clackamas Service Center (CSC)</th>
<th>Economic Stability</th>
<th>Domestic Violence Resource Center</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Key organization that provides families and individuals with food and other resources to support self-sufficiency.</td>
<td></td>
<td>Located in Portland in the Justice</td>
</tr>
<tr>
<td></td>
<td>We will work with CSC to expand the THW program by providing access to the state certification training for peer specialists (pay for training). CSC will identify the individuals to be trained.</td>
<td></td>
<td>Trillium will include this partner in the</td>
</tr>
<tr>
<td>Economic Stability</td>
<td>Dress for Success</td>
<td>Center, this organization offers confidential shelter and related services.</td>
<td>statewide Coalition partnership.</td>
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</tr>
<tr>
<td>Economic Stability</td>
<td>Transitions Project</td>
<td>Provides individuals with resources and services to secure and maintain housing.</td>
<td>We will partner to expand Permanent Supportive Housing Supports in new housing units built under the new bond.</td>
</tr>
<tr>
<td>Education</td>
<td>Children First for Oregon (CFO)</td>
<td>A statewide organization based in Portland that is actively involved in the legislative improvement recommendations for the System of Care and Wrap Around Model. Focus on child abuse prevention, foster youth advocacy, legislative solutions, and research and data.</td>
<td>Trillium will work with CFO to solicit feedback from their Oregon Foster Youth Connection on needs, youth (ages 14-21) experiences relative to health care, interventions, outreach, and access. Trillium looks forward to working closely with CFO to help improve the System of Care, particular through its expansion beyond county borders.</td>
</tr>
<tr>
<td>Education</td>
<td>Health Leadership Oregon</td>
<td>Organization is an alliance of leaders from all aspects of the health care environment across Oregon.</td>
<td>We will partner with Health Leadership Oregon to share lessons learned and best practices relative to both operational and policy related agendas. Collaborating across these systems will leverage resources from multiple organizations to advance health and socio-economic needs.</td>
</tr>
<tr>
<td>Education</td>
<td>Planned Parenthood of Southwest Oregon</td>
<td>Provides sex education and healthcare including birth control, emergency contraception, HIV services, LGBT services, STD testing, and other reproductive health services.</td>
<td>Trillium will invite Planned Parenthood to join the Clinical Advisory Subcommittee Training and Education (Lane Region) to inform cultural competence trainings. We will strengthen our collaborative</td>
</tr>
<tr>
<td>Education, Social and Community Health</td>
<td>Planned Parenthood Columbia Willamette</td>
<td>Provides sex education and healthcare including birth control, emergency contraception, HIV services, LGBT services, STD testing, and other reproductive health services.</td>
<td>Trillium will invite Planned Parenthood to join the Clinical Advisory Subcommittee Training and Education (Tri-County Region) to inform cultural competence trainings.</td>
</tr>
<tr>
<td>Education, Social and Community Health</td>
<td>Trauma Healing Project</td>
<td>Provides training for organizations in workplace wellness and trauma-informed practices as well as provides community education and trauma healing services to the community.</td>
<td>Trillium plans to engage this organization through trainings to incorporate a trauma healing perspective to staff trainings. We will explore collaboration through the Clinical Advisory Training and Education Subcommittee.</td>
</tr>
<tr>
<td>Education, Social and Community Health</td>
<td>HIV Alliance</td>
<td>Provides services for those living with HIV/AIDS and provides education and prevention efforts. Naloxone education and distribution for the prevention of overdose deaths is also a priority for this organization.</td>
<td>HIV Alliance will continue to be engaged as a stakeholder and participant on the Pain Guidance and Safety Alliance. This stakeholder group brings trainings to the provider network and the community about opioid overdose reversal. Engage in the Clinical Advisory Substance Use Disorder Subcommittee monthly meeting. Will explore options to provide funding for needle exchange expansion and naloxone distribution. Invite to participate on the CAC Prevention Workgroup.</td>
</tr>
<tr>
<td>Education, Social and Community Health</td>
<td>Lane Equity Coalition (LEC)</td>
<td>The LEC works on priorities set out by the CHP and engages the community though educational events and trainings. Trillium is a partner and provides technical assistance and funding for the LEC community events.</td>
<td>Trillium is a sponsor of the LEC and will continue to consult and collaborate by ensuring a Trillium staff member who can inform financial decisions is represented on the coalition. We will also continue to sponsor and be involved in planning the quarterly community education events, which</td>
</tr>
<tr>
<td>Neighborhood and Built Environment</td>
<td>Home Forward (Multnomah Housing Authority)</td>
<td>Serves as the primary housing authority in Multnomah County.</td>
<td>Trillium will work with this partner for the Tri-County Health and Housing State Collaborative.</td>
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</tr>
<tr>
<td>Neighborhood and Built Environment</td>
<td>Homes for Good</td>
<td>Federal program that assists families with rental housing including private landlords and provides rental housing managed by Homes for Good.</td>
<td>Engagement through the CAC and RAC. Will collaborate with this stakeholder through the Clinical Advisory Panel ED Utilization Workgroup.</td>
</tr>
<tr>
<td>Neighborhood and Built Environment</td>
<td>Innovative Housing Inc.</td>
<td>Provides affordable housing and support services to individuals and families in the Portland area.</td>
<td>Trillium will partner with this organization to support two apartment buildings – one for IDD/BH and other for families. We will support this organization in developing sustainable initiatives, including an on-site THW and health care services such as blood pressure assessments, support groups, and care gap outreach, with focus groups to determine need.</td>
</tr>
<tr>
<td>Neighborhood and Built Environment</td>
<td>Washington County Department of Housing Services</td>
<td>Serves as the primary housing authority in Washington County.</td>
<td>We will jointly develop a pilot program to develop integrated Housing and Permanent Supportive Housing services approach and model to be replicated in other counties.</td>
</tr>
<tr>
<td>Neighborhood and Built Environment</td>
<td>LOVE Inc. of Central Lane County</td>
<td>Common services include medical rides, furniture donations, yard work, cleaning, and painting. Partners with churches around the area.</td>
<td>Trillium will invite LOVE Inc. to join the CAC and THW Hub and to join the same-day transportation ED Utilization Workgroup.</td>
</tr>
<tr>
<td>Neighborhood and Built Environment, Social and Community Health</td>
<td>Lane Independent Living Alliance (LILA)</td>
<td>LILA serves individuals with disabilities and helps them live independent lives. This stakeholder represents our disabled population. The Blue Path Program assesses businesses for ADA compliance.</td>
<td>LILA is engaged through the CAC Member Engagement Workgroup and Prevention Workgroup and the Lane Equity Coalition. Trillium will explore engagement through the support of programs including the Blue Path Program (marketing tool for people with disabilities), Disability Navigator</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>Boys &amp; Girls Clubs of Portland Metropolitan Area</td>
<td>Provides evidence-based development and enrichment programs to youth, including leadership/community service; academic enrichment; science and technology; performing and visual arts; health and fitness; college prep and workforce training; and recreation and sports leadership leagues.</td>
<td>Program, and OPAL Network (consumer-driven group). We will engage LILA in the Health Navigators Taskforce.</td>
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<tr>
<td>Social and Community Health</td>
<td>Cascade AIDS Project (CAP)</td>
<td>Community-based provider of HIV services, housing, education, and advocacy servicing Multnomah, Washington, Clackamas, and Clark (SW Washington State).</td>
<td>We will partner with the Boys &amp; Girls Clubs of Portland Metropolitan Area to support school-based health services and education programs.</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>Cornerstone Community Housing</td>
<td>Cornerstone provides the community with quality affordable housing for people living on limited incomes and provides opportunities for personal growth and economic independence.</td>
<td>Trillium has an executed MOU with Cornerstone Community Housing as a SDOH-HE partner. We plan to engage this agency through the Health Navigators Taskforce under the Clinical Advisory Panel. We will continue to encourage collaboration through the THW Hub, BOD, CAC Member Engagement Workgroup, and Prevention Workgroup.</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>Court Appointed Special Advocates (CASA)</td>
<td>Provides volunteers who advocate in juvenile dependency court for children who have been abused or neglected.</td>
<td>We plan to engage CASA by inviting them to provide an agency demonstration on services to Trillium staff. We will continue engagement as a SDOH-HE partner with a court systems lens through the BOD, RAC, and Clinical Advisory Panel ED Utilization Workgroup- Alternative to</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>FOOD for Lane County</td>
<td>FOOD for Lane County is a nonprofit food bank dedicated to eliminating hunger by creating access to food. FOOD for Lane County serves a diverse population of people living on limited incomes including children, families, seniors, and single adults. Provides the community with low-cost meals, no-cost meal sites, food boxes, gardens, nutrition education, and children and senior programs.</td>
<td>Trillium will engage this stakeholder in the Partnership for Better Health programs, which includes Produce Plus, Veggie Rx, and Screen and Intervene. This stakeholder will be engaged in various ways to inform, consult, and collaborate to address barriers to healthy food and food security. Continue to encourage membership on the CAC. Invite to join the CAC SDOH-HE Workgroup</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>Jewish Family Services</td>
<td>Provides Jewish family services, providing referrals, advocates, special programming and home and nursing facility visits and housing navigation.</td>
<td>Trillium will engage Jewish Family Services to learn about Jewish culture and how to best care for Jewish members. We will consider this stakeholder as a collaborator in the decision-making processes affecting dual-eligible members and the disabled population through the CAC.</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>Lift Urban Portland (Lift UP)</td>
<td>Food distribution agency. Provides emergency food closet, delivered food boxes, and healthy eating workshops. Delivered food boxes are monthly deliveries to vulnerable residents in need that are unable to travel.</td>
<td>We will refer members to Lift UP to reduce food insecurity and we will participate in Lift UP’s nutrition workshops. We will explore using medical offices within their service area as additional points of food distribution.</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>Looking Glass</td>
<td>Provides emergency shelter for runaway or homeless youth, 24-hour crisis intervention, emergency transportation, and family reconciliation services.</td>
<td>We plan to continue collaboration as a member of the Trillium Board, Finance Committee, Clinical Advisory Subcommittee Early Childhood Mental Health monthly meeting, and Alternative to ED Use Taskforce. Trillium will also engage Looking Glass in CLAS and cultural competency</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>Native American Youth and Family Center Development and Community Engagement (NAYA)</td>
<td>Provides services to all tribes, families, individuals, youth, with an emphasis on all things community – housing and rental assistance, building of housing, recovery programs, transportation, college readiness, LGBTQ support and other programs to support the Native American community in Oregon.</td>
<td>Trillium has asked this partner to serve on the Tribal Advisory Council as well as explore potential innovations surrounding affordable housing, and/or assisting homeless high school youths, and youth with LGBTQ issues. Collaboratively we will work together to share innovations, leverage resources and explore partnerships.</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>Options</td>
<td>Focus on providing families with strengths-based therapy and mental health and family preservation services. Options works with vulnerable families. The individuals listed in this row are actively engaged in community work with Trillium.</td>
<td>Options will be encouraged to participate in the Innovators Learning Collaborative and to continue participation in the Trillium Behavioral Health All Providers meeting, Finance Committee, and PreManage Workflows group under the Clinical Advisory Panel to engage in CLAS and Cultural Competence training.</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>Oregon Alliance of Children’s Programs</td>
<td>The Alliance is a statewide association of child placing agencies and supports programs in child welfare, juvenile justice, BH, developmental disabilities, diversity and equity.</td>
<td>Trillium will work with the Alliance to learn the needs of the child welfare system, gaps and needs relative to the system of care, partnerships and improved processes surrounding the wrap around and MDT process, and a united focus of helping children and families in safety, well-being and permanency.</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>Oregon Coalition Against Domestic Violence and Sexual Assault</td>
<td>Non-profit organization that provides training and technical assistance to local crisis centers and communities and supports the development of effective practices and systems advocacy to serve survivors of domestic and sexual violence.</td>
<td>Trillium will work with this organization to provide training for network providers, connect with Native American experts, discuss appropriate screening questions to be used by providers, improve knowledge and understanding of resources in our Service Area, and discuss needs and</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Social and Community Health</th>
<th>Oregon Food Bank</th>
<th>Statewide organization that collects foods from public and private sources and distributes through 21 regional food banks and food assistance sites across the state.</th>
<th>Trillium will work with the Oregon Food Bank to identify opportunities to transport food and goods to rural areas and to expand partnerships with tribes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social and Community Health</td>
<td>Relief Nursery</td>
<td>Provides various programs to aid parents in keeping their family safe and strong, with a focus on vulnerable populations and at-risk families, including programs and services for children 0-6 (MH counseling and crisis services, respite, drug and alcohol recovery program).</td>
<td>Continue to encourage collaboration with engagement through the All Providers monthly meeting. Invite this partner to join the Clinical Advisory Panel – Early Childhood Mental Health monthly meeting to inform, consult, and collaborate on childhood behavioral health.</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>ShelterCare</td>
<td>This stakeholder represents the homeless and mentally ill population providing transitional and permanent housing and support services for seniors and people with disabilities.</td>
<td>Trillium will continue to support the ShelterCare Medical Recuperation program, which provides housing and specific recovery needs to patients after medical discharge. Trillium is a visionary sponsor for many of these stakeholders’ community events. Engage in All Provider Meeting and CAC- Prevention Workgroup.</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>St. Vincent DePaul</td>
<td>This community-based organization provides social services for vulnerable and disparate populations in the community.</td>
<td>Trillium will explore engagement with St. Vincent DePaul through the BOD to provide the best possible delivery of service for the growing homeless population. We will invite St. Vincent to the CAC SDOH-HE Workgroup and will engage in CLAS and cultural competency training.</td>
</tr>
<tr>
<td>Social and Community Health</td>
<td>The Children’s Center</td>
<td>Provides assessment, interventions and trauma informed treatment for children</td>
<td>We will collaborate on trauma-related training and interventions, including family activities, in-home services, and</td>
</tr>
<tr>
<td><strong>Social and Community Health</strong></td>
<td><strong>Womenspace</strong></td>
<td>Provides resources, services and programs that empower survivors and that work with communities to end intimate partner violence.</td>
<td>Will continue to work with Trillium on individual member care coordination, enhance person-centered BH care, and identify vulnerable members that could benefit from improved care coordination.</td>
</tr>
<tr>
<td><strong>Social and Community Health</strong></td>
<td><strong>Youth ERA</strong></td>
<td>Youth empowerment and advocacy agency that provides peer support, services for youth with mental health issues. The Youth Program Builder is a training and technical assistance program that provides consultation for providers that serve the youth population or would like to start.</td>
<td>Will engage this statewide stakeholder through CAC participation. This stakeholder utilizes THWs in the form of youth peer support specialist. Youth ERA also employs a THW Commission-approved Youth Support Specialist trainer. Trillium will explore using this trainer to educate relevant staff and will engage Youth ERA in the THW Hub.</td>
</tr>
<tr>
<td><strong>Social and Community Health</strong></td>
<td><strong>YWCA Oregon</strong></td>
<td>Provides domestic violence, family preservation, senior, social justice, and youth services to women, children, and families.</td>
<td>Trillium will partner with the YWCA for Health Equity and Social Justice training across the entire proposed Service Area.</td>
</tr>
<tr>
<td><strong>Social and Community Health, Economic Stability</strong></td>
<td><strong>United Way of Lane County</strong></td>
<td>UWLC is the local hub for engagement and advocacy focused on social determinants of health. They are the conveners for the Lane Equity Coalition, which is a CHP workgroup.</td>
<td>Trillium will support UWLC through participation in the Loaned Executive Program in 2020. This program allows an employee to work with United Way for 3-months to build relationships throughout the county and inform community members of current community conditions and social determinants of health.</td>
</tr>
</tbody>
</table>

**Providers, physical health, including culturally specific providers as available (list in first column below)**
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Lower Umpqua Hospital District</th>
<th>Serves a rural population and can provide a rural perspective. This provider uses a community calendar for coastal Douglas community events and trainings.</th>
<th>We will engage Lower Umpqua Hospital District through the Older Adult BH Initiative and through local events and trainings. We will collaborate to host community meetings at this location.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care, Emergency Department, Behavioral Health</td>
<td>McKenzie-Willamette Medical Group</td>
<td>Large provider network that includes ED, hospital, outpatient, physical and mental health services.</td>
<td>We will continue to encourage engagement through the BOD and the Finance, Pharmacy, and Compensation Committees and will plan to engage in the Clinical Advisory Panel Intensive Outpatient Services and Supports Subcommittee, the All Providers Meeting, and Pain Guidance &amp; Safety Alliance.</td>
</tr>
<tr>
<td>Primary Care, OB/GYN</td>
<td>Pacific Women’s Center</td>
<td>Provides women’s healthcare and prenatal and childbirth services.</td>
<td>This stakeholder has been an active respondent in the cultural competence provider survey. We will engage in CLAS and cultural competency trainings and in the Health Navigators Taskforce and THW Hub.</td>
</tr>
<tr>
<td>Primary Care, OB/GYN</td>
<td>Women’s Care</td>
<td>Provides women’s healthcare, OB/GYN, prenatal and postnatal care, specialist services, and referrals.</td>
<td>We will engage Women’s Care through the BOD, Compensation Advisory Committee and through provider meetings. We will also engage this provider in CLAS and cultural competence trainings.</td>
</tr>
<tr>
<td>Primary Care, Specialist, Emergency Department</td>
<td>PeaceHealth Medical Group</td>
<td>This is one of the largest primary care, emergency department, and specialty care providers within the network.</td>
<td>Continue engagement through the Lane Equity Coalition, provider meetings, Pain Guidance and Safety Alliance, and the Innovators Learning Collaborative. Engaged in PreManage Workflows, Alternative to ED, and Credentialing. Will work with PeaceHealth to complete cultural competency training.</td>
</tr>
<tr>
<td>Primary Care/Behavioral Health/Safety Net</td>
<td>Community Health Centers of Lane</td>
<td>As a local government agency,</td>
<td>Engagement through the Pain</td>
</tr>
<tr>
<td>Provider</td>
<td>County</td>
<td>this provider will be included as a stakeholder to help identify, promote, and execute new programs and initiatives.</td>
<td>Guidance and Safety Alliance and All Providers meeting, CAC, CAP, Finance, Quality Improvement, and Compensation Committees. Will engage in CLAS and cultural competence trainings.</td>
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</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Camas Swale Medical Clinic</td>
<td>Community-based medical clinic in a rural location (Creswell)</td>
<td>Trillium will engage Camas Swale through the RAC and will partner to support activities and trainings for the community.</td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Choices for Health PC</td>
<td>A small, private, nurse practitioner-owned office. Services include prescriptive medications and non-pharmacological options.</td>
<td>This stakeholder has been an active respondent in the cultural competence provider survey. Will engage in CLAS and cultural competence trainings. Plan to invite this stakeholder to attend the Chronic Pain Programs Subcommittee, the PCP Health Care Collaboration, and ED Utilization Workgroup.</td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Healing Spirit Integrative Health Center</td>
<td>Primary care clinic that provides lymphedema management and health promotion services.</td>
<td>Engagement through the provider meetings and THW Hub. Will engage in the Innovators Learning Collaborative.</td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Kaiser Foundation Health Plan of the NW</td>
<td>Primary care provider for Eugene-Springfield, Portland, and Salem. Some care provided includes maternity, cardiac, and cancer treatments.</td>
<td>This stakeholder has been an active respondent in the cultural competence provider survey. Will engage in CLAS and cultural competence trainings. Invite to the Innovators Learning Collaborative. Reengage in the Pain Guidance and Safety Alliance. Invite to join the Alternative to ED Use Workgroup, High-Risk Population Workgroup, and the PCP Health Care Collaboration.</td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>McKenzie Family Practice</td>
<td>Included to help support cultural competency training efforts.</td>
<td>All physicians at this practice are culturally trained and can provide insight on the efforts needed to support small practices in completing cultural training. Plan to invite to the</td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>McKenzie River Clinic</td>
<td>Oregon’s first rural health clinic in Blue River. Provides services in preventative care, treatment of illnesses and injuries, chronic condition management, prescriptions, physicals, and specialist referrals.</td>
<td>This stakeholder has been an active respondent in the cultural competence provider survey. Will engage in CLAS and cultural competence trainings. Will explore best fit for joining a committee. Will invite to join the Chronic Pain Programs Subcommittee and Pain Guidance &amp; Safety Alliance.</td>
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</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Orchid Health (Oakridge)</td>
<td>Serves a rural population and can provide a rural perspective.</td>
<td>Plan to engage through the Training and Education Subcommittee, the All Providers meeting, and the RAC.</td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Oregon Integrated Health (Eugene and Florence)</td>
<td>Metro and rural provider focusing on integrative primary care. Florence is a telemedicine clinic that can provide valuable feedback to other stakeholders on this method of receiving services in rural areas.</td>
<td>Will be engaged to support the work being done with telemedicine and how to provide this service to other rural providers. Invite to attend the Training and Education subcommittee. Will consider this stakeholder to participate in the BOD.</td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Oregon Medical Group (OMG)</td>
<td>One of the largest contracted provider networks providing care to approximately 13,000 members. This provider responded to the 2014 and 2016 Provider Network Cultural Competency Survey.</td>
<td>Trillium will continue to engage OMG in provider meetings and will engage OMG in the Trillium Clinical Advisory Subcommittee. OMG is engaged in the Compensation, Finance, and Quality Improvement Committees, CAC, and Clinical Advisory Panel.</td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Prevention Plus Clinic</td>
<td>This small individual practitioner clinic provides a holistic integrated approach to care and is culturally trained, providing a valuable perspective to help plan for other small practices to become culturally trained.</td>
<td>We plan to use this stakeholder in developing a cultural competency training plan for other providers who are in need of cultural competence training for staff. We will invite Prevention Plus to join the Training and Education Subcommittee.</td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Prime Care Partners</td>
<td>Belongs to Trillium’s primary care network. This group values patient advocacy and has culturally trained all contracted</td>
<td>Engagement will include a focus on creating a cultural training plan for other providers to adopt with internal staff through the Training &amp; Education</td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Organization</td>
<td>Description</td>
<td>Workgroup</td>
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<tr>
<td>Primary Care/Clinic</td>
<td>Sacred Heart Physicians</td>
<td>Engagement with this group will help in developing a cultural training plan for other contracted providers.</td>
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</tr>
<tr>
<td>Workgroup. This provider excels in</td>
<td></td>
<td>cultural competence training and would benefit the entire provider network. We will invite Prime Care to join the All Providers meeting and Pain Guidance &amp; Safety Alliance.</td>
<td></td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Santa Clara Medical Clinic</td>
<td>A small local physician’s network providing care in North Eugene.</td>
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</tr>
<tr>
<td>Workgroup. Will engage through provider</td>
<td></td>
<td>meetings and cultural competence trainings. Invite to attend the Training and Education Subcommittee for CLAS and cultural competency trainings.</td>
<td></td>
</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>South Hilyard Clinic (Cultural Training-CT and ASL Signage)</td>
<td>Represents a small provider clinic who has completed cultural training and is aware of how to provide these trainings and the importance of culturally responsive services for members.</td>
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</tr>
<tr>
<td>Workgroup. Engagement through CLAS trainings as an informed stakeholder and collaborator.</td>
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</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Springfield Family Physicians</td>
<td>Engaged in Trillium’s Integrated Complex Care Management (ICCM) pilot program to help reduce disparities among high-needs members.</td>
<td></td>
</tr>
<tr>
<td>Workgroup. Continue to encourage current engagement in the ICCM program with Trillium and the Center for Family Development and through the All Provider’s Meeting.</td>
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</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Volunteers in Medicine</td>
<td>Primary care medical clinic for low-income, underserved adults and families in Lane County.</td>
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</tr>
<tr>
<td>Workgroup. Will explore engagement through the CAC Prevention Workgroup and CAP. Invite to join the Pain Guidance and Safety Alliance. Engage in CLAS training.</td>
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<tr>
<td>Primary Care/Clinic</td>
<td>Wild Rose Medical Clinic</td>
<td>Specializes in family medicine.</td>
<td></td>
</tr>
<tr>
<td>Workgroup. This stakeholder has been an active respondent in the cultural competence provider survey. Will engage in CLAS and cultural competence trainings. Invite to attend the PCP Health Care Collaborative.</td>
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</tr>
<tr>
<td>Primary Care/Clinic</td>
<td>Yakima Valley Farm Workers Clinic</td>
<td>Offers services and programs that address basic needs like food,</td>
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<tr>
<td>Workgroup. Will explore a partnership for the Tri-County Region through the CAC and</td>
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<tr>
<td>RFA Community Engagement Plan TABLES</td>
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<tr>
<td><strong>Primary Care, Pediatrics</strong></td>
<td>Eugene Pediatrics Associates</td>
<td>Represents the family and pediatric population. Since 2014, this provider submitted responses to the bi-annual cultural competence survey.</td>
<td>CAP in addition to program/services support.</td>
</tr>
</tbody>
</table>

| **Specialist: Acupuncture** | Turning Point Center | Licensed acupuncturists offering acupuncture, massage, moxibustion, nutritional therapy, and herbal medicine. | This stakeholder has been an active respondent in the cultural competence provider survey. Will engage in CLAS and cultural competence trainings. Invite to the Chronic Pain Program Subcommittee and the Pain Guidance & Safety Alliance. |

| **Specialist: Dermatology** | Advanced Skin Center | Specialist in skin cancer treatment and surgery clinic also providing medical dermatology. Locations in Roseburg, Grants Pass, Reedsport, and Coquille. | This stakeholder has been an active respondent in the cultural competence provider survey. Will engage in CLAS and cultural competence trainings through the Training and Education Subcommittee. |

| **Specialist: Medical Imaging** | McKenzie Medical Imaging | Provides diagnostic information, medical imaging, and mammography. | This stakeholder has been an active respondent in the cultural competence provider survey. Will engage in CLAS and cultural competence trainings. Will explore best fit for joining a Trillium committee. |

| **Specialist: Medical Imaging** | Oregon Imaging Centers | Services include bone density screening, low-dose CT, fluoroscopy, pediatric imaging, digital mammography, MRI, PET/CT, platelet rich plasma, ultrasound, and digital X-ray. | This stakeholder has been an active respondent in the cultural competence provider survey. Will engage in CLAS and cultural competence trainings. |

<p>| <strong>Specialist: Oncology</strong> | Cascade Surgical Oncology | Provides comprehensive cancer care. | This stakeholder has been an active respondent in the cultural competence provider survey. |</p>
<table>
<thead>
<tr>
<th>Specialist: Oral Surgery</th>
<th>Oregon Oral Surgeons</th>
<th>Specializing in dental implants, wisdom teeth, sleep apnea, IV sedation and orthognathic surgery.</th>
<th>This stakeholder has been an active respondent in the cultural competence provider survey. Will engage in CLAS and cultural competence trainings. Will invite to attend the Pain Guidance &amp; Safety Alliance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist: Surgery</td>
<td>Keiperspine</td>
<td>This provider is a participant of the Provider Network Cultural Competency Survey and would benefit as a stakeholder in providing informed decisions on quality translation services.</td>
<td>Engagement through CLAS training. Plan to engage as a collaborator in the Pain Guidance and Safety Alliance.</td>
</tr>
<tr>
<td>Specialist: Surgery and Orthopedics</td>
<td>Slocum</td>
<td>Provides orthopedic and surgical services.</td>
<td>Plan to continue engagement through the BOD, Clinical Advisory Panel, High Risk Population Workgroup, and ED Utilization Workgroup. Invite this stakeholder to join the Chronic Pain Management workgroup and the Pain Guidance &amp; Safety Alliance.</td>
</tr>
<tr>
<td>Providers, behavioral health, including culturally specific providers as available (list in first column below)</td>
<td></td>
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</tr>
<tr>
<td>Behavioral Health</td>
<td>Psychiatry Associates of Eugene</td>
<td>Provides psychiatry to members.</td>
<td>Engage through CLAS and cultural competence trainings.</td>
</tr>
<tr>
<td>Behavioral Health Collaboration</td>
<td>Western Lane Behavioral Health Network</td>
<td>Provides collaboration and strategic planning for integrated physical and behavioral health services in Mapleton and Florence. Works with the Siuslaw School District to integrate behavioral health into school clinics. Collaborating to improve crisis response for western Lane County.</td>
<td>Include this stakeholder in the RAC to inform decisions being made around integration and collaborating with other counties on behavioral health programs and initiatives.</td>
</tr>
<tr>
<td>Behavioral Health Provider</td>
<td>Christians as Family Advocates (CAFA)</td>
<td>Provides domestic violence intervention for offenders and victims, parenting classes, supervised visitation services, and individual therapy.</td>
<td>Trillium plans to engage this partner by informing Trillium staff of agency services and programs. We will invite CAFA to the Health Navigators taskforce under the Clinical Advisory Panel.</td>
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<tr>
<td>Behavioral Health Support and Training</td>
<td>Oregon Family Support Network (OFSN)</td>
<td>OFSN can provide training, technical assistance, and a family and youth advocacy network for support groups and education.</td>
<td>Engaged as a training provider for the Older Adult Behavioral Health Specialist on Mental Health First Aid. Will continue to engage through the BOD and trainings for providers and community members with children who have mental health needs or developmental disabilities. OFSN will be engaged in CLAS and demographic record keeping training and in Early Childhood Mental Health.</td>
</tr>
<tr>
<td>Behavioral Health: Intensive and Crisis</td>
<td>Youth Villages Oregon</td>
<td>Provider of intensive community-based services, including intensive in-home services, crisis response services, and support to youth aging out of the foster care system in Multnomah, Washington, and Clackamas with willingness to expand to Lane and Douglas.</td>
<td>Plan to engage to help communities keep families together, reduce child abuse and neglect, and increase access to social services that address economic, education, neighborhood, and workforce needs. Will develop a value-based contract, pilot/test new innovations, explore expansion of services to new counties.</td>
</tr>
<tr>
<td>Community Mental Health Program</td>
<td>Adapt/Compass</td>
<td>Supports individuals with mental illness, addiction treatment, medical, and prevention education in Douglas County.</td>
<td>Engagement through the Trillium BOD, Clinical Advisory Panel, and High-Risk Population Workgroup under the Compensation Committee. Plan to engage in cultural competence training.</td>
</tr>
<tr>
<td>Counseling</td>
<td>Strong Integrated Behavioral Health</td>
<td>Provides individual, couples, or family therapy. Specializing in depression, anxiety, traumatic stress disorders, psychological evaluations for chronic pain and ADD, stress management, and</td>
<td>Continue to engage in bi-monthly provider meetings and Pain Guidance and Safety Alliance. Engage in CAC SDOH-HE Workgroup. Plan to engage in the THW Hub (does not currently use THWs).</td>
</tr>
<tr>
<td><strong>RFA COMMUNITY ENGAGEMENT PLAN TABLES</strong></td>
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<tr>
<td><strong>Counseling and Mental Health Services</strong></td>
<td>Cascade Health Solutions Behavioral Health</td>
<td>Provides a variety of long-term care and BH services. Provides education on nutrition and helps members to live more independently at home.</td>
<td>Engagement through the provider meetings. Will engage in CLAS and demographic training.</td>
</tr>
<tr>
<td><strong>Counseling and Residential Services</strong></td>
<td>Looking Glass</td>
<td>Highly utilized BH provider for referrals to young individuals requesting services for crisis response, BH treatment, basic human services and SUD treatment.</td>
<td>Engagement through provider meetings will explore support of the Independent Living Program for Youth Transitioning to Independence and will continue to encourage engagement through the CAP ED Utilization Workgroup –PreManage Workflows and Quality Improvement Committee. Will engage in CLAS trainings.</td>
</tr>
<tr>
<td><strong>Culturally-Specific Behavioral Health</strong></td>
<td>Centro Latino Americano</td>
<td>Provides mental health treatment and resources to social services to the youth population and Latinx population.</td>
<td>Continue to encourage engagement through the CAC, Lane Equity Coalition, and provider meetings and to provide language interpretation resources and trainings on cultural competency. Will invite to join the Training and Education Subcommittee and the THW Hub. Explore ways to support the Alcohol and Addiction Program.</td>
</tr>
<tr>
<td><strong>Family Support</strong></td>
<td>Direction Service</td>
<td>Provides services to the disabled and special needs population</td>
<td>Engagement through provider meetings, and cultural competence training.</td>
</tr>
<tr>
<td><strong>Intensive Mental Health Services</strong></td>
<td>Laurel Hill Center</td>
<td>Provides intensive mental health services to members. Provides services through peer supports as well.</td>
<td>Engagement through provider meetings and Compensation Committee. Will engage in CLAS and demographic records trainings.</td>
</tr>
<tr>
<td><strong>Local Government Behavioral Health Provider</strong></td>
<td>Lane County Behavioral Health</td>
<td>Provider for behavioral health counseling and program referrals.</td>
<td>Engagement through the Health Navigators Taskforce under the CAP ED Utilization Workgroup, provider meetings, SPMI Workgroup. Will engage in Training and Education Workgroup.</td>
</tr>
<tr>
<td>Mental Health and Counseling</td>
<td>Western Psychological &amp; Counseling</td>
<td>Provides counseling and mental health services. This provider has a presence in 35 schools and is open to value-based contracts.</td>
<td>We plan to partner with Western Psychological &amp; Counseling to expand/support their mental health programs including increasing access to services in a school-setting and within the Latino community.</td>
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<tr>
<td>Mental Health and Rehabilitation Services</td>
<td>Neurotherapeutic Pediatric Therapies</td>
<td>Provides mental health and therapy services, including occupational, physical, speech, developmental, and family therapy and peer-directed services</td>
<td>We have a Letter of Agreement with Neurotherapeutic Pediatric Therapies and plan to partner with them to develop a value based system of care that aligns with member’s individual strengths and capacities, as well as to provide other critical services and trainings aimed at sustaining members in the community.</td>
</tr>
<tr>
<td>Mental Health and Rehabilitation Services</td>
<td>Trillium Family Services</td>
<td>Provides community and rehabilitation services including school-based outpatient, therapeutic equine, intensive community treatment services, and psychiatric residential.</td>
<td>We plan to continue a collaborative partnership with Trillium Family Services to offer a full continuum of children’s mental health and BH services to members throughout our proposed Service Area.</td>
</tr>
<tr>
<td>Mental Health/SUD</td>
<td>Acadia Healthcare/Allied Health Services</td>
<td>Provides behavioral health inpatient, residential, day, outpatient, and SUD treatment.</td>
<td>Plan to engage in provider meetings. We have a LOA with this provider to provide mental health and SUD services in the Tri-County Region.</td>
</tr>
<tr>
<td>Mental Health/SUD</td>
<td>Morrison Child &amp; Family Services</td>
<td>Provides a comprehensive continuum of mental health, substance abuse and prevention and education services for youth, from birth through age 21.</td>
<td>Plan to collaborate with Morrison Child &amp; Family Services to provide mental health and BH services including substance abuse services for children and families in the Tri-County Region.</td>
</tr>
<tr>
<td>Mental Health/SUD</td>
<td>Native American - Rehabilitation Association of NW (NARA)</td>
<td>Provides education, physical and mental health services and substance abuse treatment that is culturally appropriate to AI/AN populations.</td>
<td>NARA NW has agreed to serve on the Tribal Advisory Council, serve as a physical and behavioral health provider in our network, and will collaborate on various SDOH-HE initiatives.</td>
</tr>
<tr>
<td>Mental Health/SUD</td>
<td>Quest Center for Integrative Health</td>
<td>Provider of mental health</td>
<td>We have a Letter of Agreement with</td>
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<td><strong>RFA COMMUNITY ENGAGEMENT PLAN TABLES</strong></td>
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<tr>
<td><strong>Mental Health/SUD</strong></td>
<td><strong>Sequoia Mental Health Services/Tri County Behavioral Health Association</strong></td>
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<tr>
<td>services and therapy, including skill building workshops, mental wellness programs, pain management program, outpatient SUD treatment, naturopathic and Chinese medicine, and HIV services and LGBTQ health services</td>
<td>Quest Center for Integrative Health and plan to partner with them to develop a value based system of care that aligns with members individual strengths and capacities, as well as to provide other critical services and trainings aimed at sustaining members in the community.</td>
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<tr>
<td><strong>Mental Health/SUD</strong></td>
<td><strong>Youth Contact</strong></td>
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<td></td>
<td>Engage through provider meetings, Pain Guidance and Safety Alliance, and through CLAS trainings. We have a LOA with this provider to provide mental health and SUD services in the Tri-County Region.</td>
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<tr>
<td><strong>Outpatient Behavioral Health</strong></td>
<td><strong>Emergence (Florence and Eugene)</strong></td>
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<td></td>
<td>Will continue to encourage collaboration through provider meetings and the Clinical Advisory Sub Committee. Will explore ways to support the programs in Florence and THW integration. Invite to the THW Hub and Intensive Outpatient Services and Supports Subcommittee. Will engage provider in CLAS training and identify opportunities to support the Endeavor and Odyssey Community Counseling Programs.</td>
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<tr>
<td><strong>Outpatient Behavioral Health and Crisis Services</strong></td>
<td><strong>The Child Center</strong></td>
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<td>Engaged through Compensation Committee and provider meetings. Will engage in demographic records training</td>
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<tr>
<td>Barry Rider</td>
<td>RFA COMMUNITY ENGAGEMENT PLAN TABLES</td>
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<td>crisis response, parenting classes, and community resources. and through CLAS training.</td>
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<tr>
<td>Outpatient Behavioral Health Services</td>
<td>Shangri-La</td>
<td>Provides disability services, mental health services, family services, and outpatient mental health in Lane &amp; Linn Counties. Engagement through provider meetings. Will engage in CLAS trainings. Plan to engage in the THW Hub (does not currently use THWs).</td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health and Substance Use Disorder (SUD) Treatment</td>
<td>Center for Family Development</td>
<td>Supports positive individual and family functioning, acceptance, empowerment and growth through outpatient and group mental health, outpatient SUD recovery, health integration, and offense-specific services. Engagement through the Clinical Advisory Panel, provider meetings, SUDS workgroup, ICCM Project. Consider a seat on the BOD.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health Services</td>
<td>Madrone Mental Health Services</td>
<td>Provides outpatient BH services and has a Spanish program. Provides Adult Day Treatment Eating Disorder services. Engagement through provider meetings, Systems of Care Advisory Committee, and CLAS training.</td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Oregon Psychiatric Partners</td>
<td>Provides psychiatric services to children, adolescents, and adults. Engagement through the Compensation Committee including membership on the High-Risk Population Workgroup, and the ED Utilization Workgroup under the Clinical Advisory Panel, and provider meeting.</td>
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</tr>
<tr>
<td>Psychiatry Services</td>
<td>Betts Psychiatric Group</td>
<td>Stakeholder is a prescriber and can diagnose for psychiatric disorders. Plan to engage in provider meetings. Engage in cultural competence and CLAS trainings.</td>
<td></td>
</tr>
<tr>
<td>Referrals and Support</td>
<td>Kids First (Forensic Intervention Response &amp; Support Team)</td>
<td>Provides intervention and advocacy for children who are victims of or witnesses to crime. Continue engagement in the CAP Early Childhood Mental Health bi-monthly meetings and provider meetings. Engage in CLAS trainings.</td>
<td></td>
</tr>
<tr>
<td>Research and Non-Profit Organization</td>
<td>Oregon Community Programs</td>
<td>Provides research-based treatment and prevention services and programs to children, youth, and families. Engagement through the Compensation Committee, Early Childhood Mental Health bi-monthly meeting as well as BH All Providers meeting, and CLAS training.</td>
<td></td>
</tr>
<tr>
<td>Research and Non-Profit Organization</td>
<td>OSLC Developments (ODI)</td>
<td>A collaborative, multidisciplinary center dedicated to increasing scientific understanding of social and psychological processes related to healthy development and family functioning.</td>
<td>Engagement through provider meetings and Early Childhood Mental Health meetings. Will engage in CLAS and cultural competence training.</td>
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<tr>
<td>Substance Use Disorder (SUD) Treatment</td>
<td>Integrated Health Clinic (Eugene)</td>
<td>Provides methadone treatment to the community.</td>
<td>Will continue to encourage collaboration through the Pain Guidance and Safety Alliance invitation. Will engage in provider CLAS trainings.</td>
</tr>
<tr>
<td>Substance Use Disorder (SUD) Treatment</td>
<td>Serenity Lane</td>
<td>Provides detox from opiates and outpatient services for those struggling with addiction.</td>
<td>Engage through provider meetings, Pain Guidance and Safety Alliance, and through CLAS trainings.</td>
</tr>
<tr>
<td>Substance Use Disorder (SUD) Treatment</td>
<td>Springfield Treatment Center</td>
<td>Provides medication assisted therapy and group counseling and referrals for individuals with substance use disorder.</td>
<td>Engagement through Pain Guidance and Safety Alliance, and cultural competence/CLAS trainings.</td>
</tr>
<tr>
<td>Substance Use Disorder (SUD) Treatment</td>
<td>Lane County Methadone Program</td>
<td>Provides methadone treatment to the community.</td>
<td>Will continue to encourage collaboration through the Pain Guidance and Safety Alliance.</td>
</tr>
<tr>
<td>Substance Use Disorder (SUD) Treatment and Counseling</td>
<td>Country Counseling &amp; Exodus Recovery</td>
<td>Supports individuals with addiction recovery services</td>
<td>Engagement through provider meetings, SUDS Workgroup, cultural competence training, and CAP Older Adults Subcommittee.</td>
</tr>
<tr>
<td>Substance Use Disorder (SUD) Treatment and Counseling</td>
<td>LifeWorks NW</td>
<td>Provides mental health, addiction, and prevention services to children, young adults, and families in the Tri-County Area.</td>
<td>We have a Letter of Agreement (LOA) with LifeWorks NW and plan to partner with them to expand/support their CCBHC model as well as other critical services aimed at sustaining members in the community (e.g. ACT, Wraparound, peer support) and training.</td>
</tr>
<tr>
<td>Substance Use Disorder (SUD) Treatment and Counseling</td>
<td>Sponsors</td>
<td>Provides SUD treatment, mental health counseling, and transitional housing and support for justice involved men and women transitioning from</td>
<td>Engagement through the Pain Guidance &amp; Safety Alliance, CAC, and CASC SUDS Workgroup. Involve stakeholders in the THW HUB as they utilize peer support specialist.</td>
</tr>
<tr>
<td>Service Type</td>
<td>Provider/Participant</td>
<td>Overview</td>
<td>Engagement Activities</td>
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</tr>
<tr>
<td>Substance Use Disorder (SUD) Treatment and Counseling</td>
<td>Willamette Family Inc.</td>
<td>Provides addiction treatment services, behavioral health crisis services, counseling, and dental services.</td>
<td>Engage in provider meetings, CAC Prevention Workgroup, the SUDS Workgroup, and the Intensive Outpatient Services and Supports subcommittee under the Clinical Advisory Committee. Invite to join the THW Hub.</td>
</tr>
<tr>
<td>Substance Use Disorder (SUD) Treatment, Counseling, Crisis Services</td>
<td>White Bird Clinic</td>
<td>Provides services for the most complex and at-risk community members experiencing mental health and addiction struggles.</td>
<td>Engagement through the Clinical Advisory Subcommittee, the SUDS Workgroup, and provider meetings.</td>
</tr>
<tr>
<td>Support Services</td>
<td>Transponder</td>
<td>An LGBTQ advocacy organization that provides training and support to our members, and education to our staff and providers in the community.</td>
<td>Engagement through staff training and education to learn more about the LGBTQ community. Will invite to join the CAC.</td>
</tr>
<tr>
<td>Providers, oral health, including culturally specific providers as available (list in first column below)</td>
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<tr>
<td>Dental Provider</td>
<td>Advantage Dental Services</td>
<td>Dental provider.</td>
<td>Will engage through the Innovators Learning Collaborative and provider meetings. Will continue to encourage involvement in the CAC. Plan to engage in the Trillium Training and Education Program.</td>
</tr>
<tr>
<td>Dental Provider</td>
<td>Capitol Dental Care</td>
<td>Dental provider.</td>
<td>Will engage through the Innovators Learning Collaborative and provider meetings. Will also continue to engage and support the use of mobile and on-site dental technicians to be integrated into primary care and behavioral health providers. Will continue to encourage engagement through the CAC Member Engagement Workgroup and Clinical Advisory Panel ED Utilization Workgroup – Health Navigators Taskforce.</td>
</tr>
<tr>
<td>Providers, long term services and supports, including culturally specific providers as available (list in first column below)</td>
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</tr>
<tr>
<td><strong>Area Agency on Aging (AAA) /Aging and Persons with Disabilities (APD) Local Office</strong></td>
<td><strong>Oregon City APD</strong></td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
<td>We will enter into an MOU that delineates how we will work together to ensure effective coordination and collaboration between the CCO and DHS-funded LTC delivery system that includes appropriate sharing of information to promote whole person care; use of interdisciplinary care teams, and coordination around transitions of care.</td>
</tr>
<tr>
<td><strong>Area Agency on Aging (AAA) and Aging and Persons with Disabilities (APD) Local Office</strong></td>
<td><strong>Lane Council of Governments (LCOG) Senior &amp; Disability Services</strong></td>
<td>Provides social services for older adults and those with disabilities.</td>
<td>Engagement of their Diversity Committee to provide an older adult and disability lens to future trainings for providers. Engaged in the CAC and the LEC. Membership on the BOD and Clinical Advisory Panel High Risk Population Workgroup.</td>
</tr>
<tr>
<td><strong>Area Agency on Aging (AAA)/Aging and Persons with Disabilities (APD) Local Office</strong></td>
<td><strong>Asian Health Services</strong></td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services.</td>
<td>We will enter into an MOU that delineates how we will work together to ensure effective coordination and collaboration between the CCO and DHS-funded LTC delivery system that includes appropriate sharing of information to promote whole person care; use of interdisciplinary care teams, and coordination around transitions of care.</td>
</tr>
<tr>
<td>Area Agency on Aging (AAA)/ Aging and Persons with Disabilities (APD) Local Office</td>
<td>Beaverton APD</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
<td>We will enter into an MOU that delineates how we will work together to ensure effective coordination and collaboration between the CCO and DHS-funded LTC delivery system that includes appropriate sharing of information to promote whole person care; use of interdisciplinary care teams, and coordination around transitions of care.</td>
</tr>
<tr>
<td>Area Agency on Aging (AAA)/ Aging and Persons with Disabilities (APD) Local Office</td>
<td>Clackamas County Adult Protective Services</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
<td>Based on our engagement activities to date in the Tri-County Region, Trillium has provided a draft MOU to Multnomah County Aging, Disability &amp; Veterans Services Division, Washington County Developmental Disability Program and Clackamas County Mental Health/Developmental Disabilities with respect to the negotiation and development of a single mutually agreeable MOU post CCO contract award and the continued collaboration between Trillium and the AAAs/APDs in the Tri-County region to further build, develop and enhance our strategic relationship for members receiving DHS Medicaid-funded LTC services.</td>
</tr>
<tr>
<td>Area Agency on Aging (AAA)/ Aging and</td>
<td>Neighborhood House</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
<td>We will enter into an MOU that includes appropriate sharing of information to promote whole person care; use of interdisciplinary care teams, and coordination around transitions of care.</td>
</tr>
<tr>
<td>Persons with Disabilities (APD) Local Office</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
<td>We will enter into an MOU that delineates how we will work together to ensure effective coordination and collaboration between the CCO and DHS-funded LTC delivery system that includes appropriate sharing of information to promote whole person care; use of interdisciplinary care teams, and coordination around transitions of care.</td>
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</tr>
<tr>
<td>Area Agency on Aging (AAA)/Aging and Persons with Disabilities (APD) Local Office</td>
<td>Canby APD</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
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</tr>
<tr>
<td>Area Agency on Aging (AAA)/Aging and Persons with Disabilities (APD) Local Office</td>
<td>Estacada APD</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
<td></td>
</tr>
<tr>
<td>Area Agency on Aging (AAA)/Aging and Persons with Disabilities (APD) Local Office</td>
<td>Hillsboro APD</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
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</tr>
<tr>
<td>Area Agency on Aging (AAA)/Aging and Persons with Disabilities (APD) Local Office</td>
<td>Multnomah County Aging &amp; Disability</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
<td>Based on our engagement activities to date in the Tri-County Region, Trillium has provided a draft MOU to Multnomah County Aging, Disability &amp; Veterans Services Division, Washington County Developmental Disability Program and Clackamas County Mental Health/Developmental Disabilities with respect to the negotiation and development of a single mutually agreeable MOU post CCO contract award and the continued collaboration between Trillium and the AAAs/APDs in the Tri-County region to further build, develop and enhance our strategic relationship for members receiving DHS Medicaid-funded LTC services.</td>
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</tr>
<tr>
<td>Area Agency on Aging (AAA)/Aging and Persons with Disabilities (APD) Local Office</td>
<td>Portland Impact</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
<td>We will enter into an MOU that delineates how we will work together to ensure effective coordination and collaboration between the CCO and DHS-funded LTC delivery system that includes appropriate sharing of information to promote whole person care; use of interdisciplinary care teams, and coordination around transitions of care.</td>
</tr>
<tr>
<td>Area Agency on Aging (AAA)/Aging and Persons with Disabilities (APD) Local Office</td>
<td>Tigard APD</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
<td>We will enter into an MOU that delineates how we will work together to ensure effective coordination and collaboration between the CCO and DHS-funded LTC delivery system that includes appropriate sharing of information to promote whole person care; use of interdisciplinary care teams, and coordination around transitions of care. We will enter into an MOU that delineates how we will work together to ensure effective coordination and collaboration between the CCO and DHS-funded LTC delivery system that includes appropriate sharing of information to promote whole person care; use of interdisciplinary care teams, and coordination around transitions of care.</td>
</tr>
<tr>
<td>Area Agency on Aging (AAA)/Aging and Persons with Disabilities (APD) Local Office</td>
<td>Washington County Disability, Aging and Veterans Services</td>
<td>Provides critical supports and services to CCO members that are eligible for and are receiving DHS-funded LTC services, health and wellness programs, caregiver support services and Older American Act services. The engagement, coordination and collaboration between CCO and LTC system is central to ensuring whole person and coordinated care.</td>
<td>Based on our engagement activities to date in the Tri-County Region, Trillium has provided a draft MOU to Multnomah County Aging, Disability &amp; Veterans Services Division, Washington County Developmental Disability Program and Clackamas County Mental Health/Developmental Disabilities with respect to the negotiation and development of a single mutually agreeable MOU post CCO contract award and the continued collaboration between Trillium and the AAAs/APDs in the Tri-County region to further build, develop and enhance our strategic</td>
</tr>
<tr>
<td><strong>RFA Community Engagement Plan Tables</strong></td>
<td></td>
<td>relationship for members receiving DHS Medicaid-funded LTC services.</td>
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<tr>
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</tr>
<tr>
<td><strong>Area Agency on Aging (AAA) Association</strong></td>
<td><strong>Oregon Wellness Network (OWN)</strong></td>
<td>We have a LOA in place with OWN, the division of the Oregon Association of Area Agencies on Aging and Disabilities that serves as a network hub for the 17 AAAs across the State. We will partner with them to deliver SDOH-HE services.</td>
<td></td>
</tr>
<tr>
<td><strong>Aging Supports and Education</strong></td>
<td><strong>Successful Aging Institute: Lane Community College</strong></td>
<td>Provides classes and education for seniors, manages Senior Companions Program. Engagement through training and Clinical Advisory Subcommittee – Older Adults Stakeholder monthly meeting.</td>
<td></td>
</tr>
<tr>
<td><strong>Assisted and Independent Living, Home Health</strong></td>
<td><strong>EmpRes Healthcare Management</strong></td>
<td>Provides LTC services including skilled nursing, rehabilitation therapy, assisted living, independent living, and home services. We have a Letter of Agreement with EmpRes Healthcare Management for our proposed Service Area and plan to partner/support programs and services that help members receiving LTC services and supports stay in a community-setting.</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Provider</strong></td>
<td><strong>Cascade Health: Pete Moore Hospice House</strong></td>
<td>Provides hospice services. Engagement through the Clinical Advisory Subcommittee – Older Adults Stakeholder monthly meeting.</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Provider</strong></td>
<td><strong>Addus Homecare</strong></td>
<td>Provide Personal Care, Attendant Care, Homemaker, Respite, Home Health, Hospice services. Engagement through provider meetings. Will continue to support integrated clinical case management with in home supportive care and program evaluation.</td>
<td></td>
</tr>
</tbody>
</table>

**Providers, traditional health workers, including culturally specific providers as available (list in first column below)**

<p>| <strong>Behavioral Health Provider (THW)</strong> | <strong>Center for Family Development</strong> | Supports positive individual and family functioning, acceptance, empowerment and growth through outpatient and group mental health, outpatient SUD recovery, health integration, and offense-specific services. Engaged as one of the agencies as part of the Integrated Complex Care Management (ICCM) program. Will continue engagement in provider meetings. |
| <strong>Behavioral Health Provider (THW)</strong> | <strong>Centro Latino Americano</strong> | Provides mental health treatment and resources to social services to Continue to encourage engagement through the CAC, Lane Equity Coalition, |</p>
<table>
<thead>
<tr>
<th><strong>RFA Community Engagement Plan Tables</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioral Health Provider (THW)</strong></td>
</tr>
<tr>
<td>PeaceHealth</td>
</tr>
<tr>
<td>Large provider network that can support cultural competence trainings for hospital locations.</td>
</tr>
</tbody>
</table>

| **Behavioral Health Provider (THW)**     |
| Willamette Family Inc.                   |
| Provides behavioral health and addiction treatment services. Has the only THW Commission approved CHW trainer in Lane County. Employed certified CHW is not currently doing CHW work. Utilized peer support specialist on a daily basis. | Engage this stakeholder in the Pain Guidance and Safety Alliance and through provider meetings. Will continue to support the use of dental technician integration. Plan to engage in the THW Hub. |

| **Doula (THW)**                           |
| Daisy C.H.A.I.N.                          |
| Daisy C.H.A.I.N. provides home visiting postpartum services and lactation support services. | We have a Letter of Agreement in place for our members in Lane County and plan to support/partner to ensure members access postpartum care and lactation support services. |

<table>
<thead>
<tr>
<th><strong>Providers, health care interpreters (list in first column below)</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Language Interpretation Services</strong></td>
</tr>
<tr>
<td>Centro Latino Americano</td>
</tr>
<tr>
<td>Provides Spanish translation services and peer support services. Other services include SUD treatment, community</td>
</tr>
<tr>
<td>Language Interpretation Services</td>
</tr>
</tbody>
</table>

**Early learning hubs (list in first column below)**

| Early Learning Clackamas | Clackamas Early Learning HUB and Clackamas Parenting Together | Provides family and parenting resources across six key projects in Clackamas County. | In collaboration with The Children’s Center of Clackamas County, Trillium will work with the Early Learning HUB and Clackamas Parenting Together to identify needs and program enhancements as well as improve coordination of care. |

| Early Learning Hub of Linn, Benton, and Lincoln Counties | Linn-Benton Community College: Early Learning Hub of Linn, Benton, and Lincoln Counties | Supports projects and work groups in Linn, Benton, and Lincoln Counties and the Confederated Tribes of the Siletz Indians | Will explore a partnership with the college and the United Way Early Learning Alliance to align priorities and eliminate barriers to action. |

| Early Learning Multnomah | United Way of the Columbia-Willamette: Early Learning Multnomah | Provides investments in three areas for families in Multnomah County: kindergarten readiness, family stability, and system alignment. | Will explore a partnership with the United Way of the Columbia-Willamette, align priorities around identified member/community needs and support/partner on programs to address those needs. |

| Early Learning Washington County | Children, Youth and Families: Early Learning Washington County | Offers programs in school readiness and success and family health and stability to families in Washington County. | Will explore a partnership with the Children, Youth and Families: Early Learning Washington County, align priorities around identified member/community needs and |
## RFA Community Engagement Plan Tables

<table>
<thead>
<tr>
<th>Stakeholder (first column)</th>
<th>Support/Partner (second column)</th>
<th>Description (third column)</th>
<th>Notes (fourth column)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lane Early Learning Alliance</td>
<td>United Way of Lane County: Lane Early Learning Alliance</td>
<td>This stakeholder is the central hub for resources and information on the CHP. They administer the CHA and facilitate community events, trainings, and conversations.</td>
<td>Trillium will continue to support (financially &amp; representative) the Lane Equity Coalition and participate in the Early Learning Alliance.</td>
</tr>
<tr>
<td>South-Central Oregon Early Learning Hub</td>
<td>Douglas Education Service District: South-Central Early Learning Hub</td>
<td>Supports six key projects and pilot programs in Douglas, Klamath, and Lake Counties.</td>
<td>We will explore a partnership with the Douglas Education Service District to align priorities and identified member/community needs.</td>
</tr>
</tbody>
</table>

### Local Public Health Authorities (List in First Column Below)

| Local Public Health Authority: Clackamas County | Clackamas County Public Health Division | Clackamas County’s public health department. | We have met with Clackamas County and have provided a draft MOU in compliance with the Sample Contract, ORS 414.153 for the CCO 2.0 program. Multnomah, Washington and Clackamas Counties have indicated a willingness and interest in jointly developing a MOU should Trillium be awarded a CCO 2.0 Contract in these areas. |
| Local Public Health Authority: Douglas County | Douglas Public Health Network | Douglas County’s public health department. | We have a Letter of Agreement with the Douglas Public Health Network to provide services in compliance with the Sample Contract, ORS 414.153 for the CCO 2.0 program. |
| Local Public Health Authority: Lane County | Lane County Public Health | Lane County’s public health department. | We maintain an MOU with this stakeholder and they are engaged through participation in the Pain Guidance and Safety Alliance. Will continue to partner on community health Prevention Projects such as the Quadruple P Parenting Program. Seat on the BOD and CAC. |
| Local Public Health Authority: Linn County | Linn County Public Health | Linn County’s public health department. | We have met with Linn County and will execute an agreement in compliance with the Sample Contract, ORS 414.153 for the CCO 2.0 program. |
| Local Public Health Authority: Multnomah County | Multnomah County Health Department | Multnomah County’s public health department. | We have met with Multnomah County and have provided a draft MOU in compliance with the Sample Contract, ORS 414.153 for the CCO 2.0 program. Multnomah, Washington and Clackamas Counties have indicated a willingness and interest in jointly developing a MOU should Trillium be awarded a CCO 2.0 Contract in these areas. |
| Local Public Health Authority: Washington County | Washington County Public Health | Washington County’s public health department. | We have met with Washington County and have provided a draft MOU in compliance with the Sample Contract, ORS 414.153 for the CCO 2.0 program. Multnomah, Washington and Clackamas Counties have indicated a willingness and interest in jointly developing a MOU should Trillium be awarded a CCO 2.0 Contract in these areas. |

**Local mental health authorities (list in first column below)**

| Local Mental Health Authority (LMHA): Clackamas County | Clackamas County Behavioral Health | Clackamas County’s LMHA providing mental health and addiction services. | We have met with Clackamas County and have provided a draft MOU in compliance with the Sample Contract, ORS 414.153 for the CCO 2.0 program. Multnomah, Washington and Clackamas Counties have indicated a willingness and interest in jointly developing a MOU should Trillium be awarded a CCO 2.0 Contract in these areas. |
| Local Mental Health Authority (LMHA): Douglas County | Adapt | Douglas County’s LMHA providing mental health and addiction | We have a MOU with Adapt and will partner with them on our mutual goal |
| Local Mental Health Authority (LMHA): Lane County | Lane County Behavioral Health | Lane County’s LMHA | Engaged through the BH All Providers meetings, Lane County Pain Guidance & Safety Alliance, CAC (Prevention Workgroup), CAP ED Utilization Workgroup (PreManage Workflows), and Early Childhood Mental Health Workgroup. |
| Local Mental Health Authority (LMHA): Linn County | Linn County Mental Health | Linn County’s LMHA providing mental health and addiction services. | We have a MOU with Linn County Mental Health and will partner with them on our mutual goal to coordinate services and efforts to meet members BH needs, support culturally-specific BH services, maintain the mental health safety net, work towards achieving improved mental health outcomes, and partner to develop a BH plan and a shared community health assessment. |
| Local Mental Health Authority (LMHA): Multnomah County | Multnomah County Mental Health and Addiction Services Division | Multnomah County’s LMHA providing mental health and addiction services. | We have met with Multnomah County and have provided a draft LMHA MOU in compliance with the Sample Contract, ORS 414.153 for the CCO 2.0 program. Multnomah, Washington and Clackamas Counties have indicated a willingness and interest in jointly developing a MOU should Trillium be awarded a CCO 2.0 Contract in these areas. |
| Local Mental Health Authority (LMHA): Washington County | Washington County Mental Health | Washington County’s LMHA | We have met with Washington County |
| Washington County Authority providing mental health and addiction services. and have provided a draft LMHA MOU in compliance with the Sample Contract, ORS 414.153 for the CCO 2.0 program. Multnomah, Washington and Clackamas Counties have indicated a willingness and interest in jointly developing a MOU should Trillium be awarded a CCO 2.0 Contract in these areas. |

| **Other local government (list in first column below)** | **Department of Human Services (DHS)** | **Department of Human Services (DHS)** | Oregon’s human services department Engaged through the CAC Prevention Workgroup, seat on the CAC. Will continue to encourage engagement through the CAP/ED Utilization Workgroup (PreManage Workflows) and alternative to ED Use Taskforce. |

| **Tribes, if present in the service area (list in first column below)** | **Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians** | **Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians** | Meaningful engagement with Tribes, including the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians, is essential to developing a culturally appropriate response tailored to the diverse resources, patterns of care, and needs of each Tribe. Engagement through the CAC. Explore options to sponsor or participate in the next job fair and the next Oregon Tribes’ Youth Summit. Explore engagement through providing an internship program for tribal members interested in a career in the healthcare field. Utilize tribal member staff members/CCO Tribal Engagement Taskforce to engage in committees relevant to align priorities. Explore engagement through presentations at tribe community centers on population health risks such as chronic pain treatment with opiates. Engage the tribes through a bi-annual or quarterly dental-health clinic bus to areas that may be far from a dental clinic. Continue to engage tribal members by |

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<table>
<thead>
<tr>
<th>Tribe</th>
<th>Tribes, including the Grand Ronde Tribe, is essential to developing a culturally appropriate response tailored to the diverse resources, patterns of care, and needs of each Tribe.</th>
<th>Inviting them to community events and, if taking place on tribal lands, request an opening prayer by a Tribal Elder. Requesting partnership and community collaboration. Requested a participant for the Trillium Tribal Advisory Council.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tribe</td>
<td>Tribes, including the Coquille Indian Tribe, is essential to developing a culturally appropriate response tailored to the diverse resources, patterns of care, and needs of each Tribe.</td>
<td>Explore engagement through projects that involve educational assistance, healthcare, and housing (Tribes priorities). The Coquille Indians pride themselves on self-sufficiency and their Elder population.</td>
</tr>
<tr>
<td>Tribe</td>
<td>Tribal providers is essential to developing a culturally appropriate response tailored to the diverse resources, patterns of care, and needs of each Tribe.</td>
<td>A member from Siletz Tribe will join the Tribal Advisory Council. Siletz has offered to provide cultural sensitivity training to Trilliums care coordination team and providers as needed. Siletz will be part of the Tribal team that helps us shape care.</td>
</tr>
<tr>
<td>Tribe &amp; Tribal Provider</td>
<td>Cultural competency training. Collaborate to enhance identified needs, such as social determinant supports, substance addiction treatment, and integrated care.</td>
<td>Provide Cultural Competency Training. Collaborate to enhance identified needs, such as social determinant supports, substance addiction treatment, and integrated care.</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Description</td>
<td>Collaboration</td>
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</tr>
<tr>
<td>Regional Health Equity Coalition</td>
<td>Linn Benton Health Equity Alliance</td>
<td>Collaborates to identify and address health equity issues for key populations in Linn and Benton Counties.</td>
</tr>
<tr>
<td>Regional Health Equity Coalition</td>
<td>Oregon Health Equity Alliance (Multnomah, Clackamas &amp; Washington Counties)</td>
<td>Collaborates to identify and address health equity issues for key populations in the Tri-County Region.</td>
</tr>
<tr>
<td>Early Childhood Development Provider</td>
<td>Early Childhood CARES</td>
<td>Provides early intervention and early childhood special education to infants, toddlers, and preschool-aged children in Lane County</td>
</tr>
</tbody>
</table>
### Table 2: Major activities and deliverables for which the CCO will engage the community

All applicants must complete this full table.

<table>
<thead>
<tr>
<th>Part 2a. List and describe the five to eight major projects, programs and decisions for which the CCO will engage the community.</th>
<th>Part 2b. 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SDOH-HE Funding process:</strong> Trillium will build on best practices from our existing Prevention Fund and Innovation Fund grant funding process to award funding for SDOH-HE projects. The process will use standardized criteria for selecting awardees, informed by CCO 2.0 objectives, the priorities of community members and community needs identified and communicated through the CHA/CHP development process, and our community-oriented committees, subcommittees and workgroups including the CAC, RAC, Health Equity Council and Tribal Advisory Council.</td>
<td>Consult, Involve, Collaborate, and Shared decision-making</td>
</tr>
<tr>
<td><strong>CAC Expansion:</strong> Trillium recently established a new CAC in Douglas County. Our governance structure for CCO 2.0 and our proposed Service Area will include Regional CACs that report up to Regional Boards of Directors (BOD), as detailed in our response to Att.6. F. Composed of representatives of the community and county government, with consumers making up a majority of the membership in accordance with ORS 414.625 and ORS 414.627. Duties of the CAC include, but are not limited to, identifying and advocating for preventive care, SDOH-HE, and Health-Related Services (HRS) practices for Trillium; overseeing a community health needs assessment; and adopting a CHP to serve as strategic guidance for Trillium to address health disparities and meet the health needs of their region. This structure supports our ability to obtain valuable input from each of the communities we serve.</td>
<td>Consult, Involve, Collaborate, and Shared decision-making</td>
</tr>
<tr>
<td><strong>CHA/CHP Collaboration:</strong> Trillium is an active partner in Live Healthy Lane, through which we work with local governments and community partners to develop the CHA and CHP. We are actively engaging with counties, providers, existing CCOs, and community organizations in our proposed Service Area to support a streamlined, coordinated CHA and CHP process. As an example of our commitment to supporting implementation of regional CHPs through community engagement, the Lane Equity Coalition will convene community educational events that address one or more of the priorities set forth by the Lane Equity Coalition.</td>
<td>Inform/communicate, Consult, Involve, and Collaborate</td>
</tr>
</tbody>
</table>
RFA COMMUNITY ENGAGEMENT PLAN TABLES

<table>
<thead>
<tr>
<th>Provider Training and Engagement: To support our efforts to engage providers throughout our existing and proposed Service Area, Trillium’s Fourth Friday Innovators Learning Collaborative consolidates training and learning into a monthly event that will rotate through various topics in each of our Regional Service Areas. As another example, the Pain Guidance &amp; Safety Alliance will be providing trainings to the community and our Provider Network on pain management, opiate use disorder, addiction treatment options, and alternatives to treatment.</th>
<th>Inform/communicate, Consult, Involve, Collaborate, and Shared decision-making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership for Better Health with Food 4 Lane County provides Oregon Health Plan (Medicaid) benefits for over 90,000 residents of Lane County and the Reedsport community of Douglas County. Trillium strives to create a strong, community-based healthcare system that focuses on prevention and delivering high-quality service to members through coordination, collaboration, and partnerships. We will look to establish partnerships with food banks in the Tri-County Region.</td>
<td>Inform/communicate, Consult, and Collaborate</td>
</tr>
<tr>
<td>The Frequent User System Engagement (FUSE) initiative, which Trillium plans to expand into the Tri-County Region, seeks to assist the most vulnerable, homeless adults to thrive and live with dignity, rather than cycle through institutions. Targeting this population can reduce stress on hospitals, jails and police because frequent users often utilize a disproportionate amount of public resources. We will establish similar programs and partnerships (i.e. transitional housing providers such as Washington County Housing Services) in the Tri-County Region.</td>
<td>Inform/communicate and Involve</td>
</tr>
</tbody>
</table>
**RFA COMMUNITY ENGAGEMENT PLAN TABLES**

<table>
<thead>
<tr>
<th></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Consult: Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions.</td>
</tr>
<tr>
<td>3.</td>
<td>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.</td>
</tr>
<tr>
<td>4.</td>
<td>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.</td>
</tr>
<tr>
<td>5.</td>
<td>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.</td>
</tr>
</tbody>
</table>
**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>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><strong>Local public health authorities (list in this column below)</strong></td>
<td><strong>Current Service Area:</strong> Lane County Health and Human Services, Lane County Public Health (LCPH)</td>
<td>Collaboration</td>
<td>Trillium maintains a comprehensive administrative services agreement with Lane County Health and Human Services to facilitate collaboration and communication across programs. Trillium and Lane County are partners with United Way and PeaceHealth in Live Healthy Lane, a community-based</td>
<td>Not applicable.</td>
<td>Not applicable. Trillium will continue to collaborate with Lane County in developing the CHA and CHP and will report on progress to OHA as required.</td>
</tr>
</tbody>
</table>
A collaborative effort to develop the CHA and CHP. Shared health priorities, as identified in the most recent CHA and CHP included as Att. 10.A.2 and Att. 10.A.3, include:

- Employment and Income
- Housing
- Food Security
- Food and Nutrition
- Early Childhood Development
- Tobacco, Alcohol, and Drug Use
- Mental Health
- Sexually Transmitted Infections
- Preventative Care
- Access to Care
- Collaboration, Coordination, and Navigation

| Non-profit hospitals (list in this column below) | Collaboration | Not applicable | Not applicable | Not applicable. Belongs to the PeaceHealth health system and a partner in the Lane County CHA and CHP.

Current Service Area: Cottage Grove Community Hospital Foundation | Collaboration | Not applicable | Not applicable. Trillium will continue to collaborate in developing the CHA and CHP and will report on progress to OHA as required. | Not applicable. Belongs to the PeaceHealth health system and a partner in the Lane County CHA and CHP.
## RFA Community Engagement Plan Tables

<p>| Current Service Area: Peace Harbor Hospital Foundation | Collaboration | Tobacco, Alcohol, and Drug Use | Mental Health | Sexually Transmitted Infections | Preventative Care | Access to Care | Collaboration, Coordination, and Navigation | Not applicable | Not applicable. Trillium will continue to collaborate in developing the CHA and CHP and will report on progress to OHA as required. | Not applicable. Belongs to the PeaceHealth health system and a partner in the Lane County CHA and CHP. |
| Current Service Area: Sacred Heart Hospital Guild Inc. | Collaboration | Tobacco, Alcohol, and Drug Use | Mental Health | Sexually Transmitted Infections | Preventative Care | Access to Care | Collaboration, Coordination, and Navigation | Not applicable | Not applicable. Trillium will continue to collaborate in developing the CHA and CHP and will report on progress to OHA as required. | Not applicable. Belongs to the PeaceHealth health system and a partner in the Lane County CHA and CHP. |</p>
<table>
<thead>
<tr>
<th>Current coordinated care organizations, as of 2019 (list in this column below)</th>
<th>Tobacco, Alcohol, and Drug Use</th>
<th>Mental Health</th>
<th>Sexually Transmitted Infections</th>
<th>Preventative Care</th>
<th>Access to Care</th>
<th>Collaboration, Coordination, and Navigation</th>
</tr>
</thead>
</table>
| Proposed Service Area: Family Care (Washington, Multnomah, Clackamas counties) | Not applicable | Not applicable | Not applicable | Trillium plans to support existing CHA and CHP efforts in our proposed Service Area expansion counties through coordination with the other CCOs. Health priorities include:  
- Community assessment of engagement of transition age youth in their health and healthcare  
- Increased care coordination and engagement in health and healthcare for transition age youth population | Not applicable | Not applicable |
| Proposed Service Area: Health Share Oregon (Clackamas, Multnomah, and Washington Counties) | Not applicable | Not applicable | Not applicable | Not applicable | Trillium plans to support existing CHA and CHP efforts in our proposed Service Area expansion counties through coordination with the other CCOs, including Health Share. Health priorities include:
- Behavioral health
- Chronic disease preventable through physical activity and nutrition |

| Proposed Service Area: InterCommunity Health Network (IHN) (Benton, Lincoln & Linn Counties) | Not applicable | Not applicable | Not applicable | Not applicable | Trillium plans to support existing CHA and CHP efforts in our proposed Service Area expansion counties through coordination with the other CCOs, including IHN. Health priorities include:
- Children’s mental health (prevention and early intervention)
- Mental health and wellness promotion and stigma |
| Proposed Service Area: Umpqua Health Alliance (Douglas county) | Not applicable | Not applicable | Not applicable | Not applicable | Trillium plans to support existing CHA and CHP efforts in our proposed Service Area expansion counties through coordination with the other CCOs, including Umpqua Health Alliance. Health priorities include: Access, Addictions, Mental Health, Healthy Lifestyles, Parents & Children |
| Proposed Service Area: Yamhill County Care Organization (partial Clackamas, Washington) | Not applicable | Not applicable | Not applicable | Not applicable | Trillium plans to support existing CHA and CHP efforts in our proposed Service Area expansion |
counties through coordination with the other CCOs, including Yamhill County Care Organization. Health priorities include:

- Chronic conditions
- Oral health
- PCP capacity and Medicaid enrollment
- Behavioral health and addiction

<table>
<thead>
<tr>
<th>Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)</th>
<th>Unknown</th>
</tr>
</thead>
</table>

* 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. Part 3. Applicants with an existing CHA and CHP will describe gaps in existing relationships with identified organizations. Part 4. Applicants with an existing CHA and CHP will describe the steps the applicant will take to address the identified gaps prior to developing the next CHA and CHP and the dates by which the applicant will complete key tasks for engagement.**</td>
<td>Part 2a. Applicants without an existing CHA and CHP or that intend to change their service area will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO 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 other CHAs or CHPs by entering one of these responses: a) The organization was explicitly involved in developing one or more CHAs or CHPs; b) The organization was not explicitly involved in developing a CHA or CHP; c) unknown. Part 4a. Applicants without an existing CHA and CHP or that intend to change their service area will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area by describing the steps the applicant will take to form relationships and secure participation by each organization prior to developing the first or next CHA and CHP, and the dates by which the applicant will complete key tasks for engagement.**</td>
</tr>
</tbody>
</table>
**Note:** For our existing Service Area, thousands of community members and hundreds of organizations representing public, private and non-profit groups contributed to the Lane County 2015/2016 CHA and the development of the 2016-2019 CHP. For purposes of Table 4, Trillium has included only key CHA and CHP contributors and members of the CAC given the large volume of participants. Additionally, where appropriate we have included additional lists of organizations that address SDOH-E in our Service Area to comply with the types of organizations identified by OHA in the RFA Community Engagement Reference Document.

| 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. | Trillium has established a working partnership. | CTCLUSI provides dental services and primary health care through the Coquille Health and Wellness Center. However, all specialty and hospital services are provided in urban areas and there is a need to collaborate on more intensive care coordination, access and discharge planning. | Trillium plans to engage with this Tribe by:  
- Trillium has extended an invitation to a representative to serve on the Tribal Advisory Council.  
- Extended a personal invitation to join the RAC and CAC. Trillium hand delivered personal invitation to member of interest (Q3-07/01/2019)  
- Participation and presence at various Tribe events open to the public and as invited. Trillium will share event information with | Unknown | Trillium and CTCLUSI have discussed a variety of potential innovative projects such as: expand food access and address food insecurity; provide trauma informed care training for clinicians, and the identification and establishment of post hospital discharge options for individuals traveling to urban areas for health care services. |
| Confederated Tribe of the Siletz Indians | Trillium is in the process of establishing a partnership with Siletz Tribe. A Siletz Tribal member will serve on the Tribal Advisory Committee, but opportunities exist to build trust/relationship more in-depth across the Tribal Council and services departments. | Gaps include:
Need to establish ongoing partnership and processes to share information and health care needs. | CTCLUSI and CTCLUSI will include Trillium on event notices and newsletter distribution. Engage in one event by Q3 07/01/2019
- Engaging Tribal representative in conducting Identity and Culture training. | The organization was explicitly involved in developing one or more CHAs or CHPs. | Trillium would like to meet with the Tribe and learn firsthand the needs and barriers to health care and socio-economic needs, invite others from the community as appropriate, and strategize culturally appropriate solutions together based on identified needs. |
meetings with Tribal representatives will occur in Tribal meeting locations as allowed by the Tribe. Housing, youth programs, and education are top priorities.

- Engaging with Siletz Health Clinic by 12/1/2019
- Conducting an assessment of the healthcare and community needs of the Tribe to collaborate on solutions built on mutual respect and learning. (Ongoing)
- Trillium sign-up for annual subscription of Siletz News

| Coquille Tribe | Trillium has established a working partnership. | Gaps include:  
- The need exists to address community resources and specialty service access.  
- Lack of current partnership with Tribal health centers. | A representative from the Coquille Community Health Center (a Tribal spouse) has agreed to serve on the Trillium Tribal Advisory Council. | Unknown | Trillium would like to meet with the Coquille Tribe and learn firsthand the needs and barriers to health care and socio-economic needs, invite others from the community as appropriate, and strategize culturally appropriate solutions together based on identified needs. |
Cow Creek Band of Umpqua Tribe of Indians | Trillium has established a working partnership with the Clinic and met with the Cow Creek Tribe. Trillium has shared the desire to build a longer-term relationship, based on trust (as we were informed that individuals outside the Tribe are not trusted – part of the cultural history). | Gaps Include: Continue building a relationship through establishment of meetings and listening sessions that focus on the tribe’s needs. | Trillium plan to engage with the Tribe by: Confirming participation in the Trillium Tribal Advisory Council Holding an introductory meeting with Trillium Board representatives and key leadership and the Tribal Council Set up cadence for ongoing meetings. | Unknown | Approach to partnership will be two-fold as Cow Creek tribal members reside on the reservation and across several counties. We will let Cow Creek lead this partnership – as our goal is to be sensitive and support programs that work for the Tribes.

| All regional health equity coalitions (RHECs) that are present in the service area (list in this column below). If no RHEC is present in the service area, note there are none. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | The organization was explicitly involved in developing one or more CHAs or CHPs. | The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a |
| Proposed Service Area: Oregon Health Equity Alliance (Multnomah, Clackamas & Washington Counties) | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | The organization was explicitly involved in developing one or more CHAs or CHPs. | The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process. |
| Local government, including counties | | | | | |
| Cascade West Council of Governments | Not applicable - this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | The organization was explicitly involved in developing one or more CHAs or CHPs. | The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements.
<table>
<thead>
<tr>
<th>City of Beaverton</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>The organization was not explicitly involved in developing a CHA or CHP.</th>
<th>to support a coordinated and streamlined CHA and CHP process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Canby</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>City of Colton</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was not explicitly involved in developing a CHA or CHP.</td>
<td></td>
</tr>
<tr>
<td>City of Estacada</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
<td></td>
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</tbody>
</table>

The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.
<p>| City of Eugene | Partnership with the City on various initiatives and meetings as well as through the Lane County CHP process through representatives from, City Council, Adaptive Recreation, Planning &amp; Development, Public Works, Public Library, NAACP Chapter, School District, Transportation Services, Eugene Water and Electric Board, Police &amp; Fire Department, Prevention Coalition, Senior Services and recreation services. Member of the CAC. | Currently engaged through the CAC as a SDOH partner providing a community lens. There are no gaps in Trillium’s existing relationship with this organization. | Trillium will maintain the strong relationship with the City of Eugene through continued engagement with the Trillium Board of Directors. | Not applicable | Not applicable |
| City of Forest Grove | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | The organization was not explicitly involved in developing a CHA or CHP. | The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area. |</p>
<table>
<thead>
<tr>
<th>City of Gladstone</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>The organization was explicitly involved in developing one or more CHAs or CHPs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Gresham</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was not explicitly involved in developing a CHA or CHP.</td>
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</table>

The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.
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<table>
<thead>
<tr>
<th>City of Happy Valley</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>The organization was explicitly involved in developing one or more CHAs or CHPs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Hillsboro</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was not explicitly involved in developing a CHA or CHP.</td>
</tr>
</tbody>
</table>
| City of Oregon City | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | The organization was explicitly involved in developing one or more CHAs or CHPs. 
needs of our members. 
We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process. |
| City of Portland | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | The organization was explicitly involved in developing one or more CHAs or CHPs. 
The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. 
We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process. |
<p>| City of Reedsport | Did not participate in the Lane County CHP process but was included in the population assessment and CHA. Partners with Compass/Community Health Alliance to provide mental health services to members. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | The organization was not explicitly involved in developing a CHA or CHP. | The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process. |
| City of Roseburg | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | The organization was not explicitly involved in developing a CHA or CHP. | The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process. |
| City of Sandy | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | The organization was explicitly involved in developing one or more CHAs or CHPs. |
| City of Sweet Home | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | Not applicable – this organization did not contribute to the Lane County CHA or CHP. | The organization was not explicitly involved in developing a CHA or CHP. |</p>
<table>
<thead>
<tr>
<th>Organization</th>
<th>Participation Status</th>
<th>CHA/CHP Participation Status</th>
<th>CHA/CHP Development Status</th>
<th>Multi-Sector Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Tigard</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>City of Welches</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>County</td>
<td>Participation Details</td>
<td>CHA or CHP Process Details</td>
<td>Multi-Sector Partnerships</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Clackamas County</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
<td></td>
</tr>
<tr>
<td>Douglas County</td>
<td>Did not participate in the Lane County CHP process but was included in the population assessment and CHA.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
<td></td>
</tr>
</tbody>
</table>
## RFA Community Engagement Plan Tables

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contributions</th>
<th>Gaps in Relationship</th>
<th>Engagement</th>
<th>OHA Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lane County Health and Human Services</td>
<td>The Public Health Division contributed to the Lane County CHA and CHP with their Community Health Analyst and AmeriCorps VISTA Volunteer and Public Health Advisory Committee Member, Senior Community Health Analyst, Public Health Officer, and Prevention Team.</td>
<td>No gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>With OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Lane County Public Health</td>
<td>This organization was a key contributor to the Lane County CHA/ CHP and is a member of the CAC.</td>
<td>No gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Linn County</td>
<td>This organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements.</td>
</tr>
<tr>
<td>Linn County Health Services</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Linn County Mental Health</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
</tbody>
</table>

The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.
<table>
<thead>
<tr>
<th>County</th>
<th>Public Health Organization</th>
<th>CHA/CHP Contribution</th>
<th>CHA/CHP Development</th>
<th>Multi-Sector Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linn County Public</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Multnomah County</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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<tr>
<th>Washington County</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
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<th>The organization was explicitly involved in developing one or more CHAs or CHPs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizations that address the four key domains of social determinants of health* (list in this column below).</td>
<td></td>
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<td></td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Adventures Without Limits</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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</tr>
<tr>
<td>Albany InReach Services</td>
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</tr>
<tr>
<td>Boys &amp; Girls Club of Corvallis</td>
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</tr>
</tbody>
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<tr>
<th>Boys &amp; Girls Club of the Greater Santiam</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>The organization was explicitly involved in developing one or more CHAs or CHPs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center Against Rape &amp; Domestic Violence</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
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<table>
<thead>
<tr>
<th>Organization</th>
<th>Participation</th>
<th>Description</th>
<th>Multi-sector Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colton Helping Hands</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Communities Helping Addicts Negotiate Change Effectively (CHANGE)</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Organization</td>
<td>Contribution to Lane County CHA/CHP</td>
<td>Multi-sector partnerships</td>
<td>Success in Meeting Needs</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------</td>
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</tr>
<tr>
<td>Community Health Centers of Benton and Linn Counties</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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<tr>
<td>Cornerstone Community Housing</td>
<td>This organization was a key contributor to the Lane County CHA/CHP. Member of the LiveHealthy 100% Health Community Coalition Executive Committee; CHNA/CHIP Core Team and CAC.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Corvallis School District</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
</tr>
</tbody>
</table>
### Food for Lane County

Partnered with Food for Lane County to support various programs and initiatives, such as support of the Veggie Rx and Food for Better Health Programs. This organization is also involved in the CAC and various other Trillium committees. This organization contributed to the Lane County CHA/CHP.

There are no gaps in Trillium’s existing relationship with this organization.

Not applicable

Not applicable

Not applicable

The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.

### Head Start

Not applicable – this organization did not contribute to the Lane County CHA or CHP.

Not applicable – this organization did not contribute to the Lane County CHA or CHP.

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The organization was explicitly involved in developing one or more CHAs or CHPs.
### RFA Community Engagement Plan Tables

<table>
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<tr>
<th>Organization</th>
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<tr>
<td><strong>Jackson Street Youth Shelter</strong></td>
<td></td>
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<tr>
<td><strong>Kidco Head Start</strong></td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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<table>
<thead>
<tr>
<th>Linn Benton Health Equity Alliance</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
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<td>Linn-Benton Housing Authority</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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<tr>
<td>Linus Pauling Institute – Healthy Youth Program Love, Inc.</td>
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<td>Meals on Wheels</td>
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<tr>
<td>Mid-Valley Health Care Advocates</td>
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<td>Milestones Family Recovery</td>
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<td>Multi-Cultural Resource Center</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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</tr>
<tr>
<td>Oregon Cascades West Council of Governments</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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<td>OSU Extension</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
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<td>Philomath School District</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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<tr>
<td>Organization</td>
<td>CHP process.</td>
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</tr>
<tr>
<td>Self-Enhancement Inc.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs. The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
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</tr>
<tr>
<td>ShelterCare</td>
<td>The organization was a key contributor to the Lane County CHA/CHP and is a member of the CAC. There are no gaps in Trillium’s existing relationship with this organization. Not applicable Not applicable Not applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Mary’s Church/Stone Soup</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs. The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
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</tr>
<tr>
<td>Ten Rivers Food Web</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
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<tr>
<td>The Intertwine Alliance</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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</thead>
<tbody>
<tr>
<td><strong>United Way of Lane County (UWLC)</strong></td>
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<tr>
<td><strong>Verde</strong></td>
</tr>
<tr>
<td><strong>VOZ Worker’s Rights Education Project</strong></td>
</tr>
<tr>
<td>Willamette Neighborhood Housing Services</td>
</tr>
<tr>
<td>Proposed Service Area Expansion: Clackamas, Washington,</td>
</tr>
</tbody>
</table>

To identify additional entities that should be engaged in CHA/CHP
Multnomah

| Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column). | 
|---|---|---|---|---|
| Engagement through the Clinical Advisory Panel. Engaged as one of the agencies who is a part of the Integrated Complex Care Management project with Trillium. Will continue engagement in the All Providers meeting. This organization contributed to the Lane County CHP. | There are no gaps in Trillium’s existing relationship with this organization. | Not applicable | Not applicable | Not applicable |

| Center for Family Development (CHWs) | 
|---|---|---|---|---|
| Engagement through the LiveHealthy Lane 100% Health | There are no gaps in Trillium’s existing relationship with this | Not applicable | Not applicable | Not applicable |

<p>| Centro Latino Americano (Peer Support Specialist) |
|---|---|---|---|---|
| Engagement through the LiveHealthy Lane 100% Health | There are no gaps in Trillium’s existing relationship with this | Not applicable | Not applicable | Not applicable |</p>
<table>
<thead>
<tr>
<th>Organization</th>
<th>Engaged through</th>
<th>Relationship Notes</th>
<th>Notes</th>
<th>Notes</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Coalition Executive Committee, CAC, Lane Equity Coalition, and All Providers meeting. Will continue to engage this stakeholder to providing language interpretation resources to the community as well as trainings on cultural competency and will invite to join the Training and Education Subcommittee. This organization contributed to the Lane County CHP.</td>
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</tr>
<tr>
<td>Cornerstone Community Housing (CHWs)</td>
<td>Engagement through the Health Navigators Taskforce under the Clinical Advisory Panel. This organization contributed to the Lane County CHP. Member of LiveHealthy 100% Health Community Coalition Executive Committee and the CAC.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Laurel Hill Center (Peer Support Specialist)</td>
<td>Engagement through the All Provider Meeting. This organization contributed to the Lane County CHP.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>NAMI of Lane County (Peer Support)</td>
<td>Trillium has contracted with this organization to</td>
<td>There are no gaps in Trillium’s existing</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Specialist</td>
<td>Oregon Family Support Network (Family Support Specialist)</td>
<td>PeaceHealth (CHWs, Patient Navigator)</td>
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</tr>
<tr>
<td>provide family and peer education and classes addressing needs of those with chronic mental illness. This organization contributed to the Lane County CHP.</td>
<td>Engaged as a provider for trainings for the Older Adult Behavioral Health Specialist on Mental Health First Aid. Will continue to engage through the Board of Directors and trainings for providers and community members with children who have mental health needs or developmental disabilities. This organization contributed to the Lane County CHA/CHP.</td>
<td>Engagement and partnership through the Lane Equity Coalition, All Providers Meeting, Pain Guidance and Safety Alliance, and the Innovators Learning Collaborative. Engaged in PreManage Workflows, Alternative to ED, and Credentialing. This</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>relationship with this organization.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization with regards to CHA/CHP engagement.</td>
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<tr>
<td>Organization</td>
<td>Engagement Details</td>
<td>Not Applicable Comments</td>
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</tr>
<tr>
<td>ShelterCare (Peer Support Specialist)</td>
<td>Contributed to the Lane County CHA/CHP. Member of the LiveHealthy 100% Health Community Coalition Executive Committee and CHNA/CHIP Core Team.</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>The Child Center (CHWs)</td>
<td>Engaged through the Lane County Pain Guidance and Safety Alliance. This organization did not contribute to the Lane County CHP.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Will engage in demographic records training. Plan to engage in the Clinical Advisory Subcommittee Severe and Persistent Mental Illness workgroup (SPMI).</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Willamette Family Treatment (CHWs, Peer Support Specialist)</td>
<td>Trillium engages with this stakeholder in the Lane County Pain Guidance and Safety</td>
<td>There are no gaps in Trillium’s existing relationship with this organization</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
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<tr>
<td><strong>Alliance and through the All Provider meetings. Will continue to support the use of dental technician integration. This organization did not contribute to the Lane County CHP.</strong></td>
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<tr>
<td><strong>Youth ERA (Youth Support Specialist)</strong></td>
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<tr>
<td>Youth ERA also employs a THW Commission approved Youth Support Specialist trainer. Trillium will explore using this trainer to educate relevant staff. This organization did not contribute directly to the Lane County CHA/CHP.</td>
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<tr>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
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<tr>
<td>Not applicable</td>
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<td>Not applicable</td>
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<tr>
<td><strong>Proposed Service Area Expansion: Clackamas, Washington, Multnomah (examples: Bridges to Change, Lifeworks NW, Native American Rehabilitation Association)</strong></td>
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<tr>
<td>Not applicable</td>
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<td>Not applicable</td>
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<td>Not applicable</td>
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<tr>
<td>Not applicable</td>
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<tr>
<td><strong>Culturally specific organizations and organizations that work with underserved or at-risk populations (list in this column below).</strong></td>
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</tbody>
</table>

Trillium will work with providers, THW associations, and representatives in our proposed expanded Service Area to identify and verify organizations that employ THWs that Trillium should engage in the CHA/CHP process by March 2020 as we have done in Lane County.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Engagement Through</th>
<th>Relationship with Trillium</th>
<th>Involvement in CHA/CHP Development</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging and People with Disabilities (APD)/Lane Council of Governments</td>
<td>The Department of Human Services Aging and People with Disabilities (APD) program assists seniors and people with disabilities of all ages to achieve well-being through opportunities for community living, employment, family support and services that promote independence, choice and dignity. This organization contributed to the Lane County CHA/CHP.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Centro LatinoAmericano</td>
<td>Engagement through the LiveHealthy Lane 100% Health Community Coalition Executive Committee, CAC, Lane Equity Coalition, and All Providers meeting. Will continue to engage this stakeholder to providing language interpretation resources to the community as well as trainings on cultural competency and will invite to join the Training and Education Subcommittee. This organization</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Organization Name</td>
<td>Key Contribution</td>
<td>Existing Relationship/Committee Engagement</td>
<td>Not Applicable Description</td>
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</tr>
<tr>
<td>Lane County Developmental Disabilities.</td>
<td>This organization was a key contributor to the Lane County CHA/ CHP and is a member of the CAC.</td>
<td>No committee engagement.</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Womenspace</td>
<td>Provides safety, hope, and healing for survivors of domestic violence. This organization contributed to the Lane County CHA/ CHP.</td>
<td>Trillium will seek to engage Womenspace in Collaborative and committees.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
<td></td>
</tr>
<tr>
<td>Youth ERA</td>
<td>Trillium has an agreement with Youth ERA to provide child and youth Wraparound and Peer Support Services. This organization contributed to the Lane County CHA/ CHP.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Other organizations (list in this column below).</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4J School District</td>
<td>This organization was a key contributor to the Lane County CHA/ CHP and is a member of the CAC.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Adelante Mujeres</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Contribution to CHA/CHP</td>
<td>Relationship Status</td>
<td>Not Applicable</td>
<td>Remarks</td>
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<tr>
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</tr>
<tr>
<td>Advantage Dental</td>
<td>This organization was a key contributor to the Lane County CHA/CHP and is a member of the CAC.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Africa House</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>APANO</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
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Page 91 of 111
The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>The organization was explicitly involved in developing one or more CHAs or CHPs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Family Center</td>
<td></td>
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</tr>
<tr>
<td>Asian Health &amp; Services Center</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Organization</td>
<td>Success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
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</tr>
<tr>
<td>Cascade Health Solutions</td>
<td>This organization was a key contributor to the Lane County CHA/ CHP and is a member of the LiveHealthy 100% Health Community Coalition Executive Committee. There are no gaps in Trillium’s existing relationship with this organization. Not applicable Not applicable Not applicable</td>
<td></td>
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</tr>
<tr>
<td>Center for Intercultural Organizing</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP. Not applicable – this organization did not contribute to the Lane County CHA or CHP. Not applicable – this organization did not contribute to the Lane County CHA or CHP. The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
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<tr>
<td>Community Health Centers of Lane County</td>
<td>This organization was a key contributor to the Trillium’s existing Not applicable Not applicable Not applicable</td>
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</tbody>
</table>

The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Relationship with this organization.</th>
<th>Contributions to Lane County CHA/ CHP</th>
<th>Contributions to CHAs or CHPs</th>
<th>Multi-sector partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lane County CHA/ CHP and is a member of the CAC; LiveHealthy 100% Health Community Coalition Executive Committee; CHNA/CHIP Core Team.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA/ CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA/ CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA/ CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Coquille Indian Tribe Community Health Center</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA/ CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA/ CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA/ CHP.</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Domestic Violence Resource Center</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Organization</td>
<td>OHA Requirement</td>
<td>CHA or CHP Engagement</td>
<td>CHP Process Engagement</td>
<td>Multi-Sector Partnerships</td>
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</tbody>
</table>
| El Centro Milagro (Miracle Theater) | Not applicable  | Not applicable        | Not applicable         | The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.
<p>| Elders in Action                    | Not applicable  | Not applicable        | Not applicable         | The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process. |</p>
<table>
<thead>
<tr>
<th><strong>Organization</strong></th>
<th><strong>CHA Process</strong></th>
<th><strong>CP Process</strong></th>
<th><strong>Notes</strong></th>
<th><strong>Notes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hacienda Community Development Corporation</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Head Start</td>
<td>This organization was a key contributor to the Lane County CHA/ CHP and is a member of the CAC.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>HomePlate Youth Services</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
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</table>

The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Relationship with the Lane County CHA/CHP</th>
<th>Existing Relationship</th>
<th>Contributions to CHA/CHP</th>
<th>Future Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homes for Good</td>
<td>This organization was a key contributor to the Lane County CHA/CHP and is a member of the CAC.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Immigrant &amp; Refugee Community Organization</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Jewish Family &amp; Child Services</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
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</tbody>
</table>

We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.

The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.
<table>
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<tr>
<th>Organization</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</th>
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<tbody>
<tr>
<td>Kairos PDS</td>
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<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>This organization was a key contributor to the Lane County CHA/CHP and is a member of the LiveHealthy 100% Health Community Coalition Executive Committee.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Lane County Consumer Council</td>
<td>This organization was a key contributor to the Lane County CHA/CHP and is a member of the CAC.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Latino Network</td>
<td>Not applicable – this organization did not</td>
<td>Not applicable – this organization did not</td>
<td>Not applicable – this organization did not</td>
<td>The organization was explicitly involved in</td>
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</tbody>
</table>
<pre><code>                                      |                                                                                  |                                                                                  |                                                                                  | The multi-sector partnerships that we will                                                                 |
</code></pre>
<table>
<thead>
<tr>
<th>Organization</th>
<th>Contribute to the Lane County CHA or CHP.</th>
<th>Contribute to the Lane County CHA or CHP.</th>
<th>Contribute to the Lane County CHA or CHP.</th>
<th>Developing one or more CHAs or CHPs.</th>
<th>Establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lines for Life</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
<td>Trillium has collaborated with this organization to support opiate reduction work, including hosting their Director and speakers for the Lane County Opiate Reduction Summit in 2016, and sponsorship of the 2018 Oregon Pain Guidance and Safety Conference. We continue to collaborate and will be supporting the 2019 Conference this year in Bend. The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>RFA Community Engagement Plan Tables</td>
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<tr>
<td><strong>Los Ninos Cuentan</strong></td>
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<tr>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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<tr>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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<tr>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
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<tr>
<td>success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
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</tbody>
</table>

<p>| <strong>Lutheran Community Services Northwest</strong> |
| Not applicable – this organization did not contribute to the Lane County CHA or CHP. |
| Not applicable – this organization did not contribute to the Lane County CHA or CHP. |
| Not applicable – this organization did not contribute to the Lane County CHA or CHP. |
| The organization was explicitly involved in developing one or more CHAs or CHPs. |
| The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process. |</p>
<table>
<thead>
<tr>
<th>Organization</th>
<th>Engagement Details</th>
<th>Relevant Information</th>
<th>Partnership Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>McKenzie-Willamette Medical Center</td>
<td>This organization was a key contributor to the Lane County CHA/CHP and is a member of the LiveHealthy 100% Health Community Coalition Executive Committee.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Monika’s House</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Native Youth and Family Center (NAYA)</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
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<table>
<thead>
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<th>Organization</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA/CHP.</th>
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<th>The organization was explicitly involved in developing one or more CHAs or CHPs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon Health &amp; Science University</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon Medical Group</td>
<td>This organization was a key contributor to the Lane County CHA/CHP and is a member of the LiveHealthy 100% Health Community Coalition Executive Committee.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>PacificSource Health Plans</strong></td>
<td>This organization was a key contributor to the Lane County CHA/CHP and is a member of the Live Healthy 100% Health Community Coalition Executive Committee.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td><strong>PeaceHealth</strong></td>
<td>This organization was a key contributor to the Lane County CHA/CHP and is a member of the LiveHealthy 100% Health Community Coalition Executive Committee and CHNA/CHIP Core Team.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization as it relates to the CHA/CHP.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Planned Parenthood of Southwestern Oregon</strong></td>
<td>This organization was a key contributor to the Lane County CHA/CHP and is a member of the LiveHealthy 100% Health Community Coalition Executive Committee.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Portland African American Leadership Forum</strong></td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Portland Community Reinvestment Initiatives</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Portland Indian Leaders Roundtable</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
</tbody>
</table>

The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.

The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Contribution</th>
<th>CHA/CAP Contribution</th>
<th>CHP/CAP Contribution</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portland Youth &amp; Elders Council</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs. The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Project Access NOW</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs. The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Sacred Heart Medical</td>
<td>This organization was a</td>
<td>There are no gaps in</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Center</td>
<td>key contributor to the Lane County CHA/CHP and is a member of the LiveHealthy 100% Health Community Coalition Executive Committee.</td>
<td>Trillium’s existing relationship with this organization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Safe Families for Children</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs. The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Slavic Network of Oregon</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
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</tr>
<tr>
<td>Organization</td>
<td>Contributions</td>
<td>Relationships</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>South Lane Mental Health</td>
<td>This organization was a key contributor to the Lane County CHA/ CHP and is a member of the LiveHealthy 100% Health Community Coalition Executive Committee.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Tigard Turns the Tide</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Todos Juntos</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Tualatin Together</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
<tr>
<td>Urban League of Portland</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</td>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
</tr>
</tbody>
</table>

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The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.
### RFA Community Engagement Plan Tables

<table>
<thead>
<tr>
<th>Organization</th>
<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
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<th>Not applicable – this organization did not contribute to the Lane County CHA or CHP.</th>
<th>The organization was explicitly involved in developing one or more CHAs or CHPs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voices Set Free</td>
<td></td>
<td></td>
<td></td>
<td>The multi-sector partnerships that we will establish with entities, providers, and organizations in our proposed Service Area are foundational to our success in meeting the needs of our members. We will outreach and engage with this stakeholder by March 2020 in accordance with OHA requirements to support a coordinated and streamlined CHA and CHP process.</td>
</tr>
<tr>
<td>Volunteers in Medicine</td>
<td>This organization was a key contributor to the Lane County CHA/ CHP and is a member of the LiveHealthy 100% Health Community Coalition Executive Committee.</td>
<td>There are no gaps in Trillium’s existing relationship with this organization.</td>
<td>Not applicable</td>
<td>Not applicable</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.

<table>
<thead>
<tr>
<th>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.</th>
<th>Part 1a. Source for priority (i.e. which CHP it came from).</th>
<th>Part 1b. 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>Economic development: invest in workforce strategies that provide sustainable, family wage jobs</td>
<td>Lane County Regional, Washington County, Community Powered Change (Multnomah County)</td>
<td>Other</td>
</tr>
<tr>
<td>Affordable housing: encourage safe, affordable housing including integrated and supportive housing</td>
<td>Lane County Regional, Washington County</td>
<td>Priority population</td>
</tr>
<tr>
<td>Access to healthy food: assure availability of affordable healthy foods and beverages</td>
<td>Lane County Regional, Yamhill CCO, Health Share CCO, Douglas County</td>
<td>Health outcome goal</td>
</tr>
<tr>
<td>Address the underlying causes of chronic disease, improve prevention efforts, and reduce the burden of chronic disease</td>
<td>Linn County</td>
<td>Health outcome goal</td>
</tr>
<tr>
<td>Early childhood development: promote programs for positive development and safe/nurturing environments</td>
<td>Lane County Regional</td>
<td>Priority population</td>
</tr>
<tr>
<td>Preventive healthcare services: support evidence-based preventive screening and referral policies and services</td>
<td>Lane County Regional, Washington County, Health Share CCO</td>
<td>Health outcome goal</td>
</tr>
<tr>
<td>Collaboration: strengthen collaborations and align resources to improve community well-being</td>
<td>Lane County Regional, Community Powered Change (Multnomah County), Linn County</td>
<td>Other</td>
</tr>
<tr>
<td>Healthy workplaces: encourage organizations to integrate health criteria into decision making</td>
<td>Lane County Regional, Douglas County</td>
<td>Health outcome goal</td>
</tr>
<tr>
<td>Education: Increase healthy lifestyle resources and education for preschool-aged children</td>
<td>Washington County, Douglas County</td>
<td>Priority population</td>
</tr>
<tr>
<td>Racial Disparities: Reduce systemic racism and racial disparities in access to care</td>
<td>Clackamas County, Community Powered Change (Multnomah County), Health Share CCO</td>
<td>Priority population</td>
</tr>
<tr>
<td>Access to culturally and linguistically appropriate care</td>
<td>Yamhill CCO, Community Powered Change (Multnomah County), Health Share CCO</td>
<td>Priority population</td>
</tr>
</tbody>
</table>
### RFA Community Engagement Plan Tables

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Area</th>
<th>Health Outcome/Priority Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation: Convene non-emergent medical transportation (NEMT) group to increase access and coordination of transportation in Douglas County</td>
<td>Douglas County, Linn County</td>
<td>Health outcome goal</td>
</tr>
<tr>
<td>Reduce tobacco use and initiation</td>
<td>Linn County</td>
<td>Health outcome goal</td>
</tr>
<tr>
<td>Improve access and appropriate utilization of mental health services</td>
<td>Linn County</td>
<td>Health outcome goal</td>
</tr>
<tr>
<td>Delay initial onset of youth substance use</td>
<td>Linn County</td>
<td>Priority population</td>
</tr>
<tr>
<td>Expand options for drug-free housing for recovering addicts in treatment</td>
<td>Linn County</td>
<td>Priority population</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.

Each of Trillium’s Regional Community Advisory Councils (CAC) will review all Service Area CHPs to identify an initial set of SDOH-HE priorities by January 15, 2020. SDOH-HE priorities identified from the CHPs will include any priorities that impact economic stability, education, neighborhood and built environment, and social and community health. The initial list of priorities will include housing, in line with the statewide priority, as identified in the current priority list above. Each CAC will be charged with defining each of the initial priorities as part of their priority identification process. This initial list will be reviewed by each CAC and will be shared with community partners through various stakeholder communication methods (committees, email lists, website, CHP entities, and direct communication by Trillium staff). The CAC will incorporate community partner feedback and revise the list of priorities to submit to the Trillium Board of Directors by March 1, 2020. Upon Board approval, staff will submit the final list of priorities, including input from the CAC and community partners, to OHA by March 15, 2020.

*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.
As a locally-based, community-rooted CCO, Trillium Community Health Plan (Trillium) has over 20 years’ experience engaging and developing sustainable partnerships with community members, providers, and stakeholders to collaboratively address and improve health and disparities that exist amongst our members and the community, as shown in Table 1 of Att. 10.

RFA Community Engagement Plan Required Tables.

**Community Engagement.** Trillium has a trusted presence in our existing Service Area of Lane, and contiguous zip codes in Benton, Coos, Douglas, and Linn Counties (Lane Region). We have experience engaging with multi-sector partners including local, State and county agencies, providers, consumers and consumer advocates, community-based organizations, and school districts. Our collaborations focus on key issues (e.g. increasing access to services; workforce development; addressing social determinants of health and health equity (SDOH-HE) and health promotion and prevention). Our community engagement strategy framework includes assessment of community need, engaging local stakeholders, jointly establishing community health and equity priorities, identifying shared solutions to address priorities, implementing strategies based on stakeholder input, and tracking outcomes for continuous quality improvement. We will tailor our strategies to each community and intend to dovetail with and leverage existing community health assessment (CHA) and community health improvement plan (CHP) processes in place today in the Tri-County Region (Clackamas, Multnomah and Washington Counties), Linn and Douglas Counties.

Process for Stakeholder Input that Informs Decision-Making, Programs and Investments.** Trillium takes a grassroots approach to engaging the community via Trillium’s extensive governance structure (described in detail in Att. 6.F. Oversight and Governance) including the Community Advisory Council (CAC), Rural Advisory Council (RAC), Clinical Advisory Panel (CAP), Compensation Advisory Committee, and the Finance Advisory Committee. We are also establishing a Tribal Advisory Council and Health Equity Council (chaired by our Health Equity Officer), which will report directly to our Trillium Governing Board (Board). These committees are Board-chartered, and report directly to the Board or Regional Board of Directors (BOD).

**CHA and CHP.** Over the last six years as a CCO, Trillium has engaged community partners and providers in conducting a CHA and developing a CHP, in collaboration with Live Healthy Lane (a collaboration between Trillium, the United Way of Lane County, Lane County Public Health, and PeaceHealth). CHA/CHP engagement includes physical (PH) behavioral health (BH), oral health, long term care (LTC), education, housing, business, economic development, early childhood, social services, and non-emergent transportation sectors. The multi-faceted process includes surveys, interviews, focus groups, and community events to solicit input from residents, consumers, key stakeholders and other partners. To date, *this community-driven process has engaged over 2,500 individuals and 200 organizations.* The CHA outlines community needs and disparities and the CHP identifies priorities, shared goals, and metrics that Trillium uses to inform investment decisions. The Board uses the CHP to inform their decisions about health transformation initiatives. Through the Live Healthy Lane website, we also publish the CHA/CHP and other relevant resources and articles to promote awareness of initiatives and opportunities to improve the health of our community. **CAC and RAC.** Trillium has both a CAC and RAC that meets monthly in-person. The RAC is focused on disparities in rural areas such as access, transportation, BH and SDOH. Trillium also recognized the need for an advisory council in Reedsport that reflects the unique challenges faced by that community. Quarterly meetings in
Reedsport have been scheduled with consumers, healthcare and safety net providers to discuss opportunities for broader member engagement. As documented in the CAC Charter, the purpose of the CAC and RAC is to engage Trillium members and the community as a whole to advise and make recommendations to the Board on the strategic direction of the organization, ensure that Trillium remains responsive to consumer and community health needs, and advise on the design and priorities of Trillium in achieving the Triple Aim. The Board includes representation from the CAC and RAC to provide a direct conduit and bi-directional feedback process between the community and the Board. For CCO 2.0, Trillium is in the process of updating its CAC Charter to reflect the central role the CAC will play in tracking, reviewing and determining how Trillium’s SDOH-HE spending occurs. CAP. The CAP is designed to engage providers in the region to build networks of care to improve patient outcomes and satisfaction and reduce cost. The CAP includes a broad spectrum of clinicians representing primary care, LTC, BH, rural providers, community clinics, and other specialties. Providers are also engaged through other educational opportunities such as our Innovators Learning Collaborative.

Additional Stakeholder Input Mechanisms. Trillium tailors community engagement strategies based on needed decisions and impacts, as outlined in Table 2 of Att. 10 RFA Community Engagement Plan Required Tables. For example, when developing this Application, Trillium conducted stakeholder interviews with 21 multi-sector community stakeholders and conducted listening sessions with 20+ community organizations. We inform the community through press releases and information shared through community partners and our public website; consults with the community through public meetings and listening sessions; involves the community through key stakeholder meetings and roundtables such as our monthly Trillium Innovators Collaboratives, collaborates through our advisory committees and CHA/CHP process; engages stakeholders through subcommittees and workgroups such as the Alternatives to Emergency Room Task Force, Member Engagement subcommittee; and shares decisions with the community by engaging them in our investment assessment process.

Elevating the Member Voice. Two individual member representatives sit on the Trillium Board. The CAC, which is made up of 51% OHP consumers, presents a written monthly update to the Board and reports to the Board on special projects. The CAC Prevention Subcommittee, comprised of consumers and stakeholders, is charged with evaluating prevention investments in accordance with the Prevention Plan. The Subcommittee makes recommendations to the CAC, which goes to the Finance Committee and Board for adoption.

Potential Barriers for Community Engagement and Proposed Solutions. Based on our experience with the CAC and RAC and identified needs through the CHA and CHP, potential barriers and solutions are outlined below:

<table>
<thead>
<tr>
<th>Community Engagement Barriers and Solutions</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation costs</td>
<td>Consumer members of the RAC who travel to meetings from rural communities receive mileage reimbursement. CAC/RAC members with disabilities or mobility issues receive free transportation through our transportation partners.</td>
</tr>
<tr>
<td>Language barriers</td>
<td>Trillium accommodates consumers facing language barriers by providing interpreter services and translating materials in the consumer’s preferred language and formats.</td>
</tr>
<tr>
<td>Literacy</td>
<td>Trillium accommodates different learning styles. We use popular education techniques to engage members in meetings (i.e. small groups, round robin, and physical exercises) to meet stakeholder needs.</td>
</tr>
<tr>
<td>Rural isolation</td>
<td>Trillium maintains the RAC to represent rural perspective and needs. We also recently appointed a rural health clinical provider to the Board. We support the voice of our rural communities.</td>
</tr>
</tbody>
</table>
### Community Engagement Barriers and Solutions

<table>
<thead>
<tr>
<th>Accessibility for members with disabilities</th>
<th>Meetings are held in accessible buildings. Trillium has accommodated hard-of-hearing stakeholders with the use of an amplifier. Trillium also conducts meetings using a trauma-informed framework to support those with BH disabilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tribal disenfranchisement</td>
<td>Trillium includes a Native American member on the CAC and continues targeted outreach to tribes in our Service Area including Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians; Coquille Tribe; and the Siletz Tribe. Trillium is also hiring a Tribal Liaison to catalyze tribal engagement in our current and planned Service Areas.</td>
</tr>
</tbody>
</table>

### Quality Improvement

We maintain bi-directional feedback between the Board and the CAC to ensure issues that arise are quickly identified and addressed. Progress, decisions or resolutions are reported back to the CAC. For example, the CAC provided a root cause analysis to the Board on missed appointments and the Board tasked Trillium with developing strategies to address.

### CAC and RAC

Trillium is highly committed to supporting engagement through the CAC and RAC, which starts with ensuring representative recruitment, creating strong linkages between the CAC, RAC, and Board, and engaging the CAC/RAC in critical CCO decision-making. Trillium’s philosophy is in alignment with OHPB recommended Policy #4 and CAC meetings follow requirements as outlined in ORS 414.627.

### Current CAC Structure and Roles

Trillium’s CAC includes representatives of the community and each county government in our Service Area, with consumers comprising a majority of the membership, including one at large consumer member of the CAC that also serves on the Trillium Board. Two co-chairs lead the CAC and the CAC Coordinator facilitates the meetings. Duties of the CAC include, but are not limited to, identifying and recommending preventive programs to be funded by Trillium prevention dollars, overseeing the CHA and adopting a CHP to serve as strategic guidance for Trillium to address health disparities and needs in Lane County and western Douglas County. Today, three CAC members serve as representatives on the Trillium Board. Two of the representatives are consumer members of the CAC, and the other a non-consumer, community leader member of the CAC. These representatives are full voting members of the Trillium Board and are responsible for ensuring two-way communication between the CAC and the Board regarding CAC activities and recommendations and assisting the Board in its work to communicate with the larger community. We recently established a CAC in western Douglas County to address needs of our members in the Reedsport area. RAC.

Trillium’s RAC provides critical input and makes recommendations to the Trillium Board regarding the important needs of rural areas. Two RAC members serve on the CAC, with one serving as a representative to the Trillium Board. As with the CAC, the RAC representative is a full voting member of the Board and is responsible for ensuring two-way communication between the RAC and the governing board regarding RAC activities and recommendations, as well as assisting the governing board in its work to communicate with rural areas of Lane and Western Douglas County. Trillium also recently appointed a rural health clinical provider to the Trillium Board to represent the rural perspective. Plan for Adapting CAC Structure.

### Aligning Priorities

Trillium strongly believes that each Region in our proposed Service Area requires its own CAC given communities’ unique characteristics, needs, and resources. To ensure each CAC is benefiting from the knowledge and best practices of other CACs, Trillium proposes to establish a CAC Council where each of the CAC/RAC leadership can meet quarterly and share region-specific priorities, initiatives, success factors and provide feedback. Where rural needs are aligned, we will consider establishing a regional RAC or RACs as opposed to an individual RAC per Region.
paired with internal data to capture the characteristics of the communities we serve. We use a tool based on the OHA CAC Member Assessment Recruitment Matrix to ensure all appropriate communities are represented on the CAC/RAC, taking into account race/ethnicity, age, sexual orientation, gender, ability, language, and national/native origins. For non-consumer members, we use the priorities in the CHP to ensure that the community organizations we recruit to serve on the CAC and RAC can effectively inform CHP activities. We will use this same process in our proposed Service Area expansion, building on our Lane County success in CAC and RAC recruitment and retention.

Engaging Consumers on the CCO Board. The CACs will report at least annually to the Board and the Regional BODs. For CCO 2.0, CACs will have two representatives on each Regional BOD. In addition to CAC members serving on the Board and Regional Board, Trillium leaders and staff attend CAC meetings to ensure bi-directional engagement. The Board places significant value in obtaining the consumer perspective. For example, the entire Prevention Plan and budget is assigned to the CAC and the CAC plays a role in project selection, evaluation, and oversight. Similarly, the CAC has been asked to review the Member Handbook and identify opportunities to improve its usability. By engaging the CAC and RAC in critical CCO decision-making, consumers feel respected and empowered. We will hire a Tribal Liaison to encourage further engagement with our tribal communities at the Board level.

Collaboration. Trillium takes CAC member recruitment and retention seriously and goes deep into the community to identify the right individuals to participate on the CAC. We recruit both individuals with previous board experience and members who are new to boards to build capacity. For this reason, we often have several candidates per available seat on the CAC and do not overburden members by asking them to sit on more than one committee. We will coordinate with other Service Area CCOs to leverage the resources in the community across our CACs and set up infrastructure to share information. We will also collaborate with other CCOs, local Public Health and Hospitals on the CHA/CHP development process so that the community is not burdened by parallel data collection and priority setting processes. We will remain flexible to accommodate processes in the best interest of the community.

CHA and CHP. Trillium has designed a CHA and CHP development process with responsibilities identified in OAR 410-141-3145, in compliance with ORS 414.627 and ORS 414.626 and compatible with Sample Contract Exhibit N, Section 2. As noted above, Trillium is an active partner in Live Healthy Lane, a collaborative effort with Lane County, the 100% Health Community Coalition, United Way of Lane County, PeaceHealth, and other cross-sector community partners, to develop the CHA and CHP. We are seeking opportunities to participate in the CHA and CHP process for each of our proposed expansion counties and will seek to partner with each of the entities listed in our RFA Community Engagement Plan. Trillium’s 2015-2016 Lane County Regional CHA and the 2016-2019 CHP are included as Att. 10 2015-2016 Lane County Regional CHA and Att. 10 2016-2019 Lane County Regional CHP. We determine SDOH-HE spending priorities based on state priorities and the stakeholder engagement through the CHP. Existing priorities include: affordable housing, economic development, access to healthy food, early childhood development, preventive services, collaboration, and healthy workplaces. Alignment with the CHP is one of the key criteria by which HRS Community Benefit partnerships are advertised and evaluated. The Community Investment and Transformation Committee, along with the CAC/Tribal Advisory Council/Health Equity Council, is accountable for ensuring funding is aligned with community needs and priorities.
ATTACHMENT 10 - SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. For definitions related to SDOH-HE, please refer to the SDOH-HE Glossary. Page limits for this Social Determinants of Health and Health Equity is 14 pages, excluding the RFA Community Engagement Plan and the THW Integration and Utilization Plan. The RFA Community Engagement Plan must be limited to 4 pages, excluding required tables. The THW Integration and Utilization Plan must be limited to 5 pages.

A. COMMUNITY ENGAGEMENT

1. EVALUATION QUESTIONS

a. Did Applicant obtain Community involvement in the development of the Application?

As a locally-based, responsive organization, Trillium Community Health Plan (Trillium) highly values member and community guidance and feedback. Our Application is a reflection of ideas and recommendations for programs, initiatives, innovations, investments, and improvements from community members across our proposed Service Area including OHP members, providers, community organizations, county representatives, Council members (i.e. Community Advisory Council (CAC), Rural Advisory Council (RAC), Clinical Advisory Panel (CAP)), and others.

Obtaining Community Involvement. To obtain community involvement and direction on CCO, starting in the summer of 2018, Trillium interviewed 21 community stakeholders including direct service providers, community organizations, local government partners, Trillium members, and subcontractors to solicit advice and guidance on the strategic direction in the CCO 2.0 approach and Oregon Health Policy Board (OHPB) policy goals. Upon RFA release, we conducted listening sessions with 20+ community organizations including Meals on Wheels, FOOD for Lane County, and Cornerstone Community Housing. We presented ideas and proposed innovations that specifically addressed questions asked in the Application to our Board of Directors (BOD), CAC, RAC, CAP, and other committees, Lane County partners and representatives, and Traditional Health Workers (THWs) through the THW Hub (a coalition sponsored by Direct Service, PeaceHealth and Kaiser Permanente) which provides technical assistance and training opportunities and supports THW utilization. For the Tri-County Region, our Community Development Team has boots on the ground in Clackamas, Multnomah, and Washington Counties meeting in person and establishing formal channels of communication to identify issues, solicit needs and desired solutions, and build sustainable relationships to jointly partner and solution now and in the future. Through a formalized intake process, we have acted on feedback and incorporated ideas into our Application. For example, based on feedback, we are:

- Establishing a Health Equity Council and Tribal Advisory Council, which will report to the Governing Board.
- Prioritizing social determinants of health and health equity (SDOH-HE) issues including housing, food insecurity, and transportation.
- Offering member and community access to the Trillium Resource Exchange, an online searchable database of vetted and regularly updated social service, health, and wellness resources.
- Creating a Member Concierge Team to further assist members with scheduling provider and transportation appointments.

We are confident that our Application takes into account community feedback in alignment with OHA, CCO 2.0 program goals, and OHBP policy recommendations.

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.

Please see Att. 10 RFA Community Engagement Plan Requirement Components and Att. 10 RFA Community Engagement Plan Required Tables.

B. SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY (SDOH-HE) SPENDING, PRIORITIES, AND PARTNERSHIP

CCOs will be expected to invest in services and initiatives to address the Social Determinants of Health and Health Equity in line with Community priorities, through a transparent decision-making process that involves the CCO’s CAC and involving meaningful partnership with SDOH-HE Partners. For the first two years of SDOH-HE spending, OHA has designated a statewide priority for spending on Housing-Related Services and Supports, including supported housing. OHA reserves the right to continue and/or establish a new statewide priority during the subsequent years of the Contract.

Beginning CY 2020, CCOs will be required to spend a portion of end-of-year surplus, derived from annual net income or excess reserves, on Health Disparities and the social determinants of health. This statutory requirement – ORS 414.625(1)(b)(C) – will be operationalized through Oregon Administrative Rule, as described in the rule concepts accompanying this RFA.

Further, OHA intends to establish a two-year incentive arrangement – the SDOH-HE Capacity-Building Bonus Fund (“SDOH-HE Bonus Fund”) – to offer bonus payments above and beyond the capitation rate to CCOs that meet SDOH-HE-related performance milestones. Performance will be evaluated, and payments awarded to qualifying Contractors beginning CY 2021. The SDOH-HE Bonus Fund will be contingent on availability of funds under the Medicaid growth cap and any required CMS approval. CCOs will receive monetary bonus payments from the SDOH-HE Bonus Fund based on measured performance improvement according to key performance milestones throughout the calendar year. Total SDOH-HE Bonus Fund payments will be subject to a maximum percentage of the CCO’s annual capitation rate. CCOs will be required to provide OHA with narrative and financial reporting of SDOH-HE Bonus Fund expenditures, including any funds distributed to SDOH-HE partners, in the manner and form required by the agency.

OHA intends to develop the program structure, including performance milestones, Payment distribution methodology, and reporting requirements, between January 2019 and November 2020, with a targeted implementation during CY 2021. OHA additionally intends to establish a public advisory group, the SDOH-HE Measurement Workgroup, to recommend SDOH-HE related performance milestones, and outcome measures as relevant to OHA, and the Health Plan Quality Metrics Committee and Metrics and Scoring Committee. Metrics may include a combination of process and outcome metrics, where process metrics are designed to reward CCOs for successfully taking key steps to address SDOH-HE (for example, form necessary partnerships, build program infrastructure) and outcome metrics are designed to reward CCOs for performance in addressing SDOH-HE. Further, CCOs will be required to align spending of SDOH-HE bonus funds received with the CCO’s SDOH-HE priorities, in order to continue growing and increasing impact in this critical area.

In the fall of 2020, OHA intends to issue to CCOs:

- The list of performance milestones, benchmarks, and specifications for CY2021
- Full program documentation, including SDOH-HE Bonus Fund structure, methodology and disbursement timeline for the subsequent year, published on the OHA website.
- The estimated maximum Payment each CCO could qualify to receive in 2021 if it meets all performance milestones under the program
- The estimated percentage of 2021 capitation rates CCOs could qualify to receive in 2022 under the SDOH-HE Bonus Fund (i.e. estimated percentage of 2022 Payments)
The SDOH-HE Bonus Fund is intended to be part of a coordinated strategy to incentivize and support increased spending on SDOH-HE over the course of the five-year contract. Additional elements of this strategy include:

- **Performance-based reward:** implement a variable profit margin to award CCOs according to efficiency and quality of care (evaluation beginning in 2020, incorporated into rates in 2022).
- **Risk adjustment for social factors:** risk adjust capitation rate based on social factors at the population and/or Member level (evaluation beginning in 2020, incorporated into rates in 2022). OHA intends to explore incentivizing collection of Member-level data through the SDOH-HE Bonus Fund starting in CY2020 to inform risk adjustment beginning in 2022.
- **SDOH-HE Quality Pool metrics:** Recommend SDOH-HE quality metrics to the Health Plan Quality Metrics and Scoring Committees via the Health Equity Measurement and SDOH-HE Measurement Workgroups.

1. INFORMATIONAL QUESTIONS

*a. Does Applicant currently hold any agreements or MOUs with entities that meet the definition of SDOH-HE partners, including housing partners? If yes, please describe the agreement.*

**Formal Agreements.** Trillium has executed and planned agreements with SDOH-HE partners to address CHP priorities in our current and proposed Service Area, including housing, food insecurity, cultural competence, and connection to peers and community social service resources, as shown in the table below. Agreements outline the goals and services to be delivered to the target population, if applicable, and how the services or collaboration will be evaluated for effectiveness. Future agreements will include all elements outlined in Exhibit N, Section 3d of the Sample Contract and will be submitted to OHA no later than 30 days after execution.

<table>
<thead>
<tr>
<th>Entity Name</th>
<th>Category</th>
<th>Agreement Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ShelterCare</td>
<td>Housing</td>
<td>Administrative Service Agreement (ASA) to provide recuperative care for adult members who are homeless</td>
</tr>
<tr>
<td>Lane County</td>
<td>Housing/Government</td>
<td>ASA to provide the Frequent Users Systems Engagement (FUSE) Program; help participants address barriers to housing, provide case management, and connect participants to community resources</td>
</tr>
<tr>
<td>FOOD for Lane County</td>
<td>Food Bank</td>
<td>MOU to provide funding for Produce Plus, Veggie Rx, and Break the Bank programs to address food insecurity in Lane County</td>
</tr>
<tr>
<td>Healthy Directions Coalition</td>
<td>Local Public Health Authority</td>
<td>MOU to foster collaboration with the school district, police departments, tribes, housing and community services agency, and others to promote health and well-being of children and families in rural Western Lane County</td>
</tr>
<tr>
<td>Live Healthy Lane (United Way, Peace Health, Lane County)</td>
<td>Community Coalition</td>
<td>MOU to foster collaboration among local government, health care organizations, insurers and social service agencies in Lane County to reduce health disparities, promote health equity and improve overall health</td>
</tr>
<tr>
<td>National Alliance on Mental Illness of Lane County</td>
<td>Education, Family Support</td>
<td>ASA provides for training expertise in severe and persistent mental illness and cultural competence</td>
</tr>
<tr>
<td>Direction Service</td>
<td>Social Services</td>
<td>ASA to provide child and youth Wraparound and Peer Support Services</td>
</tr>
<tr>
<td>Centro Latino Americano</td>
<td>Social Services / Cultural Org</td>
<td>ASA to provide child and youth Wraparound and Peer Support Services, specifically for the Latino population</td>
</tr>
<tr>
<td>Youth ERA</td>
<td>Social Services</td>
<td>ASA to provide child and youth Wraparound and Peer Support Services</td>
</tr>
<tr>
<td>Lane Independent Living Alliance</td>
<td>Social Services</td>
<td>ASA to provide an array of services to help members gain skills for independent living and socialization</td>
</tr>
<tr>
<td>Oregon Family Support Network</td>
<td>Social Services</td>
<td>ASA to provide Wraparound peer services and family support services</td>
</tr>
<tr>
<td>Cornerstone Community Housing</td>
<td>Housing, Social Services</td>
<td>MOU to provide community outreach, low income housing and supportive housing services for our membership in addition to nutrition/cooking classes, social activities, and oral health (OH) services (e.g. oral exams, cleanings)</td>
</tr>
</tbody>
</table>
Outside of our current Service Area, we are in active conversations with and have received letters of support (LOS) from several SDOH-HE partners across the state. For example, we have an LOS with Home Forward, the Multnomah Housing Authority; Washington County Housing Services, and Innovative Housing Inc. We plan to develop and lead a pilot program with the Washington County Housing Services for an integrated housing and permanent supportive housing services approach and model that we will replicate across our proposed Service Area. Please see **Att. 10 RFA Community Engagement Plan Required Tables** for a more extensive list.

**Informal and Evolving Agreements.** Trillium continuously adds to this list and has many informal agreements to support SDOH-HE. For example, we sit on the governance and steering committee for the Oregon Pediatric Improvement Partnership, with a focus on pediatric social complexity; the board of Cornerstone Community Housing; and the Lane County Poverty and Homelessness Board. We have agreements with Medicaid-billing providers such as the Center for Family Development for Intensive Community Care Management, which requires the tracking of ICD-10 Z-codes to capture patient SDOH. As an example of an evolving relationship, Housing is Health is a collaboration between Trillium and Lane County to identify the best housing types for individuals who are homeless given their conditions. From this relationship we will get a monthly list of members who are homeless and in turn will send a Hot-Spotter Report for those members on the list to help target outreach, engagement and social support. Additionally, Trillium has a Letter of Agreement with a local non-emergent medical transportation (NEMT) provider in the Tri-County Region and are exploring a partnership to develop innovative transportation solutions. For example, we have discussed the development of creating a shared profile generated from the results of a member’s transportation needs assessment. This would enable an integrated approach to sharing data around member’s transportation needs, allow improved coordination of care, and help members overcome transportation barriers.

**Social Health Bridge.** Social Health Bridge, a new Centene subsidiary, is a first in the nation effort to move from grant funding for community-based organizations to sustainable funding from the health sector. As a true community solution, Social Health Bridge aims to bridge the divide by working with any health plan or provider that wants to leverage the best of community organizations while paying for value. The first application in Oregon will be with Oregon Wellness Network (OWN). We will leverage our propriety SDOH Engagement Specialists, technology, processes and protocols, and evidence-based models to address SDOH-HE of OWN consumers. As we close gaps in care and lower ED and hospitalization utilization, we utilize these dollars to provide a steady income stream to our CBO partners.

**b.** 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.**

Trillium uses a combination of process and outcome measures to track progress in meeting SDOH-HE milestones based on CHP priorities, and impacting disparities based on race, ethnicity, culture, geography, language, gender, disability, and socioeconomic status.
**Plan Level SDOH-HE Metrics.** Trillium conducts an annual review of CCO metrics stratified by race as one indicator to track progress in addressing racial disparities. Trillium tracks its investments in SDOH-HE using a proprietary macro to ensure that SDOH-HE interventions are advancing the Triple Aim. The macro compares an intervention group and comparison group on (1) cost per member per month and (2) utilization rates for inpatient, ED, primary care provider (PCP), specialist, behavioral health (BH), NEMT, and pharmacy utilization. By applying the macro for our ShelterCare Respite Housing program investment, we found that PCP visits, NEMT, and pharmacy utilization increased while inpatient stays remained lower than the comparison population, suggesting the program was effective at promoting preventive and routine care for this vulnerable population. Trillium also ensures our Trillium Innovation Fund grantees are measuring SDOH-HE impact. Innovation Fund applicants are required to report on what they intend to measure to define program success, how they will define the baseline, how they will gather and analyze data, and how return on investment (ROI) will be measured. Examples of metrics to be reported among 2018 funded entities are:

- New member engagement
- Patient satisfaction
- No-show rates
- ED utilization, HbA1c, and blood pressure rates
- SDOH screening completion/referrals to community resources
- Cost containment

**Provider-Level SDOH-HE Metrics.** Providers participating in the Intensive Community Care Management program must track Z-codes that capture SDOH-HE, including food security, shelter/housing, legal issues/justice, transportation, education/literacy, social supports and violence/safety/trauma. Once these codes are in broader use, Trillium will use them to determine whether individuals are being connected to interventions to address underlying SDOH-HE issues and whether the interventions are successful over time. Trillium is also piloting Simple Screens to promote the use of standardized SDOH-HE screenings, such as PRAPARE, and will track screening completion rates by provider. To support our providers in improving outcomes related to SDOH-HE, Trillium shares a monthly Hot-Spotter Report with providers, which includes health risk scores and targeted data on a provider’s member panel, including SDOH ICD-10 codes such as Z55-Z65. Providers can use this data to provide support, education, and build engagement with members that address and recognize SDOH-HE. To supplement this report, Trillium will take advantage of our parent company, Centene’s, proprietary SDOH predictive model and risk score referred to as the Neighborhood, Environment and Social Traits (NEST) score. The NEST model uses member and public data sources to predict member-level risk attributed to SDOH factors. This single risk metric helps to target members at risk for adverse health outcomes due to their social, economic, and environmental conditions and track outcomes over time. The NEST score uses machine learning to determine the SDOH factors most significant in impacting health care utilization. Scores are aggregated at geographic levels and heat maps are generated with identification of SDOH leading indicators that are correlated with poor health outcomes.

c. Does Applicant have a current policy in place defining the role of the CAC in tracking, reviewing and determining how SDOH-HE spending occurs? If yes, please attach current policy. If no, please describe how Applicant intends to define the role of the CAC in directing, tracking, and reviewing SDOH-HE spending. Please see Att. 10 CAC Charter for Trillium’s CAC Charter policy. For CCO 2.0, Trillium is in the process of updating its CAC Charter to reflect the central role the CAC will play in tracking, reviewing and determining how Trillium’s SDOH-HE spending occurs. The CAC informs SDOH-HE spending priorities, informs the criteria by which SDOH-HE projects and partners are selected, and makes recommendations on what should be
funded and how project performance should be monitored. The CAC also reviews SDOH-HE spending no less than annually, along with impact reports, and makes recommendations for future spending priorities.

d. Please describe how Applicant intends to award funding for SDOH-HE projects, including:
   (1) How Applicant will guard against potential conflicts of interest;
   (2) How Applicant will ensure a transparent and equitable process;
   (3) How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the Community.

**PROCESS TO AWARD FUNDING FOR SDOH-HE PROJECTS**

Building off best practices from our current Prevention and Innovation Grant funding processes, Trillium will establish a transparent process to award funding for SDOH-HE projects. The process will use common, published criteria for selecting awardees, and will be informed by CCO 2.0 objectives, the priorities of community members as communicated through the CHA/CHP development process, and our community-oriented committees including the CAC, RAC, Health Equity Council and Tribal Advisory Council. Trillium will develop a common application, which will be posted on our website and shared among stakeholders and community members, that outlines the funding priorities, process for application, who may apply, available funding and evaluation criteria. Initial evaluation of applications from potential SDOH-HE partners will be reviewed by our Trillium leadership team against CAC approved criteria. Applications that meet criteria will be presented to the local CAC for review, assessment, and funding recommendations to be submitted to the Board for final approval and to the Finance Committee for appropriate payment set-up and accounting.

**Guarding Against Conflicts of Interest.** Internal staff and committees reviewing SDOH-HE project applications are asked to disclose conflicts of interest and are expected to recuse themselves from voting if any conflict is revealed as stated in our policies and procedures and Committee charters. Any ownership, business, or financial relationship between a SDOH-HE partner and Trillium will be disclosed using OHA’s ownership disclosure form. Part of each CAC’s role in directing and reviewing planned investments will be to ensure that any awards are in the best interest of the community.

**Ensuring a Transparent and Equitable Process.** Trillium will continue to widely disseminate funding opportunities and applications, including publication on our public website, encouraging and informing interested organizations how to apply. We leverage a broad network of providers and community stakeholders, including announcements at community events, Advisory Committee meetings, and Provider Newsletters. Funding opportunities will clearly specify eligible entities, the required elements of response, available funding, and established scoring/evaluation criteria. After awards are made, Trillium will provide feedback for those who did not receive funding to allow them the opportunity to refine their application in future years.

**Demonstrating the Outcome of Funded Projects.** Trillium shares the results of SDOH-HE project awards to members, SDOH-HE partners, all governance committees, and the broader community through plan communications, announcements on our website, and press releases. Trillium currently provides blurbs in internal provider newsletters and the Lane County Medical Society newsletter as way to inform providers of new initiatives and will include local medical society newsletters across our proposed Service Area. Awardees will report on specific metrics to demonstrate the outcome of funded projects, linked to community-established priorities, and Trillium will share progress on these metrics with SDOH-HE partners and governance committees, including the CAC, as a standing item on the committee calendar.

**Sustainable Funding.** To maximize funding for SDOH-HE partners, we will also introduce Social Health Bridge (see Section 1.a above) as a mechanism to support sustainable funding.
e. For the statewide housing priority only: please provide proposed metrics for assessing the impact of investments in this area.

Based on our experience implementing and evaluating the ShelterCare, Cornerstone, and FUSE programs, which address the State’s – and Trillium’s – priority of housing-related services and supports, we propose the following metrics to assess impact of investments:

- Enrollment in housing-related services and supports programs
- Cost per member (total medical, BH, and pharmacy per member per month (PMPM) spend)
- Utilization trends (ED, Inpatient, NEMT, oral health, pharmacy, primary care, BH)
- Cost of housing and related services

By comparing housing services and supports outcomes with a comparison group, Trillium can test the relative impact of the investment on these metrics and make adjustments to maximize the impact of housing funds.

2. EVALUATION QUESTIONS

a. Please describe the criteria Applicant will apply when selecting SDOH-HE partners.

SDOH-HE partners selected for funding will be evaluated on the following criteria:

- Type and scale of the proposed project’s benefit to the local community: alignment with community-defined SDOH-HE priority areas and CCO 2.0 goals; number of total individuals and Trillium members impacted by the project
- Budget/Total Cost
- Implementation: capacity of partner to implement the proposed project/services; complexity of implementation; required technology infrastructure, if any
- Outcomes: specificity of stated outcomes; metrics and methods used to track outcomes; return on investment (cost-benefit analysis)

When considering partners that do not have existing outcomes data, Trillium requests that the prospective partner provide a roster of individuals they serve and the enrollment period. Trillium applies a cost and utilization macro before and after program enrollment to look for expected impact in key areas such as primary care and BH utilization, accompanied by lower hospital and ED visits. Positive movement on these indicators signifies that Trillium’s investment will have an impact. As noted above, community members are involved in and informed of partnership decisions to ensure investments are aligned with the community need.

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, the availability of funding for projects, how interested parties can apply for consideration, and the project selection process.

As we have done for our Innovation and Prevention Fund grants, each SDOH-HE funding opportunity announcement will be broadly communicated and will outline spending priorities, who can apply, funding amounts, how to apply, the selection process, and the timeline for evaluating proposals, selecting partners, and implementing projects. We will do so through:

- Publishing funding opportunities and applications on the community section of Trillium’s public website
- Sharing funding opportunities through all of Trillium’s committees and governance bodies, Trillium Innovators Collaboratives (monthly learning collaboratives with rotating topics), and existing SDOH-HE and provider
TRILLIUM COMMUNITY HEALTH PLAN
RESPONSE TO RFA OHA #4690-19 – CCO 2.0
ATTACHMENT 10 - SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY

partners via standing meetings and targeted outreach -- asking to distribute further to interested parties
△ Email distribution to stakeholder lists, including entities logged in the Trillium Resource Exchange, and in email alerts to providers
△ Announcement to the public through a press release

Trillium will tailor communications to the cultural and linguistic composition of local communities to ensure entities that reflect the community are able to apply for funding.

c. Please describe how Applicant will track and report SDOH-HE expenses and outcomes, including technological capacity and process for sharing and collecting data, financial systems, and methods for data collection.

Tracking and Reporting SDOH-HE Expenses. Trillium’s accounting department tracks and reports SDOH-HE expenses separately from other plan expenses to ensure we are meeting spending goals. We identify and tag SDOH-HE spending across our various funding streams including our Prevention Fund, Innovation Fund, Health-Related Services, and agreements with SDOH-HE partners. We will use our claims processing system, for services such as transportation, and financial systems, for those services paid outside of claims via grants or invoices, to track SDOH-HE spending based on category of expense tied to SDOH-HE. We will have MOUs with our SDOH-HE partners describing the scope of work, financial arrangements, expected outcomes and metrics, and tracking and reporting requirements. Trillium will provide a report on SDOH-HE expenditures in accordance with OHA requirements.

Tracking and Reporting SDOH-HE Outcomes. All SDOH-HE partners are and will be required in their MOUs to report outcomes for their funded initiatives, which Trillium will compile for external reporting. Trillium also conducts internal evaluations of these SDOH-HE programs using our cost and utilization macro. For example, our evaluation of the Cornerstone Housing project identified trends including decreases in ED use and increases in dental and BH utilization after program participation. We also collect data to assess the overall impact of SDOH-HE initiatives on our members and the community using the following data sources:
△ SDOH-HE elements (e.g. housing and food security) from completed Initial Risk Screenings, Comprehensive Assessments, and SDOH-HE assessments completed in provider offices
△ ICD-10 Z codes related to SDOH-HE from claims data
△ Utilization and referral data from our community database, Trillium Resource Exchange

Designated Trillium analysts on our Data and Analytics team will combine, track, and trend the data elements above to be included in our SDOH-HE Outcomes Report submitted no less than annually to the CAC, RAC, Health Equity Council, Tribal Advisory Council, CAP and Trillium Board for review and action. Our analytics team includes staff trained in health economics and epidemiology improving the rigor of our evidence-based programs and practices. As an example of program outcomes, our VeggieRx pilot project integrates access to fresh fruits and vegetables with diabetes prevention education. Forty-four members participated in the initial pilot program where they received Trillium VeggieRx vouchers and educational classes focused on weight management, nutrition, and healthy eating to help manage their diabetes. Preliminary results indicate that members that used Veggie Rx vouchers lost nearly twice as much weight on average compared to members that did not use the vouchers.

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.
Each local CAC will recommend SDOH-HE spending priorities, based on existing CHP priorities, which includes the statewide priority on Housing-Related Services and Supports. The CAC will vet its initial spending priority recommendation with the Health Equity Council, each regional Board of Directors, and with SDOH-HE partners to ensure a transparent, inclusive and community-driven process as outlined in Att. 10 RFA Community Engagement Plan Requirement Components and Att. 10 RFA Community Engagement Plan Required Tables.

C. HEALTH-RELATED SERVICES (HRS)

1. INFORMATIONAL QUESTIONS

a. 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.

Trillium is committed to the continued and expanded use of Health-Related Services (HRS) to improve health outcomes and reduce avoidable health care services utilization and cost. We have developed an HRS policy in accordance with OAR 410-141-3150, 45 CFR 158.150 or 45 CFR 158.151 to promote and ensure the delivery and payment of HRS that improve population health and health care quality.

Process for Making HRS Community Benefit Decisions. Trillium seeks to maximize HRS funds and impact SDOH-HE priorities identified through the CHA and CHP. Drawing again from our experience with the Prevention and Innovation Funds, where we leverage CAC involvement in reviewing candidates for funding, we will adopt the same process described above for SDOH-HE spending.

Types of Entities Eligible for Funding. Requests for funding can be submitted by entities that have the capacity to impact population health and health care quality through our application process, such as entities that address health disparities, food, housing, and population health needs. Referrals can come from internal Trillium staff, the CAC/RAC, the Health Equity Council, Tribal Advisory Council, SDOH-HE partners, community organizations, non-profit organizations, and local businesses.

How Entities May Apply. Trillium will develop a formal application that requestors can use to apply for HRS funds. We will develop an application, based on our current application for the Prevention and Innovation Funds, to outline all the required elements of response, evaluation criteria, and timelines.

How Funding will be Awarded. Funding will be awarded based on how the HRS applicant scores on specified criteria, informed by the CAC and CHP and consistent with SDOH-HE project criteria outlined in the response to B.2.a. The HRS criteria also includes availability of funding; whether the project can be funded by more appropriate funds, such as SDOH-HE or Innovation Funds; and whether the project meets OAR requirements for HRS. Funding awards are recommended by the CAC and approved by the Board as described below.

Role of the CAC and other Advisory Councils. After the Trillium leadership team completes an initial review of requests for HRS funds against the criteria, applications that meet criteria are submitted to the local CAC for additional review, analysis and prioritization based on available funds. The CAC may elect to solicit additional input from the Health Equity Council and/or Tribal Advisory Council to help prioritize funding awards. Based on CAC and other appropriate input, CAC recommendations proceed to the Finance Committee before final approval by the Board.

How HRS Spending Aligns with CHP Priorities. As noted above, alignment with CHP is a key criterion that the leadership team and CAC will look to when reviewing proposals for funding. When advertising the HRS funding opportunities, Trillium will emphasize that we are seeking proposals that address the CHP priorities of each community we serve. We understand the importance of aligning to the CHP to ensure our investments address community needs and have a collective impact.
D. COMMUNITY ADVISORY COUNCIL MEMBERSHIP AND ROLE

1. INFORMATIONAL QUESTIONS

a. Please identify the data source(s) Applicant proposes to use when defining the demographic composition of Medicaid Members in the Applicant’s Service Area.

Trillium captures member-level demographics from the member eligibility files we receive from OHA. When reviewing the demographic composition of the population in a region, we use data from multiple sources including the OHA Office of Health Equity and Inclusion, the OHA Center for Public Health Practice, the Oregon Center for Health Statistics, federal data from the Census or the Centers for Disease Control and Prevention, and data from the relevant county. We intentionally align our demographic composition analysis with the categories of the CAC Member Assessment and Recruitment Matrix to ensure our consumer committees are representative of our members and the community at large and represent populations who experience health disparities. Specifically, we consider gender, sexual orientation, race/ethnicity, written language, age, and disability when recruiting for the CAC and the RAC. Geographic location factors into whether the member serves on the CAC or RAC of each area we serve.

2. EVALUATION QUESTIONS

a. Applicant will submit a plan via the RFA Community Engagement Plan, as referenced in Section A, for engaging CAC representatives that align with 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.

Please see Att. 10 RFA Community Engagement Plan Requirement Components and Att. 10 RFA Community Engagement Plan Required Tables.

E. HEALTH EQUITY ASSESSMENT AND HEALTH EQUITY PLAN

1. INFORMATIONAL QUESTIONS

a. 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 Subcontractors to complete training topics on health and Health Equity.

TRAINING ON HEALTH AND HEALTH EQUITY

Trillium is committed to ongoing compliance with Sample Contract Exhibit N - SDOH and HE (5)(a)(4) by providing a training program across our organization and our provider and subcontractor network. Leading our health equity focus since 2012, our Health Equity Officer is charged with developing, administering and monitoring health equity training, including implicit bias fundamentals training. Supporting this work is our health informatics system to identify health inequities across the system, monitor impact of our trainings and interventions, and inform future training activities. Trillium currently mandates and monitors completion of staff health equity training at hire. In 2019, all supervisory and management staff are mandated to receive annual cultural competence and implicit bias training. Starting in 2020, we will require network provider and subcontractor training on health equity and cultural competence, using Relias to train providers and track participation. We will also require that all staff train on cultural competence and implicit bias.

Internal Activities. Our Health Equity Officer attends Advisory and Board meetings and leads our monthly internal Diversity and Health Equity Committee that reports into the Health Equity Council. Starting in 2019, Trillium will be holding a Diversity Week focused on diversity activities to highlight the importance of these issues in our work and workplace. We will also offer a Diversity Book Club and Lending Library to increase staff awareness on health equity.
Provider Activities. Trillium uses the results of the bi-annual Provider Survey to collect network demographics, assess cultural awareness, and determine responsiveness to patient diversity and equity issues. Our provider training program, Trillium University, sponsors a variety of provider training events, providing CME and CEU credits for attendees. The 2018 theme was “Health Literacy: A Universal Precautions Approach.” Trillium is a key partner in the Lane Equity Coalition, a collaborative initiative between Lane County, Trillium, PeaceHealth, and United Way. The unique, and highly regarded Coalition was developed from two years of grassroots work with community partners and has been coached by OHA’s Office of Equity and Inclusion.

b. Please describe Applicant’s capacity to collect and analyze REAL+D data.

Trillium uses the monthly member file from OHA as an initial source for member race and ethnicity data. Our Initial Risk Screening (IRS), administered with all new members (see Att. 7.2), solicits demographic data in alignment with REAL+D requirements. REAL+D data collected from OHA, the IRS, or staff/member interactions is systematically stored (see Att.10.2.a below), shared across Trillium staff, and reportable through our Enterprise Data Warehouse (EDW). Trillium also plans to integrate SDOH-HE data collected in provider offices via Simple Screens, described further in Att.9.D. Data can be analyzed against utilization and outcomes data and will be used to inform trainings, interventions, and quality improvement activities. Provider REAL+D data is collected during credentialing, stored in our provider data management system for inclusion in the Provider Directory, and used to inform our assessment of network adequacy and capacity.

2. EVALUATION QUESTIONS (HEALTH EQUITY ASSESSMENT)

a. 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.

Our Health Equity Officer, in collaboration with the Health Equity Council, is accountable for facilitating the integration of cultural and linguistically appropriate services across the organization and the delivery system. This includes staff, provider and subcontractor expectations, training, and targeted outreach to address disparities. Key to these activities is data. Trillium collects SDOH-HE data through screenings and assessments, Welcome Calls, and ongoing staff/member interactions, all captured and stored in our staff-facing systems. Trillium has the capability today to match collected demographic and SDOH-HE data with claims and quality data through our suite of HIT including our Unified Member View System, which validates, integrates, manages, transmits, and reports on all levels of member demographics across all systems as the single source of truth. Data are integrated with our EDW, which aggregates data for population health analysis, informing quality initiatives, training, and network recruitment to promote a culturally responsive delivery system. The Health Equity Officer will report on diversity and equity trends across all of our Advisory and Governance Committees on a quarterly basis.

b. Please describe the strategies used to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the Service Area.

Our staffing policies and practices support cultural competency and health equity. Our Health Equity Officer and support staff ensure that our staff have an intrinsic understanding of the unique characteristics and needs of CCO 2.0 members and the communities we serve through ongoing training, education and oversight. We advertise across diverse sources, including ethnic media and community centers, leveraging our Health Equity Council and other Advisory Committees for input and recommendations. We promote a diverse and supportive workplace through health equity training and cultural events to celebrate the diversity of our staff and membership. Trillium’s parent organization, Centene, was named to the 2018 list of the Best Places to Work for People with Disabilities, presented by the American Association of People with Disabilities and the U.S. Business Leadership Network.
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 alternate 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.

All member-facing staff and providers are trained on the use and availability of our telephonic Language Line and in-person interpreter services, including certified medical language interpreters. Written materials include taglines and large print explaining the availability of free written or oral translation, and the toll-free TTY/TDY and Oregon Relay numbers. Materials are available in alternative languages and formats, including large print, braille and auditory translation. Our Provider Directory indicates languages each provider/office speaks. Members can search for providers via our online directory and refine the search by languages spoken.

**Improving Capacity.** We recognize certified medical interpreters is a workforce gap based on stakeholder feedback and information obtained from our CCO 2.0 stakeholder engagement process. To address this gap, we will 1) support providers in accessing and training local certified medical interpreters through technical assistance; 2) build length of stay requirements into certified interpreter agreements; and 3) include wage differentials for certified interpreters. We contract with Community Interpreters for individuals with hearing and speech impairments in need of assistance making critical connections to information and people in their environment. We also link with contracted American Sign Language interpretation upon request.

**Evaluation.** We measure the quality of our Language Line through monthly call audits to ensure performance standards and customer service quality standards are maintained. For instance, in November 2018 our Linguava call audits found that 100% of agents were knowledgeable and able to handle the call/questions. In 2018, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction survey supplemental items were expanded to include patients’ experiences with health literacy and interpreter services, which Trillium will incorporate in 2019.

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 a description of how Applicant plans to monitor access for Members with disabilities with all contracted providers.

Trillium’s contracted interpreters include those experienced in serving people with disabilities who may have communication challenges. Interpreters are available to provide in-person translation services for members during provider appointments, Trillium home visits and community outreach events, as needed at no charge. Through these and other interactions we identify additional auxiliary aids and services that may be required and provide at no cost.

**Increasing Provider Accessibility.** Trillium is committed to providing equal access for members with disabilities. Supported by Centene, we will launch the Provider Accessibility Initiative (PAI) in Oregon, designed to help providers meet minimum federal and state disability access standards. Over the course of our Contract, Trillium will implement PAI, which includes:

- **Enhancing provider education** on disability access requirements and tools to assist with compliance
- **Improving the accuracy and completeness** of disability access data in our Provider Directory
- **Conducting a needs assessment** of our Provider Network to measure accessibility and areas for improvement and potential **grant funds to address access barriers**
3. REQUESTED 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.

Please see Att. 10 Policies and Procedures.

F. TRADITIONAL HEALTH WORKERS (THW) UTILIZATION AND INTEGRATION

1. INFORMATIONAL QUESTIONS

a. Does Applicant currently utilize THWs in any capacity? If yes, please describe how they are utilized, how performance is measured and evaluated, and identify the number of THWs (by THW type) in the Applicant’s workforce.

Traditional Health Workers (THWs) are a key part of Trillium’s delivery system network that extend the reach of Care Coordination services. Trillium believes THWs are a critical part of the System of Care and serve as valuable assets for diverse member engagement and health improvement. Two THWs currently serve on Trillium’s CAC and Board of Directors as well as participate in the CHA/CHP development process.

Number and Utilization of THWs. Trillium members receive care from certified Peer Support Specialists, Peer Recovery Specialists, Health Navigators, Community Health Workers (CHWs), and other THWs employed by our SDOH-HE partners and providers. The number and type of THWs employed by organizations in Trillium’s current Service Area include at least:

- **CHWs**: 12 organizations with approximately 15 CHWs
- **Peer Support Specialists**: 11 organizations with at least 11 Peer Support Specialists, Family Support Specialists, or Youth Support Specialists
- **Peer Wellness Specialists**: 1 organization with a certified Peer Wellness Specialist
- **Patient Navigators**: 1 organization with a CHW-certified Patient Navigator
- **Doulas**: Doulas are privately contracted in our current Service Area

These THWs support respite, Wraparound, and crisis services, and outpatient services for adults and children. We use provider-contracted Peer Support Specialists as a member’s first point of contact following a hospitalization for mental illness. They connect members to community resources and support them in understanding how to manage their conditions and utilize non-medical supports for positive health outcomes such as exercise and diet. As a result, *Trillium’s rate of members receiving follow-up after a mental health hospitalization was nearly 85% in 2017*. Trillium also uses Peer Recovery Specialists to aid in BH and substance use disorder (SUD) recovery through contracted BH agencies. Peer Recovery Specialists assist individuals in SUD treatment with social supports such as community 12-Step meetings, sober living facilities, and help them problem solve difficult situations where they might relapse into substance use.

*Member Connections® /CHWs*. Trillium currently employs five MemberConnections® Representatives (MCRs), three of whom are OHA-certified CHWs. These MCRs assist Trillium members one-on-one with understanding their health, health benefits and services, and other community resources. They provide navigation assistance such as: finding a physician to meet a member’s individual needs, knowing what questions to ask during their appointment, and assisting members with understanding their benefits and access to care standards to ensure timely access to care. They also assist members in accessing transportation, food, shelter, or other health-related or social programs. *From March through December 2018, MCRs received 1,833 referrals to assist members and followed up through 801 home visits and 888 phone outreaches.*

*THW Performance Measurement and Evaluation*. Trillium is currently creating a tracking system to track utilization of certified THWs in our contracted network so that the THW Liaison can, in coordination with physical health, BH, and SDOH-HE providers, develop a process for performance measurement and evaluation. In addition to reviewing claims to identify billed THW services, Trillium also began gathering member-level
information from contracted community-based BH programs and plans to expand this information request to capture information on utilization of THWs. We will also conduct an assessment of member satisfaction with THW services and will continue to work with OHA and the THW Commission to obtain and adopt best practices in community-based THW performance measurement and evaluation.

**Continuing Efforts.** Through our Community Development Team’s efforts to develop relationships with key providers and community organizations across our proposed Service Area, supported by information in the Oregon THW Registry, Trillium is identifying additional key THW partners and will continue to support the efforts of agencies that employ and support OHA-certified THWs. This includes organizations listed under ORS 414.629 that serve as partners in the local CHA and CHP process, so that Trillium can refer our members to diverse, community-based CHWs and other THW that support member health and wellness. We will partner to expand THW presence in non-traditional settings such as primary and oral health care, where members could benefit from additional coordination supports. Trillium will also partner with the THW Hub which provides technical assistance and training opportunities and supports THW utilization. We will leverage the THW Hub to gain more insight into available THW resources and gaps throughout our proposed Service Area. Trillium will support entities like the Oregon CHW Association by convening educational forums to address barriers to certification, billing, and reimbursement. For example, Trillium hosted a listening session for the State in September 2018 around reimbursement of THW services. A grant Trillium provided to Cornerstone resulted in workforce training for five THWs. Trillium attends OHA THW Commission listening sessions and will continue to integrate best practices for THW services in consultation with the Commission. Trillium will establish a THW Liaison in 2019 to increase recruitment and retention of THWs and help connect members to services provided by THWs, as detailed in **Att. 10 THW Integration and Utilization Plan**. As funding is available, we will evaluate additional opportunities to provide funding support for the THW workforce.

**b. If Applicant currently utilizes THWs, please describe the payment methodology used to reimburse for THW services, including any alternative payment structures.**

Trillium reimburses for THW services in multiple ways. First, OHA-certified Peer Support Specialists working within a BH organization bill for eligible services through claims and are reimbursed as specified on the Trillium fee schedule. Trillium also has agreements with community-based BH programs that use Peer Support Specialists, which are reimbursed through invoices. In addition, Intensive Community Care Management (ICCM) program teams, which include CHWs, Patient Navigators, and Peer Support Specialists, are reimbursed on a per-member per-month basis. Trillium ensures that encounter claims are submitted for any THW interactions that are eligible to be submitted and processed as encounter claims. Trillium recognizes the value of THW services for our members and will continue to develop opportunities to expand the workforce through sustainable reimbursement structures developed in collaboration with the THW Hub, Oregon CHW Association, Advocacy and Outreach Workers of Lane County, and THW Commission. We hosted a listening session around reimbursement for THW services and will work in partnership with OHA and THWs to identify opportunities to compensate THWs for their work – enhancing recruitment and retention of this workforce.

**2. EVALUATION QUESTIONS**

**a. Please submit a THW Integration and Utilization Plan which describes:** • Applicant’s proposed plan for integrating THWs into the delivery of services; • How Applicant proposes to communicate to Members about the benefits and availability of THW services; • How Applicant intends to increase THW utilization; • How Applicant intends to implement THW Commission best practices; • How Applicant proposes to measure baseline utilization and performance over time; • How Applicant proposes to utilize the THW Liaison position to improve access to Members and increase recruitment and retention of THWs in its operations.

Please see **Att. 10 THW Integration and Utilization Plan.**
TRILLIUM COMMUNITY HEALTH PLAN
TRADITIONAL HEALTH WORKER INTEGRATION AND UTILIZATION PLAN

Mission:
Trillium Community Health Plan (Trillium) provides services to people of all cultures, races, ethnic backgrounds, sexual/gender orientations and religions, as well as those with disabilities, in a manner that recognizes, values, affirms and respects the worth of the individual members and protects and preserves the dignity of each.

Goal:
To increase responsiveness of our system to address health disparities and provide the best possible care within Trillium and its contracted agencies by placing a focus on health equity and prevention and utilizing Traditional Health Workers (THWs).
The intended impact of this five-year plan is to:
1. Develop the THW workforce by supporting a sustainable payment method for services.
2. Increase access to preventative care in the community.
3. Increase access to culturally and linguistically diverse providers.
4. Improve member health outcomes.

Trillium believes that when implemented to fidelity and best practices, THWs are highly effective in producing positive outcomes in social determinants of health and health equity (SDOH-HE), reducing health care costs, creating better health outcomes, and informing health systems on health equity. Trillium will align our work with OHA, the THW Commission (in accordance with Oregon Health Policy Board recommended Policy #6), and the THW organizations in our Service Area to maximize the impact of efforts to increase THW utilization.

Trillium will report on our THW Integration and Utilization Plan annually in accordance with OHA requirements to demonstrate a continuous improvement process.

PLAN FOR INTEGRATION OF THWS IN THE DELIVERY OF SERVICES
To achieve the goals above, Trillium plans to build on our current THW infrastructure in terms of expanding the types of THWs available to our members, the volume of certified practitioners, and the availability of THWs where our members are located. Trillium has a strong foundation for building an effective system of THW utilization in our current Service Area and looks forward to growing THW resources throughout our proposed Service Area.
THWs are embedded into Trillium’s delivery system network to extend the reach of Care Coordinators in addressing physical, behavioral, and social needs through contracted providers and partners. Peer Support Specialists, Peer Recovery Specialists, Navigators, Community Health Workers (CHWs) and other THWs employed by providers and SDOH-HE partners support Wraparound, respite, and crisis services, and outpatient services for both adults and children. Trillium also uses Peer Recovery Specialists to aid in behavioral health (BH) and substance use disorder (SUD) recovery through contracted BH agencies. Recovery Specialists assist individuals in SUD treatment with social supports such as community 12-Step meetings, sober living facilities, and help them problem solve situations where they might relapse into substance use.
Trillium also employs five MemberConnections® Representatives (MCRs) – three of whom are OHA-certified CHWs – who act as CHWs and support member engagement and care coordination. These MCRs assist Trillium members one-on-one with understanding their health, health benefits and services, and other community resources. They provide navigation assistance...
such as: finding a physician to meet a member’s individual needs, knowing what questions to ask during their appointment, assisting members with understanding their benefits and access to care standards to ensure timely access to care. They also assist members in accessing transportation, food, shelter, or other health related or social programs. From March through December 2018, MCRs received 1,833 referrals to assist members and followed up through 801 home visits and 888 phone outreaches.

Trillium also includes THW representation on our Governance committees and in the CHA/CHP development process to ensure the THW perspective is represented when making decisions on community priorities and Trillium initiatives.

**Challenges and Solutions to Integration.** Based on our experience in Lane and Douglas Counties and work with THW stakeholder groups, Trillium understands the complexities involved in expanding the THW workforce and integrating them into care delivery. These challenges include:

- Lack of low-cost trainings
- Barriers to timely certification
- Lack of sustainable funding for non-billable worker types
- Misunderstanding of scope of practice

Trillium also understands the importance of THWs being embedded in the community as experiments with phone-based CHW outreach proved to be ineffective. Therefore, Trillium has prioritized partnerships with organizations who employ and support THWs to enhance their ability to grow this workforce. For example, Trillium granted $125,000 to Cornerstone Community Housing in 2015 for their Community Health Worker program. With the help of this and another grant, Cornerstone has trained and deployed five CHWs who work with Trillium members across their 12 low-income housing communities. These workers provide immediate on-site resources and referrals, offer education on chronic disease prevention and other health issues, better prepare clients for doctor’s visits, and help clients follow medication plans.

Through SDOH-HE investments, Innovation Funds, and Prevention Funds, Trillium will continue to incent organizations who employ THWs, train them, and integrate them into Trillium’s care coordination program.

To further address reimbursement challenges, Trillium will continue to test payment structures that support the use of THWs. For example, Trillium’s Intensive Community Care Management (ICCM) program teams are required by contract to include a combination of Community Health Workers, Patient Navigators, and Peer Support Specialists. Trillium reimburses the ICCM contractor on a per-member per-month basis based on achievement of specified metrics and outcomes. Expanding value-based payments to organizations who use THWs will improve the sustainability of these THW employment opportunities and ensure THW-delivered services are efficient and effective.

Finally, Trillium will continue to engage stakeholders focused on expanding THW capacity to develop shared solutions to better integration of THWs in the delivery system. Trillium will meet with the Oregon Community Health Workers Association (ORCHWA) to identify opportunities to more effectively use their workers. Trillium also partners with the Traditional Health Worker (THW) Hub, which, in conjunction with Direct Service, PeaceHealth and Kaiser Permanente provides technical assistance, training opportunities, promotes culturally-specific programs, facilitates conversations on health equity, provides sub-contract supervision, and supports THW utilization. Trillium will leverage the THW Hub to gain more insight into the available THW resources/types and gaps in our proposed Service Area. For example, currently there are no
community-based doula organizations in our existing Service Area; Trillium will work with the THW Hub and others to determine how to make this resource available to members and to ensure workers are compensated. In the second quarter of 2019, Trillium will host an Innovators Collaborative to convene organizations that use THWs to discuss opportunities to expand the THW workforce. Trillium will continue to play a role as a convener in partnership with OHA to address challenges to THW expansion.

**Role of the THW Liaison.** Trillium will designate a liaison as a central contact for THWs with the capacity to coordinate the workforce, payment models, utilization, supervision, service delivery, and member accessibility to THW services. The THW Liaison is accountable to implement the provisions of this five-year THW Integration and Utilization Plan and to help connect members to services provided by THWs. The THW Liaison will identify needed capacity for THWs to support the delivery of culturally competent services for Trillium members and will develop a recruitment plan to either hire THWs within the community or contract with THWs through affiliated provider organizations.

To understand existing community resources, the THW Liaison will work with partners, such as ORCHWA and the THW Hub, and will review the OHA THW Registry. As part of the work to assess needed capacity, the THW Liaison will review the Transformation and Quality Strategy (TQS) components and build upon current Trillium programs that utilize THWs to advance this work and improve member outcomes.

The THW Liaison will develop policies and procedures outlining how Trillium providers and staff should engage with each type of THW to deliver services. This includes policies outlining when a Care Coordinator should refer a member to a THW, the services a THW is able to provide, and the systems the THW should use to ensure coordination. The THW Liaison will be evaluated on their ability to improve THW access to members and increase recruitment and retention of THWs in Trillium’s operations.

**Communicating to Members About Benefits of THW Services.** Trillium will clearly and consistently inform members about the types of THWs, the roles they play in the System of Care, how working with THWs may benefit the member, and how members may access and request THW services. Planned communication methods include but are not limited to the Member Handbook, resources on Trillium’s website and Member Portal, periodic newsletter updates, and materials that Care Coordinators can share with members if they are considering a THW referral. Trillium will also link to the THW Hub on our public website, and resources will be searchable through the Trillium Resource Exchange. Trillium will continually engage the CAC/RAC on the best methods to share this information with members. In addition to member communication, Trillium staff receive a policy that outlines when it is appropriate to refer members to employed THWs and THWs in the community and the process to refer and document.

**Plan to Increase THW Utilization.** Trillium recognizes the value that THWs bring to our members and the community in addressing SDOH-HE and health disparities. Therefore, we will continue our efforts to improve the utilization of THWs in concert with OHA’s THW Commission and our local THW collaboratives such as the Advocacy and Outreach Workers of Lane County. The Advocacy and Outreach Workers of Lane County serves as a hub in the community for certified THWs and for those working towards certification. Trillium will continue to host this group quarterly – and will participate or lead similar efforts throughout our proposed Service Area – to understand what resources THWs need to achieve certification and

Attachment 10  3
reimbursement and expand their services in the community and how Trillium may support them in concert with OHA.

The THW Liaison will serve as an advocate for the over 400 actively certified THWs in Lane County alone who are seeking to provide services to Trillium members and the community at large. Trillium will work with OHA, the THW Commission, and other CCOs on developing more streamlined certification and payment methodologies to sustain this critical workforce. For example, a goal of Trillium’s is to expand the THW workforce in unconventional ways, such as in primary care and oral health offices where our members are already seeking care. Trillium plans to work with the THW Hub to conduct a needs assessment, identify available workforce, develop additional workforce, and ensure there are opportunities for THWs to be used and reimbursed for their services in these non-conventional settings. Building these workforce opportunities will be important to sustain THWs, as many roles are entry level and retention has been a significant challenge.

*Implementing THW Commission Best Practices.* Trillium will align our THW practices with the goals and strategic priorities of the OHA THW Commission and will coordinate with the OHA Office of Equity and Inclusion for any needed implementation supports. The THW Liaison will attend THW Commission meetings and regularly monitor its website for new materials to ensure Trillium’s THW recruitment, retention, performance measurement, and evaluation activities are drawing from Commission recommendations. Trillium maintains relationships with members of the THW Commission and will engage them in developing solutions for THWs in Trillium’s proposed Service Area.

*Measuring Baseline Utilization and Performance over Time.* The THW Liaison will determine a method of analysis for the number of THWs Trillium will need to assist members throughout our proposed Service Area in the next five years, including the development of a baseline analysis on 2019 THW utilization. The THW Liaison will also oversee the collection of data to measure the integration and utilization of THWs using the reporting template provided by OHA. This data will be submitted by April 1 of each contract year for data collected in the prior contract year. Submitted information will include:

- An assessment of member satisfaction with THW services
- Ratio of THWs to the total number of members
- Number of THWs employed by Worker Type (FTE/Contracted)
- Number of requests from members for THW services (by THW types)
- Number of engagements of THWs as part of the member’s Care Team (by THW types)
- Demographics of THWs and CCO membership: including Race, Ethnicity, Language, and Disability
- The number of clinic and community-based THWs
- The number of interactions between THWs and members in the clinic setting, non-clinic setting, and community-based setting

Trillium will also report to OHA each type of payment model it uses to reimburse THWs and the number of THWs paid under each payment model it utilizes. Currently, this includes a combination of PMPM payments, invoice-based payment, and claims reimbursement. Since many THWs are serving members as employees of other organizations and may not bill independently, or are not providing billable services, Trillium faces a challenge in adequately capturing information on THW utilization from claims data. Therefore, until claims data is more robust, Trillium will supplement claims data by requesting reports from contracted providers.
who use THWs. These reports will capture member-THW interactions as well as member satisfaction with THW services. Providers will report on how many THWs they employ and their demographics relative to the patient/client population. Trillium will also monitor any complaints related to THW interactions to capture member satisfaction information.

For our internal MCR workforce, Trillium currently collects Community Health Worker productivity data, including the number of referrals, completed referrals, home visits, and successful phone interactions with members. We will expand this data collection to meet OHA reporting requirements.

This plan was created by Trillium’s Health Equity Workgroup in consultation with the Traditional Health Worker Commission utilizing information from certified traditional health workers and the Office of Equity and Inclusion at the Oregon Health Authority (OHA), as part of the CCO 2.0 application process.
ATTACHMENT 11 - BEHAVIORAL HEALTH QUESTIONNAIRE

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Include reasons why your organization is able to effectively complete the CCO service delivery and program design requirements, and how this will be accomplished in time to meet the needs of Members on implementation. Page limit for this Behavioral Health Questionnaire is 66 pages, items that are excluded from the page limit will be noted in that requirement.

A. BEHAVIORAL HEALTH BENEFIT

Applicant must be fully accountable for the Behavioral Health benefit to ensure Members have access to an adequate Provider Network, receive timely access to the full continuum of care, and access effective treatment. Full accountability of the Behavioral Health benefit should result in integration of the benefit at the CCO level. Applicant may enter into Value-Based Payment arrangements; however, the arrangement does not eliminate the Applicant’s responsibility to meet the contractual and individual Member need. Applicant must have sufficient oversight of the arrangement and intervene when a Member’s need is not met or the network of services is not sufficient to meet Members’ needs.

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?

Seamlessly integrating member healthcare across behavioral health (BH), physical health (PH), substance use disorders (SUD), Oral Health (OH), and Social Determinants of Health and Health Equity (SDOH-HE) improves member health and satisfaction outcomes. Trillium Community Health Plan ensures the integrated system of care approach is infused across our CCO structure in equal attention to all aspects of need (PH, BH, OH and SDOH-HE). We do this through formalized partnerships with County and community organizations-including BH management organizations (BHMO) and dental care organizations (DCO), a top down integrated approach for staffing and committees, supported by enhanced care coordination via our shared integrated CC team; attention to needs across the whole person continuum (and its providers) of Care; use of technology to enhance information sharing, and our community partnership approach.

Top-down Approach. Our local Clinical Advisory Panels (CAPs), report directly to our Board of Directors, and include providers from across our service areas with expertise in PH, BH/SUD, OH, SDOH-HE and long-term care. The CAP oversees all coordination functions and processes performed by BHMOs, DCOs and on behalf of Trillium to ensure member care coordination and communication processes are seamless, non-duplicative and support full integration. The local CAPs in each service area are supported by our Quality Improvement Program staff and committee structure, which provides the CAPs with the results of their tracking and monitoring for outcomes of initiatives, interventions and partnerships for integration at the member level and at the overall system of care level. Additionally, Trillium monitors the effectiveness of information sharing and coordination activities using a Plan-Do-Study-Act approach that includes PH, BH, OH, and SDOH-HE.

Through our Community Advisory Councils, Rural Advisory Councils, System of Care Advisory Committee, other community forums, and through the Community Health Assessment (CHNA) process we continually seek feedback on our integration system of care approach, and look for opportunities for further improvement and partnership.

Formalized Partnerships. Trillium has a long history of strong partnership with reimbursement for all services delivered in integrated clinics by qualified Providers. Local Mental Health Authority (LMHA), Lane County Health and Human Services (LCHHS). Since 2012, Trillium has provided fully integrated physical and behavioral, whole-health approach to address member goals for recovery and ensure continuity of care through
our contracted relationship with Trillium Behavioral Health a division of LCHHS that serves as the BHMO. This contractual partnership has enabled a greater level of integration for health care services and needed SDOH-HE supports through our shared Care Coordination Team, use of fully integrated technology platforms for coordinated care planning, integrated network, and working with community partners to promote integration. As we expand into our service areas to include the Tri-County area, we will formalize partnerships through contracts with the local BHMOs and DCOs and work with the local community to ensure successful transition without disruption to members. We will build on our successful approach and experience serving Lane County and Western Douglas County; however, we strongly believe that health care is a local experience and we will tailor our integrated approaches to meet the needs of the Tri-County members and providers for integrated service delivery and coordination. Trillium is committed to working with any other CCOs selected in our service areas, MCOs, PIHPs or PAHPs to coordinate care, reduce duplication and develop shared processes and initiatives that further enhance integration across our shared system of care. This includes dedicating equal attention and resources to BH, OH and SDOH-HE evidenced by compliance with parity, enhancing integration with DCOs, reducing barriers to provider level integration (e.g. prohibition of reimbursement for multiple services on same day in single setting).

**Integrated Care Coordination Team (CC Team).** Trillium’s commitment to partnership with our local BHMOs, CMHPs, and DCOs has enabled us to develop and implement collaborative fully integrated processes for assessments, care planning, care coordination, evaluation, and advocacy to guide care coordination processes and ensure a seamless experience so that members are unaware of how benefits are managed. Our approach is flexible for members and providers, as we understand that integrated care exists on a continuum and our CC Team provides support from communication and coordination, to co-management, onsite coordination, and support to our fully integrated PCPCHs. Our CC Team consists of registered nurses, licensed BH clinicians, social workers, and non-clinical support staff from both Trillium and the BHMO. Members are engaged by a Care Coordinator that has appropriate expertise to address the primary needs of the member. This Care Coordinator serves as the primary point of contact for the member and coordinates the full spectrum of covered/non-covered service needs including oral health and SDOH-HE needs. Our Care Coordinators are supported by the full expertise of our medical management team (BH/SUD, PH, OH, SDOH-HE, pharmacy, etc.), which enables seamless support for members with multidisciplinary expertise. Our CC Team utilizes an integrated Comprehensive Assessment that includes questions on BH/SUD, PH, OH and SDOH-HE, as well as a shared individualized care plan (ICP) to further ensure seamless coordination. Through daily communications, shared member clinical documentation systems, ad hoc CC Team collaboration meetings, and integrated joint operating committee meetings (formal, scheduled opportunities to collaborate on member care).

Trillium’s collaboration with our BHMO and the Lane County Choice Program is an example of CC Team and provider co-location to support integrated care coordination and successful OSH discharge planning. The Choice Program serves approximately 180 Trillium members and coordinates community-based services as clients discharge from OSH. This includes meeting the member at OSH prior to discharge, coordinating with Trillium CC for the interdisciplinary care team meetings, and providing comprehensive supports for adults with BH conditions in the most independent environment possible as they transition back to the community. All needs are considered during the discharge/transition process and our CC Team works with the Choice Program to be sure OH and SDOH-HE are incorporated into the member’s integrated ICP.

**Use of Technology to Enhance Information Sharing.** Ensuring that our integrated CC Team, BHMOs, DCOs and providers have access to timely integrated, whole-health information, and trended analytics is critical for both seamless member coordination, and integrated program development. Our Centelligence® health informatics platform integrates data from multiple sources to provide actionable population/member-level
TRILLIUM COMMUNITY HEALTH PLAN  
RESPONSE TO RFA OHA #4690-19 – CCO 2.0  
ATTACHMENT 11 - BEHAVIORAL HEALTH QUESTIONNAIRE

information to our integrated CC Team via our TruCare, our integrated care management system, and to our providers via our secure Provider Portal. The Member Health Record, available on our secure Provider Portal, allows providers to view clinical history and current interventions on their members including member contacts, claims (physical, behavioral, pharmacy), lab results, ICPs, allergies, eligibility history, participation in Trillium programs and more to assist providers in their practice of coordinated care delivery. We are continually working to make the information available to providers more integrated, and for CCO 2.0 we will add OH data from the Hot-Spotter report to the Provider Portal in a user-friendly way. Our Centelligence® platform integrates administrative, demographic, and clinical data making our Member Health Record a secure, web-based clinical data home. The Provider Portal also enables quick review and filter on detail level information and care gap alerts. These alerts notify a provider about the potential need for interventions, diagnostic tests, and labs, or for EPSDT and preventive service needs for their members. In addition to supporting integrated, secure information exchange through our Provider Portal, we also work with the Pre-Manage® tool, which enables our staff to identify and track members within risk cohorts and securely communicate care coordination information to providers/hospitals immediately to promote seamless service delivery. Trillium currently participates in Lane County’s Pre-Manage Collaborative, as well as the Tri-County Pre-Manage Collaborative based in Portland. The Lane County PreManage Collaborative is working to accelerate the process for supporting BH Providers get access to PreManage, as well as developing a methodology for using Pre-Manage to allow a member’s integrated CC Team to access an interactive shared care plan to support member management. We anticipate that these efforts will further support our ability to help Members access the right level of support at the right time, including reducing unnecessary ED utilization for BH reasons. We use Admission, Discharge, and Transfer (ADT) feeds when available to enhance our review and identification of members with high emergency department (ED) use and allow our staff to be immediately made aware of ED visits to facilitate interventions. ADT feeds coupled with the use of the PreManage® tool allow for more timely data exchange. We support data exchanges with providers, OHA, and regional and state Health Information Exchanges (HIEs) to enable standards-based data interchanges, such as Health Level Seven (HL7) Fast Health Care Interoperability Resources (FHIR) and Continuity of Care Document (CCD) exchanges. Trillium will take similar approaches as described above in proposed Service Areas.

Enhancing Our Integrated Network. Trillium is committed to further enhancing our network in Lane, Western Douglas and Southwestern Linn Counties, and expanding our network in the Tri-County area to deliver a robust and integrated network with a diverse provider population. We work with providers at all levels of integration. Across our current service area and proposed service area expansion counties, the Patient-Centered Primary Care Home model has been widely adopted; however, provider groups are in various stages on the continuum of integrated health delivery. To assess readiness and integration across our network, Trillium collaborated with OHA on the Integrated Needs Assessment Pilot. Based on these assessments, we are continuing to partner with Patient-Centered Primary Care Home (PCPCH) and BH health homes for expansion of integration across the system of care. We are working with our providers to enhance contracting to provide better support as they deliver integrated care, streamline administrative burden regarding payment mechanisms and ensuring reimbursement for all services delivered in integrated clinics. We will further
support enhanced quality of care through operational and community-driven improvements including the technology supports (described above) and our multidisciplinary Care Coordination Team approach with options for on-site support and telehealth solutions to improve communication. In addition, we will focus on successful outreach to all PCPCH at OHA Tier 3 or higher, for initiatives that improve access, empower and engage members in person-centered and culturally/linguistically appropriate ways, increase efficiencies, improve discharge planning for mental health admissions, decrease wait times, integrate OH and incorporate value-based payment mechanisms that align with target benchmarks for quality care. We provide access to evidence based screening tools, training and support to ensure fidelity to models of integration as providers implement or enhance their approaches to integration. We will partner with integrated service providers such as White Bird Community Health Center in Lane County that fully integrates PH, BH, OH, and SDOH-HE services and Lifeworks Northwest in the Tri-County area that incorporates integrated prevention and health care into their comprehensive BH services. Working with providers like these allows us to offer members a variety of integrated support and coordination options such as wraparound services for children with BH conditions that are inclusive of all member needs and Peer Delivered Services (PDS) embedded within provider settings such as residential treatment centers, mobile crisis providers and/or other facilities to increase access to all covered benefits to develop an effective and responsive BH system for members. Other examples of how we have successfully partnered for comprehensive integration includes our partnerships with co-located PH/OH clinics in our current service area. Such as the Lane County Community Health Center’s Delta Oaks Clinic, and Springfield Family Physicians, which have Expanded Practice Dental Hygienists onsite to provide OH screenings, fluoride varnish and sealant applications, OH education, and Primary Dental Provider referrals.

Collaborating with Community Partners to Promote Integration. We collaborate with providers and community partners to streamline coordination of services with all providers serving the member to ensure processes are in place to promote a coordinated BH System of Care that is invisible to the member. For example, Trillium began partnering with the Center for Family Development and Springfield Family Physicians to administer the Intensive Community Care Management (ICCM) Program in January 2019. Our ICCM engages high-cost, complex members with at least five chronic PH conditions and one BH condition. The multidisciplinary ICCM Team, who can assist the member in all levels of care, identifies and addresses barriers to service, including SDOH-HE, enlists auxiliary and specialty services, and coordinates partnerships across a range of agencies to ensure integrated care. Additionally, we work with community partners to develop the Community Health Needs Assessment (CHNA) and obtain community feedback on all aspects of our services, network and processes. By sharing our information, experience and data between the CCO and the community partners, we are able to capture a unified, system-wide overview of the BH, PH, OH, and SDOH-HE needs in our service areas. In Lane County, we have worked with key partners such as the United Way of Lane County, Lane County Public Health, and PeaceHealth. We are expanding our service area into Tri-County and we will work with County community partners, BHMOs, DCOs and any other CCO selected to promote integration across the service delivery system through programs like our ICCM, partnering on the CHNA, and other community driven initiatives—tailored to the community to promote full integration.

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-defined 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?

Trillium is committed to offering fully integrated health care. For this reason, we will only contract for BH care management with BHMOs (or similar type organizations) that are able to offer coordination and full integration.
with Trillium, and share our commitment to an integrated whole person approach. Trillium provides covered services within the Global Budget (as defined in ORS 414.025) in a fully integrated manner. To achieve this, we do not, and will not identify a pre-defined cap nor will we separate funding for BH and PH by fully delegating the responsibility for care coordination to any entity that does not coordinate and integrate care. All funding decisions are based on Medical Necessity guidelines without regard to cost to assure that BH treatment is timely, cost-effective, and follows evidence-based approaches. To manage the Global Budget, Trillium reviews data and reports daily, monthly, quarterly, and annually as appropriate to assess whether our BH service expenditures are appropriate. In addition, we will review EQRO reports, and guidance from OHA. We will analyze our network adequacy adherence, quality metrics, and access standards to evaluate the sufficiency of BH access for our members to meet the requirements in compliance with Exhibit C: Administrative Rule Concepts, Section e. Behavioral Health and Exhibit M, Section 1.i of the Sample Contract. We use this data to inform the allocation of BH resources from the annual Global Budget. In our current service areas work with Trillium Behavioral Health, our local BHMO to provide completely integrated service delivery. We have existing MOUs with the LMHAs and CMHPs in Lane, Douglas, and Linn Counties that set forth roles and responsibilities to coordinate and integrate services, and efforts to meet the BH needs of the communities we serve and to achieve improved outcomes in compliance with the Sample Contract, ORS 414.153, and other State requirements. Trillium has met with LMHAs and CMHPs across our proposed Service Area to ensure we will have an MOU/contract in place prior to Readiness Review. In the Tri-County Region, we have met with the LMHAs in Multnomah, Clackamas, and Washington Counties and have provided draft MOUs for the CCO 2.0 program. Multnomah, Washington and Clackamas Counties have indicated a willingness and interest in jointly developing a MOU should Trillium be awarded a CCO 2.0 contract in these areas.

3. How will Applicant fund Behavioral Health for its Service Area in compliance with the Mental Health Parity and Addiction Equity Act of 2008?

We are committed to funding BH services in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Trillium understands that health care parity regulations are intended to increase access and appropriate utilization through non-discrimination and comparability for funding and coverage of all offered mental health and SUD covered services. Trillium follows our established corporate policies and procedures, which are fully compliant with MHPAEA, federal and OHA regulations regarding BH parity. To ensure that our funding of BH is in compliance, we will not set separate aggregate spending limits to fund BH in our Service Areas. Trillium does not establish a maximum lifetime or annual financial benefit amount for BH services available to members. We will ensure that Medical Necessity determinations for mental health and SUD benefits are available to all members in the same manner as medical/surgical benefits in full compliance with MHPAEA and applicable federal and state regulations. Specifically, we do not and will not set quantitative treatment limitations (QTL) that are more restrictive than those applied to same class medical/surgical benefits. In compliance with MHPAEA we define benefit classifications as: inpatient, outpatient, emergency care and prescription drug coverage. We further ensure parity in application of non-quantitative treatment limitations (NQTL) with that of medical/surgical benefits. Through our plan, do, study, act approach we continually monitor to ensure ongoing compliance with MHPAEA, and other applicable federal and state regulations regarding parity for funding and coverage of BH services for our members. Our Clinical Advisory Panel (CAP) reviews all utilization management policies, processes, standards, and criteria that apply to mental health/SUD services in comparison to processes, standards and criteria that apply to medical/surgical services to ensure compliance with MHPAEA. We further conduct annual internal mock audits to identify areas for improvement in compliance. Should there be findings from Trillium’s mock audits, or OHA annual audits, our Quality Committee reviews recommended actions, interventions or process modifications with our CAP, and going
forward our Health Equity committee to ensure that we are in full compliance, and working to identify any potential health equity/disparity parity implications.

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?

When monitoring the need for BH services and funding for BH services we look at a broad cross-section of data, but also incorporate these key concepts into our work with providers and community stakeholders to gain a better understanding of BH prevalence and the relationship to utilization and reimbursement:

- Ensuring an understanding of BH service needs through engagement with members, providers and other stakeholders
- Ensuring an understanding current referral and utilization patterns
- Ensuring analysis of our network adequacy and identifying access solutions that strengthen access to BH services
- Maintaining strong and collaborative relationships with all BH providers that are currently contracted with Trillium

Trillium has access to a broad spectrum of data including prevalence information and BH service utilization. We look at acuity of the membership as attributed to their local provider, based on diagnosis and treatment needs rather than historical high and low utilization (low utilization does not necessarily indicate low need, rather it could indicate presence of unmet needs). Not less than annually, Trillium leadership from across our company including Quality Improvement, Medical Management, Finance and Network review the comprehensive data for macro level trends at the provider and system level to monitor the sufficiency of BH timely access for members, to address prevalence and ensuring expenditures on BH services are appropriate. This comprehensive data approach incorporates but is not limited to, review of EQRO reports; member satisfaction surveys; Hot-Spotter reports; network adequacy and access, including monitoring out of network service utilization; penetration rates; complaints and grievances; and PreManage other data sources related to hospital/ED utilization. Other examples include disease management prevalence analysis, BH prioritization spend, and High Risk population analysis. Our grievance process also reviews trends and care gaps. This information is reported to our local CAPs who review the data and make recommendations to our Board of Directors and Quality Improvement leadership to guide planning and intervention development should modifications to our overall program or funding need to be made in order to ensure that BH services are responsive to the identified needs of our overall population. If gaps or lower than expected penetration rates based on diagnosis and acuity are identified, Trillium will consider both financial and non-financial mechanisms to correct. We will collaborate with our community partner organizations on provider training and technical assistance (e.g. Project ECHO), support funding to enhance capacity or capabilities through Innovation Grants, and engage providers in Value-Based Payment (VBP) strategies that incentivize system to build appropriate capacity. In addition, Trillium in coordination with the Centene Center for Behavioral Excellence and our local BHMO will implement an enhanced BH Auditing process that will conduct further review and collaborate with our leadership on recommendations for improvements.

**Funding BH.** We will continue to fund BH to address prevalent needs rather than historical spending by accounting for BH trends that are identified in our enhanced BH Auditing process and allocate funds to identified BH services needs and trends. Our BH Audit process will include a quality Medicaid audit that ensures OAR compliance in order to obtain a standard of care across all contracted BH organizations, agencies, and providers. Trillium’s funding approaches for BH reimbursement include non-capitation, and VBP with varying levels of risk along the HCP-LAN continuum. Our reimbursement approaches are designed with
Medicaid providers in mind, and we tailor these approaches to the capabilities of the providers, and the needs of the members they serve. We will work with our Health Equity to both monitor our VBP approaches, as well as develop innovative strategies to incentivize high quality BH care that incorporates whole person, integrated approaches for the best outcomes. We will closely monitor the reimbursement approaches for unintended consequences of VBP arrangements that could negatively impact our members (e.g. providers not accepting SPMI or high risk members). This type of misalignment could create health disparities or cause increase utilization of the ED or higher levels of care. We will ensure accountability within our process by having all VBP approaches reviewed by our Health Equity Committee prior to Readiness Review, and review trending quarterly thereafter with specific attention to the communities served and acuity of the member mix that is served by those locations.

**Cost and Utilization.** We monitor cost and utilization of the BH benefit by stratifying high-risk members, analyzing population health risk and acuity, reviewing over/under utilization and standards of care. Trillium also conducts analysis that compares utilization rates per 1,000 members per month and cost per member per month (PMPM). We also monitor utilization of the BH benefit using dashboards such as our online Executive Key Performance Indicator (KPI) Dashboard that has drill down capabilities for multi-faceted analysis. Through Centelligence, we have the ability to report on all datasets in our platform, including HEDIS, EPSDT services, claims timeliness, Performance Improvement Projects, and other critical aspects of operations. We have enhanced our monitoring processes by implementing Prometheus, an analytical tool that applies clinical expertise to various data-driven/analytical approaches using the managed care program encounter data to identify unnecessary healthcare expenditures and potential avoidable complications that can be addressed through improved efficiencies and Care Coordination processes.

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?**

Ensuring “no wrong door to care” is a guiding principle in health care and particularly BH services and supports. We work with our provider network to ensure that our members have access to BH screenings and referrals to treatment no matter how they access their health care. We reimburse for covered BH services rendered in a primary care setting by qualified BH providers and reimburses for covered PH services provided by qualified medical providers in BH care settings. To contract for BH services in primary care service delivery locations and PH services in BH Care service delivery locations, we work individually with each provider to develop a contract that is tailored to the needs, capabilities, and readiness of the provider. We reimburse for services across the continuum of care, provider type and level of need. We encourage all providers to conduct BH, SUD, Trauma and SDOH-HE screenings for early intervention during interactions with members. We support this through training on screening tools and modalities, such as SBIRT, on our Provider Website. Trillium covers specialty care and inpatient level of care, with any applicable incentives for care transitions to ensure continuity and maintenance of outcomes of investment in high levels of care.

**Demonstrated Experience and Outcomes.** In our experience, reimbursement often leads transformation and integration, and strategies that incentivize ready access to right service, right setting, right provider for individuals’ needs have strong outcomes. For example, we have worked to promote integration in our provider network through Trillium’s Integration Incubator Program (TIIP), which focused on providing enhanced reimbursement for integrated services provided to members with co-occurring BH/PH conditions. Through TIIP, we funded eight BH/PH integrated clinics, which are still operating today and three have recently added
OH services. 50% of clinics saw costs decline for member’s use of urgent care, ED use, and inpatient stays. Eugene Pediatrics alone had a 17.3% cost decrease and 57% increase in utilization of BH services.

In addition to our successful TIIP program, we are and will work with providers to develop capitated and risk based VBP focuses on integrated service delivery and enhanced care coordination approaches within the provider location, for example with PCPCHs, or as we have done with the ICCM program. Capitated arrangements are only used when services and coordination can be fully integrated, and provider sites are able to offer PH, BH, SUD, OH and support SDOH-HE needs of our members. For providers that may need specific elements of their program or locations funded in order to advance integration, we award Innovation Grants. These grants enable providers to solve challenges and remove barriers to integration and offer integrated service delivery.

**BH Benefit Reimbursement.** Configuration. Trillium’s information technology solutions and technical capabilities provide support to appropriately configure our provider contracts and VBP to reimburse for integrated care and to address common challenges for integrated care. For example ensuring that if a member sees multiple providers at the same location on one day, that all providers are able to paid for that same date of service. Trillium and utilizes AMISYS Advance (AMISYS) to efficiently support accurate claim adjudication for complex benefit plans and multiple provider reimbursement models. We use AMISYS for BH/PH processing, Medicare Advantage administration, and for our Exchange family of individual insurance products; enabling a uniform approach to coordinated benefits administration. AMISYS fully supports HIPAA standard Electronic Data Interchange and Electronic Funds Transfer capabilities and real time clinical edits and advanced Fraud Waste and Abuse detection.

In addition, to ensure provider integration of BH/PH services we use the following methods:

**Shared Platforms.** The shared use of TruCare, our member-centric health management platform, and availability of the individualized care plan (ICP) within TruCare ensures that multiple parties serving the member has the full range of information about their needs, goals, and services in order to promote a seamless integrated experience for the member. Our secure Provider Portal also supports provider administrative capabilities including eligibility inquiry, authorization submission and status, claim submission, claim status inquiry, claim payment history, and a growing number of clinical applications to promote collaborative coordination.

**Data Analytics.** Our robust Centelligence platform is based on a comprehensive data set that includes PH and BH data. As part of this platform, we have sophisticated practice profiling tools which have supported our Primary Care Provider (PCP) VBPs. This platform will be used to develop additional reports and practice profiles that add more data to support our integrated models and help providers understand their unique opportunities and how to measure improvements in outcomes. We will also be working with integrated practices to understand the capability of their EHR system to process data files into their EHRs and for abstraction of supplemental data to improve the robustness of our data set, which will drive performance improvement, improved care coordination, and care gap closure.

**Baseline Metrics and Year 1 and 2 Reporting.** Trillium is in agreement with the metrics and reports outlined in Attachment C: Administrative Rule Concepts Section E. Behavioral Health and specifically those included in Policy #18 and will use OHA tools for reporting, or will develop reports in collaboration with OHA and other CCOs.

### 6. How will Applicant ensure the full Behavioral Health benefit is available to all Members in Applicant’s Service Area?

Trillium ensures the full BH benefit is available by continued review/enhancement of our network, and leveraging our community partnerships and referral systems. This includes:
Review of BH Network. Under the CCO 2.0 Program, Trillium’s Network Development team will be responsible for regular assessment of and reporting on network adequacy on a quarterly basis, to ensure sufficient numbers, areas of practice, and geographic distribution of our Provider Network as well as incorporating adequacy by prevalence. Our assessment will measure the accessibility and adequacy of our Provider Network, including PH/BH providers, SUD providers (including access to residential treatment providers) and OH providers. We will analyze geographic access mapping results, network reports, and self-reported member data, and will incorporate additional data into our overarching review such as grievances, appeals and complaint data; anecdotal information learned from field based Traditional Health Workers or MemberConnections® Representatives, and our CC Team; member satisfaction data; CAC and RAC feedback; and appointment availability audits. Our Network Development team is responsible for providing the BH Delivery System Network (DSN) report. The DSN identifies key information about our BH network adequacy including: all individual providers and facilities that hold written agreements with the health plan to provide services to its members, with an appropriate range of BH providers sufficient in number, mix and geographic distribution to meet Member needs. Network Development staff in coordination with our local CAPs will be responsible for identifying specific factors to create and monitor BH Provider Panels, and incorporate this information into network reporting.

All reporting and analysis is shared with our Quality Improvement Committee (QI Committee) to oversee any needed performance improvement initiatives; however, we also share this information with our CAP and Health Equity Committee for feedback and recommendations for addressing gaps.

Ensuring Member Access to Timely Care. Should Trillium identify a gap, or a member contact us requesting an out-of-network provider, we have an established single case agreement approach to ensure that the member is able to receive care in a timely and appropriate manner. When such requests are received, our Network contracting staff are able to reach out to providers to get them engaged for contracting. We will continuously work to identify or recruit and contract SUD residential providers, providers that are trained in needed evidence-based practices (e.g. Trauma Informed Care; Applied Behavioral Analysis) and providers that align culturally and linguistically with our membership.

Leveraging Community Partnerships to Address Gaps in Services. We will continue to build and maintain our network and leverage our relationships with community partners and resources to ensure that we continue to have local insight to the evolving BH service landscape in our Service Areas. For example, Trillium participates in state programs such as The Innovation Café, which promotes transparency within our community for members, providers and CCOs. Feedback from these interactions helps us to identify new providers or programs to contract with as well as provides education about what programs Trillium offers to members and providers.

7. How will Applicant ensure timely access to all Behavioral Health services for all Members?

Trillium monitors and evaluates network access to ensure timely access for BH services. We continually assess network adequacy and capacity using multiple data sources, applying a methodical approach to assess ongoing network needs. For example, reviewing and analyzing geo-maps and capacity reports, provider to member ratios are one method. However to truly understand the member experience we look at appointment availability and wait time audits, patterns of care, out-of-network and out-of-state utilization, member complaints, and stakeholder feedback. This information provides better insight into the time from request of services to actual access to services. We monitor provider performance and quality of services across the network to ensure members have access to quality providers through our Quality Improvement (QI) Program. Provider performance is reported to the QI Committee and quality information is accessible to members and providers through our public website and Member and Provider Portals. We also maintain a shared online resource tool.
with providers that shows wait times and openings for providers, which is updated weekly. In addition, we ensure members receive services from non-participating providers for BH 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. We also have written policies and procedures (P&Ps) for BH covered services, which address administration of the benefit and as described in Exhibit M, Section 2.a to ensure timely access. These P&P will be available to OHA by the beginning of CY 2020.

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?

Trillium contracts across Service Area lines to ensure that we have access to the BH provider types and services needed to support our members. To ensure that members can receive BH services out of the Service Area, the member’s Care Coordinator works to locate provider and/or service referrals for needed BH services. Arrangement of out of the Service Area or out of the state BH care includes linking the member to a referral for the needed provider type/service, supporting the member with scheduling appointments, arranging for transportation, and following up with the member after the appointment to ensure connectivity as needed. Our CC Team staff also works with providers to ensure they have our contact information for potential questions and/or concerns. Simultaneously, our Network contracting staff work to engage the provider in a single case agreement or recruit the provider for our network to provide greater access and coverage in the future. One example of services that are not readily available in every county in Oregon, but can be located in the state is SUD residential care and higher levels of care for children. Trillium contracts with these providers in additional Service Areas to ensure we can quickly engage our members for care, even if there are no providers available within the Service Area.

Paying for Out of Service Area Care. Trillium understands that we are responsible for reimbursement and payment of BH services that are provided to the member. To achieve this, we will adequately and timely process authorizations for services that are out of the Service Area. Specifically, we record prior authorizations issued by other payers and deliver uninterrupted services for the shortest period of 90 calendar days following the effective date of coverage; until the end of the current authorization period or until we evaluate and assess the member and issue a determination. Whenever appropriate or necessary to support continuity of care, we offer timely access to out-of-network providers for medically necessary services and not otherwise available within our network. Trillium requires single case agreements only if the provider will not accept Medicaid reimbursement or if the out-of-network provider wants a single case agreement for their records. This strategy reduces unnecessary paperwork and provider burden while ensuring continuity of care. We also provide support for non-health related services, supports/activities that can be expected to improve a member’s BH condition including flexible funding as defined by the SOCWI guidance document link found in Exhibit B, part 2(4)(m)(1).

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?

As mentioned above, Trillium supports the “no wrong door” approach to accessing care and critical to this is recognizing that BH conditions are often first identified in non-BH settings. Trillium will ensure providers complete comprehensive BH, PH, and OH screenings and comply with all Sample Contract screening requirements by: 1) Offering training about evidenced-based (EB) screening tool options; 2) Conducting a BH Audit to monitor the use of EB screening tools and; 3) Offering a simplified screening process option.

Offering Training. Trillium offers face-to-face training to providers through our educational program, Trillium University (TU). TU brings together PH, BH, and OH agencies, social service agencies and community based...
organizations, school districts, Traditional Health Workers (THW) and Community Advisory Council (CAC) and Rural Advisory Council (RAC) members to learn about and share experiences with SDOH-HE, HIT, integration, and Health Equity. As part of TU, a 4th Friday’s Innovators Collaborative is offered, which centers on monthly provider trainings such as but not limited to the integration of BH/OH in school-based clinics; accessing community resources; chronic pain and opiate use; health literacy; and Trillium specific programs/innovations. We also offer provider tool kits that include written information about specific EB screening tools. Trillium will offer technical assistance for providers regarding how to incorporate screenings into your workflow and how to get Trillium assistance for referrals or follow up care coordination. To supplement this technical assistance we will begin offering online training through Relias Learning Management System (Relias). Relias offers provider 24/7 access to continuing education related to BH topics including the training, “SBIRT: Intervention and Treatment Services for Individuals with Substance Use.” Our CC Team staff are also valuable resources for both members and providers, as our Initial Risk Screening and Comprehensive Assessment incorporate brief screenings for all health care needs and SDOH-HE.

**Monitoring Use of Tools.** In 2019, we will administer a sample BH Audit (as part of our BH Audit process described in question 4) to introduce providers to new contractual requirements related to screening including mandated screenings such as Child and Adolescent Needs and Strengths Comprehensive Screening (CANS Oregon) and SBIRT. We will use a statistically significant sampling of providers, and if a provider fails the audit, they will be re-audited at periodic intervals until screening performance improves. The sample will monitor required BH provider protocols such as but not limited to the completion of a face-to-face screenings, administration of periodic update to screenings to ensure the members evolving needs are always being met, and that relevant documentation has been captured by the provider. After the sample BH audit in 2019, our ongoing BH audit will begin in 2020 and will be administered by TBH. Trillium will use TBH’s BH Audit model and leverage best practices to monitor the use of tools in proposed Service Areas beginning in 2021.

**Offering Simple Screenings.** We are in the process of implementing Simple Screens, which will allow members to complete a variety of screenings such as but not limited to the Patient Health Questionnaire, Tobacco Screen, and a Dental Caries Risk Screening on an easy to use HIPAA compliant tablet in provider settings. Screening data is shared with providers and our Enterprise Data Warehouse (EDW), which through Centelligence, systematically receives, integrates, and transmits internal/external administrative and clinical data, including PH/BH, and OH data. Trillium will provide technical assistance to providers on how to incorporate Simple Screens into their workflow for better engagement and utilization, and how to reach Trillium if they need referrals or follow up support for the member.

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?**

Trillium ensures access to Mobile Crisis Services by contracting with the appropriate providers to promote stabilization in a community setting rather than arrest, presentation to an emergency department (ED), or admission to an acute psychiatric care facility. One critical way we have worked to expand access and coordination with mobile crisis providers is through community engagement of key first responder stakeholders such as law enforcement and first responders, and relationships with county jails. We work collaboratively to find and fund services to meet this need. We are conducting a community based strengths/needs assessment to identify un-covered areas for crisis response, and working with our partners at the Counties to find innovative ways to expand access and capacity.
In accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, 309-019-0243 and 309-019-0300 to 309-019-0320, we will contract with mobile crisis providers who provide mobile crisis risk assessments and/or supportive crisis services in the member’s home, hospital, or other setting. This ensures the availability of service, supports or appropriate alternatives 24 hours a day/7 days a week to remediate a BH crisis in a non-emergency department setting. For example, we contract Adult and Child Crisis Services who collaborate with Crisis Assistance Helping out on the Streets (CAHOOTS). CAHOOTS works with Hourglass, a 23-hour crisis respite facility for adult services in Lane County. We also contract with The Child Center for youth who coordinates and partners with Jasper Mountain and Looking Glass Community Services for crisis respite services. To support streamlined access to mobile crisis services, our designated BH Crisis Liaisons work directly with crisis providers/other providers to develop and monitor shared workflows that help support coordination during/after crisis interventions to remove barriers to care and ensure follow-up services are accessed. Our BH Crisis Liaisons support the entire CC Team by coordinating logistics with mobile crisis providers to share member information (as applicable and with member consent), follow-up post crisis, refer to coordination services (if not enrolled), and/or schedule appointments with BH providers for follow-up outpatient BH services.

Additionally, Trillium has established written P&Ps and monitoring systems for an emergency response system, including post-stabilization care services and Urgent Services for all members to meet all requirements as described in Exhibit M, Section 2.g in the Sample Contract.

11. Describe how Applicant will utilize Peers in the Behavioral Health system.

Trillium utilizes Peer Delivered Services (PDS), in a variety of ways in alignment with OHA regulations and Oregon Administrative Rules, including OAR 309-019-0105. Trillium encourages the use of PDS, which are delivered by certified Peer Support Specialists, Peer Recovery Mentors, Health Navigators, MemberConnections® Representatives (MCRs), and other Traditional Health Workers (THWs), for members with BH conditions to provide invaluable support and mentoring from individuals with a history of shared experiences. Trillium also support access to Peer Support Specialists and Peer Recovery Mentors to support BH and SUD recovery through contracted BH agencies as described below in question 12. Trillium provides access to PDS for each member seeking these services consistent with OAR 309-019-0105, as we have seen positive member health outcomes and improved recovery when PDS services are engaged. We will ensure that members are informed of their benefit to access in the Member Handbook, which includes a description of PDS and how to access it, a description of the types of PDS providers, an explanation of the role of the PDS provider, and ways that PDS can enhance a member’s care.

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?

We understand that the context of a member’s life is multi-faceted and specific to their own health conditions, familial support/background, and SDOH-HE needs, which can impact overall health outcomes. The following
approaches describe some of the methods we take to support identification and mitigation of SDOH-HE, integration into the community, and access to peer services and networks.

**Assessing for SDOH-HE Needs.** Through our Initial Risk Screening (IRS) and our Comprehensive Assessment (CA), SDOH-HE needs such as food insecurity and homelessness status are captured by our CC Team. Once needs are identified, the member’s Care Coordinator will link members to needed resources to ensure connectivity. Additionally, we will require providers to screen for SDOH-HE concerns. For those providers that are using the PRAPARE screening tool, using ICD-10 codes, or Simple Screens to collect and report on SDOH-HE, we will incorporate that into our TruCare population health management and documentation system for enhanced coordination and rapid support. We are also piloting Simple Screens to promote the use of standardized SDOH-HE screenings in provider settings and will track screening completion rates by provider beginning in 2019 to ensure SDOH-HE needs are identified. We will meet all requirements as described the Sample Contract in Section Exhibit M, Section 2.b and require providers to screen members for adequacy of supports for the family in the home.

**Expanding Access to SDOH-HE Support.** To enhance linkage to SDOH-HE needs, we are hiring a THW Liaison to increase member access to THWs, who also serve as another member access point for SDOH-HE resources. Trillium also currently employs five MCRs. These MCRs assist members in accessing transportation, food, shelter, or other health or social programs. To expand access, Trillium plans to support agencies that employ OHA-certified THWs so that we can refer our members to diverse, community-based MCRs, Doulas, and other THW types to support member health and wellness. Trillium is also implementing an internal SDOH-HE committee that will include TBH and CAC representation.

**Integration into the Community.** Additionally, we promote integrated community supports by ensuring capacity to provide the required full range of BH/PH, SUD, and OH services. This includes maintaining and supporting a fully contracted network that includes more than 1,500 OH providers in our current and throughout our proposed Service Areas. Maintaining a diverse network allows our CC Team and our providers to access the needed community support seamlessly and increases the opportunity for integration into the community.

**PDS Access.** In addition, Trillium provides access to PDS for each member seeking these services consistent with OAR 309-019-0105. To ensure access, we contract with diverse BH providers and maintain a specific billing code to streamline the claim process. We also support organizations that offer PDS such Oregon Family Support Network, Youth ERA, and Centro Latino and will continue to expand this practice as we expand our Service Area into Tri-County. We offer a variety of referral entry points to link members to PDS including access through internal referrals, provider referrals, and member may also self-refer to PDS.

**B. BILLING SYSTEM AND POLICY BARRIERS TO INTEGRATION (RECOMMENDED PAGE LIMIT 2 PAGES)**

Applicant must identify and address billing system and policy barriers to integration that prevent Behavioral Health Provider billing from a physical health setting. Applicant will develop payment methodologies to reimburse for Warm Handoffs, impromptu consultations, integrated care management services and all services for evidence-based treatments (for example, Wraparound, ACT, PCIT, EASA, Peer Delivered Services). Applicant will examine equity in Behavioral Health and physical health reimbursement.

I. 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.

In accordance with OAR 309-032-0860, we will conduct Warm Handoffs (WHs) by supporting member transitions from one provider to another prior to discharge with member face-to-face meetings. This process helps to remove barriers to care, and ensure full understanding of the transfer of responsibility from one
provider to another. We also recognize that WHs involve the coordination and transfer of responsibility for ongoing care to ensure continuity. We describe WHs below using a referral to a BH provider for “Sara” as a potential example during discharge planning. This process includes:

**Initial Engagement.** The Care Coordinator, who is a licensed behavioral health professional, engages Sara in-person after receiving a referral for a WH at the weekly discharge meeting attended by the Care Coordinator and hospital social work staff, where members that are presently admitted like Sara are discussed. In collaboration with the discharge team, the Care Coordinator collaborates in the development of a discharge plan for Sara.

**WH Initiation.** The Care Coordinator then makes a clinical determination based on Sara’s needs regarding whether to reach out first to the assigned BH provider or to Sara directly to ensure seamless care coordination. If Sara is contacted first, the Care Coordinator will clarify if she needs support in understanding the details of her next appointment, has transportation to her appointment, and if she needs additional resource linkage. The Care Coordinator and the TOC Care Coordinator may also engage in additional collaboration before or after contact is made with provider/member to ensure all needs are met.

**Confirm the WH.** The Care Coordinator then follows up with Sara and her provider after the scheduled appointment to confirm attendance. Sara and her provider’s feedback and/or concerns are documented in TruCare. To ensure WHs occur and are documented, we are expanding the capabilities of PreManage®, which allows staff to identify/track members within risk cohorts and communicate care coordination information to providers immediately when a member event occurs. Use of ADT feeds coupled with the use of PreManage allows for more timely data exchange. Trillium will report on the number of Warm Handoffs that occur to OHA. Potential barriers for ensuring WHs include Care Coordinator staff shortages, inability to engage the member in coordination services, and inconsistent use of PreManage/HIEs. We address these potential barriers by monitoring staff to member ratios, making at least three attempts to engage members in services, and providing training to staff/providers about the benefits of PreManage/HIE use.

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?**

Trillium assesses the need for in-home services through tools such as Health Risk Screening and/or TOC Assessment. Our assessments are designed to assess need, and expedite connection to the appropriate services and supports that can help to maintain a member safely in their home and community, and reduce barriers to care. Potential criteria for in-home BH services includes members with serious BH condition such as severe anxiety or agoraphobia. Members and/or their providers may request in-home services and be linked to a referral through our Care Coordinator. If a need is determined, the Care Coordinator will complete a referral and will link the member to the appropriate provider, such as Oregon Community Programs, for in-home BH care services. We monitor utilization by using Clinical Risk Grouping (CRG) software via Centelligence®, which allows us to analyze claims data, including utilization of in-home services. CRG provides our Quality Management (QM) staff with a review performance dashboard to quickly identify trends in over- or under-utilization for in-home services and enabling targeted approaches for clinical intervention or provider education leadership. Our QM staff analyze trends at a population level and work with providers to compare their performance to network benchmarks.
3. Please describe Applicant’s process for discharge planning, noting that discharge planning begins at the beginning of an 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.

Trillium understands that effective discharge planning starts at the beginning of an episode of care. Our discharge planning process focuses on: 1) Collaboration with the discharging facility, treatment team, the member, and the member’s representative; 2) Identification of member triggers and care gaps while the member is inpatient using our Transition of Care (TOC) Assessment and; 3) Facilitating smooth discharges with all activities documented within the member’s ICP. For our members with severe and persistent mental illness (SPMI), our Transitions Coordinator on our Transitional Care Team will offer a WH as part of the discharge planning process and as defined in OAR 309-032-0860(22). In addition, we will work with community partners to ensure that members who are discharged are linked to housing and we will work with psychiatric hospitals, such as Oregon State Hospital, to develop housing assessments for members to meet all requirements as specified in Exhibit M, Section 3.f.10 of the Sample Contract. To ensure a seamless experience, part of our process includes the coordination of all benefits to reduce potential billing system errors. For example, if we encounter members needing services not covered by OHP but by Third Party Resources (TPR) during the transition process from one level of care to the next or next episode of care, we follow our transition process as if OHP is the primary payer to ensure continuity. Our Concurrent Review (CR) Nurses and Care Coordinators coordinate care for members with more than one payer to ensure appropriate placement/care across settings. For hospitalized members, our CR nurses may also refer members to a BH Care Coordinator during the CR process regardless of primary payer. Our evidenced-based clinical review resource, InterQual, also includes discharge criteria for continued stay approvals. In addition, our BH Medical Director reviews all inpatient stays over eight days to monitor ongoing medical necessity, identify potential BH referrals, discharge needs, and barriers to integrated care.

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.

Trillium coordinates care and benefits for covered services with Medicare payers and providers, as medically appropriate, through our Dual Eligible Special Needs Plan Program (D-SNP), which provides multi-disciplinary coordination services for fully dual eligible members. This program, which has a dedicated Special Needs Plan (SNP) team, focuses on BH specialized care, reducing high costs, reducing readmissions, and addressing SDOH-HE needs. Care Coordinators participate as a support to the D-SNP RN Care Coordinator, members, and/or BH providers to address BH care gaps and coordination of BH services for non-CHOICE (formerly AMHI) eligible D-SNP members as needed.

Trillium has operated a Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP) in Lane County since January 1, 2007 and as of March 2019, the Trillium Advantage Dual HMO SNP (contract number H2174) has 2,484 members. Our affiliate, Health Net, operates a MA HMO plan (contract number H6815) in Lane, Washington, Clackamas, Multnomah, Douglas and Linn, Counties and a PPO plan (contract number H5439) in Lane, Washington, Clackamas, Multnomah, Linn, and Douglas Counties. We intend to expand our D-SNP product in 2021 to cover any additional counties that we may be awarded through this Application.

When the member is receives Medicaid coverage through Trillium, but is enrolled in another plan’s D-SNP or Medicare Advantage plan, our Member Services, Utilization Management and Care Coordination staff are trained to identify who to contact and how to ensure proper coordination of benefits, and proactively prevent
inappropriate claims denials. Whether a member is in our affiliated D-SNP/OHP or enrolled in an unaffiliated OHP/D-SNP/FFS Medicare, we ensure seamless, continuous, and appropriate care/services across the care continuum, including transitions between settings and coverages.

To ensure proper billing, we collect and store TPR, such as but not limited to Medicare, data in our Management Information System (MIS). This data is made available to our CC Team, Utilization Management team, Claims Department, Customer Service Representatives, Discharge Planners, Nurse Advice Line Clinicians, CR Nurses, and providers. Our ability to make TPR information readily available creates a framework that enables facilitation of claim processes that ensure appropriate and accurate payment of services and coinsurance/copayments; coordination of drug formularies to ensure appropriate coverage of prescription drug benefits and; identification of dually-eligible members/programs that provide the right levels of support for members living in the community or at home.

To avoid potential barriers, our first priority is making sure member services are not interrupted and that members have access to the services they need, when they need them. We understand when members have Medicare as the primary insurance and the benefit limits have been exhausted, the services are now a Medicaid expense. In this event, all members with ongoing needs are referred to our D-SNP program to address barriers to accessing OHP covered services. The Care Coordinator consults with the provider and member/family to ensure needed services are in the member’s ICP and services requiring ongoing authorization are submitted by the provider and reviewed promptly. We educate providers on how to notify us when Medicare benefits have been exhausted and how to submit a letter of exhaustion or Explanation of Benefits (EOB) along with their authorization request. This documentation is required prior to paying the claim. This systematic approach helps ensure that members are not experiencing a delay in receiving services once the benefit limit is exhausted.

C. MOU WITH COMMUNITY MENTAL HEALTH PROGRAM (CMHP) (RECOMMENDED PAGE LIMIT 6 PAGES)

Applicant will enter a MOU with Local Mental Health Authority that will be enforced and honored. Improved health outcomes and increased access to services through coordination of safety net services and Medicaid services.

1. Describe how Applicant plans to develop a comprehensive Behavioral Health plan for Applicant's Service Area. Please include dates, milestones, and Community partners.

Trillium has a strong history of collaboration with Community Mental Health Programs (CMHP) to provide comprehensive BH care for members through our memorandum of understanding (MOU). In our current Service Area we work with Lane County Health and Human Services (H&HS) to develop a BH Plan. With respect to Local Mental Health Authority (LMHA) services, the MOU sets forth roles and responsibilities to coordinate services to meet the BH needs of the communities we serve and refers to the BH Plan. Additionally, we are pursuing an MOU with Adapt/Compass BH in Douglas County, which recently integrated with Community Health Alliance as the county’s CMHP, which will also refer to the BH Plan. We will have signed MOUs with all LMHAs and contracts for services with the CMHPs for all the counties in our Service Area including for the Tri-County area.

BH PLAN DEVELOPMENT

Working with a BH Collaborative like the Community BH Consortium is a critical first step for developing the BH Plan. The Community BH Consortium includes input from community partners/providers from the LMHAs and CMHPs, county public health departments, crisis responders, law enforcement, school districts, local AAs, I/DD supports, and providers and organizations that touch every aspect BH for children, adolescents and adults and their circles of support. In Lane County, we have collaborated with organizations such as Looking Glass, PeaceHealth, Laurel Hill, Child Center, Emergence, WhiteBird, Center for Family Development,
Willamette Family Services, Oregon Community Programs, Options, South Lane Mental Health, and Lane County BH. We have and will continue to deploy our Chief BH Officer to work collaboratively with the Community BH Consortium for the development of the BH Plan. Our steps include the following approaches:

- **Identify Objective/Priorities**
- **Formulate and Prepare**
- **Implement Strategies**
- **Monitor Services/Initiatives**

The table below shows a sample of past/current milestones that have contributed to the development of our BH plan. Trillium plans to take similar approaches to collaborate and coordinate with LMHAs to inform the BH Plan for our proposed Services Areas. We have included a representative sample of community organizations/stakeholders that we would collaborate with in the Tri-County area.

<table>
<thead>
<tr>
<th>Phase</th>
<th>BH Plan Milestones</th>
<th>Dates</th>
<th>Community Partners</th>
</tr>
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<tbody>
<tr>
<td><strong>Identify Objective/Priorities</strong></td>
<td>• Trillium Chief BH Officer engages with the Community BH Consortium</td>
<td>May 2019-Ongoing</td>
<td>Springfield Family Physicians (Tier 5 PCPMH)</td>
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<td></td>
<td>• Monthly meetings to identify local BH trends and BH service needs to inform</td>
<td>June 2019-Monthly</td>
<td>-Center for Family Development</td>
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<td></td>
<td>the development of the BH Plan.</td>
<td>meetings ongoing</td>
<td>-Lane County H&amp;HS</td>
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<td></td>
<td>• Begin to gather local data (demographics/utilization/SDOH-HE, network provider</td>
<td>May 2019-September 2019</td>
<td>-OR DHS</td>
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<td></td>
<td>detail)</td>
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<td>-Direction Services</td>
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<td>-Oregon Family Support</td>
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<td>-Network</td>
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<td>-Youth Era</td>
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<td>-Centro Latino</td>
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<td>-OHA</td>
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<td>-CAHOOTS (Crisis Assistance Helping Out on the Streets)</td>
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<td>-Eugene and Springfield and other Law enforcement/first responders</td>
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<td>-Lane County H&amp;HS</td>
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<td>-Community advocacy organizations, -Non-profit BH providers.</td>
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<td>-Laurel Hill</td>
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<td>-Lane County H&amp;HS/ TBH</td>
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<td>-AMHI System/CHOICE</td>
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<td>-Multnomah County public health department</td>
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<td>-Multnomah LMHAs and CMHPs</td>
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<td>-Washington County public health department</td>
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<td>-Washington County LMHAs and CMHPs</td>
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<td>-Clackamas County public health department</td>
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<td>-School districts</td>
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<tr>
<td><strong>Formulate and Prepare</strong></td>
<td>• Once BH needs are identified, we work with the Community BH Consortium and other</td>
<td>August 2019</td>
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<td></td>
<td>specialized committees to formulate strategies to address BH needs to include in</td>
<td>September 2019</td>
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<td></td>
<td>the BH Plan.</td>
<td>October 2019</td>
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<td>• During this process, milestones/goals are established for the specific focus</td>
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<td>areas of the Plan.</td>
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<td>• Engage additional Subject Matter Expertise to provide input. (For instance, our</td>
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<td>Vice President of Finance and Plan President have attended Community BH</td>
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<td>Consortium meetings to provide health plan information and answer questions.)</td>
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<td></td>
<td>• Obtain additional community stakeholder feedback including members and families</td>
<td>October 2019</td>
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<tr>
<td><strong>Implement Strategies</strong></td>
<td>• Work with the Community BH Consortium to fund and deploy initiatives and</td>
<td>January 2020-June 2020</td>
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<td></td>
<td>interventions based on mutual agreements/decisions.</td>
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</tbody>
</table>
### Monitor Services/Initiatives

- Continue to monitor and evaluate program and fidelity to design
- Monitor outcomes service effectiveness to ensure we are making an impact based on mutual goals.
- Establish sustainability plan for successful initiatives that continue. For initiatives that have limitations or do not meet goals, do root cause analysis and implement modifications or cease as appropriate.
- Provide progress reports to OHA and community.

### January 2020 to ongoing through Monthly meetings and reporting

- January 2020 to ongoing through Monthly meetings and reporting
- June 2020 for initiatives that began in January; December 2020 for those that began in June.
- June 2019.

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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.

**COMMUNITY HEALTH IMPROVEMENT PLAN (CHP) DEVELOPMENT**

Trillium has a long history of collaborating with community partners to drive milestones for transformation, and we will continue to do so as we expand our Service Area into the Tri-County area. Collaboration and coordination for development of the CHP must align with the priority areas identified by the local Behavioral Health Plan and the Community Health Needs Assessment (CHNA). In Lane County, Trillium has collaborated with our BHMO and DCOs, United Way, Lane County, PeaceHealth and community partners such as but not limited to Lane County Behavioral Health, PH/BH health systems, educational system partners, economic development partners, housing partners, and criminal justice/public safety partners. As the CCO 2.0 program is implemented, we will also work with any other CCOs in our Service Areas to collaborate on the development of the CHP to ensure this information is contained in a single guiding document that reflects and supports the whole community. We align our timelines for CHP completion with those of the CHA—which is every three years. We will continue to coordinate and collaborate on the development of the CHP under ORS 414.627 with LMHAs and CMHPs for the delivery of mental health services under ORS 430.630 and the CHP will be referenced in MOUs/agreements. In the previous question regarding development of the local BH Plan, we provided a basic template for our approach that includes the steps shown below and a forward looking timeline for milestones. The table in the response to Att.11.C.1 also provides an abbreviated list of community partners that we would engage, which includes many of the same organizations and stakeholders we would engage for development of the CHP. The process we outlined provides a solid foundation and approach for both CHP and CHA development as well. Below, the bullet points present the steps for how we would coordinate with the LMHAs to develop the CHP. Our steps will include the following approaches:

- **Identify Objective/Priorities:** Engage with our CHP partners (as described above) monthly to collectively identify CHP priorities: Social Determinants, Healthy Behaviors, and Collaborative Infrastructure, to inform the development of the CHP Plan. For example, Trillium recently supported the completion of the...
Mental Health and Addictions Plan (MHA/LADPC) as a milestone to advance BH goals, which is part of the CHP, in collaboration with OHA and the LMHA in 2019.

**Dates for CCO 2.0: Initiate in May 2019**

**Formulate and Prepare:** Once health needs are identified, we work with our CHP partners monthly to formulate and develop strategies to address the health priorities to include in the CHP Plan. During this process, milestones/goals are established and priorities are further analyzed. For instance, the recent MHA/LADPC identified that children, youth, older adults, and residents of rural Lane County have limited access to BH services.

**Dates for CCO 2.0: August 2019**

**Implement Strategies:** This process involves working with our CHP partners to deploy initiatives and interventions based on mutual agreements/decisions and identified priorities.

**Dates for CCO 2.0: January to June 2020**

**Monitor Services/Initiatives:** Once initiatives are live, we continue to monitor and evaluate initiative effectiveness annually to ensure we are making an impact based on mutual goals. The CHNA is completed every three to five years and reviewed annually, which informs and drives CHP priorities.

**Dates for CCO 2.0: June to December 2020 and ongoing**

The table below shows the targeted milestones and initiatives from our past/ongoing CHP that contributed to the development of the CHP. Trillium plans to take similar approaches to collaborate and coordinate with LMHAs to inform the CHP for our proposed Services Areas.

<table>
<thead>
<tr>
<th>CHP Milestones/Initiative Descriptions and Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone:</strong> Promotion of Evidenced-Based Practices</td>
</tr>
<tr>
<td><strong>Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).</strong> As part of our SOC workgroup, we are funding certified TF-CBT training consultant services for the next two years to enhance our service delivery methods using trauma-informed care methodology. The certified consultant will support us in the development a comprehensive initial four hour training and a subsequent one hour refresher training for Trillium staff. We are also hosting training sessions for providers through TU’s 4th Friday Innovators Collaborative. <strong>Dates:</strong> 09/2019; trainings will be ongoing/annual.</td>
</tr>
<tr>
<td><strong>Screening, Brief Intervention, and Referral to Treatment (SBIRT) Approach.</strong> We provided SBIRT training for providers related to short-term interventions that can be used in health settings to identify, reduce, and prevent problematic use, and dependence on alcohol and illicit drugs. We also offered incentives for reaching targets and increased our SBIRT rates. Trillium reimburses providers referrals when SBIRT screenings are positive and the provider follows-up with an intervention. <strong>Dates:</strong> 2015-Ongoing</td>
</tr>
<tr>
<td><strong>Milestone:</strong> Integration Advancement</td>
</tr>
<tr>
<td><strong>Lane Early Learning Alliance.</strong> We collaborated with Lane Early Learning Alliance on a shared quality measure for developmental screenings, which resulted in meeting the OHA benchmark of 74%. We also participate in Pediatric Advisory Committee meetings monthly to determine to address health disparities in the pediatric population. <strong>Dates:</strong> 2014-Ongoing</td>
</tr>
<tr>
<td><strong>Integration Needs Assessment Pilot.</strong> We collaborated with OHA to participate in a large community health systems needs assessment focused on integration. Objectives of the assessment included determining existing integration in Lane County, exploring opportunities to integrate services, and identifying the associated barriers to and resources for integration. <strong>Dates:</strong> 2018</td>
</tr>
<tr>
<td><strong>Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) Collaborative.</strong> We collaborated with Quality Care Connections to implement the NAP SACC program, which provides assessment and training for best practices in nutrition and physical activity in child care settings. Lane County Public Health contracted with Quality Care Connections to deliver the program to child care centers in Lane County with funding provided by Trillium. Based on an evaluation of the program, significant improvements were made in nutrition practices in which we had score increase from 3.08 to 3.55 from in initial assessment scores in 2016 to three-month post assessment scores in 2017. <strong>Dates:</strong> 2014-Ongoing</td>
</tr>
<tr>
<td><strong>Milestone:</strong> Increased Housing/Crisis Service Access for Members Experiencing Homelessness</td>
</tr>
</tbody>
</table>

Attachment 11
<table>
<thead>
<tr>
<th>CHP Milestones/Initiative Descriptions and Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FUSE.</strong> We collaborated with Lane County and ShelterCare to develop FUSE, which strives to break the cycle of homelessness and crisis events. FUSE began with a goal of engaging homeless members with a high utilization of health, social, government services. As 2017, out of 98 possible participants, 26 members were engaged in street outreach. Costs decreased by 53%, ED use decreased by 26%, and inpatient stays decreased by 55%. BH use also decreased 14% as a result of this partnership. Trillium provided $200,000 between 2017 and 2018 for FUSE. <strong>Dates:</strong> 2016–Onngoing</td>
</tr>
<tr>
<td><strong>The Commons on MLK.</strong> We collaborated with Housing First, Lane County, and Lane County BH to support the development of a 51-unit Housing First apartment that will provide housing and 24/7 supportive services to chronically homeless individuals. The development will serve chronically homeless individuals with SPMI. Trillium committed $500,000 to the development. <strong>Dates:</strong> 2017–On-going</td>
</tr>
<tr>
<td><strong>School-Based OH Screenings.</strong> We established an OH Collaborative and partnered with DCOs (Advantage Dental, MODA, Willamette Dental and Capital Dental) to provide OH school-based screening services to school-aged kids, using all the DCOs as well as certified community providers including White Bird, Community Health Centers of Lane County, Lane Community College, South Lane Children’s Dental Clinic, and multiple independent dentists in rural areas. This initiative provides school-based OH screenings to 100% of Lane County school districts. <strong>Dates:</strong> 2018–On-going</td>
</tr>
<tr>
<td><strong>Eugene Pediatric Home Visiting Program.</strong> With support from our CAP, we supported a VBP arrangement for Eugene Pediatric Associates, a children’s primary care clinic with integrated with BH and OH Services, to conduct home visits to our young members. The frequency of the visits vary by the member’s acuity or level of need. <strong>Dates:</strong> 2018</td>
</tr>
<tr>
<td><strong>Tobacco Age Initiative.</strong> We collaborated with Lane County Public Health, State Commissioners, and the State Legislature to raise the age of legal tobacco purchase in Oregon from 18 to 21. Trillium was instrumental in this movement in promoting education and support of this initiative. <strong>Dates:</strong> June 2018</td>
</tr>
<tr>
<td><strong>Parenting Programs.</strong> We collaborated with local agencies to expand the number of parenting educational opportunities and increased the number of class facilitators. One example of this is facilitation of classes delivered in Spanish on a variety of parenting topics. These programs have been impactful in our rural Service Areas. <strong>Dates:</strong> 2014–On-going</td>
</tr>
</tbody>
</table>

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.

Our partnership with Lane County H&HS and Lane County BH has resulted in a unified local plan, and we anticipate that collaborations with Multnomah, Washington and Clackamas County LMHAs will have similar success towards development of the local plan. The purpose of the local plan is to develop strategies to provide initiatives that are responsive to the whole health needs of members and represents the priorities of Mental Health Advisory/Local Alcohol and Drug Planning Committee (MHA/LADPC), which is a Lane County Board of County Commissioners mandated committee who oversees the development of the Lane County Local Mental Health and Addictions Plan. We will continue to work with our partners and the local plan will be referenced in MOUs/agreements.

**LOCAL PLAN DEVELOPMENT**

In question 11.C.1 we outlined a basic template for our approach, that includes the steps shown below and a forward looking timeline for specific milestones, with an abbreviated list of community partners that we would engage in both our current Service Areas, as well as the addition of the Tri-County area, many of which are the same organizations and stakeholders we would engage in working with the LMHA on the local plan. The bullet points presented in the steps below provide additional information on milestones and dates for timeline. dinate with the LMHAs to develop the CHIP.

Our steps will include the following approaches:
Identify Objective/Priorities: Engage with our local plan partners monthly to collectively identify BH trends/priorities to inform the development of the local Plan. For example, the local plan identified mental health as public health priority.
  - Dates for CCO 2.0: Initiate in May 2019

Formulate and Prepare: Once BH priorities are identified, we work with our partners to formulate strategies to address the BH priorities that will be included in the local Plan. During this process, milestones/goals are established and a strategy is developed. For instance, the local plan is exploring hosting an event for the community in the “Let’s Talk” format focused on BH as public health priority as described above.
  - Dates for CCO 2.0: August 2019

Implement Strategies: This process involves working with local plan partners to deploy pilots, initiatives, and interventions based on mutual agreements/decisions.
  - Dates for CCO 2.0: January to June 2020

Monitor Services/Initiatives: Once initiatives are live, we continue to monitor and evaluate initiative effectiveness annually to ensure we are making an impact based on mutual goals. Like the CHP, the local plan is completed every three to five years and reviewed annually, which informs and drives local plan priorities.
  - Dates for CCO 2.0: June to December 2020 and ongoing

The table below provides examples of our specific ongoing milestones for our local plan in our current Service Area developed in coordination with the LMHA. We plan to take a similar approach to collaborate and coordinate with LMHAs to inform the local plan for our proposed Services Areas and ensuring collaboration with other CCOs in the Service Area for a unified plan.

<table>
<thead>
<tr>
<th>Local Plan Milestones and Initiative Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone:</strong> Promotion of Prevention</td>
</tr>
<tr>
<td>Lane County works closely with a range of non-profit organizations, schools, research entities, and Trillium to deliver services founded in health promotion/prevention. Examples include:</td>
</tr>
<tr>
<td>Suicide Prevention: We will provide community trainings in suicide prevention and follow-up after a crisis event; a media campaign; coordination of the countywide suicide prevention steering committee; technical aid to community partners; continued surveillance of deaths by suicide and other related data; implementation of a county Suicide Fatality Review Team, which will assist in developing or updating policies with partners including County school districts. <strong>Dates:</strong> 2018-Ongoing.</td>
</tr>
<tr>
<td>SUD Prevention: Lane County has been the recipient of multiple grant awards. One example is The Partnership for Success federal grant which is providing support to Western Lane County and helped form the Healthy Directions Coalition, which focused on prevention of alcohol use among youth. <strong>Dates:</strong> 2015-Ongoing</td>
</tr>
<tr>
<td>Problem Gambling Prevention: Our prevention work focuses on building awareness of this issue through community and parent education, presentations, media coverage/campaigns, and working in partnership with other prevention specialists to reduce risk factors that contribute toward problematic behavior. <strong>Dates:</strong> 2012-Ongoing</td>
</tr>
<tr>
<td><strong>Milestone:</strong> Improving Services in Rural Areas</td>
</tr>
<tr>
<td>Current plans include:</td>
</tr>
<tr>
<td>- Increased availability of both BH and SUD providers in Cottage Grove in 2017.</td>
</tr>
<tr>
<td>- Integrated BH services at Peace Harbor in Florence in 2015.</td>
</tr>
<tr>
<td>- The emergence of the RAC as a voice for improvement in 2013.</td>
</tr>
<tr>
<td>- Expansion of mobile crisis on the coast in 2018.</td>
</tr>
<tr>
<td>All plans are ongoing.</td>
</tr>
<tr>
<td><strong>Milestone:</strong> Increased School-Based BH Services</td>
</tr>
<tr>
<td>Lane County expanded school-based BH services by providing trauma-informed training to students (such as the Good Behavior Game), trained school staff in Mental Health First Aid and how to refer them to Trillium, and made BH services available onsite. <strong>Dates:</strong> 2014-Ongoing</td>
</tr>
<tr>
<td><strong>Milestone:</strong> Expansion of Mobile Crisis Services</td>
</tr>
</tbody>
</table>
Local Plan Milestones and Initiative Descriptions

<table>
<thead>
<tr>
<th>Milestone:</th>
<th>Increased Access for Opioid Addiction Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Lane County expanded the Lane County Methadone Treatment Program to provide increased availability of buprenorphine and suboxone treatment to reduce wait times and improved quality of care.</td>
</tr>
<tr>
<td>Dates:</td>
<td>2017-Ongoing</td>
</tr>
</tbody>
</table>

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.

We do not anticipate any challenges in obtaining or executing the MOUs for the LMHAs in any of our planned Service Areas. However, we recognize that CCO 2.0 may include multiple CCOs in each Service Area. We recognize that collaboration with fellow CCO partners will be essential to effectively meeting the needs of the communities we serve. In addition, we recognize that LMHAs working with more than one CCO will be a new experience under the CCO 2.0 Program. In preparation for this change, we have met with Lane County and Adapt/Compass BH in Douglas County, and have had discussions with the LMHAs in the Tri-County Service Area to learn about their concerns related to increased administrative burden and the overall complexities of the CCO 2.0 Program. Trillium is committed to listening and collaborating on potential solutions in order to develop approaches to minimize potential barriers/concerns such as those described above to lead support and innovation across partnerships.

To address other potential barriers, we will develop collaborative relationships with system partners as we have in our existing Service Areas to offer support such as but not limited to co-location in shared office space support, information technology and infrastructure support, and training support to facilitate seamless care coordination as we build MOUs with system partners. For instance, in Lane County, an improvement we have experienced is the sharing and exchange of data. Over time, Trillium built rapport within Lane County H&HS by sharing Trillium data analyses to build trust and foster ongoing data exchanges. Trillium will take similar approaches to resolving potential challenges in proposed Service Areas.

D. PROVISION OF COVERED SERVICES (RECOMMENDED PAGE LIMIT 6 PAGES)

Applicant must monitor its Provider Network to ensure mental health parity for their Members.

1. Please provide a report on the Behavioral Health needs in Applicant’s Service Area.

The table below shows our report of BH needs in our Service Area that show the top five BH conditions, corresponding individual diagnosed members, and percent of those members that are adults versus children. For our provider report, please see question 2 below.

<table>
<thead>
<tr>
<th>Priority BH Needs</th>
<th>Diagnosed Members</th>
<th>Percent of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Over 18 (7,914) Under 18 (1,092) Total=9,006</td>
<td>Over 18 (14.6%) Under 18 (3.2%)</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Over 18 (4,742) Under 18 (921) Total=5,663</td>
<td>Over 18 (8.7%) Under 18 (2.7%)</td>
</tr>
<tr>
<td>Attention Deficit Disorders</td>
<td>Over 18 (1,362) Under 18 (1,871) Total=3,233</td>
<td>Over 18 (2.5%) Under 18 (5.5%)</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>Over 18 (1,745) Under 18 (41) Total=1,786</td>
<td>Over 18 (3.2%) Under 18 (0.12%)</td>
</tr>
<tr>
<td>Opioid or Barbiturate Dependence</td>
<td>Over 18 (1,966) Under 18 (16)</td>
<td>Over 18 (3.6%) Under 18 (0.47%)</td>
</tr>
</tbody>
</table>
Trillium’s report of the BH needs in our Service Areas found that 32% of our total membership has a BH condition such as depression, anxiety disorders, and attention deficit disorders (as listed further in the table). Overall, our results indicated that 23% of our adult members and 9% of child members of our total membership have a BH condition. In terms of SUD, approximately 7% of our adult members and less than 1% of our child members have a BH condition related to a substance. In our preliminary research for proposed Service Areas, we have seen that Clackamas has also identified depression as a primary BH need. We also know that in Washington County, attention deficit disorder and post-traumatic stress disorder (PTSD) were identified as priority BH needs, with American Indian /Alaska Native (AI/AN) youth with the highest prevalence of diagnosed PTSD at 7.4%. In Multnomah County, we saw in the Multnomah County Mental Health System Analysis Final Report (August 2018) that BH workforce issues were identified as a priority in terms of being reflective of the racial, ethnic, and cultural diversity of the population. Access issues were also identified for Multnomah County. For proposed Service Areas, in preparation for Readiness Review we will collaborate with OHA and other CCOs to do a more comprehensive analysis of BH prevalence, utilization and demographic information that would enable a complete picture of BH needs for our Service Areas.

2. Please provide an analysis of the capacity 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.

Today, we have contracts and LOAs with a network of providers across Lane, Western Douglas, Southwestern Linn, and the Tri-County Service Area, that includes approximately 57 BH facilities that provide a combination of inpatient, outpatient, and residential treatment services. Additionally, our network includes over 2,600 individual BH practitioners, with primary specialties that serve members with behavioral health needs, such as addiction, substance use disorder, psychology, child and adolescent psychiatry, clinical neuropsychology, and developmental behavioral pediatrics. The breadth of our network today, ensures that we have adequacy to serve the membership.

<table>
<thead>
<tr>
<th>BH Workforce</th>
<th>Current Service Area</th>
<th>Tri-County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>Outpatient</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Residential</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total BH Facilities</strong></td>
<td>47</td>
<td>10</td>
</tr>
<tr>
<td><strong>Individual Practitioner</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>333</td>
<td>57</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1915</td>
<td>386</td>
</tr>
<tr>
<td><strong>Total BH Practitioners</strong></td>
<td>2228</td>
<td>441</td>
</tr>
</tbody>
</table>

However, we know that simply having providers does not ensure that the network is fully accessible or appropriate for member age, cultural and linguistic needs, and specific challenges that each member faces. We used our BH needs report for Lane County as described in question one as a base for understanding simple prevalence based on penetration rate for the top five diagnosis in our current membership. We used this report to guide the analysis of our workforce to respond to question two. The table below shows our workforce capacity (shown as unique providers performing the service) that are providers that are available to treat the identified corresponding top five BH needs and adult/youth membership numbers. We will develop out this
reporting further to include a more robust depiction of the alignment of our network with the specific needs of our members across all Counties in our Service Area.

For evaluation and treatment of BH needs, our Financial Advisory Committee captured that diagnostic evaluation costs increased by 55% for both child/adult members from 2016 to 2018. Further, individual psychotherapy services costs increased by 69% for both child/adult members from 2016 to 2018. For SUD detoxification, costs increased by 131% and 86% for intensive outpatient treatment for both child/adult members from 2016 to 2018. Our analysis of these results indicate that members are accessing BH services more each year for growing child and adult BH needs. To continuing supporting workforce needs, Trillium has developed and implemented a methodology to establish and monitor network provider capacity in accordance with Exhibit B Part 4 Section 3.a.2 of the Sample Contract as described in detail in Att.7.4.a.1-6. To drive workforce support in proposed Service Areas, we will implement a Workforce Development Taskforce (WDT) to ensure we are providing supplemental support in addition to completing network capacity analyses. The WDT will include participation by our BH Operations Committee and will be led by our co-led by our Chief BH Officer and Chief Medical Officer.

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?

Trillium’s Workforce Development Taskforce (WDT) will work with our local/state communities and educational resources to develop an action plan including activities related to promoting educational resources, customizing our training to align with workforce needs, and monitoring the success and efficacy of our trainings.

<table>
<thead>
<tr>
<th>Priority BH Needs Identified in Lane County Service Area</th>
<th>Available Workforce Capacity to Serve Members Based on Identified Provider Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Providers=1,415 (for members over 18)&lt;br&gt;Providers=607 (for members under 18)&lt;br&gt;Total Providers=2,022</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Providers=966 (for members over 18)&lt;br&gt;Providers=433 (for members under 18)&lt;br&gt;Total Providers=1,399</td>
</tr>
<tr>
<td>Attention Deficit Disorders</td>
<td>Providers=539 (for members over 18)&lt;br&gt;Providers=558 (for members under 18)&lt;br&gt;Total Providers=1,097</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>Providers=722 (for members over 18)&lt;br&gt;Providers=28 (for members under 18)&lt;br&gt;Total Providers=750</td>
</tr>
<tr>
<td>Opioid or Barbiturate Dependence</td>
<td>Providers=540 (for members over 18)&lt;br&gt;Providers=17 (for members under 18)&lt;br&gt;Total Providers=557</td>
</tr>
</tbody>
</table>

**Developing the Plan.** We will develop CAPs in each county of our Service Areas. These local CAPs will include provider and community representative from PH, BH, SUD, OH and SDOH-HE services. We will include local CAPs as a key stakeholder for feedback and input. With this as the starting point for input regarding service gaps, including those related to serving special populations, SPMI, children/adolescent, members with long-term care needs, individuals with cultural and linguistic needs, SDOH-HE needs, individuals with I/DD, pregnant mothers, and individuals with SUD. We would expand the circle for feedback to other community stakeholders, state and local agencies, and community organizations. Once gaps for development are identified, we would follow a similar path as outlined previously: identify objective/priorities,
formulate and prepare, implement strategies, monitor services/initiatives. The specific actions outlined below highlight the strategies that we believe will be effective in developing the workforce, and that we would seek feedback on from the local community.

**Promote Local/State Resources.** We promote by using our Provider Website, which contains sections dedicated to Provider Events/Training, which provides a list of upcoming trainings/resources such as our sponsorship of the American Society of Addiction Medicine (ASAM) OpiEnd Training, which is a free training for providers to qualify for the waiver to prescribe buprenorphine. This training will be conducted by ASAM in June 2019 and features curriculum designed for women’s health providers in partnership with the American College of Obstetricians and Gynecologists.

**Customize Trainings.** Our Provider Events section also lists our face-to-face training for providers through our educational program, TU, which brings together PH, BH, and OH agencies, social service agencies and community-based organizations. We will use TU to deliver customized training based on workforce needs. For example, we are funding certified TF-CBT training consultant services for the next two years to enhance Trillium staff and workforce service delivery methods using trauma-informed care for BH conditions such as depression, anxiety, and PTSD. The certified consultant will support us in the development a comprehensive initial four hour training and a subsequent one hour refresher annual training for Trillium staff beginning in September 2019. We will leverage this opportunity and will host annual TF-CBT training, developed for our workforce, through TU’s 4th Friday Innovators Collaborative.

**Monitor Trainings.** Our WDT will work with community stakeholders such as the Lane Workforce Partnership, DCOs for OH, Lane County Medical Society, Oregon Health and Science University and other CCOs to monitor existing workforce resources to assess for gaps and/or specific interests for workforce development and preparedness using our Provider Survey. We will use this feedback to inform the development of our future trainings to ensure they are aligned with workforce feedback to support the delivery of services in a culturally-responsive and trauma-informed manner. Trillium will work to execute the Action Plan within a minimum of one year from January 1, 2020 or within Year One upon contract award.

### 4. What is Applicant’s strategy to ensure workforce capacity meets the needs of Applicant’s Members and Potential Members?

Trillium’s Provider Network Management Team (Network Team) analyzes geographic access mapping results, Delivery System Network (DSN) reports, out of network utilization, Medical Management requests, results of subcontractors’ network adequacy assessments, and self-reported member data. In the absence of contract or regulatory standards, Trillium plans to use industry-accepted standards and guidelines, such as National Committee for Quality Assurance (NCQA) provider-to-member ratios. We will use NCQA provider-to-member ratios as a strategy to determine the minimum number of providers required to serve our members by provider type, for example, a ratio of 1 physician per 2,000 members. As part of an ongoing monitoring strategy, we will inquire about and document provider panel capacity upon contract execution, and assess panel limit against actual and contracted membership. The Network Team will monitor access to services annually using member feedback such as CAHPS survey results, utilization of services quarterly using claims data, and provider appointment availability annually, through call auditing to ensure capacity meets demands. In addition, we are committed to exploring BH-centric telehealth services to support workforce capacity in our current and proposed Service Areas. This includes supporting member/potential member access to BH clinicians through tele-consultation to increase PCP care related to prescribing psychiatric medications. For example, we are establishing a contract with BH telehealth vendor to increase access to BH workforce and offer members live video access to psychiatrists, psychiatric nurse practitioners, and Licensed Clinical Social Workers to target member populations with BH needs. This strategy would provide a viable new option for recruiting BH
workforce from both within and outside of Oregon. We will also identify and cultivate opportunities to support clinical supervision via teleconsultation for providers in rural areas.

5. What strategies does Applicant plan to use to support the workforce pipeline in Applicant’s area?

To support the workforce pipeline our Provider Engagement staff will support providers to increase capacity for integrated health screenings and collaborative care models. We will also provide on-demand learning opportunities through Relias, Trillium University and expert led trainings through Project ECHO and RubiconMD. Our proposed strategies, which will be guided by our WDT, to support the pipeline include:

**Educational Institution Partnerships.** We partner with educational institutions to identify opportunities to expand training programs for high need positions. For example:
- We partner with Project ECHO, which supports our workforce in urban, rural, and underserved areas to help them manage members with a variety of health conditions. Providers are supported in this forum by discussing complex de-identified member experiences to support treatment planning in a secure environment. We will leverage our partnership with Project ECHO to support providers in proposed Service Areas.

**Expansion of BH/PH/OH Recruitment Opportunities.** For example:
- With the support of a $125,000 transformation grant from Trillium, Cornerstone Community Housing has trained and deployed five MCRs who work across 12 low-income member housing communities. MCRs provide immediate onsite referrals/resource linkage, education on disease prevention and other health issues, and better prepare member for provider visits and help them follow medication plans.
- Through our OR Solutions Project, we collaborated in 2018 with OHA, the Governor’s office, and Regional Solutions to support information gathering related to increasing Physician Assistant and Nurse Practitioner workforce. We helped identify workforce gaps and a potential action plan for this initiative. We will work with OHA, the Health Care Workforce (HCWF) Committee, our WDF, and other local stakeholders on shared priorities to support workforce recruitment. For example, Trillium will support grant funding opportunities through our Trillium Innovation Fund to encourage local talent to return to their home areas to practice in our awarded Service Areas.

**Training Initiatives.** These proposals are as follows:
- For developing the PH, BH, and OH workforce, we will host training through our TU’s 4th Friday’s Innovators Collaborative on topics like interviewing preparation and workplace culture to help increase the likelihood of retention when entering the workforce.
- Through TU, we will host annual comprehensive training related to culturally and linguistically appropriate care in PH, BH, and OH settings. We will require Trillium’s workforce to complete a cultural responsiveness training in accordance with House Bill 2611. Trillium has already made strides to advance cultural/diversity-centric training. For instance, in October 2018, we provided Diversity and Health Equity training that covered a range of topics including cultural competency around working with members in Tribes; members who identify as lesbian, gay, bisexual, transgender, and questioning (LGBTQ); and members with disabilities through TU’s Staff Lunch and Learn Sessions.

We will continue to support our workforce following initial trainings by leveraging the support of the WDT who will conduct monthly outreach via email blasts and targeted telephonic outreach to current and future providers in proposed Service Areas and we will replicate TU’s 4th Friday Innovators Collaborative trainings in those communities. To further support providers, our BH Medical Director offers telephonic 1:1 consultations to directly support BH providers and has provided targeted consultation such as SPMI specialty discussion to providers at Laurel Hill. Our workforce may also access our Oregon Psychiatric Access Lines (OPAL A and OPAL K) to receive support telephonically for treatment of adult and child members.
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?

We utilize data to identify members (with SPMI and other conditions) that have BH needs who require referral to BH, PH, and OH services. Additionally, using our network of BH Providers, our Enterprise Data Warehouse (EDW) is able to link members to BH providers using PH/BH/pharmacy claims data. This enables our Care Coordinators and other Medical Management staff to determine whether the member has visited a certain BH Provider, and allow us to follow up with that provider, if needed, such as to report medication contraindication issues. Under the CCO 2.0 Program, we will consider developing cohorts within PreManage for specific subsets of the population, including individuals with SPMI, which would allow us to track and manage their care transitions.

In addition, we use SPMI data to enhance our predictive models, monitor individual member progress and needs in a holistic manner, and identify trends that require collaboration to improve the quality of services and outcomes. For example, we use our SPMI data to identify and support specific sub-populations among individuals living with SPMI through targeted interventions. For example, as a new enhancement under the CCO 2.0 Program, we will use data to identify members living with Schizophrenia and implement a Schizophrenia Inpatient Model (SIM) to support transitions for members with an increased risk of relapse that may result in schizophrenia-related ED visits and hospitalizations, such as failure to fill medications. SPMI data is also used to inform our SPMI Subcommittee discussions, which specifically works to improve quality performance measures/metrics and supports providers to improve services and outcomes for members with SPMI.

Other Data/Processes. On at least an annual basis, an in-depth analysis of care utilization and cost data is conducted to identify trends by medical service type, region/county, and product to identify possible issues with access to care and other patterns of use that may suggest the need for targeted interventions for members with SPMI. In addition, our Centelligence enterprise platform integrates data from multiple sources, and provides actionable data on member characteristics to inform the targeting of interventions to improve outcomes. Centelligence electronically receives, integrates, and continually analyzes data such as PH/BH claims from our AMISYS Advance claims processing system; pharmacy claims data; vision claims; lab test results; assessments and authorization information; member demographic and eligibility information; and provider demographic and specialty information. We use our proprietary predictive modeling and care gap/health risk identification suite to anticipate, identify, monitor, and address issues and improvement opportunities. When improvement opportunities are identified, we address the SPMI need in collaboration with a diverse range of partners and stakeholders as described in detail in Att.11.E.4.a. We bring relevant findings to CCO Learning Collaborative meetings to ensure data, process information, and lessons learned can be shared with community stakeholders.

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?

We are building a collaborative and trusting relationship with Tribes within Oregon for the service of our local tribal members and for the over 880 AI/AN members identified through OHA eligibility data. Trillium adopts a culturally-respectful approach in outreach to Tribes and our tribal contacts to provide responsive and culturally-
appropriate services. Additionally, Trillium respects and honors tribal sovereignty and self-governance as a potential system partner of Oregon Tribes.

**OUTREACH ACTIVITIES TO ESTABLISH PLAN FOR COLLABORATION**

Our steps to engage Tribes and Indian Health Care Providers (IHCPs) include: 1) Developing outreach opportunities to build relationships; 2) Leveraging outreach opportunities and; 3) Establishing MOUs when possible with Tribes and tribal affiliates. To facilitate leadership engagement, Trillium will hire a Tribal Liaison to support tribal partners. This role will be the primary contact for questions/concerns related to Tribes and will serve as a representative on the CAC. We will also establish a Native American Advisory Council, which will be organized by our Tribal Liaison and report directly to the CAC. Our Native American Advisory Council will convene on a rotating basis to maximize individual Tribe participation efforts and will include input by our first recruited participant from the Siletz Tribe. The following strategies/activities show our approaches to engage Tribes.

*Developing Outreach Opportunities.* As part of our Health Equity Planning, we include specific outreach activities for Tribes and IHCPs. This includes deploying our Tribal Liaison and leveraging the support of our existing tribal-centric CAC representative to ensure Trillium has ongoing tribal expertise support when working with Tribes. We have also established targeted outreach with the Eugene Tribal Outreach Office for the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians. Through this collaboration, we are establishing contact with the Chief Administrator this tribe to strengthen our relationship and support for tribal activities.

*Leveraging Outreach Opportunities.* We also leverage educational events such as the quarterly Tribal Parent Night meeting to develop relationships with Tribes. In addition, we outreach to Tribes through participation in tribal wellness activities and encouragement for tribal participation in the CHP process. For IHCPs, we encourage IHCPs to join our network and continue to develop relationships with providers to increase our understanding of local tribal customs. We meet with IHCPs to learn about their individual needs to strengthen the capabilities of tribal health programs based on their identified IHCP goals. We also continue to support events such as the Opioid Reduction Summit, which had a tribal component, to develop our relationships with IHCPs. As a new engagement measure, we will use analytical tools to track/monitor activities to measure engagement activities. Analytical reports and data will be monitored by our Health Equity Committee.

**MOUs.** We leverage partnerships with Tribes and tribal affiliates, such as IHCPs to establish formal agreements for collaboration and support. For IHCPs, we focus on developing a trusting relationship that combines a sense of understanding their unique needs, which is captured in MOUs. We believe in learning about their preferences and earning the respect of IHCPs over time to provide comprehensive and culturally appropriate services.

**PLANS FOR COORDINATION**

We coordinate with Tribes and IHCPs by: 1) Coordinating with Tribes and IHCPs to learn about their needs and how we can assist; 2) Coordinating with Tribes and IHCPs to offer education about Trillium and access to services and; 3) Coordinating with Tribes and IHCPs to develop a plan for collaborative discharge and follow-up to ensure continuity of care.

*Coordination of Care.* Our plan for coordination of care with Tribes includes providing education about our CC Team, which promotes access to and ensure the delivery of BH, PH, and OH services as well as coordinates care for Tribal members, both on and off tribal lands. As part of our plan, we are collaborating with Tribes to deploy a member-centered, culturally relevant coordination of care process for all covered and non-covered services to create a SOC around each member. To build rapport and develop relationships to plan for coordination of care with IHCPs, we provide education about the benefits of being part of our Provider
Network. This includes but is not limited to providing information about our care coordination services, member/provider services, and support related to administrative processes.

**Access to Services.** In addition to having all IHCPs within our Provider Network, members are given additional options to access IHCPs in a timely manner to drive access to services. Participating IHCPs are paid at a rate equal to the rate negotiated between Trillium and the provider involved, which for an FQHC may not be less than the level and amount of payment, which Trillium would make for the services if the services were furnished by a participating provider which is not an FQHC. Non-Participating IHCPs that are not an FQHC will be paid at a rate that is not less than the level and amount of payment, which Trillium would make for the services if the services were furnished by a participating provider which is not an IHCP. For non-participating IHCPs that are an FQHC, will be paid at a rate equal to the amount of payment that Trillium would pay an FQHC that is a participating provider with respect to Trillium but is not an IHCP for such services.

**Crisis Services.** Trillium maintains a contract with White Bird Clinic to provide crisis services, which offers 24-hour crisis intervention services including walk-in support in Lane County and telephonic support to reach members, including members affiliated with Tribes, in rural areas. White Bird also manages CAHOOTS vans, which provide mobile crisis intervention services alongside first responders in the Eugene Springfield metro area.

**Coordination of Patient Release.** Our Care Coordinators ensure the safe and effective transition of Tribal members to and from Trillium, including members with special healthcare needs. Our Care Coordinators work with AI/AN members, system partners such as IHCPs, and other CCOs to complete transitions and follow up with members to ensure care gap closure, resource linkage, and continuity of care.

**E. COVERED SERVICES COMPONENTS**

**1. SUBSTANCE USE DISORDER**

**How will Applicant support efforts to address opioid use disorder and dependency? This includes:**

Our OpiEnd program is a multi-dimensional approach to addressing opioid use and abuse based on local and national input and experience. The Lane County Summit on Chronic Pain and Reduction in Opiate Use and Chronic Pain and Addiction Stakeholder Workgroup is just one example of our local approach to addressing opioid use and dependency.

**Comprehensive.** OpiEnd uses integrated strategies targeting four domains: members, providers, pharmacy care, and the community and spanning prevention, identification, treatment, and evaluation. For example, 1) Provider engagement, reporting, and training to identify and curb excessive opioid prescribing; 2) Engagement and targeted member outreach and care and chronic pain management, using our Opioid Dashboard and predictive modeling to identify members at risk; 3) Pharmacy utilization management to safely titrate opioid dependent members and accelerate access to medication assisted treatment (MAT) as appropriate; and 4) Community awareness campaigns, summits, and community access to naloxone to prevent overdose death.

**Culturally Competent.** We will support and confirm the cultural responsiveness of OpiEnd and all of our SUD programs, providers and services through training, translation services, identification of member preferences, the use of Traditional Health Workers (THWs), and ongoing assessment of our network. For example, we assess for and document each member’s primary and preferred language and communication preferences as part of our initial risk screening (IRS) process, systematically sharing this information across Trillium staff. Trillium staff and our providers have access to the Linguava Language Line and are trained on and follow all 15 CLAS standards, disability sensitivity, cultural competency, and People First Language with emphasis on developing
skills to communicate appropriately and address even the most unique linguistic, disability, and/or culturally-related needs. Accountable for evaluating and ensuring our services and delivery system are culturally responsive and linguistically appropriate is our Health Equity Officer with support from our existing monthly internal Diversity and Health Equity Committee and proposed external Health Equity Council. Collectively, this group is charged with identifying gaps, delivering or facilitating trainings, implementing solutions, and monitoring impact.

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?

We employ a low-barrier *no wrong door* approach to all SUD services.

**SUD Network.** We contract with all willing and qualified SUD providers along the SUD treatment continuum. Our existing network includes all available SUD providers in our current Service Area and we are building an all-inclusive network in our proposed Service Area, including providers who offer services in Spanish and other languages using bicultural and bilingual staff. All contracted providers are required to develop and regularly update collaborative treatment plans in the member’s preferred language. All 16 of our existing SUD providers employ peer recovery mentors or peer staff to engage and support the complex needs of our members.

**Community Training.** As we have done in Lane County, we will work with coalitions and associations across our proposed Service Area to collaborate on trainings and initiatives to improve care and access across the SUD continuum. For example, Trillium is a founding member of the Lane County Equity Coalition (LEC). In partnership with the LEC, we provide quarterly trainings to providers, social services agencies, and community advocates. These trainings attract hundreds of attendees annually, emphasize strategies to address disparities, and offer opportunities and resources available to provide care in a culturally and linguistically appropriate manner. In 2019, we will offer additional trainings and events on detecting and addressing implicit racial/ethnic, gender, sexual orientation, socioeconomic status and disability biases in SUD services.

**Full Continuum of SUD Care.** We employ a comprehensive approach to a complex issue, all built around our circular continuum of care addressing prevention (e.g. pharmacy safeguards, education, and community outreach); intervention and treatment (e.g. early identification and access to services); and recovery support (e.g. integrated care and peer supports), and designed around member specific needs and preferences, including cultural and linguistic needs.

b. How will Applicant provide culturally responsive and linguistically appropriate alcohol, tobacco, and other drug abuse prevention and education services that reduce Substance Use Disorders risk to Members?

Any effective SUD program starts with prevention. Our screenings and assessments, which can be administered in any language, identify members who use alcohol, opiates or other substances, and/or tobacco products and/or are at-risk for SUD. Based on results, members are referred for appropriate services, educational outreach or additional screenings. Prevention and education available to our members include our *OpiEnd program*; Chronic Pain disease management program; Chronic Condition Dental Management program that manages dental disease for members with high dental risk who use tobacco; *myStrength online virtual mental health club* (for CCO 2.0 Contract); Quit Tobacco in Pregnancy (QTiP), a collaborative between Trillium, Lane County Public Health Prevention and Lane County WIC; *Start Smart for Your Baby®* (Start Smart) including education on risk of substance use in pregnancy and resources to help quit; Good Behavior Game to encourage healthy behaviors in schools; and referrals and partnership with HIV Alliance to reduce risk (e.g. needle
exchange). We also provided training funds for 50 tobacco treatment specialists, plus one trainer serving as Tobacco Cessation Counselors across our current Service Area. Our educational materials are also offered in alternative languages and formats.

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?

Our Member Handbook, which includes information on all covered SUD services, is printed in both English and Spanish, available for translation in any language and alternative formats, including audio. If a member screens positive for a SUD, we help identify and facilitate an appropriate referral to a treatment setting that meets their cultural preferences and is consistent with their intensity of need and American Society of Addiction Medicine (ASAM) criteria. This process is done in our member’s preferred language. We promote the use of peer recovery mentors for our members who express ambivalence toward care, and our staff are trained to provide empathic and sensitive responses to member inquiries for SUD services. Our Provider Directory available on our public website and Mobile App includes the continuum of SUD services, allowing members to search by provider type and specialty, such as residential treatment facility or addiction counselor. We also train providers on SUD benefits and services and engage them in care planning to better serve and inform members requiring SUD services. Our Care Coordinators work closely with members and providers to ensure members fully understand their options and benefits and how to access SUD services.

d. In collaboration with local providers and CMHPs, 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.

Trillium takes a lead role in promoting a SUD System of Care in Lane County and will extend this effort across our proposed Service Area, working with providers and CMHPs in each community. For example, Trillium and Lane County established the Lane County Pain Guidance and Safety Alliance (LC-PGSA) in 2016 to promote community education, naloxone distribution, and safe opioid prescribing. In 2018, we collectively sponsored a Summit on Chronic Pain and Reduction in Opiate Use, a full-day meeting to provide education and resources to create community level action to treat chronic pain and reduce prescription opiate abuse. Sessions aimed at healthcare professionals included diagnosing and treating chronic musculoskeletal pain; the impact of opioids in the community; the use of PCPCHs for integrated treatment of chronic pain; and use of the state’s PDMP. Other sessions focused on a community response, including law enforcement for drug diversion; proper storage of narcotics in the home and proper disposal of unused medications; and the use of naloxone to prevent overdose death. Medical professionals were also educated in the CDC Guidelines for proper dosing and tapering of medications, and the use of SUD treatment referrals and MAT.

**Adequate Workforce and Provider Capacity Monitoring.** We will create a BH CAC Subcommittee devoted to SUD issues to actively monitor capacity and make recommendations to the CAC and CAP, which will be replicated in each region in our Service Area.

**Provider Training and Monitoring.** We provide ongoing training to providers on topics such as Screening, Brief, Intervention and Referral to Treatment (SBIRT) and other SUD screenings; referring to SUD services; use of and referring to THWs, including peer supports; the Oregon PDMP; and opioid prescribing guidelines. We monitor provider compliance through our Opioid Dashboard, medical record audits, and other reporting. For example, providers whose opioid prescribing patterns are comparatively high are identified and referred to our CC Team or Medical Director for additional outreach and training.
e. Coordinate with Providers to have as many eligible Providers as possible be DATA Waived so they can prescribe MAT drugs.

In 2018, Trillium increased our MAT prescribers by 32% to 127; and members on MAT by 47% to 1,116. Continued efforts to increase DATA Waivered MAT prescribers include:

△ Promoting Project ECHO’s Psychiatric and Addictions Case Consultation module, a free resource to educate providers on prescribing MAT and offer remote case consultation

△ Sponsoring provider participation in ASAM’s DATA training program as part of OpiEnd

△ In year 2 of the new contract, Trillium will pilot a bundled payment for initiating, engaging, and maintaining MAT treatment for members with SUD

f. Coordinate care with local Hospitals, Emergency Departments, law enforcement, EMS, DCOs, certified Peers, housing coordinators, and other local partners to facilitate continuum of care (prevention, treatment, recovery) for individuals and families struggling with opioid use disorder in their Community.

LC-PGSA stakeholders include first responders, providers, and community-based organizations; meeting monthly to prioritize strategies to safely decrease opioid prescribing, increase care coordination, and accelerate access to SUD services in our current Service Area. To promote coordination across our proposed Service Area we will leverage existing forums for collaboration, taking a lead role in bringing stakeholders together from all aspects of the SUD System of Care. We will also promote the use of PreManage and our Provider Portal to facilitate data sharing and provide access to our Community Partner Portal for community agencies serving common members. For example, EDs can identify members displaying drug seeking behaviors by having real time access to recent ED utilization. We also train community partners such as law enforcement and EMS on Mental Health First Aid and Trauma Informed Care to better support our members as they present. As part of our Care Coordination processes, Trillium connects members with community providers that address SDOH-HE and psychosocial services integral to supporting long-term recovery. Our efforts further include closed-loop referrals to permanent supportive housing organizations, sober living facilities, peer supports and other THWs, and food security agencies. We engage family members by offering SUD interventions recognized by the National Institute of Drug Abuse (NIDA), including Brief Strategic Family Therapy (BSFT), Family Behavior Therapy (FBT), and Multidimensional Family Therapy (MDFT).

g. Additional efforts to address opioid use disorder and dependency shall also include:

* Implementation of comprehensive treatment and prevention strategies

As described above, Trillium launched OpiEnd in 2019 to identify and intervene for members at risk for opioid use disorder. This comprehensive solution supports our circular continuum of care and leverages data and analytics to engage members, providers, pharmacies and communities.

* Care coordination and transitions between levels of care, especially from high levels of care such has hospitalization, withdrawal management and residential

Trillium has a comprehensive Transitions of Care program available to all members as described in more detail in Att. 11.3 and Att. 7.6.A. ASAM clinical standards guide our approach to SUD care transitions. Our Care Coordinators with clinical expertise in SUD monitor member and provider adherence to treatment plan settings and connect members to outpatient treatment and community services upon discharge from higher levels of care, adjusting the member’s care plan and continuously monitoring progress. We actively engage our community partners to identify new transition models for this complex population, such as Improving Addiction Care Team (IMPACT) developed by Oregon Health & Science University (OHSU) and Portland State University. IMPACT is an emerging peer-reviewed community planning process that convenes local stakeholders to streamline post-hospitalization SUD services to reduce readmissions.
• **Adherence to Treatment Plans**
  We engage members and support adherence to treatment plans through Motivational Interviewing, strengths-based approaches that concentrate on the inherent strengths of members and families, person-centered care planning, patient activation models, use of peer supports, and equipping members with tools and resources to support health, wellness and recovery.

• **Increase rates of identification, initiation and engagement**
  Part of our SUD Segmentation Model, our proprietary *Opioid Risk Classification Algorithm (ORCA)* prioritizes members at-risk for SUD for CC engagement based on social and clinical factors. ORCA augments our CC Engagement Score, which prioritizes members for outreach, and anticipates the need for alternative outreach to high-risk, difficult to engage members. Upon identification, our Care Coordinators outreach to members to engage in CC. For difficult to engage members, we may deploy a Community Health Worker or Peer Support Specialist to engage with members in the community or partner with the member’s PCP or CMHP to initiate treatment. *These approaches have led to all-cause ED utilization reductions for members with SUD from 227 to 120 per 1,000 member months (MM). In the same period, all-cause hospitalizations for members with SUD decreased from 25 to 19 per 1,000 MM.* To support our providers in the identification and referral of members with or at risk for SUD, we offer PCP training on SBIRT and other SUD screenings and train on how to refer to services, including treatment and THW and the promotion of Project ECHO’s Psychiatric and Addictions Case Consultation module among our network of providers, described above.

• **Reduction in overdoses and overdose related deaths**
  Reduction in overdoses and related deaths is included in our OpiEnd training and outreach. Trillium covers all forms of naloxone and works to ensure that providers are able to educate their patients on proper utilization. Our CC Team works with providers to train members, and their families and support systems on naloxone administration; and refers members to resources for training and free atomizers. Trillium has supported trainings and distribution sites to promote the distribution of over 1,000 naloxone kits.

2. **FEWER READMISSIONS TO THE SAME OR HIGHER LEVEL OF CARE PRIORITIZE ACCESS FOR PREGNANT WOMEN AND CHILDREN AGES BIRTH THROUGH FIVE YEARS**

**Applicant will prioritize access for pregnant women and children ages birth through five years to health services, developmental services, Early Intervention, targeted supportive services, and Behavioral Health treatment.**

a. **How will Applicant ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting? What will take place if the screening reveals concerns?**

**Screening.** We promote social-emotional screenings in primary care in accordance with Bright Futures and American Academy of Pediatrics (AAP) periodicity standards, which recommend a Psychosocial/Behavioral Assessment using a family-centered tool to include an assessment of child social-emotional health, caregiver depression, and SDOH at every age/visit milestone from Newborn through Adolescent. We educate PCPs on clinical guidelines through our new provider orientation, Provider Manual, newsletters, and provider engagement and utilization reviews. We support PCPs with resources, including 1) provider trainings on screening, such as establishing an assessment baseline using a validated tool (e.g. Ages and Stages Questionnaire (ASQ); 2) a website with additional tools and resources salient to each social-emotional developmental milestone, including PCP guidance to educate parents on evidence-based practices such as Attachment Therapy, Trauma-Informed Care, and modeling emotional awareness and self-regulation. Our Start Smart prenatal and postpartum management program augments our clinical and CC approach with education for
new moms on the importance of well-child care, including social-emotional and development screenings, and what to expect at each milestone.

**Referral and Follow Up.** If at any time screening reveals enhanced risk for – or actual irregularity with development, PCPs are educated on available services in the network and/or community and directed to refer as indicated, including referral to Trillium for appropriate CC services. Our CC Team will ensure that members are linked to appropriate resources, documented in a care plan as appropriate. Salient services include access to pediatric behavioral analysts, development psychologists and family therapy providers. PCPs and our CC Team monitor interventions progress compared to baseline assessments. The CC Team will also prepare and educate families and caregivers on signs and symptoms to watch for and how to monitor their child’s progress and raise any concerns with the PCP.

**Quality Assurance.** Our Early Childhood Mental Health Workgroup is charged with monitoring the described processes. The Workgroup meets monthly to review screening trends and our performance with the Child Core Set developmental screening measure, service utilization review, and chart audit results. The Workgroup proactively marshals resources to address opportunities for improvement. If a PCP is found to be noncompliant, they are referred to Provider Relations to receive training to improve performance. PCPs can also be placed on a Corrective Action Plan (CAP) that details steps to achieve compliance, as necessary.

**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?**

We are active participants in the Oregon Pediatric Improvement Partnership’s effort to implement ACEs assessments for every child, and our parent, Centene, is a national expert on Trauma Informed Care (TIC), completing, for example, over 60,000 TIC trainings since 2008.

**ACEs Tools.** Centene has consulted with a range of experts in ACEs and trauma to evaluate effective treatment measures and create trauma toolkits, including a comprehensive list of screening assessment tools that are available at no cost in the public domain and are free for providers to download and use. These include but are not limited to:

- Trauma Events Screening Inventory Child Report Form Revised (TESI-CRF-R)
- Child PTSD Symptom Scale for DSM 5 (CPSS5)
- Mood and Feeling Questionnaire (MFQ)
- Center for Epidemiological Studies Depression Scale for Children (CES-DC)
- Screening for Anxiety and Related Emotional Disorders (SCARED)
- National Child Traumatic Stress Network (NCTSN) Child Welfare Referral Tool (CWRT)

Elements of validated ACEs screening tools, such as the Resilience Questionnaire and Family Health History and Health Appraisal Questionnaire, are embedded in our Comprehensive Assessment. We provide training and education to our providers on AAP screening tools for ACEs, including mind-body therapies for children and youth, and ACEs and toxic stress treatment guidelines. These efforts are supported by our Simple Screens platform to streamline ACEs screening in provider offices.

**Assessing Member Resiliency.** Our trauma-informed framework to assess member resiliency is consistent with AAP’s Trauma Guide, which we will make available on our website.

**Evaluating the Use of Screenings and Application in Developing Service Plans.** Our work in TIC follows the definitions “trauma-informed approach” identified by the Substance Abuse and Mental Health Service Administration (SAMHSA) and adheres to guidelines for characteristics of a Trauma Informed System established by the NCTSN. To support this TIC System, we include TIC training for all CC staff as well as providers and community stakeholders. Through this lens, our Care Coordinators will collaborate with
providers to evaluate and monitor consistent use of screenings. Results are used to inform the member care plan which is monitored by the CC Team with input from providers. Our CC Team monitors service utilization data and conducts chart audits to ensure fidelity to evidence-based standards. For example, when we identify members with BH needs resulting from ACEs, we will work to connect them to BH providers with expertise in trauma-informed treatment such as Trauma-Focused Cognitive Behavioral Therapy.

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?

We require providers to screen all pregnant women for BH needs at least once during- and post-pregnancy to ensure timely referrals and follow-up. Our Provider Manual and website note the requirement to both screen and document, and provide resources to support provider efforts, including validated screening tools and access to our CC Team to help engage non-compliant members. We contact providers who have not conducted these screenings to ascertain barriers to completion and work with providers to address barriers, such as deploying peers to help engage members. Identification of pregnant members is included in our monthly Hot-Spotter Report, which providers are expected to use for targeted outreach. To further support provider efforts, once identified as pregnant or postpartum, Trillium sends an assessment packet to the member via mail to assess PH/BH risk. Our prenatal packet administers the Kessler Psychological Distress scale, and our postpartum packet utilizes the Edinburg Postnatal Depression Scale (EPDS). In 2021, we will augment these efforts by piloting a case rate for completing and submitting a notice of pregnancy, with a completed risk assessment, within the first 6 months of pregnancy, in addition to flu vaccinations and adherence to prescribed prenatal and postpartum care measures.

d. How will Applicant ensure that clinical staff providing post-partum care is 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?

We provide free training to providers, including OB/GYNs, on best practices to screen for BH needs and streamline access to BH/SUD diagnostic and treatment services, and resources are included in our Provider Manual and website. When screening yields a positive screen for post-partum BH/SUD risk, our obstetrical providers conduct referrals to the clinically-appropriate specialist based on the member’s unique needs for further evaluation and diagnosis. For example, post-partum members diagnosed with SUD are referred to the proper setting of care based on the ASAM Levels of Care. All pregnant members who do not refuse will be enrolled in our Start Smart program, with Care Coordinators responsible for post-partum education and outreach to ensure appropriate assessment and follow-up. Members with any BH risk or need may also be referred to CC for development of a care plan with scheduled outreach, monitoring and follow up. In 2019, as part of Start Smart, we will be deploying automated, patient-directed, mobile text messaging based patient adherence tool designed to improve health outcomes for pregnant women and other targeted populations in partnership with the University of Oregon.

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?

Access to Dyadic Treatment. Trillium is committed to facilitating access to Dyadic treatment for all members, including postpartum members and their children through age five where attachment and trauma challenges are evident, and as clinically-appropriate. We rely on a variety of attachment-oriented approaches for children and their families, including individual therapy, parent training, peer (parent) support as well as staff training to thoroughly understand this treatment model and the implications of trauma, abuse and neglect on attachment. We will identify providers in our network who offer evidence-based Dyadic treatment, such as Child Parent
Psychotherapy (CPP) and Parent-Child Interaction Therapy (PCIT), and train providers, parents, and our CC Team on the availability of these treatments and how/when to refer.

**Assertive Case Management.** Our Care Coordinators will work with providers to expedite access to Dyadic treatment for members in-need. Our approach will begin with identifying members who are at-risk for attachment/trauma challenges and/or engagement by Child Protective Services. Our CC Team is trained to assess prenatal, perinatal, and postpartum clinical and social risk factors that can disrupt health and normal parent-child attachment and/or traumatize children. Factors include SPMI, BH, and SUD diagnoses; prolonged and/or traumatic intrapartum period; and presents of ACEs or SDOH. We also train PCP and specialty providers on these factors and risks. Once identified, our Care Coordinators work with members, family/caregivers, the PCP, family therapy providers, and psychosocial support providers to create a succinct Dyadic treatment experience. Our Dyadic treatment model will augment treatment models such as CPP and PCIT with home- and office-based interventions that provide feedback, recommendations, and processing for both the parent and the child immediately. The aim of these activities will be to maximize the likelihood the children remain in the home. Other available resources include Triple P, Positive Parenting Program, and Family Check Up.

- **Triple P** is an internet virtual learning intervention for children age 2-12 and their parents. It emphasizes five core principles pertinent to promoting child-parent attachment, including 1) Create a safe overall environment, 2) Create a safe learning environment, 3) Use of assertive discipline, 4) Realistic expectations development, and 5) Parental self-care.
- **Family Check-Up** is an evidence- and strength-based family assessment to improve at family functioning, including observational training for parents/caregivers and their children that encourages calm communication, positive behaviors, conflict resolution, and boundaries across three 90-minute sessions. Early data in Lane County demonstrates positive outcomes with 99.4% of participants reporting the program helped them see their strength as parents and 91% saying the program gave them realistic ideas for making changes in their family.

**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)?**

Trillium promotes and supports assessment of SDOH, including family and informal supports, by providers, using such tools as PRAPARE. Trillium collects and monitors SDOH data from providers through provider submission of ICD-10 Z codes to identify SDOH needs and sharing of assessment data through our Simple Screens assessment platform. Information on available SDOH screening and assessment tools and how to refer members for social services and supports through our provider orientations, Provider Manual, newsletters, and on our website. This includes access to our online community resource database, *Trillium Resource Exchange*, which facilitates closed loop referrals to community-based organizations that address SDOH. We also ensure providers are aware of home visiting resources, including Nurse Family Partnership, Babies First!, Parenting Now!, CaCoon, and Healthy Families Oregon. In 2018, *Trillium conducted 660 confirmed referrals to home visiting programs.*

**g. Describe how Applicant will meet the additional Complex Care Management and evidence-based Behavioral Health intervention needs of children 0-5, and their caregivers, with indications of ACEs and high complexity.**

Trillium is dedicated to addressing effects of trauma and ACEs and building a Trauma Informed System across our proposed Service Area, through staff, provider and stakeholder training and the promotion of screening and assessment tools to identify ACEs and other special health care needs. We will include ACEs screening
questions in our Comprehensive Assessment to identify and address trauma-related behavioral and emotional issues. In addition, our Care Coordinators are trained in principles of TIC, ACEs, and trauma. Once identified through assessments and screenings described above, a Care Coordinator serves as the single point of contact for members with indications of ACEs and high complexity to streamline access to integrated medical, BH, and psychosocial support services. The assigned Care Coordinator duties include:
- Provide ongoing care coordination between visits including communication with family, PCPs and specialists
- Navigate members, their caregivers and families across the full healthcare and social services continuum, including closed-loop referrals to community resources
- Offer behavior management and skills training for members, parents and caregivers
- Identify and link to providers that address BH, social-emotional development, and have been trained in TIC
- Ensure collaborative care plans are developed and monitored with progression milestones

**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?**

Our Care Coordinators will coordinate Dyadic services for children referred to day treatment, subacute, or PRTS treatment settings with the parents/caregivers, the facility and the Dyadic treatment providers to arrange for onsite or virtual services and prevent disruption. In addition, we will proactively prioritize Dyadic training for high acuity treatment providers who work with children. The home visiting programs noted above are also available to provide services in day treatment, subacute, and PRTS treatment settings with parents/caregivers where clinically appropriate. For example, Trillium coordinates with CaCOON for children with special needs. CaCOON’s trained nurses conduct services in subacute and PRTS settings, and work with parents of complex care members to identify their child’s strengths and needs; connect with healthcare and other community supports; and ensure the functionality of care teams.

**i. Describe Applicant’s annual training plan for Applicant’s staff and Providers that addresses ACEs, trauma informed approaches and practices, tools and interventions that promote healing from trauma and the creation/support of resiliency for families.**

Our Intergenerational Trauma 101 module provides an overview of screening for trauma, the effects of trauma, what to know about interacting with members, and the impact of ACEs. Training and education is geared by audience, such as provider type, and provided locally to our staff, provider network, members, families and caregivers, and community stakeholders such as law enforcement and juvenile justice. In addition to our standard ACEs and TIC trainings, we will offer Mental Health First Aid, concepts of Recovery and Resiliency, and specific topics such as “Self Care: Preventing Compassion Fatigue and Secondary Traumatic Stress” and “Trauma Training for Caregivers.” We also adapt trainings to account for cultural traditions and preferences. For example, to support our Tribal members, providers, staff and first responders, we will use the University of Oklahoma Adaptation of Trauma-Focused Cognitive Behavioral Therapy adapted for Native American Children, “Honoring the Child, Mending the Circle.”

**Annual Training Plan for Staff and Providers.** Trillium will provide ACEs and TIC training, approaches, tools and interventions across our staff, network, and community. Trainings are provided online, in person in the community, and through lunch and learns.

**Staff.** ACEs and TIC training are mandatory components of our employee orientation process, and annually thereafter. Ongoing trainings are offered through our proprietary online learning platform. Initial ACEs and TIC training is included in our classroom style new employee onboarding, with additional online trainings available to clinical and member-facing staff.
Provider. We will offer ACEs and TIC training to our providers multiple times a year throughout our proposed Service Area. We will provide an annual calendar of available in-person trainings by location that will be maintained on our website and promoted during provider orientations and in our newsletters. We will also offer online trainings through Trillium University. By 2020, we will make continuing medical education training available related to ACEs and TIC.

Community. By 2020, we will offer an annual calendar of in-person trainings available to our community stakeholders, maintained on our website and promoted through community events.

3. CARE COORDINATION

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 for substance use disorder (SUD), and Members of a 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). Applicant must establish outcome measure tools for Care Coordination.

CARE COORDINATION MODEL

Trillium has a well-established Care Coordination (CC) program that today serves nearly 90,000 OHP members and over 2,400 dual eligible members in our companion D-SNP in Lane County. With over six years of direct experience as a CCO, we are well positioned to achieve OHA’s program goals and fully comply with the CCO 2.0 Sample Contract, including Exhibit B, Statement of Work- Part 4, Care Coordination requirements. Our policies and procedures and care management (CM) tools incorporate Case Management Society of America Standards of Practice, NCQA standards and meet OHA requirements. Our person-centered CC program, including Intensive CC (ICC) services, promotes whole-person care, including Social Determinants of Health and Health Equity (SDOH-HE).

Examples of our CC successes include:
- **29% reduction in readmission rates** from 2017 to 2018.
- Significant **decrease in ED utilization** since the implementation of our ED Diversion Case Management program from 59.07 in January 2018 to 47.08 per 1,000 members in November 2018.
- In 2018, Trillium members reported **100% satisfaction with the help they have received from their dedicated Care Coordinator.**

a. Describe Applicant’s screening and stratification processes for Care Coordination, specifically:

As step one and two of our CC process (see Figure 11.3.A below), Trillium employs a multi-faceted screening and stratification approach, leveraging proprietary tools and best practices to promote early identification and interventions. Our model includes four levels of CC (Figure 11.3.B below), including transitional CC activities and targeted wellness programs. We recognize that every member has unique needs, requiring varying level of services and interventions at varying times and intensity across the care continuum. CC activities are intentional based on level and assessed whole person needs, which shift as status changes.

Screening and Assessment. Trillium completes an Initial Risk Screening (IRS) on all members as part of the Member Welcome Call. This information is coupled with subsequent in-person comprehensive assessments (as appropriate), claims and enrollment file data as available, and information from external sources such as local Type B Area Agencies on Aging (AAA), Aging and Physical Disability (APD) field offices, and DHS.
Processes and Tools. We use risk stratification and predictive modeling tools to stratify members into the appropriate risk category. The risk scores help determine which members receive CC, the appropriate level of CC, and the most appropriate Care Coordinator. We also use a CC Engagement Score to identify member likelihood to engage in CC, prioritize high-scoring members for outreach, and employ alternative outreach methods for difficult to engage members. We use our innovative tools to drill down into special conditions, such as our SUD Segmentation Model. Through this model, individuals are stratified into one of six SUD segments directing outreach and early intervention. Our Diabetes Predictive Model identifies uncontrolled diabetes status for members without a hemoglobin lab test. As a new enhancement under the CCO 2.0 Program, we will implement a Schizophrenia Inpatient Model (SIM) to identify members with an increased risk of relapse that may result in schizophrenia-related ED visits and hospitalizations, such as failure to fill medications. We evaluate social circumstances through incorporation of SDOH-HE data in our process. Members may move between levels as their risk, acuity, needs, and preferences change. We repeat this process at least monthly for our entire membership to identify changes in severity or acuity, reassigning to the most appropriate level as appropriate. Our approach uses information we directly learn or validate from our members. We also use leading indicators such as Admission, Transfer, Discharge (ADT) data received from our hospital partners. Assessment findings, including information regularly received from AAAs and APDs, are also used to re-stratify members to reflect newly identified issues or changes in conditions.

(1) How will Applicant determine which enrollees receive Care Coordination services?

All members have access to CC services. We determine which members receive CC services through the use of:

Screening and Assessment. Based on the IRS, members with urgent or ongoing needs are triaged to the CC Team for further assessment and to address immediate needs. As triggered by the IRS, they complete a
more comprehensive assessment to effectively match members with appropriate services, such as Assertive Community Treatment (ACT) and Wraparound services; CC level; and CC Team.

**Referrals.** Member referrals to CC can include but are not limited to self, family, Primary Care Provider (PCP), Patient-Centered Primary Care Homes (PCPCHs), BH/PH specialty provider, crisis services, hospital, OHA, AAA, APD, or Trillium staff.

**Predictive Modeling.** Described above, Trillium’s predictive modeling process identifies members that can benefit from CC services, using readmission risk assessment, systematic medication review, opioid risk, SUD segmentation, and baseline assessment and utilization data, including psycho-social factors, tobacco use, housing instability, and history of trauma, and over- or under-utilization of services. This algorithm generates a risk score and determines how members are placed into CC levels, including ICC services and specialized programs.

**Proactive-Real-time Identification.** Trillium has invested in technology provided by Collective Medical (CM) to integrate PreManage into our daily CC operations. Through the design of population specific cohorts, our CC Team receives real-time notifications when our members enter and discharge from acute facilities. Our ED Diversion Program utilizes these cohorts and daily driver reports to identify at-risk members for CC engagement.

(2) How will Applicant ensure that enrollees who need Care Coordination are able to access these services?

Trillium ensures that members, providers, and staff are trained and educated on the availability and value of CC services through orientations, annual trainings, and the Member Handbook/Provider Manual. **Members in need of CC are assigned a single point of contact** based on CC level and primary diagnosis. Members receiving ICC services are provided contact information for their primary Case Manager and/or Coordinator to ensure members can easily access ICC services and supports. Our staff skill mix and ratios ensure CC services are delivered timely and member needs are met. We continuously monitor ratios against outcomes and performance and adjust those ratios accordingly. Our staffing model, including Trillium CC staff, TBH CC staff, and CC staff based in a network practice or employed by a provider, provides appropriate access to needed CC services. We engage and support our providers to participate in and lead Interdisciplinary Team (IDT) activities, equipping them with the resources and expertise needed to provide the full spectrum of CC services. Recognizing that a member’s needs may change over time, we review at least monthly. This systematic process is enhanced with regular monitoring of member utilization and progress toward health goals. We quickly identify and outreach to members with inappropriate utilization, care gaps, and other triggers, including engaging members that are not currently in CC. We refer at-risk members we are unable to reach by phone to our MemberConnections Representatives (MCRs), who are trained to help locate and engage members in person.

(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?

One of our key roles is to identify and bridge gaps in care. Our CC Team reviews a suite of reports weekly to identify and categorize care gaps, prioritize outreach, and identify members with under-, over-, or inappropriate utilization. We outreach to members with no utilization in the first six months to assist in scheduling appointments and provide education on the value of PCP engagement. If we can’t reach members by phone, we send a letter indicating our attempt to contact. Prioritized populations, including individuals at risk or with special health care needs, will be referred to a MCR for in person outreach. Our MCRs use exhaustive efforts to assist in finding members through a variety of channels, including visiting the last known member address to verify residence and/or connect in-person, and community organizations, such as homeless shelters, to become a familiar face in the community and gain trust. Our provider Hot-Spotter Report flags members with under-
utilization for direct provider outreach. On an ongoing basis, all members receive information and reminders about care gaps through the Member Portal, Mobile App, postcard reminders, and targeted telephonic outreach campaigns. All new members receive a Welcome Call to identify needs, connect them with a PCP/PCPCH, and provide relevant health education.

**b. How does Applicant plan to complete initial screening and Assessment of Intensive Care Coordination (ICC) within the designated timeline? (May submit work flow chart if desirable).**

**Initial Risk Screening and Assessment (IRS).** New member onboarding includes an IRS within 30 days of enrollment. We send an initial screening form in the Member Welcome Packet with instructions for members to complete it during our Member Welcome Call or refer members for self-service completion via our Member Portal. We place Welcome Calls within 30 days for new members and within 90 days of new Contract implementation for all members. As part of our Welcome Call, we also educate members on services offered by Trillium including CC and ICC services. Members identified during the IRS as meeting criteria for ICC are referred to a Care Coordinator who arranges an in-person comprehensive assessment (CA) and additional condition-specific and age-appropriate screenings and supplemental assessments as indicated.

**Member Engagement.** We require separate outreach attempts over several days and at varying times of the day to complete the IRS. We employ a no-wrong door approach and leverage every member touch point. If after three attempts we are unable to successfully reach a member, we will follow up with a letter that includes information on the importance of and how to complete the IRS in-person or telephonically, electronically via the Member Portal, or self-completion of the form via mail. We will also leverage providers and community partners. For example, we will utilize Simple Screens to allow members to complete the IRS in provider offices and at the point of service delivery. In addition, our other affiliates are currently piloting the use of a Health Kiosk for members to complete screening that we will monitor for potential use in Oregon as another way to complete the IRS based on results from other states.

**Hard-to-Reach Members.** For members who are difficult to engage due to outdated or incorrect contact information, or those without phones or stable housing, we will leverage our MCRs. MCRs are culturally adept and locally based to meet members in their homes, at work, or in the community. We also outreach to PCPs and pharmacy providers to validate member contact information and/or solicit help with engagement.

**c. Please describe Applicant's proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans.**

**Individualized Care Plan (ICP) Development.** The member is at the center of the care planning process and the key driver of their care, with support from their defined IDT. Based on assessment results and using Motivational Interviewing to capture personal member goals, health needs, and preferences, we develop a whole-person ICP that includes covered and non-covered PH, BH, LTC, and social support services. ICPs are developed with the member, guardians/representatives, and circles of support, with input from active providers, including PCPs, specialists, LTC, and BH providers, to develop a fully integrated ICP to optimize outcomes and meet goals. The ICP is person-centered, trauma-informed, recovery oriented, and strengths-based to empower members, with measurable short- and long-term goals, key milestones, and tailored interventions. The ICP includes, at a minimum, the member’s role and action steps, timeframes, and specialized programs, community resources, and formal/informal supports to be accessed.

**Implementation and Monitoring.** The Care Coordinator works in collaboration with the member, the member’s PCP, and IDT to implement the plan and facilitate access to holistic services. The Care Coordinator delivers health education and supports strategies for self-management, including symptom identification, risk mitigation, overcoming perceived barriers, and improving health literacy. The Care Coordinator is also responsible for
continuous and systematic monitoring and regular reassessment to evaluate adherence to the ICP and whether results are being achieved, course correct, and to identify changes in condition or status.

**ICP Updates.** ICPs will be developed within 10 days of enrollment in ICC and updated every 90 days or sooner upon a significant change in condition or status, at member request and/or upon provider or staff input. Care Coordinators re-assess needs during each visit and work with the member to revise the ICP to include progress with existing goals, interventions or authorized services. Members are provided with a copy of their ICP at completion and upon updates or changes. Members also have access to their ICP through the Member Portal.

d. How does Applicant plan to provide cost-effective integrated Care Coordination (including all health and social support systems)?

**Cost-Effective, Integrated Care Coordination.** CC is a key element of our CCO 2.0 model, designed to coordinate and integrate across the continuum of services and settings. This includes screening for and addressing SDOH-HE. Our CC framework is based on the core belief that quality healthcare is best delivered locally and provided in partnership with the community. For example:

- The **Frequent User System Engagement (FUSE) initiative** aims to reach the most frequent users of public services, including law enforcement, jails, and emergency medical care, by breaking the cycle of housing instability, homelessness and crisis. Navigators visit high utilizers where they are to talk to them about housing stability.

- The **Intensive Community Care Management (ICCM) program** is centered on the 5% of members that account for 58% of the resources. The ICCM program serves members who have five or more chronic PH conditions and at least one BH condition. Developed in partnership with Springfield Family Physician and the Center for Family Development, the model provides intensive care management services in a PCPCH setting. We will utilize lessons learned and best practices to implement additional ICCM and similar models throughout our proposed Service Area. We will promote the effective delivery of CC services with our PCPCH providers through training on person-centered care planning, facilitation of IDTs, and the provision of actionable data and analytics at the point of care.

In addition, for particular sub-populations impacted by BH conditions, we promote access to other community-based integrated CC models, such as Assertive Community Treatment (ACT) (described in Att.11.E.4.e-g) and Wraparound services (described in Att.11.E.9).

Trillium will continue our efforts to **work across multiple systems and providers to ensure integration and non-duplication of services.** We will accomplish this through highly trained CC staff, technology solutions that support the flow of information, and the provision of technical assistance and actionable data for providers.

e. What is Applicant’s policy for ensuring Applicant is operating in a way guided by person centered, Culturally Responsive and trauma informed principles?

Trillium is committed to and has policies and procedures in place to ensure we are providing CC services that are **culturally responsive, person-centered, and trauma-informed.** Care Coordinators incorporate age, development, culture, language and other individualized member characteristics into our person-centered care planning process when working with our members. CC staff and providers are trained in person-centered care planning, cultural and disability competency, adverse childhood events (ACEs) and trauma-informed care standards and principles. For example, we provide in-depth staff training on **Person Centered Thinking**, using...
training material developed by the International Learning Community for Person Centered Practices. Our parent company, Centene, has a certified Person Centered Thinking trainer on staff and Trillium is committed to having a locally-based Person Centered Thinking certified trainer on staff. Our Person Centered Thinking training module instructs staff on how to discover what is important to and for the member. The discovery is used to identify strengths, capacities, preferences, needs and desired outcomes. Our staff are also trained on 

**Culturally and Linguistically Appropriate Services (CLAS)** and follow all 15 CLAS standards, as well as disability sensitivity, using People First Language, with emphasis on developing skills to communicate appropriately and address members' linguistic, disability, and/or culturally-related needs. We monitor this through routine chart audits and do retraining at the individual or team level, as needed. Centene is also a leader in trauma-informed care with all local staff trained.

### f. Does Applicant plan to delegate Care Coordination outside of Applicant’s organization? How does Applicant plan to enforce the Contract requirement if Care Coordination delegation is chosen?

**CC Delegation.** We leverage local community-based entities and providers as our trusted partners to promote coordinated care and will delegate CC based on capability, capacity, and interest. Trillium currently delegates CC services to our strategic partner, Trillium Behavioral Health (TBH) and to Springfield Family Physicians and the Center for Family Development as part of our total cost of care, value-based pilot that provides ICCM services in a PCPCH setting. We are pursuing opportunities to delegate CC services to Tier-5 certified PCPCHs as a strategy to provide CC at the point of care across our entire Service Area.

**Delegation Oversight and Monitoring.** Trillium is ultimately accountable for ensuring all OHA CC service requirements are met. We deploy the following activities and tools to monitor and evaluate program effectiveness and outcomes and oversee contract compliance for delegates:

<table>
<thead>
<tr>
<th>Delegation Oversight and Monitoring Activities</th>
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<tbody>
<tr>
<td><strong>Pre-Delegation and Annual Audits</strong></td>
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<tr>
<td>Trillium conducts a Pre-Delegation Audit to determine ability to take on CC activities based on infrastructure, size, and experience. At least annually, we assess and audit delegate capabilities, compliance, performance, and outcomes. This includes both onsite and documentation audits such as medical record reviews, policies and procedures, and turnaround time reports. Audit tools will reflect state and federal requirements, NCQA standards and other industry best practices.</td>
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<tr>
<td><strong>Delegation Agreement and Assessment</strong></td>
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<td>Oversight and monitoring start with appropriately setting expectations and ensuring delegates have the tools to be successful in a delegated model. Once both parties mutually agree to move forward, a Delegation Agreement is signed outlining the responsibilities of each party. Our Quality Improvement Committee (QIC) reviews and approves Delegation Agreements and reviews Pre-Delegation and annual audits, and performance reporting.</td>
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<tr>
<td><strong>Ongoing Monitoring</strong></td>
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<td>Delegates are required to submit routine reporting, including, but not limited to: CC staff list and caseload ratios; timeliness reports (initial screening and assessments, notices, member outreach, ICP updates, etc.); and a list of members by CC Level.</td>
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<tr>
<td><strong>Provider Profiling and Reporting</strong></td>
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<tr>
<td>We supply delegates with comprehensive reporting that covers data points such as membership, IRS indicators and results (if completed by plan), care gaps, HEDIS and EPSDT measures, ED visits, inpatient admissions, member and provider complaints and grievances reports, and member and provider satisfaction surveys and results. We also track and report various metrics in direct alignment with VBP performance indicators, based on agreement.</td>
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<tr>
<td><strong>Integrated Case Rounds and Audits</strong></td>
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<tr>
<td>Trillium staff regularly meet with delegate staff, including monthly case audits, to review cases and verify that members are receiving the right care in the right place and the right time without duplication.</td>
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<tr>
<td><strong>Joint Oversight Committee Meetings</strong></td>
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<td>Quarterly and ad hoc meetings are held between Trillium and delegates to present actionable data, review performance, coordinate, and address issues and concerns.</td>
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<tr>
<td><strong>Corrective Action Plans (CAPs)</strong></td>
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<tr>
<td>Should any monitoring and oversight activity uncover an issue of non-compliance, risk of non-compliance, or evidence of poor performance, delegates may be placed on a CAP. Our goal is to support our delegates to effectively resolve any issues and maintain delegation, providing training and technical assistance as needed.</td>
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</tbody>
</table>
**Coordinating Care for Dual Eligibles.** Trillium is committed to continuing its efforts to ensure a seamless delivery of Medicaid and Medicare benefits and services. To facilitate coordination, we leverage our *Dual Eligible Special Needs Plan (D-SNP) in Lane County* that we have operated since 2007 and will leverage our Trillium affiliated Medicare Advantage plans offered by HealthNet, a wholly owned subsidiary of our parent company, in our proposed Service Area. In 2021, Trillium will offer a D-SNP throughout our entire Service Area. Today, 27% of our dual eligibles are enrolled in our D-SNP. Regardless of source of Medicare coverage, we assess for and enter information about Medicare benefits and providers in our care management system.

**Affiliated Plans.** Members enrolled in both our CCO and companion D-SNP are assigned a single Care Coordinator who facilitates an integrated assessment and CC process using our single integrated medical management platform that spans all Medicaid and Medicare services. Our single assessment process identifies the full range of needs, including Medicaid wraparound benefits (i.e. BH and LTC) and Medicare services. Our joint ICP incorporates Medicare and Medicaid covered and non-covered services. We honor members’ choice of Medicare PCP and maintain a strong crossover network of Medicaid and Medicare providers.

**Coordinating with other Medicare Advantage plans and D-SNPs.** Our Care Coordinators will coordinate directly with the Medicare Advantage or D-SNP Care Coordinators and participate on their care teams and/or include them in our care planning process, as appropriate. Care Coordinators collaborate to complete assessments, implement and monitor the ICP, initiate requests for Medicare services, facilitate timely authorization, and notify of changes to BH needs and services and new or changed clinical needs. Trillium recommends conducting collaborative initiatives to develop coordination protocols and to educate Medicare providers about coordinating with CCOs. Whether contracted with our D-SNP or not, Medicare providers can register (with appropriate consent) to access our secure Provider Portal to access data needed, including the ICP and other information to coordinate care. We will also make our Community Portal available to Medicare Advantage and D-SNP plans to easily participate in the care planning process if they so choose to do so.

**h. What is Applicant’s strategy for engaging specialized and ICC populations? What is Applicant’s plan for addressing engagement barriers with ICC populations?**

**Engaging Specialized and ICC Populations.** Once we identify a member with specialized or ICC needs, we assign a Care Coordinator most reflective of the member’s primary need, supported by a team of internal and external experts. We leverage existing CM/CC programs and providers that our members have developed a trusting relationship with such as AAAs and APDs. Trillium also has an established relationship with DHS to effectively engage and co-manage Foster Care children and youth. We obtain regular reports from DHS to facilitate access to necessary services, assessments, and providers and work with partners such as Oregon Community Programs, Looking Glass and The Child Center to identify and engage children, youth and families. For individuals with BH needs, we have long standing collaborative relationships and established protocols with BH providers, including ACT and Wraparound partners at Laurel Hill and South Lane Mental Health to engage members. We also encourage the use of and collaborate with several Peer Delivered Services (PDS) providers as part of member care. Our CC Team ensures that members are all informed of their PDS benefit, educating members and providers where/how to access PDS. As discussed in Att.11.A.11, we will include information about PDS in our Member Handbook. We also ensure PDS are utilized as part of our provision of other BH services, such as ACT and crisis services. Trillium participates in local initiatives such as the Mental Health Summit to engage our members with SPMI in the criminal justice system. Through our proven community
engagement strategy, we will establish similar collaborative relationships with entities such as Volunteers of America, The Children's Center, Morrison Child and Family Services; Lifeworks NW, etc. in our proposed Service Area to engage specialized and ICC populations.

**Engagement Barriers.** Utilizing Motivational Interviewing, Behavior Change Theory, Trauma Informed Care, and Strengths-Based training, Care Coordinators assess members for readiness for change and design outreach and interventions to meet members where they are and help them move them toward engagement, treatment, and recovery. For example, members with a BH condition may suffer from paranoia or be discouraged from seeking treatment due to perceived stigma associated with BH. We address these barriers by engaging integrated provider groups and reducing stigma by treating the whole person. If we are not successful in enrolling or engaging members, we will continue to monitor and engage providers, MCRs, Peer Supports, and trusted community organizations in continuous outreach.

**i. Please describe Applicant’s process of notifying a Member if they are discharged from Care Coordination/ICC services. Please include additional processes in place for Members who are being discharged due to lack of engagement.**

Members have the right to decline CC/ICC services at any time. As part of our member outreach and education process, we inform members that their participation is voluntary and if they decline participation or are discharged from CC/ICC service that other treatment or services will not be denied. If a member meets clinical criteria for discharge, the Care Coordinator works with the member, PCP, and IDT to facilitate services to ensure a successful transition. For all members discharged, a letter is mailed to the member and the member’s PCP, documenting the reason for discharge and includes, if the member has not terminated with the plan, a reminder to contact the care team in the future should concerns arise. If CC or ICC services have been refused or the member is being discharged due to lack of engagement, the Care Coordinator provides plan contact information, including our 24/7 nurse advice line and documents the refusal in TruCare, our care management system. As part of our process, we continue to monitor need to re-engage with members based on a change in condition or status through our predictive modeling analytics.

**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?**

**Coordinating Across Levels/Episodes of Care.** Our CC program supports members while in different levels of care and/or episodes of care with the goal of assuring the member receives needed supports and services to live in the most integrated community setting possible. Trillium’s Transitions of Care program is designed to ensure continuity of care across episodes of care. We ensure members transitioning to another setting or level of care are placed in settings consistent with their individual treatment goals, clinical needs, and informed choice. Our Care Coordinators coordinate across levels of care and with relevant providers to ensure members’ needs are met. The member’s Care Coordinator plays an active role in discharge planning working in collaboration with the member’s IDT, our Transitions Care Team, and Utilization Management (UM) staff to ensure successful discharge and transitions. Key activities include member contact prior to and post-discharge, warm hand-offs, development of transition plans, and coordinating and sharing information with the member’s IDT.

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**REDUCING READMISSIONS**

Trillium conducts post-discharge outreach to members identified as having a high risk for readmission and develops a transition plan. Members who received the intervention had 51% lower odds of readmission compared to those in the comparison group. Readmission rates decreased by 29% from 2017 to 2018.
Members Outside of Service Area. Trillium maintains responsibility for providing BH services if a member needs BH services outside of our Service Area due to lack of local availability. In this scenario, the member’s Care Coordinator monitors status and needs, engages with the treating provider on an ongoing basis, and plays an active role in discharge planning to ensure a smooth transition between service areas and episodes of care.

**k. How will Applicant manage discharge planning, knowing that good discharge planning begins from the moment a Member enters services?**

We require notification from inpatient facilities within 48 hours of admission and use ADT notifications to begin discharge planning at admission. Concurrent review staff monitor services and expected discharge dates daily and engage our Transitions Team in discharge planning for members with discharge needs and/or at high risk for readmission.

**Identifying Members at High Risk for Readmission.** We stratify member risk for readmission to effectively target resources using our Centelligence® predictive modeling system to quickly detect and intervene with at-risk members based on claims histories, lab results, demographics, and other factors, in addition to those methods to identify members in need of transition services. This process produces a risk score that will be reflected on our Daily Inpatient Census Report, enabling Transitions staff to quickly identify and contact identified high-risk members to address issues related to the readmission risk during their stay and through post-discharge. Readmission risk level drives which staff are involved in transition planning and follow up, as well as intensity of service.

**Designated Point of Contact.** Our successes in improving transitions across health care settings is supported by a team-based approach and includes early discharge planning and direct member outreach post-discharge to ensure effective coordination of care. Trillium will ensure that a designated point of contact leads the discharge planning process, whether it is a member’s assigned Care Coordinator or for those not currently in CC, a newly assigned Care Coordinator or Transitions Team. In all instances, there is one trained and experienced staff person supported by a team of experts that is accountable for ensuring all needs and contract requirements are met, including timely PCP notification, coordination with hospital staff and providers, timely and appropriate outreach and follow up after discharge, and documentation in our care management system.

**Post-Discharge Outreach Program.** We reach out to the member within 72 hours of discharge to provide assistance and verify that ordered services are in place and meeting the member’s needs and determine when a follow up visit should be conducted in the home. If the in-home services are not meeting the member’s need, the Care Coordinator or Transitions staff contacts the agency to discuss and resolve the issue. Support is provided to assist the member as needed to make transportation and schedule appointments. Other actions during this outreach include:

- **Review and reinforce all aspects of the discharge plan** and provide additional education on the member’s condition, needed follow-up, and the importance of adherence.

- **Medication reconciliation** (within 72 hours of discharge) by identifying all the medications the member is taking including over the counter medications, verifying if discharge prescriptions have been filled, determining how and when the member is taking the medications, and identifying potential drug interactions or duplications. We educate the member on the medications, how to take them, and red flags for contacting the prescriber as well as loop in the provider as needed. We also assist the member in obtaining medications, and communicate with our Pharmacy Department, the PCP, BH provider, or other treating provider(s) as needed regarding potential interactions, duplications or side effects.

- **Assist the member in developing an action plan** to prevent an avoidable ED visit or readmission; obtain provider input and share actions with the PCP and treating providers.
Assess safety of the home environment as needed to prevent injuries or impact to health status (in collaboration with the member’s AAA or APD case manager if they are receiving LTC services), such as determining the need for handrails in the bathtub or shower, loose rugs which may contribute to a fall, lack of air conditioning, or insufficient food.

Communicate with the member’s PCP and other treating providers to keep them informed of the member’s progress and any needs for additional services.

Connect members with a BH admission/BH need to peer supports, or other health related services, to encourage a robust recovery-oriented plan to support adherence to follow up.

l. What steps will Applicant take to ensure Care Coordination involvement for ICC Members while they are in other systems (e.g., Hospital, subacute, criminal justice facility)?

CC staff follow and support members across the continuum of care, including in person assessments and visits as indicated and permitted. CC staff will be supported by Trillium System of Care (SOC) Liaisons. A best practice in other markets, SOC Liaisons are highly-trained resources with specialized expertise to support effective, efficient coordination across entities, including other CCOs; Medicare Advantage plans; Indian Health Care Providers, Oregon State Hospital; wraparound services; AAA and APD care teams; Child Welfare, criminal justice systems; and community-based supports. They will serve as a consistent, single source of contact to help resolve system issues, identify and create solutions to fill gaps in the continuum of care, facilitate cross-systems protocol improvement, and drive practice transformation. In addition, our CC team works closely with Lane County BH which provides several community-based BH programs, including a Forensic Mental Health Program that serves individuals who have been diagnosed with a mental illness and are currently involved in the Criminal Justice System. We are actively establishing similar linkages and partnerships in our proposed Service Area.

m. Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement.

Staffing ratios and caseload assignments are systematically monitored weekly, monthly and quarterly by Trillium’s clinical management team to ensure compliance with OHA’s caseload ratio requirements. Our process for monitoring and managing caseloads for ICC, including members that are receiving ICC services and are enrolled in specialized programs, such as ACT and Wraparound services, includes monitoring of monthly caseload reports received from entities contracted to provide ICC services as a component of the specialized program. Trillium supervisors meet on a regular basis to review ICC cases, evaluate changes in member needs and adjust CC caseloads, as appropriate. We also recognize appropriate caseloads must reflect complexity of cases while remaining in compliance with OHA’s CC requirements. If a member is in a specialized program, we follow OHA’s CC standards and case load ratio requirements.

n. Which outcome measure tool for Care Coordination services will Applicant use? What other general ways will Applicant use to measure for Care Coordination?

The overarching goal of CC is to help members achieve the highest possible levels of wellness, functioning, and quality of life. We monitor data on an ongoing basis and conduct an annual evaluation to assess program effectiveness. We monitor utilization, potentially preventable events, cost, health outcomes, and compliance with evidence-based clinical practice guidelines.

Outcome Measure Tool. We utilize OHA’s CCO CC Metrics as our primary tool to measure and report on CC services, supplemented by other evidence-based tools including the Medicaid Adult Core set of health care quality measures for adult Medicaid enrollees. Trillium supports and welcomes the opportunity to work in collaboration with OHA, other CCOs, and

CARE COORDINATOR SATISFACTION

In 2018, Trillium members reported 100% satisfaction with the help they received from their dedicated care coordinator.
key stakeholders to develop and adopt a comprehensive universal outcome measure tool for CC services for use by all CCOs and systems of care providing CC services to OHP members. We believe this would allow OHA to capture and report on standardized and uniform data to inform CC policy priorities and opportunities.

**Other Methods to Measure CC Effectiveness.** We have systems and processes in place today to systematically track and monitor CC services, interventions and outcomes. Centelligence® is our proprietary decision support and health care informatics platform which provides capabilities for data collection, indicator measurement, analysis, and action. We capture and analyze data from internal, subcontractor, delegate, and external sources to evaluate the effectiveness of our CC program, including activities and processes, such as completion of the initial screening and assessment and closed loop referrals to community resources as well as improvements in clinical and health outcomes and appropriate utilization, such as ED visits and avoidable hospital admissions. In addition to outcomes, we use member satisfaction to assess program effectiveness, as measured through annual CAHPS surveys and Trillium CC surveys that measure member experience and satisfaction in terms of coordinated care and quality of life. We also monitor and measure provider satisfaction in terms of effectiveness of coordination and communication, including Trillium tools to coordinate care. We use this combined information to monitor performance expectations and effectiveness of our CC program and adjust strategies and processes on a program and individual member-level, as necessary.

**0. 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?**

We use TruCare, a fully integrated health management platform for UM and CC. All Trillium clinical staff and TBH staff have access to TruCare. We also leverage Centelligence® and our Provider, Member and Community Partner Portals to securely transmit member healthcare information to facilitate CC and holistic member care at the point of service. Information is presented in a format attuned to each user in the member’s IDT. We educate members, caregivers and providers on the availability of and how to access and use this data through our New Member Welcome Call and Packet, at each Customer Service contact point, in the Provider Manual, and during Provider Orientations and ongoing office visits.

**Supporting Providers through Information.** Providers are at varying levels of health information technology (HIT) sophistication, and we tailor our outreach and technical assistance efforts to reflect their individual needs. For providers, our integrated online tools include:
- A member panel roster with disease registry, special needs, and ED utilization flags
- Health record with PH, BH, medication history, and care gap notifications
- Access to the member’s ICP and assessment results
- Access to evidence based Clinical Practice Guidelines
- Access to PreManage to coordinate acute facility notifications

Centelligence® also integrates member demographics, and PH, BH, and pharmacy claims data, lab test results, and health screenings and assessments to produce reports on utilization, care gaps, and predictive health risk scores. Each month we share key indicators from this data in our Hot-Spotter Report, which we securely transmit to our providers. The Hot-Spotter Report includes over 40 data elements that support population health management including but not limited to: future risk (prospective relative risk scores), ED and inpatient visits, BH risk, last PCP visit, demographic information, indicators for conditions such as SPMI, ED visit probability, inpatient stay probability, and SDOH-HE ICD-10 codes such as Z55-Z65. Providers can use data elements such as “ER Visit Probability,” “Inpatient Stay Probability,” and “Maximum Impact Score” as opportunities to provide support, education, and build engagement with members. Trillium also uses the Hot-Spotter Report to guide development of population health initiatives and training.
Engaging Caregivers and Support Agencies. Engaging family, caregivers, case workers, and other authorized users is critical to a member’s whole-person care. The IDT collaborates with these individuals to enhance and develop a member’s natural supports by connecting these formal and informal supports to our portals, Trillium Resource Exchange, caregiver education, and ICP. With appropriate member consent, we offer informal caregivers access to the secure Member Portal, which enables access to information, communication, and interactive assists for caregivers who are often the most important "providers" supporting our members on a day-to-day basis. Authorized caregivers are able to view health information, view ICPs (if applicable), and communicate with Trillium staff via secure messaging, among other functions.

Interactive Tools for Members. Our Member Portal securely offers members the ability to access their information in a user-friendly manner. For example, members have access to their ICP, pharmacy service level information, and care gaps and can also search for a provider and exchange secure messages with Trillium staff. In addition, our members may opt to be notified of important additions to their records on the Member Portal, such as a care gap or health alert.

Ensuring Confidentiality Standards. We utilize technical capabilities, business processes, and policies to ensure adherence to HIPAA mandated rules and HIPAA Security and Privacy standards. This includes “sensitive” information as defined in 42 CFR Part 2, protecting the confidentiality of patient records with substance use and addiction information. In compliance with state and federal regulations, including appropriate approvals, web portal administrators have the capability to suppress, restrict user access, and/or appropriately share permissible BH information.

4. SEVERE AND PERSISTENT MENTAL ILLNESS (SPMI)
Trillium is intimately aware of and connected to the local needs and resources for individuals with SPMI. We believe that the most effective way to support members with SPMI is to link them to the right level of integrated, trauma-informed, and recovery-oriented BH care and Care Coordination (CC). We work closely with community providers, ensuring alignment with OHA’s Oregon Performance Plan and administrative rules.

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?

Collaboration with OHA and Other State Agencies. Trillium is closely connected with OHA and other state agencies across a broad range of initiatives designed to identify and address system improvements for members with SPMI. Our Medical Directors participate in OHA’s Quality and Health Outcomes Committee (QHOC), as well as the Oregon Performance Plan Committee on which OHA also participates. Trillium also partners with OHA’s Transformation Center to develop and refine PreManage workflows. In addition, Trillium continuously collects and analyzes data related to services for Members with SPMI. For example, as described in Att.11.A.4, we regularly review data related to the sufficiency of BH service access for members. When we identify issues, we share these findings with key stakeholders, including OHA and other state agencies, so that identified gaps and solutions can be disseminated across the State.

Collaboration with Other State-Funded or Operated Entities. Trillium’s Community Advisory Council (CAC) for each Region in our Service Area, which consists of Trillium members, County Health and Human Services Divisions and other state-funded system partners, will meet monthly. The CAC’s purpose is to ensure that community needs are addressed, including for adults living with SPMI. Trillium also today operates a Rural Advisory Committee (RAC) designed to help us remain responsive to rural consumers. The CAC and RAC will work together to provide input to the Trillium Board of Directors on community needs, while also helping to identify other stakeholders, including OHA, who need to be involved in treatment and system improvements.

The CAC and RAC also support the development and adoption of our Community Health Improvement Plan (CHP), which details our plan to address health disparities and member needs in our Service Area.
In addition to the CAC and RAC, Trillium’s recent CHP process for Lane Region included input from a range of stakeholders involved in supporting adults with SPMI, including but not limited to the National Alliance on Mental Illness (NAMI) of Lane County, South Lane Mental Health Trauma Healing Project, and other BH network providers. As another example, in 2015, Trillium’s Clinical Advisory Panel (CAP) initiated a SPMI Subcommittee to advise Trillium on the needs of this vulnerable and complex population that we will continue under CCO 2.0 for our Service Area. The Subcommittee meets monthly and consists of Trillium staff and providers serving adults with SPMI who focus on:

- Supporting providers to improve services and optimize care processes
- Identifying opportunities to direct funding to innovative cost saving programs
- Identifying opportunities to reduce overutilization of costly services
- Analyzing and improving quality performance measures/metrics

The SPMI Subcommittee is currently focused on aligning some BH system operations, which has culminated in an unanimously recommended tool, the Daily Living Activity Scale-20 (DLA-20), that is currently being considered by the CAP for system-wide implementation. Finally, as the Choice Program operator with Lane County Behavioral Health (LCBH), we collaborate with OHA and other state-funded entities like the Oregon State Hospital (OSH) and Secure Residential Treatment Facilities (SRTFs) through regular meetings (including the Mental Health Summit), coordination for member discharge, and information exchange. We also participate in the Lane County ED High Utilizers Community Collaborative and the associated Tri-County Collaborative. A diverse array of state-funded stakeholders participates in these groups, including Oregon Health Leadership Council, Oregon Health and Science University, CCOs, EMS, and providers like PeaceHealth, Springfield Family Physicians, and Options Counseling and Family Services. In addition, Trillium collaborates with the Community BH Consortium, which includes input from partners like Looking Glass, PeaceHealth, Laurel Hill, Center for Family Development, Willamette Family Services, Oregon Community Programs, SLMH, and LCBH, to identify community BH needs and opportunities for service improvement for adults with SPMI.

### b. How will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative 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?

Trillium tailors our services to meet the needs of each member, including those living with SPMI. This ensures that member care is coordinated with smooth transitions between appropriate levels of care as their needs evolve, no matter where a member is receiving BH services.

**Oversight and Care Coordination.** Our CC program is designed to provide oversight and support each member to receive the right level of services in the most integrated setting. For members whose primary need is BH, the assigned Care Coordinator is a licensed BH Clinician, who provides oversight and works in coordination with the IDT to support all identified needs, including those related to PH, BH, Oral Health, home and community-based services, Long-Term Care (LTC) services, and social determinants. The Care Coordinator serves as the member’s primary contact, coordinating member care and using our assessment and predictive modeling tools to tailor our support in coordination with the member and their supports. We use our comprehensive screening and assessment process to assess each member’s needs related to Activities of Daily Living (ADLs) to inform the need for services like Mental Health Rehabilitative Services, Personal Care Services and Habilitation Services. For members that are receiving DHS-funded LTC, we work closely with the member’s AAA or APD case manager to ensure access to services in the most integrated setting possible. Our CC Team
supports members to access these non-Medicaid services in close collaboration with the member’s providers by sharing available resources, supporting member eligibility applications, and coordinating with the member’s supports, such as Personal Care Assistants. On an ongoing basis, the member’s Care Coordinator engages local resources in the IDT based on member needs, including those providing 1915i and related supports, such as the Laurel Hill Center and Shangri-La. As described in Att.11.E.3, the IDT supports members to develop and monitor an individualized care plan (ICP), which reflects member goals and includes covered and non-covered services. Trillium’s secure, web-based Provider and Community Partner Portals support our CC activities with each member’s IDT (see Att.11.E.3). To support collaboration with non-Medicaid service providers serving our members, we will offer our roles-based Community Partner Portal to provide authorized users, including providers of Mental Health Rehabilitative Services, Personal Care Services and Habilitation Services, access to shared member information. Using this portal, users can check member eligibility, view member risk alerts and the ICP, and submit and view notes and documents.

**Transition Planning and Management.** Through CC, Trillium works closely with BH providers and partners to ensure that members are placed in the most integrated, community-based setting consistent with their treatment goals, clinical needs, and informed choice. When a Care Coordinator identifies that a member’s needs related to BH services have changed, they work with the member’s IDT to engage the member in a re-assessment and review/modify the ICP, including supporting a warm handoff, described in Att.11.B. We track member transitions using EDIE and PreManage, as well as our proprietary Centelligence® platform, which combines a range of data to calculate member risk, allowing us to conduct targeted follow up to members with SPMI who have escalating needs. Under the CCO 2.0 program, we will develop new cohorts within PreManage for specific populations, including individuals with SPMI that would further allow us to track and manage care transitions. As a new enhancement under the CCO 2.0 Program, we will implement a *Schizophrenia Inpatient Model (SIM)* to support transitions for members with schizophrenia who are at an increased risk of relapse that may result in mental health-related ED visits and hospitalizations, such as failure to fill medications.

Prior to a member’s transition, Trillium uses our Transitions of Care Assessment tool to evaluate the member’s PH, BH, Oral Health, LTC, SDOH-HE, and other needs. Our transition planning process, described in response to Att.11.E.4.i, includes assessment of what a member needs to be served safely in the community, including all post-discharge needs, which are captured in a Transition Plan. Our approach considers each member’s barriers and social context (e.g., stable housing, transportation access) in coordination with each member’s clinical needs, and we provide intensive support before, during, and after transitions.

In addition, Trillium’s Utilization Management (UM) team works in close coordination with the CC Team to support all members with SPMI who are transitioning to a higher level of care, providing ongoing monitoring of claims and encounter data in IDT meetings as needed. For members with complex needs, including those with SPMI, Trillium engages in weekly Interdisciplinary Care Team Conferences, which includes Care Coordinators, AAA and APD case managers, Psychiatrists, Registered Nurses, UM, Oral Health and Pharmacy Specialists, and other representatives (e.g., housing) based on the member’s needs. The goal of this conference is to identify potential interventions to assist the member, identify and address care gaps, and receive updates on the member’s progress toward recovery. Prior to the conference, the CC submits a comprehensive overview of the member’s holistic needs and strengths, which the other participants review and come prepared to discuss. Following the meeting, we document all next steps in a comprehensive Action Plan, which includes action items and follow ups, person(s) responsible, and associated completion dates, which are all integrated into the member’s ICP for ongoing follow up.
c. How will Applicant ensure Members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing Member’s housing needs?

Trillium supports members with SPMI to find appropriate housing, including Supported Housing, in the most integrated setting that is consistent with each member’s self-identified goals, clinical needs, and informed choice. Our assessment process assesses members’ housing instability, and our Care Coordinators are trained to address each member’s housing-related needs in collaboration with our community partners. All members discharged from acute BH settings receive a Housing Assessment, which is included in our TOC Assessment and documented in the member’s discharge plan and ICP. When a housing need is identified, Trillium accommodates member’s geographic and housing preferences as possible. For the CCO 2.0 Program, our Housing Specialist will support our CC Team in identifying appropriate housing options for members.

Trillium is intimately connected to the Lane County Coordinated Entry process. When a member is identified as having a housing-related need, the CC Team will connect the member to a Coordinated Entry System provider, such as Willamette Family, that can initiate the Continuum of Care (CoC) assessment process. Once the assessment is completed and the member is placed on the Centralized Wait List if eligible, Trillium’s CC Team will work with the member and IDT to connect with other resources, including those related to Emergency Housing/Shelter (e.g., St. Vincent de Paul, ShelterCare) and Transitional Housing (e.g., Eugene Mission, SPONSORS, Central City Concern, Cascadia Behavioral Health, etc.). If the member is not eligible for CoC housing, Trillium facilitates a connection to other affordable housing options, including Cornerstone Community Housing and Homes for Good covering the Lane Region. To support this identification process, we leverage available tools such as OHA’s Affordable Housing Inventory list, and as part of the CCO 2.0 Program, we will use Trillium Resource Exchange, an online tool to help us to identify, refer, and follow-up with members in need of housing and other supports. To enhance these processes, we are also connected to the statewide Homeless Management Information System (HMIS). For the Tri-County Region, our Housing Specialist will map each county’s resources, outreaching to the local Housing Coordinators to engage with the Coordinated Entry process. For example, we have letters of support (LOS) with Home Forward, the Multnomah Housing Authority; Washington County Housing Services, and Innovative Housing Inc. to develop innovative solutions to addressing housing in the Portland area. We will develop and lead a pilot program with the Washington County Housing Services to develop integrated housing and permanent supportive housing services approach and model that we will replicate across our proposed Service Area.

d. 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?

We employ person-centered planning strategies to ensure services, supports and interventions (including Supported Housing) are consistent with each member’s identified preferences, treatment goals, clinical and social needs and informed choice. As part of the care planning process, Care Coordinators assist the member with identifying strategies for accomplishing their goals and help them move them toward engagement, treatment, and recovery.

Supported Housing and Related Community Initiatives. Trillium partners with community providers to support members with SPMI to obtain housing, including Supported Housing, like ShelterCare, wherever possible. Today, we maintain an up-to-date listing of housing and Supported Housing resources in our Service Area, which will be enhanced by Trillium Resource Exchange, described above. Trillium’s key stakeholder partnerships that support members with SPMI to obtain housing/Supported Housing, which we will seek to expand and adapt in the Tri-County Region, include the following:
Frequent User System Engagement (FUSE): Provided with Lane County, ShelterCare, the Laurel Hill Center, and other community partners and will be expanded to the Tri-County Region. FUSE supports people who may be homeless and frequently use resources such as EDs and jails. Housing navigators and community partners work together to locate and engage individuals and to provide ongoing case management and support obtaining and maintaining stable housing. Trillium provides funding for FUSE ($200,000 between 2017 and 2018) and regularly meets with key FUSE stakeholders to discuss system improvements. In its pilot year, FUSE participants had a 50% decrease in average healthcare costs, with significant increases in housing stability.

Crisis Assistance Helping Out on the Streets (CAHOOTS): Community partnership with DHS, EMTs, law enforcement, White Bird Clinic, and ShelterCare that works to de-escalate individuals experiencing a BH crisis, connecting them to treatment and other resources including assistance obtaining stable housing using a Housing First approach. Each CAHOOTS team includes a medic and a mental health crisis worker. Coordination with CAHOOTS is facilitated by our Crisis Care Coordinator (CCC) (see Att.11.A.10).

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?

Trillium supports access to ACT services for all eligible adult members with SPMI in alignment with the goals of the OPP and all pertinent OARs. Today, we contract with the Laurel Hill Center and South Lane Mental Health (SLMH) to provide ACT to eligible members. We meet with these providers quarterly, monitoring their Universal ACT Referral and Tracking Forms as well as their ability to deliver ACT services with fidelity and to maintain caseload ratios. In the Tri-County Region, we have established relationships with ACT providers such as NARA Totem and LifeWorks NW and will seek to contract with all ACT providers using the same processes for ongoing collaboration and oversight. Our CC Team ensures all members with SPMI receive an assessment for ACT eligibility in collaboration with the local Single Point of Contact (SPOC), and as needed, we support the completion of the Universal ACT Referral and Tracking Form as part of the referral process. Once an individual is deemed eligible, Trillium works with our contracted ACT providers to share comprehensive information about the program, including a description of ACT, an explanation of the role of the ACT team, and ways that ACT can support a member.

Trillium understands that no individual should be without ACT services and on a waitlist for more than 30 days, and since our inception as a CCO, we have never had a waitlist for ACT. We support the creation of additional ACT capacity within our existing Service Area as needed to serve all eligible members, working with OHA and the Oregon Center of Excellence in ACT (OCEACT) to address identified gaps in the system. For example, we supported the Laurel Hill Center to develop their ACT program in Junction City, expanding our Service Area’s capacity to serve more individuals, including those transitioning from OSH.

f. How will Applicant determine (and report) whether ACT team denials are appropriate and 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?

Trillium reviews all denials of ACT services to ensure that the denial was based on established evidence-based medical necessity criteria, comprehensively recorded and compiled for accurate reporting, and in alignment with Notice of Adverse Benefit Determination. Trillium maintains open communication with our network ACT providers, and we meet with them formally on a quarterly basis. This structure allows us to receive rapid notifications about ACT denials affecting our members and to collaboratively ensure access to ACT services. When a denial is deemed inappropriate, Trillium will work with OHA and the ACT provider(s) to identify and alleviate the barriers to serving the member. For members who have appropriately received a denial for a
particular ACT team but who are eligible, Trillium will find or create a team to serve the member using our process for ACT capacity expansion described above.

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?

Trillium’s CC Team, in partnership with our contracted ACT providers, engages with all eligible members who decline to participate in ACT to identify and overcome barriers to participation. All of our Care Coordinators are trained in the evidence-based approach of Motivational Interviewing and provide ongoing outreach to eligible members who decline ACT. Motivational Interviewing enables us to meet members where they are and engage them in services that are aligned with their self-identified goals. As described in Att.11.E.3.h, our CC Team also uses Behavior Change Theory, Trauma Informed Care, and Strengths-Based training, through which we assess members for readiness for change and design subsequent outreach and interventions to help engage members in services like ACT. In collaboration with the member’s IDT, we can also connect members to Traditional Health Workers (THWs), like Peer Support Specialists, who work with the member to engage them in ACT and resolve identified barriers to participation. On an ongoing basis, Trillium documents in TruCare all efforts to provide ACT to members who initially refuse it, including how we accommodate their concerns.

h. How will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include Care Coordination?

If a member continues to decline ACT, Trillium works with our network providers to provide alternative evidence-based intensive services, including ICC (see Att.11.E.3). In addition, members who decline ACT often receive intensive care management services from a provider, who works closely with the Trillium Care Coordinator to ensure member safety, stability and appropriate treatment. Other community-based programs to which we connect these members (based on their needs) also include:

- **Lane County Human Services Dovetail Program.** Trillium contracts with Lane County’s Dovetail Program to support members to achieve their social, health, and economic goals. The program emphasizes identifying and coordinating services for members with complex needs. To be eligible, members must have unmet needs in multiple domains, including social (e.g., unstable living situation); health (e.g., overutilization of ED); and economic (e.g., financial instability).

- **ColumbiaCare Hourglass Program.** Trillium contracts with the Hourglass program to serve adults in Lane County who need short-term, mental health crisis assessment and stabilization. Hourglass staff work with community agencies to provide intensive case management to stabilize the member and ensure appropriate admission to the program, providing a warm hand-off to BH providers and services for aftercare.

- **Intensive Outpatient Community BH Treatment.** Trillium contracts with other network BH Providers, including PeaceHealth, to offer evidence-based BH treatment and services. In addition, LCBH provides several community-based BH programs, including a Forensic Mental Health Program that serves individuals who have been diagnosed with a mental illness and are currently involved in the Criminal Justice System. Members who decline ACT can receive these types of community-based BH services, in combination with ICC, until they are able to be engaged in ACT or their needs become less acute.

Similar to our approach we have taken into the Lane Region, we will work with BH providers in the Tri-County Region to provide alternative evidence-based intensive services if a member declines participation in ACT.

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 an SRTF, to a placement in the most integrated Community setting appropriate for that person?

Trillium collaborates with the Choice Program, described in Att.11.E.6, to work with the SRTF in Lane County, ShelterCare, to expeditiously move civilly committed adult members with SPMI who no longer need that level
of care to the most integrated setting. Prior to a member’s transition, Trillium, in collaboration with Choice, uses our TOC Assessment to evaluate PH, BH, Oral Health, LTC, SDOH-HE, and other needs, providing a holistic assessment of what a member needs to be served safely in the community. We use open-ended questions (i.e. Where do you want to live?) to encourage members to think about their community living preferences. Based on the assessment, Trillium’s CC and UM teams work with each member, the SRTF, and the member’s IDT to address barriers to community reintegration, connecting the member to appropriate services and supports and educating the member about all available options. The member’s ICP includes the full range of covered and non-covered services, such as Supportive Housing and peer support services, ensuring services are in place prior to the member’s transition. The Care Coordinator also assesses any caregiver needs, including training, resources, and respite services, as appropriate. Following the member’s transition, the CC Team continues to work with the IDT to assist the member with their needs and access appropriate care.

**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?**

Trillium understands that homelessness and housing instability is a growing issue in our proposed Service Area, and that this issue is significantly exacerbated among members with SPMI. We work with housing providers and housing authorities to assure sufficient Supported Housing and housing services for members with SPMI. For example, in partnership with Homes for Good, Trillium is working to develop a 51-unit Supported Housing complex in Eugene. *The Commons on MLK*, slated to open in the fall of 2020, will utilize a Housing First model to provide chronically homeless individuals with SPMI with stable housing and 24/7 supports. *Trillium has committed $500,000 to this development.* Moving into the CCO 2.0 program, we will utilize available data, including that from HMIS and local Point in Time Counts, to inform how to target our capacity development efforts in alignment with the needs of our Service Area. In addition, as described in Att.10, we will utilize a portion of our SDOH-HE funding to support the expansion and enhancement of housing capacity, including Supported Housing, as one of our SDOH-HE spending priorities. We also participate in several cross-sector housing-related work groups, such as the Lane County CoC’s Poverty and Homelessness Board (PHB), which has a primary goal of “increasing the availability and access to coordinated, supportive housing, shelter, and services.” Specifically, the PHB plans to coordinate with agencies in Lane County, including Trillium, to develop an additional 600 units of supportive housing for chronically homeless people, including those with mental illness. Trillium, in collaboration with LCBH, also committed to supporting the development of assertive engagement “wrap around” services for 150 scattered site Housing First units by the end of 2019. Finally, we will implement Social Health Bridge, a new Centene subsidiary in Oregon. Social Health Bridge is a first in the nation effort to move from grant funding for community-based organizations to sustainable funding from the health sector. The first application in Oregon will be with Oregon Wellness Network (OWN). Similar to our approach in Lane County, we will work with Housing Authorities and Housing Providers, such as Portland Housing Bureau Home Forward, Housing Authority of Clackamas County, Washington County Department of Housing Services, Central City Concern, Human Solutions, Innovative Housing, etc. in the Tri-County Region to assure supportive housing and support services are available to members with SPMI.

**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.**

In partnership with our network providers, Trillium is committed to monitoring the quality of care and provision of acute services for members with SPMI, ensuring appropriate coverage and service delivery in alignment with each member’s needs. Through our extensive governance committee and workgroup structure, we collaborate
with key stakeholders across our Service Area to identify and address coverage issues for members with SPMI. Related to Acute Psychiatric Care, our TOC planning process, described above in Att.11.E.4.i, engages all individuals being discharged from an acute psychiatric care facility with a TOC Assessment and “warm handoff” to community providers prior to discharge. This process is designed to meet each member’s holistic needs to reduce the recidivism of members being discharged from these facilities. For ED visits, as described in more detail below in response to Att.11.E.5, we track and respond to member (re)admissions to the ED through programs like our ED Reduction Initiative and connection to community-based resources. We also participate on the ED High Utilizers Community Collaborative and ED Utilization Workgroup, both of which are focused on supporting system-level initiatives to reduce ED utilization. Finally, Trillium encourages the use of Peer Delivered Services (PDS), and we collaborate with numerous providers who offer PDS as part of member care. Our CC Team ensures that members are informed of their PDS benefit, educating members and providers where and how to access PDS in the community, including information in the Member Handbook/Provider Manual. We also ensure PDS are utilized as part of the provision of other BH services, such as ACT and crisis services.

5. EMERGENCY DEPARTMENT

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 the Contractor 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.

Trillium has a long history of implementing initiatives to support the reduction of ED visits for members with high ED utilization rates. We work with OHA, our local hospital systems, and CMHPs to meet the needs of members in the community, including reducing ED (re)admissions, reducing ED lengths of stay, and ensuring connection to community-based services following an ED visit. Our CC policies address the development of a management plan for members with high rates of ED (re)admissions, including engaging the member in CC or with our Transitions Team, and we continuously refine these processes based on the needs of our membership and Service Areas. We convene an ED Utilization Workgroup, a subcommittee of the CAP that focuses on continually improving processes related to members who frequently access EDs. We also participate in Lane County’s ED High Utilizers Community Collaborative, as well as the associated Tri-County Collaborative, both of which are focused on expanding data exchange to support patient management and reduce ED utilization through tools like PreManage.

Reducing ED Admissions and Readmissions. Trillium utilizes a multi-pronged approach to identifying members who need support to reduce their ED utilization, which has resulted in a nearly 20% decrease in avoidable ED visits between 2016 and 2018. Our CC Team receives a monthly ED High Utilizer Stratification Report that flags members with four or more ED Visits in the past 12 months, stratifying them across three categories for targeted follow up, including members who visited the ED inappropriately; members who used the ED due to exacerbations of their chronic medical/BH conditions; and members with highly complex health needs. Our monthly Transitions of Care Report identifies members with 7- and 30-day readmissions, and we also utilize PreManage to identify and track members within risk cohorts, and communicate with providers when a patient event, such as an ED visit, occurs. For the CCO 2.0 Program, we will enhance our use of PreManage by developing a cohort to flag members who have two or more readmissions to an ED in the last six months. Our secure Provider Portal includes an ED high-utilizer flag, which alerts the IDT if a member has three or more ED visits in 90 days. To support providers to identify and engage members who are at risk of
future ED utilization, we share our monthly *Hot-Spotter Report*, which includes member clinical and social information and prospective health risk scores and will include avoidable ED visits. As members are identified as being in the ED, our CC Team engages them in an *ED Diversion Assessment*, which includes their Impact Pro Risk Score, reason for the ED visit, frequency of ED visits in the last three months, and connectivity to their PCP and providers like BHHs. Care Coordinators also provide the member with education about our Nurse Advice Line and other community alternatives to the ED, and our CC approach considers each member’s clinical needs, as well as those related to SDOH-HE such as housing and transportation, to help to remove barriers to accessing community services. We work to engage these members in ongoing CC/ICC, described in Att.11.E.3, as well as in the following initiatives (based on their needs):

**ED Reduction Program.** Our ED Reduction Program targets members with at least three ED visits over the last 30 days, who we support through a dedicated ED Reduction Team, that includes the member’s Care Coordinator, RNs, and BH and other Specialists based on the member’s needs. The team outreaches to each identified member within 72 hours to (re)engage them in community-based services. As a result, we have realized a 20% decrease in ED utilization among program participants from January to November 2018.

**Intensive Community Care Management (ICCM) Program.** In January 2019, Trillium began partnering with the Center for Family Development and Springfield Family Physicians to administer ICCM. ICCM engages high-cost, complex members living with at least five chronic PH conditions and one BH condition, a vast majority of whom have high rates of ED utilization. The multidisciplinary ICCM Team assists the member at all levels of care, identifies and addresses barriers to service, enlists auxiliary and specialty services, and coordinates partnerships to ensure integrated and whole person care.

**Fast Pass Program.** Trillium, in partnership with LCBH and other providers, operates a Fast Pass Program, which supports individuals with serious psychiatric needs to receive expedited access (within a week or less) to necessary BH services in the community following an acute incident, including an ED visit. This program includes ICC, as well as connections to support services in the community like PDS and Non-Emergent Medical Transportation (NEMT) to support appointment access. In addition, in April 2019, Trillium will initiate an expanded partnership with PeaceHealth to provide intensive stabilization services for high need members. Services include psychiatric care, individual/group therapy, and case management. The goal is to divert members from higher levels of care, including preventing future ED utilization. Other programs that support reductions in ED use are described elsewhere, including the Schizophrenia Inpatient Model (SIM) (Att.11.E.4.b), FUSE and CAHOOTs (Att.11.E.4.d); Dovetail and Hourglass (Att.11.E.4.h); and the Choice Program (Att.11.E.6). For highly complex members, who often have high rates of ED utilization, we support coordination during Interdisciplinary Care Team meetings (Att.11.E.4.b).

**Reducing ED Length of Stay.** Trillium uses EDIE and PreManage admission and discharge data to analyze ED lengths of stay (LOS). Today, the EDs in our Lane Region have an average LOS of 2.28 hours, with less than 0.1% of ED visits lasting longer than 23 hours. However, we know that these averages do not tell the whole story, with subpopulations like individuals who are homeless and youth with SED having much longer ED LOS. We will monitor this data (both in aggregate and by cohorts), and our Provider Relations Team will work with the hospitals to develop a remediation plan if an ED has many stays longer than 23 hours. Today, we promote short ED LOS for our members using several technology tools that disseminate real time alerts when a member arrives at the ED, described above. When our CC Team receives an alert that a member is
in the ED, they coordinate with the member’s IDT to engage the member in community-based services after their acute incident has been stabilized. Where appropriate, Trillium supports connections between the ED and community providers to facilitate member discharge and minimize ED LOS. In addition, Trillium is supporting LCBH and PeaceHealth to initiate a procurement process to identify an ED Diversion Program provider that can support youth with BH needs. Under the established scope, when youth presents to the PeaceHealth University District or Riverbend EDs, the ED Diversion Team will respond within two hours to provide onsite support.

**Ensuring Connection to Community Services following ED.** Trillium collaborates with our network providers to ensure members with SPMI have appropriate connections to community services after an ED visit, including those related to clinical and SDOH-HE needs. In addition to initiatives like ICCM and FUSE that support connection to community services, our CC Team works with local providers to ensure that all members with SPMI have a follow-up visit through ICC or with a provider, such as their BHH, within three days of discharge. We also support the use of HIT tools, including a Multi-Payer Market-Driven Portal that supports providers to identify and manage their Trillium Medicaid patients’ care gaps. In addition, Trillium contracts with PeaceHealth to provide transition services to our members through their Transition Team, which helps link members to community resources following a psychiatric ED visit. This program provides intensive case management, therapy and community supports, including assistance establishing income through employment or public benefits and stable housing.

**6. OREGON STATE HOSPITAL**

**a. How will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI?**

Trillium works with Lane County’s Choice Program to coordinate with Oregon State Hospital (OSH) related to member discharges for those who will be enrolled with Trillium. Trillium has taken over management of the Choice Program with LCBH, and the Choice Care Coordinator and Trillium Care Coordinator meet weekly to discuss highly complex members who are being discharged from OSH. Today, Choice currently serves approximately 180 Trillium members. Choice coordinates community services, including clinical and SDOH-HE, for clients transitioning from OSH, partnering with Trillium’s Care Coordinators and the member’s IDT. This includes, in collaboration with Trillium, meeting the member at OSH for IDT meetings prior to discharge when notification of discharge is received. In our proposed Service Area, Trillium is working to establish MOUs that include provisions related to coordination of OSH transitions with each of the CMHPs. We will engage members who are discharged from OSH but not enrolled in Choice in ICC. Through these efforts, Trillium will ensure that when an individual is determined Ready to Transition, they are discharged rapidly. For the CCO 2.0 program, we will designate an OSH Liaison who will further support these member transitions. We actively partner with OSH as part of the Mental Health Summit, a collaboration that also includes LCBH, the Choice Program, crisis services, BH providers, and representatives from local jails, police, and court systems. Through the Summit, we work to identify opportunities to collaboratively support individuals returning to the community from OSH. Through this and other forums, we will learn from the effective work being done in the Tri-County Region. We also participate on the OSH Rules Advisory Committee, which provides community input on the development and refinement of OSH rules when needed. Our support of OSH discharges is provided in accordance with all applicable OARs and the goals in the OPP. To evaluate the effectiveness of our efforts related to OSH discharges, Trillium will work with OSH and Choice to collect and analyze data on the following metrics to quantify the percentage of members at OSH, that once determined Ready to Transition, are: discharged within 20 days; discharged into ACT or the Choice Program; discharged to SRTFs; or admitted to EDs, ACPF, OSH, or jail (or who pass away) within 30 days and 180 days of discharge.
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?

Trillium works with our community partners, including the Choice Program, to support OSH discharges that are consistent with the individual’s treatment goals, clinical needs, and the individual’s informed choice, geographic preferences, and housing preferences. In collaboration with Choice, Trillium works with the member, family/caregivers, attending physicians, and other community-based providers to develop a transition plan, which includes a Crisis Response Plan, to support successful transition back to the community. In coordination with Choice, we support members to access BH treatment that meets their needs, including connecting them to treatment providers with whom they were engaged prior to OSH admission if desired and appropriate. In close collaboration with the Choice Care Coordinator, we support the member by scheduling timely follow-up appointments with BH, PH, and Oral Health providers, ensuring prescriptions are filled, and arranging for other community supports such as housing and transportation.

Following discharge from OSH, Trillium will support the member’s primary Care Coordinator (often staffed by Choice) to initiate an assessment of the member’s wellbeing and connection to services, verifying that post-discharge needs have been met or addressing unmet needs. Moving forward, Trillium understands that we will assume increasing accountability for members who are civilly committed and are referred to and enter OSH. We look forward to working with OHA, OSH, and our community partners like Choice to determine how we, as a CCO, can expand and enhance our support for members discharging from OSH.

7. SUPPORTED EMPLOYMENT SERVICES

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?

We are committed to supporting individuals with BH conditions and intellectual/developmental disabilities (IDD) to attain and maintain competitive employment, through Supported Employment and related services, working with our partners to engage members in alignment with OARs and the Oregon Supported Employment Center for Excellence’s best practices.

**Engaging Eligible Members in Supported Employment.** We collaborate with the DHS Office of Vocational Rehabilitation (VR) and its associated local branches within our Service Area, as well as community-based Supported Employment providers, such as Laurel Hill Center, Sequoia and SLMH, to engage eligible adult members in Supported Employment. We are working to establish agreements with each Supported Employment provider in our Service Area prior to the start of the CCO 2.0 Program. Our Care Coordinators are trained to engage members in discussions about employment, including their motivation to work, and we support providers to have these discussions with members as well by providing them with information about how to connect members to a Supported Employment Program. Our Care Coordinators use Motivational Interviewing to engage members in employment services related to their preferences and goals, meeting each member where they are and increasing their motivation to work as appropriate to their needs. If a member expresses an employment-related goal, we integrate that goal into the member’s ICP, and in collaboration with our community partners, support them to submit an application to VR and, if eligible, connect to an appropriate Supported Employment program. When desired by the member, the Supported Employment provider can be engaged as an active participant in the member’s IDT. We will utilize the **Trillium Resource Exchange** to support referrals to Supported Employment and related resources, including supporting closed loop referrals to employment resources through appointment attendance alerts. To ensure these supports are impactful, Trillium will collect and report on (1) the number of individuals referred to and receiving Supported Employment and (2) the number of individuals employed in Competitive Integrated Employment.
8. CHILDREN’S SYSTEM OF CARE

Applicant will fully implement System of Care (SOC) for the children’s system. Child-serving systems and agencies collaborating in the SOC are working together for the benefit of children and families.

Trillium has extensive experience supporting a functional children’s SOC within the Lane Region, including all required components of the SOC Wraparound model and governance structure. For CCO 2.0, we will continue to work with our community partners in the Lane and Tri-County Region to ensure the implementation of a SOC that serves children living with complex BH needs, informed by established SOC values. Our SOC work is centered around the vision that children and families have a supportive community and sufficient resources to be healthy, safe, resilient, and thriving. Within our proposed Service Area, Trillium will connect and collaborate with each county’s established SOC structure, supporting their ongoing growth, dedication, and commitment to their communities. As part of this approach, we will leverage lessons learned from our existing work in Lane County, which has established a track record as a leader based on our SOC governance structure and outcomes. To support SOCs across our Service Area, we will consider developing processes to share best practices and successes, such as a SOC learning summit or other regional communications.

a. What Community resources will Applicant be using or collaborating with to support a fully implemented System of Care?

Trillium will collaborate with a variety of community resources and stakeholders in our Service Area such as education, child welfare, public health, primary care, pediatric care, juvenile justice, mental health and SUD treatment, I/DD services, as well as youth living with BH conditions and their family members. For example, in our Lane Region, we collaborate with the following partners on the SOC Executive Council:

- Oregon Family Support Network (OFSN)
- Direction Service
- United Way
- Centro LatinoAmericano (CLA)
- Early Childhood Cares (ECC)
- Youth ERA
- Department Human Services (DHS)
- Lane County Behavioral Health (LCBH)
- Lane County Developmental Disabilities (LCDD)
- Lane County Human Services
- Lane Education Service District (ESD)

We also work closely with Portland State University’s (PSU) SOC Institute, which provides statewide training and related resources for the SOC and Wraparound Initiative (SOCWI). We attend PSU’s quarterly SOC meetings and disseminate the information to our Committees. Recently, we engaged PSU to come to Lane County to conduct SOC trainings with our SOC Committee Co-Chairs. For our Region in our proposed Service Area, we will coordinate with PSU to assess each local SOC’s infrastructure and strengthen it in partnership with local SOC stakeholders. We also collaborate with the Children’s System Advisory Committee (CSAC), sending them details about SOC barriers for additional discussion and resolution. We remain in close coordination with OHA, disseminating their SOCWI resources to our community partners and sharing information about our SOC successes and challenges with OHA.

b. Please provide detail on how Applicant will utilize the practice level work group, advisory council, and executive council.

As an existing CCO, Trillium already supports an effective SOC Governance structure in Lane County, and we will adapt our knowledge from Lane County to the SOC structures in our proposed Service Area, supporting and strengthening their existing infrastructure, including governance groups that will hold similar roles to those listed below. Each group includes two Co-Chairs that are elected through a nomination and election process. Co-chairs serve for a period of two years, and they are responsible for leading SOC meetings. Co-chairs from all groups meet monthly to discuss upcoming meetings and barrier submissions.
The **Practice Level Workgroup** identifies and addresses systemic Wraparound practice barriers. Membership is by recommendation to fill voids in areas of youth and family resources. Our Referral Review Committee, which is embedded in this Workgroup, also reviews and makes recommendations on Wraparound referrals and works to address barriers to service access, ensuring the needs of referred youth and families are addressed through connections to services for which they are eligible in alignment with their preferences. The Workgroup also recognizes SOC Providers for their delivery of effective interventions. Today, our Practice Level Workgroup consists of Trillium representatives; families from OFSN’s Family Champion’s program; Family/Youth Partner Supervisors; Wraparound, BH, and other youth-serving providers; DHS Child Welfare; LCDD: Early Childhood Cares; Lane ESD partners; and Lane County Juvenile Justice. We are pursuing additional partnerships with stakeholders from rural areas, law enforcement, primary care, OHA, Oregon Youth Authority (OYA), identified youth, Court Appointed Special Advocates (CASA), and Lane County Public Health. Members of our **Advisory Council** advocate and advise the Executive Council on youth/family policy development, expansion of resources, financing, and implementation of programs. They provide overall oversight for SOC outcomes. The Advisory Council consists of mid-level Trillium representatives; BH and youth-serving providers; rural providers; LCDD; Early Childhood Cares; DHS Child Welfare; Lane ESD; Lane County Juvenile Justice; and youth and family partners, including those from the OFSN’s Family Champion’s program. To support our SOC Advisory Council, we are pursuing additional partnerships with stakeholders from rural areas, law enforcement, primary care, OHA, Oregon Youth Authority (OYA), identified youth, Court Appointed Special Advocates (CASA), and Lane County Public Health.

**Trillium’s Executive Council**, whose membership is outlined above, is responsible for directing and leading the expansion of SOC implementation across our Service Area. Membership is by invitation, as the Council identifies possible youth-serving Executives and Community Leaders that will provide critical knowledge, support and advocacy for the SOC. In addition to setting the strategic direction for our SOC, the Executive Council works to remove barriers at the policy and finance level, informing the State Implementation Team of unresolved SOC barriers and recommendations. They review quarterly Wraparound participation reports and the use of Flex Funds, and they promote cross-sector SOC linkages. In addition to those listed above, we are working to engage other Executive Council stakeholders, including rural stakeholders, BH providers and PCPs, and family and youth members.

**c. How does Applicant plan to track submitted, resolved, and unresolved barriers to a SOC?**

Anyone in the community can submit a barrier they are experiencing to the SOC. The Practice Level Workgroup supports the identification and reporting of SOC barriers as they arise. Once a systemic barrier has been identified, the individual who is reporting the barrier is supported by one of the Practice Level Workgroup representatives to complete the SOC Barrier Submission Form. The form includes documented details about the barrier and its impact on youth/families; barrier themes (e.g., roles and responsibilities, system collaboration) and timeframe; as well as the submitter’s recommendations related to addressing the identified issue. Once completed, the Form is submitted to Trillium’s SOC Administrative Assistant, who adds the information to our SOC Barrier Tracking Spreadsheet. The SOC Barrier Tracking Spreadsheet is reviewed at the subsequent Practice Level Workgroup meeting, which documents its discussion on our SOC Barrier Submission Follow Through document. This document includes the recommended action(s) and next steps for each barrier. Following the discussion, the information is documented in our Barrier Tracking Spreadsheet.

*d. What strategies will Applicant employ to ensure that the above 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?*

We have comprehensive SOC involvement from stakeholders representing youth, families, DHS Child Welfare and I/DD, special education, juvenile justice, and BH. We are currently working to engage OYA in our SOC Governance groups. Today, the Lane County Youth Services Division Manager participates on our Executive
Board and brings information about OYA’s relevant initiatives to the SOC. Trillium also participates on the Public Safety Coordinating Council’s Juvenile Committee, along with representatives of OYA, the Assistant District Attorney, Lane County Circuit Court, CASA, and other key stakeholders, which allows for an additional forum for collaboration.

To ensure representation of children and families, we are working towards achieving youth and family participation of at least 51% as part of each of our governance groups. We are strategically working to ensure youth and families are able to meaningfully contribute across all levels of the SOC. In support of these activities, we are partnering closely with Youth ERA and OFSN, who will provide training for our SOC Committees in May 2019 about meaningful involvement of youth and families, including facilitating a welcoming environment. Both agencies will also support our connection to youth and family representatives who are interested in participating across our existing and proposed Service Area, as they currently operate statewide. We will also ensure our SOC meetings are held at times that ensure meaningful family and youth participation, including mornings, evenings, and weekends.

9. WRAPAROUND SERVICES

Applicant is required to ensure Wraparound Services are available to all children and young adults who meet criteria.

Trillium coordinates with our community partners and SOC structure described above to support the delivery of high-fidelity Wraparound services across our Service Area. Since supporting the initiation of Wraparound in Lane County in 2014, we have collaborated with our community partners to serve all eligible children and youth. Today, we contract with Direction Service and CLA, both of which provide culturally competent, high fidelity Wraparound services to children and families. We also work with two other community providers – OFSN and Youth ERA – that staff Family Support Specialists (Family Partners) and Youth Support Specialists (Youth Partners), respectively. As part of our contracts with providers that are supporting Wraparound services, we require them to consistently demonstrate adherence to Wraparound principles as part of their documentation and care plans in alignment with ORS 418.977, guidelines in PSU’s Oregon Best Practice Guide, and other SOCWI requirements.

a. Provide details on how Applicant plans to ensure administration of the Wraparound Fidelity Index Short Form (WFI-EZ)?

In 2019, Trillium began implementing several activities designed to ensure the administration of the WFI-EZ, which is fully aligned with Oregon Health Policy Board Recommendations, Policy 26. In January 2019, we updated our contracts with the two Wraparound providers in our Service Area – Direction Service and CLA – to include a contract provision that requires them to complete the WFI-EZ with their child and family teams after six months of Wraparound enrollment and enter the results in WrapTrack. As a best practice, Direction Service administers the WFI-EZ more frequently (every 60 days) with its clients to collect additional data that can be used to improve its program. Our contracts also require that these providers submit their WFI-EZ fidelity measurement reports to Trillium. Trillium has begun meeting individually with these providers’ Wraparound Managers and Directors to discuss their WFI-EZ fidelity measurement report, including the comparison of their Wraparound performance relative to the national mean from WrapTrack’s Report 8. These quarterly meetings allow us to quickly identify and troubleshoot any issues that Wraparound providers are experiencing. For example, based on our collaborations to date and review of the WFI-EZ data, we know that the two Wraparound providers in our current Service Area perform significantly better than the national mean in linking families to community resources, but that there are opportunities for improvement related to helping families understand that the Wraparound process will not end before their needs have been met. In response, we supporting these providers in using this data to provide additional coaching and supervision to their Wraparound Facilitators on how to discuss this issue with families. Moving forward, Trillium will utilize the WFI-EZ data to monitor improvement related to this and other metrics, supporting continuous quality improvement activities as needed.
b. How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?

Based on our established SOC described in Att.11.E.8, all of our partner providers involved in Wraparound today, including those implementing high fidelity Wraparound and those who staff Youth and Family Partners, are actively engaged at every level of the SOC, including the SOC Advisory Council. As a natural extension to the work of the Advisory Council, Trillium will begin sharing a blended report using the WFI-EZ data and other applicable SOC data (e.g., fidelity measures such as ratio of youth and families served to Wraparound team members) with the Advisory Council on a quarterly basis as part of their ongoing meetings. Trillium will support the Advisory Council to use this data to identify barriers to SOC and Wraparound implementation, as well as track ongoing system improvements over time based on the SOC’s established plans to address barriers. We anticipate that sharing this data will be very impactful in igniting additional collaborative solutions to addressing Wraparound implementation barriers, as all of the Wraparound providers in our proposed Service Area are engaged as part of the SOC Advisory Council today. To further improve the quality of Wraparound services across our Service Areas, Trillium’s Program Service Coordinator will develop and submit a quarterly Summary Report with this data to the JOC for their review and guidance.

c. How does Applicant plan to receive a minimum of 35 percent response rate from youth?

Both Direction Service and CLA have been administering the WFI-EZ since 2016 in partnership with their Wraparound Teams, including youth (and their caregivers for youth under 14 years of age). Based on their experience, the Wraparound Facilitators working at these two agencies currently engage each youth and family Wraparound Team to complete the WFI-EZ self-report forms during Wraparound Team meetings at least every six months (with some providers, like Direction Service, completing the WFI-EZ more frequently). This best practice helps to increase the youth response rate because they are already at the table for the Wraparound Team meeting, resulting in a response rate of more than half (56%) of eligible youth in 2018.

In addition, in early 2019, Trillium began monitoring the youth WFI-EZ completion rate in WrapTrack for each of our providers. We have also included this WFI-EZ requirement in our 2019 contracts with these providers. If either of these two agencies’ youth response rates for the WFI-EZ ever fall below 35%, Trillium will troubleshoot with them during our quarterly meetings, developing a performance improvement plan as needed to bring the youth response rate back above 35%. In addition, as needed, we will engage other community partners and stakeholders who bring significant youth engagement experience, such as Youth ERA, to support alternative solutions to increasing youth engagement in the WFI-EZ.

d. How will Applicant’s Wraparound policy address:

Trillium’s Wraparound policy was established in 2014 and is updated annually. Each year, the Wraparound policy is reviewed and approved by our SOC Executive Council and OHA.

(1) How Wraparound services are implemented and monitored by Providers?

Our Wraparound policy addresses how Wraparound services are implemented and monitored by providers. The policy establishes a phased approach to implementing Wraparound, including:

- **Engagement and Team Preparation:** The assigned Wraparound Facilitator discusses concerns, needs, and strengths with the family; listens to the family’s and youth’s vision(s) for the future; develops an initial crisis plan; and determines the participants and location for Team meetings.

- **Initial Plan Development:** The Team, including the child and family, attends Wraparound meetings to develop a mission statement and identify and address the family’s needs in alignment with their strengths. Team members take on agreed upon tasks within a written Wraparound plan of care.

- **Plan Implementation:** The Team meets regularly and reviews accomplishments, assessing whether the plan is working to achieve the child and family’s goals and adjusting the plan as needed, including assigning new tasks to team members when needed.
Transition: The Team determines when it does not need to meet regularly anymore and schedules a final meeting with a small celebration. During this phase, the family receives a record of what has been done, as well as a list of what strategies worked (e.g., those that resulted in functional/behavioral improvements).

The Team also develops a plan for the future, including who to contact if help is needed moving forward. Our Wraparound policy clearly articulates the services and supports a Wraparound Team can access on behalf of a child/family, as well as which services and supports need prior approval. Trillium does not require a referral for a BH assessment; however, if ongoing Medicaid-covered services are needed after the assessment, the Wraparound provider will work with Trillium to follow their Authorization Required Qualifier (ARQ) process in alignment with the Policy.

Monitoring Implementation of Wraparound Services. As described throughout this section, we support providers to fully adhere to SOC and Wraparound values. In collaboration with state-identified technical assistance vendors, such as PSU, we support providers through our quarterly meetings and contract requirements to utilize the WFI-EZ, as well as other tools from the Wraparound Fidelity Assessment System, including the Child and Adolescent Needs and Strengths, as part of their ongoing monitoring processes.

(2) How Applicant will ensure Wraparound services are provided to Members in need, through Applicant’s Providers?

Our Wraparound policy establishes a process for ensuring Wraparound services are provided to members in need. Specifically, when a child or youth is referred to Wraparound, the referral source must complete a Wraparound Referral Form that documents:

- The child’s involvement in two or more youth-serving systems, including documenting that the involved systems are having difficulty meeting the youth and family’s needs
- DSM and ICD diagnosis where applicable
- Family consent to be screened
- Placement and contact information
- Language preference
- Behavioral presentation
- Family needs and associated stressors
- Youth and family strengths
- Pertinent records to support the request from youth-serving systems

Once Trillium receives a Wraparound Referral Form, we will share it with our Wraparound Review Committee, which will meet to discuss the appropriateness of the referral. The Wraparound Review Committee consists of Trillium UM staff, contracted Wraparound providers, contracted Family and Youth Partner providers, SOC stakeholders, and the family and youth (as available). If additional information is needed, Trillium’s UM staff will coordinate with the Wraparound Facilitator to inform the referral source, schedule a time to meet the family directly to discuss their needs, and collect additional information. Once the child is determined to be eligible for Wraparound by the Committee, Trillium will work with one of the contracted Wraparound Facilitation Supervisors to ensure that the child and family is assigned to an appropriate Wraparound Facilitator, who will contact the family to begin engagement. If a child is determined ineligible for Wraparound services, Trillium works with our community partners to offer appropriate alternatives to meet the child’s service needs.

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.

Within our Service Area today, we work closely with our community partners participating in the Wraparound Review Committee to ensure that there is no waitlist for youth who meet criteria. In addition to reviewing all referrals submitted to the Wraparound program, the Wraparound Review Committee assists with monitoring Wraparound capacity within our Service Area, analyzes the types and mixes of referrals received, and looks for patterns and disparities, responding as needed in collaboration with our SOC infrastructure to alleviate
identified barriers. This work is supported by the SOC Executive Council, who reviews Wraparound referrals and participation on a quarterly basis to identify and address system level barriers. This process has been effective since Wraparound’s initiation in our Service Area, and Lane County has not had a waitlist for the Wraparound program since its inception. Should a situation arise where there is not enough Wraparound capacity within our Service Area to serve all eligible youth, Trillium will partner with our providers to identify how we can best support them to increase their capacity while maintaining fidelity. Trillium has also recently started working with our two high fidelity Wraparound providers to support them to monitor their client registries to ensure that youth and families are able to be appropriately and efficiently transitioned to a lower level of community services once their needs have been met. In addition, Trillium tracks the number of children receiving Wraparound services and supports on a monthly basis. In the Tri-County Region, we will adapt these processes and best practices and leverage existing county systems and processes in collaboration with local SOC and Wraparound stakeholders and providers, such as, Youth Villages and The Children’s Center.

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).

In addition to the activities described throughout this section related to supporting the delivery of high-fidelity Wraparound services, Trillium requires our Wraparound providers to submit monthly reports on their staffing pattern, including the ratio of youth and families to Wraparound Facilitators or Family/Youth Partners (based on their contract responsibilities). We monitor these reports to ensure that they do not exceed the 1:15 requirement. We also monitor the reports and WFI-EZ results to ensure that all required roles (e.g., Wraparound coaches and supervisors) are held by separate professionals, with the Wraparound Supervisor retaining responsibility for directly supervising the Wraparound Care Coordinator and Family/Youth Partners, and the Wraparound Coach helping Wraparound Care Coordinators to further develop skills related to SOC and Wraparound values and principles. We ensure access to Family Partners and Youth Partners through our contracts with OFSN and Youth ERA, which provide services statewide and will support these efforts across our entire proposed Service Area. All Family and Youth Partners hired by these agencies have experience navigating the BH, child welfare, and/or juvenile justice system, and all are trained in high-fidelity Wraparound upon hire and regularly thereafter. Family Partners and Youth Partners receive both clinical and peer supervision from their “host” agency. We contractually require OFSN and Youth ERA to track and report on these staff members’ Wraparound activities, including one-on-one support provided, support group sessions facilitated, and attendance at family and youth support events. Finally, we further ensure that all Family and Youth Partners working within our Service Area are active participants in the Wraparound process, engaging and collaborating with the systems alongside the child/youth and family through our monitoring of the WFI-EZ results.
Independent Auditor's Report
Statutory Financial Statements and
Supplemental Information
Years Ended December 31, 2015 and 2014
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<td>statutory basis</td>
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<td></td>
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<td>27</td>
</tr>
</tbody>
</table>
INDEPENDENT AUDITORS' REPORT

To the Board of Directors
of Trillium Community Health Plan, Inc.:

We have audited the accompanying statutory financial statements of Trillium Community Health Plan, Inc. (an Oregon corporation) which comprise the statements of admitted assets, liabilities, capital, and surplus - statutory basis as of December 31, 2015 and 2014, and the related statutory statements of revenue and expenses - statutory basis, changes in capital and surplus - statutory basis, and cash flows - statutory basis for the years then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the financial reporting provisions prescribed and permitted by of the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to error or fraud.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with the auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.
Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described more fully in Note 1, the financial statements are prepared by Trillium Community Health Plan, Inc. on the basis of the financial reporting provisions prescribed and permitted by the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to comply with the requirements of the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation. The effects on the financial statements of the variances between the regulatory basis of accounting described in Note 1 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to in the first paragraph do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of Trillium Community Health Plan, Inc. as of December 31, 2015 and 2014, or the results of its operations or its cash flows for the years then ended.

Opinion on Regulatory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, capital, and surplus of Trillium Community Health Plan, Inc. as of December 31, 2015 and 2014, and the results of its operations and its cash flows for the years then ended, on the basis of the financial reporting provisions of the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation as described in Note 1.

Report on Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the statutory financial statements as a whole. The supplemental summary investment schedule, investment risk interrogatories, and supplemental report of segregated premiums are presented for purposes of additional analysis and are not a required part of the statutory financial statements. Such information is the responsibility of management and was derived from and related directly to the underlying accounting and other records used to prepare the statutory financial statements. The information has been subjected to the auditing procedures applied in the audit of the statutory financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the statutory financial statements or to the statutory financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the statutory financial statements as a whole.

Eugene, Oregon
May 26, 2016
TRILLIUM COMMUNITY HEALTH PLAN, INC.

Statements of Admitted Assets, Liabilities, Capital, and Surplus - Statutory Basis

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADMITTED ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bonds</td>
<td>$17,452,254</td>
<td>$20,283,921</td>
</tr>
<tr>
<td>Stocks</td>
<td>6,806,438</td>
<td>5,740,391</td>
</tr>
<tr>
<td>Cash, cash equivalents, and short-term investments</td>
<td>105,111,295</td>
<td>86,681,259</td>
</tr>
<tr>
<td>Receivables for securities</td>
<td>1,907,095</td>
<td>-</td>
</tr>
<tr>
<td>Investment income due and accrued</td>
<td>117,003</td>
<td>123,072</td>
</tr>
<tr>
<td>Uncollected premiums in the course of collection</td>
<td>18,780,359</td>
<td>1,447,392</td>
</tr>
<tr>
<td>Accrued retrospective premiums</td>
<td>1,274,602</td>
<td>1,479,871</td>
</tr>
<tr>
<td>Amounts receivable relating to uninsured plans</td>
<td>117,297</td>
<td>1,073,936</td>
</tr>
<tr>
<td>Net deferred tax asset</td>
<td>2,236,000</td>
<td>1,009,000</td>
</tr>
<tr>
<td>Receivables from parent</td>
<td>1,000,000</td>
<td>1,000,000</td>
</tr>
<tr>
<td><strong>Total admitted assets</strong></td>
<td>$154,802,343</td>
<td>$118,838,842</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>LIABILITIES, CAPITAL, AND SURPLUS</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LIABILITIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims unpaid</td>
<td>$73,011,360</td>
<td>$47,748,800</td>
</tr>
<tr>
<td>Accrued medical incentive pool and bonus amounts</td>
<td>9,180,934</td>
<td>6,700,000</td>
</tr>
<tr>
<td>Unpaid claims adjustment expenses</td>
<td>2,542,030</td>
<td>1,038,600</td>
</tr>
<tr>
<td>Aggregate health policy reserves</td>
<td>10,022,080</td>
<td>46,179</td>
</tr>
<tr>
<td>Premiums received in advance</td>
<td>33,658</td>
<td>3,428</td>
</tr>
<tr>
<td>General expenses due or accrued</td>
<td>2,540,945</td>
<td>5,086,303</td>
</tr>
<tr>
<td>Current federal income tax payable</td>
<td>11,332,801</td>
<td>7,324,000</td>
</tr>
<tr>
<td>Amounts due to parent</td>
<td>4,858,083</td>
<td>7,434,152</td>
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<tr>
<td>Unclaimed property payable</td>
<td>150</td>
<td>2,681</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td>113,522,041</td>
<td>75,384,143</td>
</tr>
</tbody>
</table>

| **CAPITAL AND SURPLUS:**             |             |             |
| Common capital stock, $1,000 par value, voting, 5,000 shares authorized | 5,000,000   | 15,000,000  |
| Gross paid in and contributed surplus funds | 15,000,000  | -           |
| Unassigned funds                     | 12,615,212  | 23,448,977  |
| Special surplus                      | 8,665,090   | 5,005,722   |
| **Total capital and surplus**        | 41,280,302  | 43,454,699  |

| **Total liabilities, capital, and surplus** | $154,802,343 | $118,838,842 |

See accompanying notes and independent auditors' report.
TRILLIUM COMMUNITY HEALTH PLAN, INC.
Statements of Revenue and Expenses - Statutory Basis

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net premium income</td>
<td>$ 492,403,518</td>
<td>$ 400,457,788</td>
</tr>
<tr>
<td>DHS transformation grant</td>
<td>30,478,210</td>
<td>7,071,132</td>
</tr>
<tr>
<td><strong>Total revenue</strong></td>
<td>522,881,728</td>
<td>407,528,920</td>
</tr>
<tr>
<td><strong>UNDERWRITING DEDUCTIONS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims incurred</td>
<td>434,223,609</td>
<td>319,661,569</td>
</tr>
<tr>
<td>Claims adjustment expenses</td>
<td>21,633,005</td>
<td>32,461,976</td>
</tr>
<tr>
<td>General and administrative expenses</td>
<td>33,966,484</td>
<td>19,380,033</td>
</tr>
<tr>
<td>Increase in reserves for accident and health contracts</td>
<td>5,133,625</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total underwriting deductions</strong></td>
<td>494,956,723</td>
<td>371,503,578</td>
</tr>
<tr>
<td><strong>NET UNDERWRITING INCOME</strong></td>
<td>27,925,005</td>
<td>36,025,342</td>
</tr>
<tr>
<td><strong>INVESTMENT INCOME:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net investment income earned</td>
<td>844,940</td>
<td>602,614</td>
</tr>
<tr>
<td>Net realized gains</td>
<td>38,357</td>
<td>39,907</td>
</tr>
<tr>
<td><strong>Total investment income</strong></td>
<td>883,297</td>
<td>642,521</td>
</tr>
<tr>
<td><strong>NET LOSS FROM PREMIUM BALANCES CHARGED OFF</strong></td>
<td>(82)</td>
<td>(310)</td>
</tr>
<tr>
<td><strong>INCOME BEFORE TAXES</strong></td>
<td>28,808,220</td>
<td>36,667,553</td>
</tr>
<tr>
<td><strong>FEDERAL INCOME TAXES INCURRED</strong></td>
<td>14,686,196</td>
<td>14,467,759</td>
</tr>
<tr>
<td><strong>NET INCOME</strong></td>
<td>$ 14,122,024</td>
<td>$ 22,199,794</td>
</tr>
</tbody>
</table>

See accompanying notes and independent auditors' report.
### Common Capital Stock

<table>
<thead>
<tr>
<th>Source</th>
<th>Number of Shares</th>
<th>Amount</th>
<th>Gross Paid in and Contributed Surplus</th>
<th>Unassigned Funds</th>
<th>Affordable Care Act Assessment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BALANCE, December 31, 2013</td>
<td>15,000</td>
<td>$15,000,000</td>
<td>-</td>
<td>$5,873,465</td>
<td>-</td>
<td>$20,873,465</td>
</tr>
<tr>
<td>Net income</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>22,199,794</td>
<td>-</td>
<td>22,199,794</td>
</tr>
<tr>
<td>Net change in unrealized capital gains</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(68,943)</td>
<td>-</td>
<td>(68,943)</td>
</tr>
<tr>
<td>Net change in deferred income tax</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>462,000</td>
<td>-</td>
<td>462,000</td>
</tr>
<tr>
<td>Net change in nonadmitted assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>79,383</td>
<td>-</td>
<td>79,383</td>
</tr>
<tr>
<td>Special surplus</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(5,005,722)</td>
<td>5,005,722</td>
<td>-</td>
</tr>
<tr>
<td>Correction for prior year error</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(91,000)</td>
<td>-</td>
<td>(91,000)</td>
</tr>
<tr>
<td>BALANCE, December 31, 2014</td>
<td>15,000</td>
<td>$15,000,000</td>
<td>-</td>
<td>23,448,977</td>
<td>5,005,722</td>
<td>43,454,699</td>
</tr>
<tr>
<td>Paid in capital</td>
<td>-</td>
<td>-</td>
<td>5,000,000</td>
<td>-</td>
<td>-</td>
<td>5,000,000</td>
</tr>
<tr>
<td>Net income</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>14,122,024</td>
<td>-</td>
<td>14,122,024</td>
</tr>
<tr>
<td>Net change in unrealized capital gains</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(261,342)</td>
<td>-</td>
<td>(261,342)</td>
</tr>
<tr>
<td>Net change in deferred income tax</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,186,000</td>
<td>-</td>
<td>1,186,000</td>
</tr>
<tr>
<td>Net change in nonadmitted assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(41,084)</td>
<td>-</td>
<td>(41,084)</td>
</tr>
<tr>
<td>Dividends to stockholders</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(22,179,995)</td>
<td>-</td>
<td>(22,179,995)</td>
</tr>
<tr>
<td>Transferred from capital to surplus</td>
<td>(10,000)</td>
<td>(10,000,000)</td>
<td>10,000,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Special surplus</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(3,659,368)</td>
<td>3,659,368</td>
<td>-</td>
</tr>
<tr>
<td>BALANCE, December 31, 2015</td>
<td>5,000</td>
<td>$5,000,000</td>
<td>15,000,000</td>
<td>$12,615,212</td>
<td>$8,665,090</td>
<td>$41,280,302</td>
</tr>
</tbody>
</table>

See accompanying notes and independent auditors' report.
## Change in Cash, Cash Equivalents, and Short-Term Investments

<table>
<thead>
<tr>
<th>Year Ended December 31</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CASH FLOWS FROM OPERATING ACTIVITIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premiums collected net of reinsurance</td>
<td>$480,149,416</td>
<td>$402,904,278</td>
</tr>
<tr>
<td>Net investment income</td>
<td>998,032</td>
<td>635,738</td>
</tr>
<tr>
<td>DHS transformation grant revenue</td>
<td>30,478,210</td>
<td>7,071,132</td>
</tr>
<tr>
<td>Benefits and loss related payments</td>
<td>(406,618,979)</td>
<td>(301,197,109)</td>
</tr>
<tr>
<td>Commissions and expenses paid</td>
<td>(58,207,771)</td>
<td>(48,538,424)</td>
</tr>
<tr>
<td>Federal income taxes paid</td>
<td>(10,693,061)</td>
<td>(9,441,059)</td>
</tr>
<tr>
<td><strong>Net cash provided by operating activities</strong></td>
<td>36,105,847</td>
<td>51,434,556</td>
</tr>
</tbody>
</table>

| **CASH FLOWS FROM INVESTING ACTIVITIES:** |        |        |
| Proceeds from bonds matured | 4,932,940 | 2,143,589 |
| Proceeds from stocks sold | 6,307,862 | 16,804,904 |
| Cost of bonds acquired | (2,258,599) | (14,093,860) |
| Cost of stocks acquired | (7,570,923) | (20,104,113) |
| Miscellaneous investing applications | (1,907,096) | - |
| **Net cash used in investing activities** | (495,816) | (15,249,480) |

| **CASH FLOWS FROM FINANCING ACTIVITIES:** |        |        |
| Capital and paid in surplus | 5,000,000 | - |
| Dividends to stockholders | (22,179,995) | - |
| **Other cash provided (applied)** | - | 6,692,753 |
| **Net cash (used in) provided by financing and miscellaneous sources** | (17,179,995) | 6,692,753 |

**NET CHANGE IN CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS**

18,430,036  
42,877,829

**CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS, beginning of year**

86,681,259  
43,803,430

**CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS, end of year**

$105,111,295  
$86,681,259

See accompanying notes and independent auditors' report.
1. Organization and Summary of Significant Accounting Policies

Organization. Trillium Community Health Plan, Inc. (the Company) was incorporated in 2006 as a for-profit health care service contractor for the Centers for Medicare and Medicaid Services (CMS), offering a Medicare Advantage plan. In 2012, the Company became certified to provide Medicaid coverage under a new type of healthcare delivery system called a Coordinated Care Organization (CCO). The Company was awarded the contract to provide Medicaid services in Lane County through the CCO by the Oregon Health Authority.

The Company is owned by Lane Individual Practice Association, Inc. (LIPA) (60% of outstanding shares) and Agate Resources, Inc. (Agate) (40% of outstanding shares). LIPA is a wholly-owned subsidiary of Agate.

On September 1, 2015, Centene Corporation (Centene) acquired 100% of Agate Resources, Inc. Centene Corporation's core business is providing managed care programs and services to individuals receiving government-sponsored healthcare benefits.

Basis of Presentation. The accompanying statutory financial statements have been prepared on the basis of accounting practices prescribed or permitted by the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation (ODCBS). Prescribed statutory accounting practices are those practices mandated by the National Association of Insurance Commissioners (NAIC), as well as state laws, regulations, and general administrative rules. In contrast, permitted statutory accounting practices are those practices for which a company has applied for and received specific permission from its state of domicile. Oregon has adopted the NAIC's statutory accounting practices as the basis of its statutory accounting practices. Trillium follows the NAIC's statutory accounting practices and does not have permitted practices that deviate from NAIC statutory accounting practices. These practices are considered a basis of accounting other than accounting principles generally accepted in the United States of America (GAAP). The most significant differences are as follows:

- Investments in bonds are carried in accordance with valuation methods established by the NAIC. Under GAAP, investments in bonds are classified as held-to-maturity, available-for-sale, or trading securities, and the accounting treatment is dependent upon each category.
- The statutory statements of cash flows differ in certain respects from the presentation required pursuant to GAAP.
- Certain assets are designated as "non-admitted assets" and are excluded from the statements of admitted assets, liabilities, capital, and surplus - statutory basis, and the change in such assets is added to or charged against capital and surplus. Such assets, principally certain deferred income taxes, certain accounts receivable, and certain prepaid expenses, are described as non-admitted assets and are charged to surplus when acquired. Admitted assets are those assets permitted to be recognized by the ODCBS. GAAP requires that balance sheets include such assets.

(Continued)

See independent auditors' report.
1. Organization and Summary of Significant Accounting Policies (Continued)

- Deferred income taxes are provided for temporary differences between statutory financial statements and tax bases of assets and liabilities at the end of each year based on enacted tax rates. Net deferred tax assets are limited to their admissible amount according to a prescribed formula. Changes in deferred income tax assets and liabilities are reported as adjustments to surplus. Under GAAP, changes to deferred income taxes are included in income tax expense or benefit and are allocated to continuing operations and items charged directly to surplus.

Codification. The NAIC promulgates Statutory Accounting Principles (SAP) in its Accounting Practices and Procedures manual, version effective March 2015. The insurance laws and regulations of the State of Oregon require insurance companies domiciled in the state to comply with the guidance provided in the NAIC Accounting Practices and Procedures manual except as prescribed or permitted by state law.

Investments. Investments are valued in accordance with the requirements of the NAIC. Investments in bonds and mortgage/asset-backed securities are stated at amortized cost, unless otherwise required by statutory requirements. Investments in bonds with certain NAIC ratings may be required to be stated at the lower of market value or amortized cost. Amortization of premiums and discounts is calculated on an effective yield basis over the period of maturity. Equity securities are stated at values published by the NAIC, which are generally based on market values. Unrealized appreciation or depreciation of investments is reflected directly in surplus and, accordingly, has no income effect. Realized gains or losses on sales of investments are recognized on the specific identification basis.

Business Risks and Uncertainties. The Company's investments are primarily comprised of debt and equity securities. Significant changes in prevailing interest rates and market conditions may adversely affect the timing and amount of cash flows on such investments and their related values. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in values in the near-term could materially affect the Company's financial position and the results of its operations.

Cash, Cash Equivalents, and Short-Term Investments. The Company considers all cash on hand, amounts deposited with banks, money market accounts, and short-term highly liquid investments with original maturities of three months or less when acquired to be cash equivalents. The Company considers short-term investments to be all investments with remaining maturities of one year or less at the time of acquisition, excluding cash equivalents. Cash and cash equivalents are carried at cost which approximates fair value. Short-term investments are carried at amortized cost which approximates fair value. Substantially all of the cash and cash equivalents are maintained at various banks whose deposits exceed federally insured limits. The Company has not experienced any losses on such accounts and believes it is not exposed to any significant credit risk on cash, cash equivalents, and short-term investments.

(Continued)
1. Description of Operations and Summary of Significant Accounting Policies (Continued)

Statutory Deposits. The Company maintains a statutory deposit with the ODCBS. At December 31, 2015, the deposit was in the form of U.S. Treasury bills that mature through November 2016 with a fair value of $3,009,979. The deposits are included in cash, cash equivalents, and short-term investments on the statements of admitted assets, liabilities, capital, and surplus - statutory basis.

Receivables. Uncollected premiums in the course of collection represent amounts receivable from policyholders, providers, and third parties based upon coordination of benefits under health care plans. Additionally, if the Company meets or exceeds certain benchmarks, they are eligible to receive additional funding under their CCO contract. Management believes they have met the necessary benchmarks and has recorded amounts at December 31, 2015 of approximately $17 million in uncollected premiums in the course of collection. The receivable is an estimate, and while management believes the amount is appropriate, the ultimate amount collected may be in excess of, or less than, the amount provided. The estimate is continually reviewed and adjusted as necessary as new information becomes known; such adjustments are included in the period in which the revisions are determined. Actual receipts will differ from original estimates and may result in material adjustments to revenues recorded in future periods. Accrued retrospective premiums are amounts collectible for risk-score adjustments from CMS. Amounts receivable relating to uninsured health plans are amounts collectible for low income cost subsidies from CMS. All receivables of the Company are unsecured. Management monitors receivables on an on-going basis and charges off any amounts determined to be uncollectable. The Company considers receivables to be fully collectible and, therefore, has determined that no allowance for doubtful accounts is considered necessary.

Claims Unpaid and Unpaid Claims Adjustment Expenses. Claims incurred represent payments to hospitals and physicians for medical services rendered during the year. The Company establishes a liability, based on actuarial models, for unpaid claims and related administrative costs. The Company does not discount its liability for unpaid claims. Estimated salvage and subrogation are not included as a reduction of its loss reserve. The liability is an estimate, and while management believes the amount is adequate, the ultimate liability may be in excess of, or less than, the amount provided. The estimate is continually reviewed and adjusted as necessary as experience develops or new information becomes known; such adjustments are included in the period in which the revisions are determined. Actual payments will differ from original estimates and may result in material adjustments to claims expense recorded in future periods.

(Continued)

See independent auditors' report.
1. Description of Operations and Summary of Significant Accounting Policies (Continued)

Premium Deficiency Reserve. The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or actuarial forecasts indicate probable future losses. The Company establishes a premium deficiency liability in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceed related future premiums under contracts without consideration of investment income. For purposes of premium deficiency losses, contracts are grouped in a manner consistent with the Company's method of acquiring, servicing, and measuring the profitability of such contracts and represents the Company's best estimate in a range of potential outcomes. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. The Company recognized a premium deficiency liability and corresponding loss of $5,133,625 at December 31, 2015, which is recorded in aggregate health policy reserves on the accompanying statements of admitted assets, liabilities, capital, and surplus - statutory basis. No premium deficiency liability was considered necessary at December 31, 2014.

Accrued Withhold, Medical Incentive Pool, and Bonus Amounts. The Company has entered into arrangements with certain medical provider groups to provide health care services to plan members. The contracts include provisions that involve risk sharing of surplus or deficits to help manage health care costs. Under the terms of the contracts with providers, a pool reserve is established which is comprised of a percentage of provider claims that are withheld and amounts for surplus and bonus payments. Based on review of experience and utilization, the Company establishes a liability for pool surpluses payable to providers, which is paid out quarterly, beginning six months following the end of the contract year. Withhold amounts payable are recorded in claims unpaid on the statements of admitted assets, liabilities, capital, and surplus - statutory basis. The Company is entitled to retain a portion or all of the withhold amounts to cover any pool deficits.

Assessments. State mandated assessments are accrued at the time the events occur on which assessments are expected to be based.

Federal and Deferred Income Taxes. The Company will file a consolidated income tax return in accordance with applicable tax law with their parent company and related subsidiaries. Federal income tax expense is based on federal taxable income. Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for statutory financial reporting purposes and the amounts used for income tax purposes. Changes in deferred income tax assets and liabilities are recognized as a separate component of gains and losses in surplus, except to the extent allocated to changes in unrealized gains and losses. Deferred income tax assets are admitted to the extent that they meet specific criteria, including meeting certain Risk Based Capital (RBC) thresholds.

(Continued)
1. Description of Operations and Summary of Significant Accounting Policies (Continued)

Statutory Reserve. The Company is required by Oregon law to maintain minimum capital reserves of 50% of its average monthly claims incurred during the last 12 months, to a maximum of $2,500,000. Mandatory reserves at December 31, 2015 and 2014 were $2,500,000. The Company is also subject to minimum RBC requirements. See Note 10.

Revenue Recognition. Premium revenues are due monthly and are recognized as revenue during the period in which the Company is obligated to provide service to its members.

Hospital Reimbursement Adjustments. The Company excludes amounts received from the Oregon Health Authority under their CCO Contract for Hospital Reimbursement Adjustments (HRAs) from premium revenues and claims incurred. This treatment was approved by the ODBCS. HRAs of $59,858,105 and $58,998,350 were not reported as revenue or expense during 2015 and 2014, respectively.

Reinsurance. The Company seeks to limit its loss on any single insured risk and to recover a portion of benefits paid by ceding reinsurance to its reinsurer under excess coverage agreements. The Company is not relieved of its primary obligation to the policyholder in a reinsurance transaction. Failure of reinsurers to honor their obligations could result in losses to the Company. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar activities or economic characteristics. Reinsurance premiums are netted against premiums earned, and reinsurance recoveries are offset against claims incurred. Amounts recoverable under reinsurance agreements include such amounts due from the reinsurer for the reimbursement of amounts paid on claims in excess of the insurance risk transferred to the reinsurer and qualify as admitted assets.

Advertising. The Company expenses advertising costs as they are incurred. Advertising costs for the years ended December 31, 2015 and 2014 were $871,188 and $763,187, respectively.

Concentrations of Credit Risk. The Company's financial instruments that are exposed to concentrations of credit risk consist primarily of bonds, cash, cash equivalents, and short-term investments and uncollected premiums in the course of collection. Credit risk related to investments varies depending on the nature of the investments. Management believes that its credit risk related to bonds is limited due to the financial strength of the U.S. Government and supporting corporations securing such investments. Due to the Company's normal operating cash flow requirements, the Company typically has cash, cash equivalents, and short-term investments that exceed the Federal Deposit Insurance Corporation (FDIC) coverage or may not be insured at all. Management believes that its credit risk with respect to cash, cash equivalents, and short-term investments is minimal due to the relative financial strength of the financial institutions which maintain the Company's bank balances and the short-term nature of its investments. Credit risk relative to uncollected premiums in course of collection is minimal due to the nature of the receivables and due to the financial strength of the federal and state governments.

(Continued)

See independent auditors' report.
1. Description of Operations and Summary of Significant Accounting Policies (Continued)

*Fair Value Measurements.* Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The fair value framework requires the categorization of assets and liabilities into three levels based upon the ability to observe the assumptions (inputs) used to value the assets and liabilities. Level One provides the most reliable and observable measure of fair value, whereas Level Three generally requires significant judgment. When valuing assets or liabilities, statutory accounting principles require the most observable inputs to be used.

The fair value hierarchy is categorized into three levels based on the inputs as follows:

- **Level One** - Unadjusted, quoted prices in active markets for identical assets and liabilities.
- **Level Two** - Observable inputs, other than those included in Level One. For example, quoted prices for similar assets or liabilities in active markets or quoted prices for identical assets or liabilities in inactive markets.
- **Level Three** - Unobservable inputs reflecting assumptions about the inputs used in pricing the asset or liability.

The fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

*Estimates.* The preparation of financial statements in conformity with the statutory basis of accounting requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the statutory financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

*Subsequent Events.* Management evaluates events occurring subsequent to the date of the statutory financial statements in determining the accounting for and disclosure of transactions and events that affect the statutory financial statements. Subsequent events have been evaluated through May 26, 2016, which is the date the statutory financial statements were available to be issued.

*Reclassifications.* Certain 2014 amounts have been reclassified to conform to 2015 presentation. The reclassifications had no effect on previously reported net income or capital and surplus.

See independent auditors' report.
2. Cash Equivalents and Short-Term Investments

As of December 31, 2015, cash equivalents and short-term investments consisted of the following:

<table>
<thead>
<tr>
<th>Book/Adjusted Carrying Value</th>
<th>Gross Unrealized Appreciation</th>
<th>Gross Unrealized Depreciation</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Treasury securities</td>
<td>$ 3,000,549</td>
<td>$ 9,430</td>
<td>- $ 3,009,979</td>
</tr>
<tr>
<td>Total</td>
<td>$ 3,000,549</td>
<td>$ 9,430</td>
<td>- $ 3,009,979</td>
</tr>
</tbody>
</table>

As of December 31, 2014, cash equivalents and short-term investments consisted of the following:

<table>
<thead>
<tr>
<th>Book/Adjusted Carrying Value</th>
<th>Gross Unrealized Appreciation</th>
<th>Gross Unrealized Depreciation</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash equivalents:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money market funds</td>
<td>$ 250,556</td>
<td>- $</td>
<td>- $ 250,556</td>
</tr>
<tr>
<td>Total</td>
<td>$ 250,556</td>
<td>- $</td>
<td>- $ 250,556</td>
</tr>
<tr>
<td>Short-term investments:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Treasury securities</td>
<td>$ 3,007,559</td>
<td>- $ (1,643)</td>
<td>$ 3,005,916</td>
</tr>
<tr>
<td>Industrial and miscellaneous bonds</td>
<td>998,927</td>
<td>- $ (369)</td>
<td>998,558</td>
</tr>
<tr>
<td>Money market mutual funds</td>
<td>2,026,810</td>
<td>-</td>
<td>2,026,810</td>
</tr>
<tr>
<td>Total</td>
<td>$ 6,033,296</td>
<td>- $ (2,012)</td>
<td>$ 6,031,284</td>
</tr>
</tbody>
</table>

See independent auditors' report.
3. Investments

At December 31 the book/adjusted carrying value and fair value of bonds are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Book/Adjusted Carrying Value</th>
<th>Gross Unrealized Appreciation</th>
<th>Gross Unrealized Depreciation</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>December 31, 2015:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Government</td>
<td>$7,983,086</td>
<td>$53,626</td>
<td>$(23,387)</td>
<td>$8,013,325</td>
</tr>
<tr>
<td>U.S. corporate debt</td>
<td>7,450,539</td>
<td>38,151</td>
<td>(22,251)</td>
<td>7,466,439</td>
</tr>
<tr>
<td>Foreign corporate debt</td>
<td>1,754,484</td>
<td>682</td>
<td>(7,060)</td>
<td>1,748,106</td>
</tr>
<tr>
<td>Mortgage/asset backed</td>
<td>264,145</td>
<td>2,984</td>
<td>-</td>
<td>267,129</td>
</tr>
<tr>
<td><strong>Total bonds</strong></td>
<td>$17,452,254</td>
<td>$95,443</td>
<td>(52,698)</td>
<td>$17,494,999</td>
</tr>
<tr>
<td><strong>December 31, 2014:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Government</td>
<td>$8,880,506</td>
<td>$57,142</td>
<td>(10,133)</td>
<td>$8,927,515</td>
</tr>
<tr>
<td>U.S. corporate debt</td>
<td>8,692,991</td>
<td>29,701</td>
<td>(19,405)</td>
<td>8,703,287</td>
</tr>
<tr>
<td>Foreign corporate debt</td>
<td>2,385,089</td>
<td>1,919</td>
<td>(8,463)</td>
<td>2,378,545</td>
</tr>
<tr>
<td>Mortgage/asset backed</td>
<td>325,335</td>
<td>5,832</td>
<td>-</td>
<td>331,167</td>
</tr>
<tr>
<td><strong>Total bonds</strong></td>
<td>$20,283,921</td>
<td>$94,594</td>
<td>(38,001)</td>
<td>$20,340,514</td>
</tr>
</tbody>
</table>

At December 31, 2015, bonds were scheduled to mature as follows:

<table>
<thead>
<tr>
<th></th>
<th>Book/Adjusted Carrying Value</th>
<th>Fair Value</th>
<th>Unrealized Appreciation/Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due in one year or less</td>
<td>$1,443,959</td>
<td>$1,443,363</td>
<td>$(596)</td>
</tr>
<tr>
<td>Due in one to five years</td>
<td>9,640,944</td>
<td>9,642,038</td>
<td>1,094</td>
</tr>
<tr>
<td>Due in five to ten years</td>
<td>6,199,397</td>
<td>6,239,863</td>
<td>40,466</td>
</tr>
<tr>
<td>Due after ten years</td>
<td>167,954</td>
<td>169,735</td>
<td>1,781</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$17,452,254</td>
<td>$17,494,999</td>
<td>$42,745</td>
</tr>
</tbody>
</table>

(Continued)

See independent auditors' report.
3. Investments (Continued)

At December 31 the cost and fair value of common stocks are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Gross Cost</th>
<th>Gross Unrealized Appreciation</th>
<th>Gross Unrealized Depreciation</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 31, 2015:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>$ 117,886</td>
<td>$</td>
<td>$(11,316)</td>
<td>$ 106,570</td>
</tr>
<tr>
<td>Money market mutual funds</td>
<td>6,699,868</td>
<td>$</td>
<td>$</td>
<td>6,699,868</td>
</tr>
<tr>
<td>Total common stocks</td>
<td>$ 6,817,754</td>
<td>$</td>
<td>$(11,316)</td>
<td>$ 6,806,438</td>
</tr>
<tr>
<td>December 31, 2014:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>$ 4,958,814</td>
<td>$ 338,945</td>
<td>$(73,801)</td>
<td>$ 5,223,958</td>
</tr>
<tr>
<td>Money market mutual funds</td>
<td>516,433</td>
<td>$</td>
<td>$</td>
<td>516,433</td>
</tr>
<tr>
<td>Total common stocks</td>
<td>$ 5,475,247</td>
<td>$ 338,945</td>
<td>$(73,801)</td>
<td>$ 5,740,391</td>
</tr>
</tbody>
</table>

Gross realized gains of $65,985 and gross realized losses of $11,961 were included on the statements of revenue and expenses - statutory basis for 2015, net of tax of $15,667. Gross realized gains of $59,562 and gross realized losses of $3,355 were included on the statements of revenue and expenses - statutory basis for 2014, net of tax of $16,300.

Management evaluates securities for other-than-temporary impairment at least on an annual basis, and more frequently when economic or market concerns warrant such evaluation. Consideration is given to the length of time and the extent to which the fair value has been less than cost, the financial condition and near-term prospects of the issuer, and the intent and ability of the Company to retain its investment for a period of time sufficient to allow for any anticipated recovery in fair value.

The aggregate fair values of securities, by category, that had gross unrealized losses at December 31, 2015, and the securities that were in a loss position at December 31, 2014 that were still in a loss position at December 31, 2015, are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Less than 12 Months</th>
<th>12 Months or More</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fair Value</td>
<td>Gross Unrealized</td>
<td>Fair Value</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Losses</td>
<td></td>
</tr>
<tr>
<td>Bonds</td>
<td>$ 1,839,590</td>
<td>$(25,355)</td>
<td>$ 5,383,369</td>
</tr>
<tr>
<td>Common stocks</td>
<td>-</td>
<td>-</td>
<td>106,570</td>
</tr>
<tr>
<td></td>
<td>$ 1,839,590</td>
<td>$(25,355)</td>
<td>$ 5,489,939</td>
</tr>
</tbody>
</table>

(Continued)

See independent auditors' report.
3. Investments (Continued)

As of December 31, 2015, the Company had 31 securities in an unrealized loss position. All of these securities had a percentage decline of less than 11%. At December 31, 2015 and 2014, the Company did not hold any less-than-investment grade bonds.

4. Claims Unpaid and Unpaid Claims Adjustment Expenses

The liability for claims unpaid and unpaid claims adjustment expenses is based on the estimated amount payable on claims reported prior to the statutory financial statement date that have not yet been settled, claims reported subsequent to the statutory financial statement date that have been incurred during the period then ended and an estimate based on prior experience of incurred but unreported claims relating to such period.

Activity in the liability for claims unpaid and unpaid claims adjustment expenses is summarized as follows:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims unpaid and unpaid claims adjustment expenses, January 1</td>
<td>$ 48,787,400</td>
<td>$ 31,240,600</td>
</tr>
<tr>
<td>Less reinsurance receivable</td>
<td>-</td>
<td>(304,348)</td>
</tr>
<tr>
<td>Net balance</td>
<td>48,787,400</td>
<td>30,936,252</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incurred related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current year</td>
<td>461,069,406</td>
<td>355,601,733</td>
</tr>
<tr>
<td>Prior years</td>
<td>(5,212,792)</td>
<td>(3,478,188)</td>
</tr>
<tr>
<td>Total incurred</td>
<td>455,856,614</td>
<td>352,123,545</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current year</td>
<td>(385,516,016)</td>
<td>(306,509,985)</td>
</tr>
<tr>
<td>Prior years</td>
<td>(43,574,608)</td>
<td>(27,762,412)</td>
</tr>
<tr>
<td>Total paid</td>
<td>(429,090,624)</td>
<td>(334,272,397)</td>
</tr>
</tbody>
</table>

| Unpaid claims and claims adjustment expenses, December 31 | $ 75,553,390 | $ 48,787,400 |

As a result of changes in estimates of insured events in prior years, the liability for claims unpaid and unpaid claims adjustment expenses decreased by $5,212,792 and $3,478,188 in 2015 and 2014, respectively. The Company records a liability for claims unpaid and unpaid claims adjustment expenses that includes an allowance for potential shock claims.

See independent auditors' report.
5. Income Taxes

The Company will file a short-year consolidated federal and state income tax return through August 31, 2015 with Agate and other Agate subsidiaries on a GAAP basis adjusted for the tax regulations. Effective September 1, 2015, the Company became members of Centene's affiliated group that files a consolidated federal tax return. The Company's income tax provision is calculated on a consolidated return basis and allocated to affiliated companies on a separate return basis. Federal income taxes are settled between the Company and its parent based on the tax sharing agreement. Intercompany balances are settled by payment within 90 days of the filing of the tax return from which the amounts arose. At December 31, 2015 and 2014, the Company recorded federal income taxes payable, which will ultimately be settled with the parent. See Note 9.

Deferred taxes are comprised of admitted and nonadmitted assets, along with liabilities. The change in nonadmitted assets is reported separately from the change in net deferred income taxes in the statements of changes in capital and surplus - statutory basis. The admission of deferred tax assets is based upon meeting RBC thresholds, including minimum capital and surplus requirements. The change in net deferred income taxes is comprised of the following at December 31:

<table>
<thead>
<tr>
<th></th>
<th>Ordinary</th>
<th>Capital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross deferred tax assets</td>
<td>$2,364,000</td>
<td>$ -</td>
<td>$2,364,000</td>
</tr>
<tr>
<td>Less deferred tax assets non-admitted</td>
<td>128,000</td>
<td>$ -</td>
<td>128,000</td>
</tr>
<tr>
<td>Net admitted deferred tax assets</td>
<td>$2,236,000</td>
<td>$ -</td>
<td>$2,236,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Ordinary</th>
<th>Capital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross deferred tax assets</td>
<td>$1,259,000</td>
<td>$ -</td>
<td>$1,259,000</td>
</tr>
<tr>
<td>Less deferred tax assets non-admitted</td>
<td>169,000</td>
<td>$ -</td>
<td>169,000</td>
</tr>
<tr>
<td>Gross deferred tax liabilities</td>
<td>$ -</td>
<td>(81,000)</td>
<td>(81,000)</td>
</tr>
<tr>
<td>Net admitted deferred tax assets</td>
<td>$1,090,000</td>
<td>$(81,000)</td>
<td>$1,009,000</td>
</tr>
</tbody>
</table>

Change in net admitted deferred tax assets | $1,146,000 | $81,000 | $1,227,000 |

(Continued)

See independent auditors' report.
5. Income Taxes (Continued)

The components of net deferred tax assets (liabilities) are as follows at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deferred tax assets:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discounting of unpaid losses</td>
<td>$439,000</td>
<td>$1,090,000</td>
<td>$(651,000)</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>128,000</td>
<td>169,000</td>
<td>(41,000)</td>
</tr>
<tr>
<td>Premium deficiency reserve</td>
<td>1,797,000</td>
<td>-</td>
<td>1,797,000</td>
</tr>
<tr>
<td><strong>Total deferred tax assets</strong></td>
<td>2,364,000</td>
<td>1,259,000</td>
<td>1,105,000</td>
</tr>
<tr>
<td><strong>Deferred tax liabilities:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>-</td>
<td>(81,000)</td>
<td>81,000</td>
</tr>
<tr>
<td><strong>Net deferred tax assets</strong></td>
<td>2,364,000</td>
<td>1,178,000</td>
<td>1,186,000</td>
</tr>
<tr>
<td><strong>Nonadmitted assets</strong></td>
<td>(128,000)</td>
<td>(169,000)</td>
<td>41,000</td>
</tr>
<tr>
<td><strong>Net deferred tax assets</strong></td>
<td>$2,236,000</td>
<td>$1,009,000</td>
<td>$1,227,000</td>
</tr>
</tbody>
</table>

At December 31, 2015 and 2014, the Company maintained no valuation allowance for deferred tax assets, as the Company expected full realization of its deferred tax assets.

The admission calculation components as prescribed in Statements of Statutory Accounting Principles Number 101 of the deferred tax assets (liabilities) are as follows at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio percentage used to determine recovery period and threshold limitation</td>
<td>242.509%</td>
<td>324.323%</td>
</tr>
<tr>
<td>Adjusted capital and surplus used to determine recovery period and threshold limitation</td>
<td>$39,044,302</td>
<td>$42,445,699</td>
</tr>
</tbody>
</table>

There was no impact from the tax-planning strategies on the determination of adjusted gross deferred tax assets and the determination of net admitted deferred tax assets. The Company's tax-planning strategies do not include the risk of reinsurance.

(Continued)
5. Income Taxes (Continued)

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The significant items causing the difference for the year ended December 31, 2015 are as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>Tax Effect At 35%</th>
<th>Effective Tax Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income before taxes</td>
<td>$ 28,808,220</td>
<td>$ 10,082,877</td>
<td>35.00%</td>
</tr>
<tr>
<td>ACA - Health Insurance Providers Fee</td>
<td>6,990,772</td>
<td>2,446,770</td>
<td>8.49</td>
</tr>
<tr>
<td>Permanent and other differences</td>
<td>2,772,997</td>
<td>970,549</td>
<td>3.37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 38,571,989</strong></td>
<td><strong>$ 13,500,196</strong></td>
<td><strong>46.86%</strong></td>
</tr>
</tbody>
</table>

Federal income taxes incurred       | $ 14,686,196 | 50.98%             |
Change in deferred income taxes     | (1,186,000)  | (4.12)             |

**Total statutory income taxes**    | **$ 13,500,196** | **46.86%**         |

The provision for income taxes for the years ended December 31, 2015 and 2014 consisted of federal income taxes incurred.

6. Reinsurance

The Company seeks to limit its exposure to loss on any single insured paid by ceding reinsurance to a third-party insurance company under excess coverage agreements. The policy requires monthly premium payments on a per member per month basis. In return, the insurer assumes 90% of the risk in excess of $300,000 per member per year for hospital and physician services. Reinsurance premiums were $2,962,569 and $2,235,056 for 2015 and 2014, respectively, and are included in net premium income on the statutory statements of revenue and expenses - statutory basis. Recoveries under the policy are reported as a reduction of claims expense. Claims expense was reduced by approximately $300,000 and $700,000 for these reimbursements in 2015 and 2014, respectively.

(Continued)

See independent auditors' report.
6. Reinsurance (Continued)

The Company, or any representative, officer, trustee, or director of the Company, does not own in excess of 10% or control, either directly or indirectly, any non-affiliated reinsurer. The Company has not issued any policies that have been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor, an insured, or any other person not primarily engaged in the reinsurance business. The Company does not have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for any reason other than for nonpayment of premium or similar credit. The Company does not have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies.

7. Concentration of Revenue

The Company derived 10% and 12% of revenue from the premiums associated with the contract with the Centers for Medicare and Medicaid Services in 2015 and 2014, respectively. At December 31, 2015 and 2014, 7% and 62%, respectively, of the Company's total accounts receivable was due under the contract. Loss of the contract due to non-renewal or legislative decisions to discontinue funding of the program could materially affect the financial position of the Company. The contract is renewable on an annual basis effective January 1. The contract was renewed as of January 1, 2016.

The amount of net premiums written by the Company during 2015 and 2014 that were subject to retrospective rating features was $22,024,250 and $16,513,518, respectively. These amounts represent 100% of total net premiums written for Medicare Part D.

The Company reclassified $14,772,375 and $10,641,669 for 2015 and 2014, respectively, from revenue to contra-expense for Medicare Part D pharmacy expenses. As of December 31, 2015 and 2014, the Company recorded a receivable for $117,296 and $1,073,936, respectively, from CMS for the Medicare Part D Low-Income Subsidy and Reinsurance Subsidy.

The Company derived approximately 90% and 88% of revenue from the premiums associated with the CCO contract between the Company and the Oregon Health Authority in 2015 and 2014, respectively. At December 31, 2015 and 2014, 93% and 35%, respectively, of the Company's total accounts receivable was due under the contract. Loss of the contract due to non-renewal or legislative decisions to discontinue funding of the program could materially affect the financial position of the Company. The contract was renewed January 1, 2014 and continues through December 31, 2018.

See independent auditors' report.
8. Non-Admitted Assets

The following is a schedule of non-admitted assets as of December 31:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums and considerations</td>
<td>$1,772</td>
<td>$2,862</td>
</tr>
<tr>
<td>Deferred tax asset</td>
<td>128,000</td>
<td>169,000</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>123,028</td>
<td>143,292</td>
</tr>
<tr>
<td>Health care and other receivables</td>
<td>222,711</td>
<td>119,273</td>
</tr>
<tr>
<td>Balance, end of year</td>
<td>475,511</td>
<td>434,427</td>
</tr>
<tr>
<td>Balance, beginning of year</td>
<td>434,427</td>
<td>513,810</td>
</tr>
<tr>
<td>Increase (decrease) in non-admitted assets</td>
<td>$41,084</td>
<td>$(79,383)</td>
</tr>
</tbody>
</table>

9. Related Parties

Agate provides administrative services to the Company. These services included employee leasing, medical management, utilization, data processing, and records maintenance. Total administrative services for 2015 and 2014 were $37,109,120 and $27,715,643, respectively. As of December 31, 2015, $1,000,000 was receivable from Centene and is included in receivables from parent, and $4,858,083 was payable to Agate and is included in amounts due to parent.

Additionally, during 2014 Agate and the Company had an arrangement under which Agate reimbursed the Company for 90% of amounts paid for claims incurred by individual members between $100,000 and $300,000 during each calendar year. Premiums paid under this arrangement by the Company were $7,750,544 for 2014, which were included in claims incurred on the statements of revenue and expenses - statutory basis. Claims incurred on the statements of revenue and expenses - statutory basis were reduced by $2,800,000 for amounts due under this arrangement for 2014. The Company recorded a receivable for claims reimbursement of $1,000,000 as of December 31, 2014, which was included in receivables from parent and subsequently paid in 2015. During 2015, the Company terminated this arrangement. Upon termination, Agate reimbursed the Company approximately $8,900,000, which represents the net of all premiums paid less claims reimbursements received under the arrangement from contract inception, and is recorded as a contra-expense in claims incurred on the accompanying statements of revenues and expenses - statutory basis.

Under the Company's tax sharing arrangement (Note 5), the Company had payables of approximately $13,722,000 and $10,722,000 at December 31, 2015 and 2014, respectively, that will ultimately be settled with the parent for federal and state income taxes.

See independent auditors' report.
10. Statutory Financial Information

The Company, which is domiciled in Oregon, prepares their statutory basis financial statements in accordance with accounting principles and practices prescribed or permitted by the ODCBS.

The NAIC requires insurance companies to calculate risk-based capital (RBC) ratios, which serve as a benchmark for the regulation of insurance companies' solvency by state insurance regulators. The formulas for determining the amount of RBC specify various weighting factors that are applied to financial balances or various levels of activity based on a perceived degree of risk. Regulatory compliance is determined by a ratio of the enterprise's regulatory total adjusted capital to its authorized control level RBC. Enterprises below specific trigger points or ratios are classified within certain levels, each of which require specific corrective action or may cause state regulators to take certain actions. As of December 31, 2015, the Company's ratios exceed all regulatory requirements.

Dividends are paid as determined by the board of directors with the approval of the Commissioner of the ODCBS, as long as the Company meets or exceeds minimum capital and surplus requirements. During 2015 and 2014, the Company paid dividends of $22,179,995 and $0, respectively.

The Company is subject to the annual fee under section 9010 of the Affordable Care Act (ACA). This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1, 2014. As of December 31, 2015, the Company has written health insurance subject to the ACA assessment and expects to conduct health insurance business in 2016.

To determine the total assessment, the amount of subject premiums written were $494,181,890 and $402,692,844 for 2015 and 2014, respectively. The Company estimated their portion of the annual health insurance industry fee payable on September 30, 2016 to be $8,665,090, as of December 31, 2015. This amount is reflected in special surplus as of December 31, 2015. The Company estimated their portion of the annual health insurance industry fee payable on September 30, 2015 to be $5,005,722, as of December 31, 2014. This amount was reflected in special surplus as of December 31, 2014. The total fee paid was $6,990,712 and $3,046,644 in 2015 and 2014, respectively.

Accruing the ACA assessment as of December 31, 2015 would not have triggered an RBC action level. As of December 31, 2015, before the ACA assessment-related surplus adjustment, total adjusted capital was $41,280,302. As of December 31, 2015, after the ACA assessment-related surplus adjustment, total adjusted capital was $32,615,212. As of December 31, 2015 the authorized control level was $16,100,142.

See independent auditors' report.
11. Litigation and Contingent Liabilities

The Company, consistent with the insurance industry in general, is subject to litigation in the normal course of business. The Company's management does not believe that such litigation will have a material effect on its financial position.

12. Employee Benefits

Employees of the Company are covered by a defined contribution 401(k) profit-sharing plan sponsored by Agate Resources, Inc. Given that the plan is sponsored by Agate, the Company has no legal obligation for benefits under the plan.

13. Fair Value Measurement

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2015. Valuation techniques utilized to determine fair value are consistently applied.

The carrying amounts of financial instruments including cash, cash equivalents, and short-term investments, accounts receivable, accounts payable, and other short-term assets and liabilities approximate fair value, because of the relatively short maturity of these instruments.

Investments in common stocks and mutual funds are reported at fair value. These securities are traded in active markets and are valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy.

Investments in bonds are reported at amortized cost. Investments in U.S. Government securities are traded in active markets and are valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy. The fair value of all other bonds is estimated using recently executed transactions, market price quotations (where observable), bond spreads, or credit default swap spreads. The spread data used are for the same maturity as the bond. If the spread data does not reference the issuer, then data that references a comparable issuer is used. Where observable price quotations are not available, fair value is determined based on cash flow models with yield curves, bond, or single-name credit default swap spreads and recovery rates based on collateral values as key inputs. They are generally categorized in Level Two of the fair value hierarchy.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair value. Furthermore, while the Company believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

(Continued)

See independent auditors' report.
13. Fair Value Measurement (Continued)

The following table sets forth by level, within the fair value hierarchy, the Company's assets at fair value as of December 31:

<table>
<thead>
<tr>
<th>Description</th>
<th>Admitted Assets</th>
<th>Total Fair Value</th>
<th>Quoted Prices in Active Markets for Identical Assets (Level 1)</th>
<th>Significant Other Observable Inputs (Level 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>December 31, 2015</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assets recorded at fair value:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common stocks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>$106,570</td>
<td>$106,570</td>
<td>$106,570</td>
<td>-</td>
</tr>
<tr>
<td>Money market mutual funds</td>
<td>6,699,868</td>
<td>6,699,868</td>
<td>6,699,868</td>
<td>-</td>
</tr>
<tr>
<td>Assets reported at fair value:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bonds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Government</td>
<td>7,983,086</td>
<td>8,013,325</td>
<td>4,568,826</td>
<td>3,444,499</td>
</tr>
<tr>
<td>Domestic corporate debt</td>
<td>7,450,539</td>
<td>7,466,439</td>
<td>-</td>
<td>7,466,439</td>
</tr>
<tr>
<td>Foreign corporate debt</td>
<td>1,754,484</td>
<td>1,748,106</td>
<td>-</td>
<td>1,748,106</td>
</tr>
<tr>
<td>Mortgage/asset backed</td>
<td>264,145</td>
<td>267,129</td>
<td>-</td>
<td>267,129</td>
</tr>
<tr>
<td>Short-term investments</td>
<td>3,000,549</td>
<td>3,009,979</td>
<td>3,009,979</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>$27,259,241</td>
<td>$27,311,416</td>
<td>$14,385,243</td>
<td>$12,926,173</td>
</tr>
<tr>
<td><strong>December 31, 2014</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assets recorded at fair value:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common stocks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>$5,223,958</td>
<td>$5,223,958</td>
<td>$5,223,958</td>
<td>-</td>
</tr>
<tr>
<td>Money market mutual funds</td>
<td>516,433</td>
<td>516,433</td>
<td>516,433</td>
<td>-</td>
</tr>
<tr>
<td>Assets reported at fair value:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bonds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Government</td>
<td>8,880,506</td>
<td>8,927,515</td>
<td>8,927,515</td>
<td>-</td>
</tr>
<tr>
<td>Domestic corporate debt</td>
<td>8,692,991</td>
<td>8,703,287</td>
<td>-</td>
<td>8,703,287</td>
</tr>
<tr>
<td>Foreign corporate debt</td>
<td>2,385,089</td>
<td>2,378,545</td>
<td>-</td>
<td>2,378,545</td>
</tr>
<tr>
<td>Mortgage/asset backed</td>
<td>325,335</td>
<td>331,167</td>
<td>-</td>
<td>331,167</td>
</tr>
<tr>
<td>Short-term investments</td>
<td>6,033,296</td>
<td>6,031,284</td>
<td>5,032,726</td>
<td>998,558</td>
</tr>
<tr>
<td>Cash equivalents</td>
<td>250,556</td>
<td>250,556</td>
<td>250,556</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>$32,308,164</td>
<td>$32,362,745</td>
<td>$19,951,188</td>
<td>$12,411,557</td>
</tr>
</tbody>
</table>

See independent auditors' report.
Gross investments, and investments which are classified as admitted assets, consist of the following at December 31, 2015:

<table>
<thead>
<tr>
<th>Investment Categories</th>
<th>Gross Investment Holdings</th>
<th>Percentage of Gross Holdings</th>
<th>Admitted Investment Assets as Reported in the Annual Statement</th>
<th>Percentage of Total Admitted Investment Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. treasury securities</td>
<td>$ 4,553,428</td>
<td>3.47 %</td>
<td>$ 4,553,428</td>
<td>3.47 %</td>
</tr>
<tr>
<td>U.S. government sponsored agencies</td>
<td>3,429,658</td>
<td>2.61</td>
<td>3,429,658</td>
<td>2.61</td>
</tr>
<tr>
<td>Mortgage-backed securities</td>
<td>264,145</td>
<td>0.20</td>
<td>264,145</td>
<td>0.20</td>
</tr>
<tr>
<td>Other debt and other fixed income securities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unaffiliated domestic securities</td>
<td>7,450,539</td>
<td>5.68</td>
<td>7,450,539</td>
<td>5.68</td>
</tr>
<tr>
<td>Unaffiliated non-U.S. securities</td>
<td>1,754,484</td>
<td>1.34</td>
<td>1,754,484</td>
<td>1.34</td>
</tr>
<tr>
<td>Equity interests:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investments in mutual funds</td>
<td>6,806,438</td>
<td>5.18</td>
<td>6,806,438</td>
<td>5.18</td>
</tr>
<tr>
<td>Cash, cash equivalents, and short-term investments</td>
<td>105,111,295</td>
<td>80.07</td>
<td>105,111,295</td>
<td>80.07</td>
</tr>
<tr>
<td>Receivables for securities</td>
<td>1,907,095</td>
<td>1.45</td>
<td>1,907,095</td>
<td>1.45</td>
</tr>
<tr>
<td>Total invested assets</td>
<td>$ 131,277,082</td>
<td>100.00 %</td>
<td>$ 131,277,082</td>
<td>100.00 %</td>
</tr>
</tbody>
</table>

(Continued)

See independent auditors' report.
Trillium Community Health Plan, Inc.'s total admitted assets as filed in the 2015 annual statement are $154,802,343.

The Company's ten largest exposures to a single issuer/borrower/investment are as follows:

<table>
<thead>
<tr>
<th>Issuer</th>
<th>Description of Exposure</th>
<th>Amount</th>
<th>Percentage of Total Admitted Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific Continental Bank</td>
<td>Cash</td>
<td>$96,369,114</td>
<td>62.253%</td>
</tr>
<tr>
<td>Umpqua Bank</td>
<td>Cash and sweep account</td>
<td>5,741,632</td>
<td>3.709</td>
</tr>
<tr>
<td>FNMA</td>
<td>Bonds</td>
<td>1,194,096</td>
<td>0.771</td>
</tr>
<tr>
<td>Federal Farm Credit Bank</td>
<td>Bonds</td>
<td>364,818</td>
<td>0.236</td>
</tr>
<tr>
<td>Georgia Power Company</td>
<td>Bonds</td>
<td>346,339</td>
<td>0.224</td>
</tr>
<tr>
<td>Deutsc Bank AG London</td>
<td>Bonds</td>
<td>329,155</td>
<td>0.213</td>
</tr>
<tr>
<td>BB&amp;T Corporation</td>
<td>Bonds</td>
<td>327,679</td>
<td>0.212</td>
</tr>
<tr>
<td>Caterpillar Financial Services</td>
<td>Bonds</td>
<td>310,978</td>
<td>0.201</td>
</tr>
<tr>
<td>Ford Credit Floorplan Master</td>
<td>Bonds</td>
<td>303,241</td>
<td>0.196</td>
</tr>
<tr>
<td>Cisco Systems, Inc.</td>
<td>Bonds</td>
<td>302,102</td>
<td>0.195</td>
</tr>
</tbody>
</table>

The amounts and percentages of the Company's total admitted assets held in bonds by NAIC rating are as follows:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Amount</th>
<th>Percentage of Total Admitted Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAIC-1</td>
<td>$20,303,621</td>
<td>13.116%</td>
</tr>
<tr>
<td>NAIC-2</td>
<td>149,182</td>
<td>0.096</td>
</tr>
</tbody>
</table>

The amounts and percentages of the Company's largest equity interests are as follows:

<table>
<thead>
<tr>
<th>Issuer</th>
<th>Amount</th>
<th>Percentage of Total Admitted Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wells Fargo Adv Cash Inv Fund Inst Class #451</td>
<td>$6,699,868</td>
<td>4.328%</td>
</tr>
<tr>
<td>Invesco Small Cap Growth Fund-R5 #4764</td>
<td>106,570</td>
<td>0.069</td>
</tr>
</tbody>
</table>

See independent auditors' report.
Under Section 1303 of the Affordable Care Act, the Company is required to segregate premiums received for coverage not eligible for federal subsidies. For 2015, the Company reported forty-five members covered by products under the Oregon individual exchange. The Company reported the following segregated premium activity for 2015:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance - January 1, 2015</td>
<td>$ 17</td>
</tr>
<tr>
<td>Receipts</td>
<td>339</td>
</tr>
<tr>
<td>Disbursements</td>
<td>-</td>
</tr>
<tr>
<td>Balance - December 31, 2015</td>
<td>$ 356</td>
</tr>
</tbody>
</table>

See independent auditors' report.
TRILLIUM COMMUNITY HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of Centene Corporation)

Statutory Financial Statements and
Supplemental Information

December 31, 2016 and 2015

(With Independent Auditors’ Report Thereon)
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Independent Auditors’ Report

The Audit Committee of the Board of Directors
Trillium Community Health Plan, Inc.:

Report on the Financial Statements
We have audited the accompanying financial statements of Trillium Community Health Plan, Inc. (the Company), which comprise the statutory statement of admitted assets, liabilities, and capital and surplus as of December 31, 2016, and the related statutory statements of revenue and expenses, changes in capital and surplus, and cash flow for the year then ended, and the related notes to the statutory financial statements.

Management’s Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Oregon Department of Consumer and Business Services – Division of Financial Regulation. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors’ Responsibility
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors’ judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles
As described in note 2 to the financial statements, the financial statements are prepared by the Company using statutory accounting practices prescribed or permitted by the Oregon Department of Consumer and Business Services – Division of Financial Regulation, which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, the financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.
The effects on the financial statements of the variances between the statutory accounting practices described in note 2 and U.S. generally accepted accounting principles, although not reasonably determinable, are presumed to be material.

**Adverse Opinion on U.S. Generally Accepted Accounting Principles**

In our opinion, because of the significance of the variances between statutory accounting practices and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of the Company as of December 31, 2016, or the results of its operations or its cash flows for the year then ended.

**Opinion on Statutory Basis of Accounting**

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of the Company as of December 31, 2016, and the results of its operations and its cash flow for the year then ended, in accordance with statutory accounting practices prescribed or permitted by the Oregon Department of Consumer and Business Services – Division of Financial Regulation described in note 2.

**Other Matter**

The accompanying financial statements of the Company as of December 31, 2015 and for the year then ended were audited by other auditors whose report thereon dated May 26, 2016, expressed an unmodified opinion on those financial statements.

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information included in the Supplemental Summary Investment Schedule – December 31, 2016, and Supplemental Investment Risk Interrogatories – December 31, 2016, is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Oregon Department of Consumer and Business Services – Division of Financial Regulation. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

KPMG LLP

St. Louis, Missouri
May 26, 2017
### Admitted Assets

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds</td>
<td>$95,402,409</td>
<td>$17,452,254</td>
</tr>
<tr>
<td>Stocks</td>
<td>—</td>
<td>$6,806,438</td>
</tr>
<tr>
<td>Cash, cash equivalents, and short-term investments</td>
<td>$52,546,925</td>
<td>$105,111,295</td>
</tr>
<tr>
<td>Receivables for securities</td>
<td>—</td>
<td>$1,907,095</td>
</tr>
<tr>
<td>Investment income due and accrued</td>
<td>$682,657</td>
<td>$117,003</td>
</tr>
<tr>
<td>Premium and related receivables</td>
<td>$23,647,372</td>
<td>$20,054,961</td>
</tr>
<tr>
<td>Healthcare and other receivables</td>
<td>$57,280</td>
<td>$117,297</td>
</tr>
<tr>
<td>Amounts due from affiliates</td>
<td>—</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Net deferred tax asset</td>
<td>$2,385,014</td>
<td>$2,236,000</td>
</tr>
<tr>
<td><strong>Total admitted assets</strong></td>
<td><strong>$174,721,657</strong></td>
<td><strong>154,802,343</strong></td>
</tr>
</tbody>
</table>

### Liabilities and Capital and Surplus

#### Liabilities:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims payable</td>
<td>$89,926,036</td>
<td>$73,011,361</td>
</tr>
<tr>
<td>Accrued medical incentive pool and bonus amounts</td>
<td>$1,032,302</td>
<td>$9,180,934</td>
</tr>
<tr>
<td>Unpaid claims adjustment expenses</td>
<td>$921,982</td>
<td>$2,542,030</td>
</tr>
<tr>
<td>Premium deficiency reserve</td>
<td>$2,028,533</td>
<td>$5,133,625</td>
</tr>
<tr>
<td>Return of premium payable</td>
<td>$4,454,530</td>
<td>$4,888,455</td>
</tr>
<tr>
<td>General expenses due or accrued</td>
<td>$676,698</td>
<td>$2,540,945</td>
</tr>
<tr>
<td>Amounts due to affiliates</td>
<td>$7,507,105</td>
<td>$4,858,083</td>
</tr>
<tr>
<td>Federal income tax payable</td>
<td>$1,685,880</td>
<td>$11,332,801</td>
</tr>
<tr>
<td>State income tax payable</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>$316,017</td>
<td>$33,807</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td><strong>$110,245,314</strong></td>
<td><strong>$113,522,041</strong></td>
</tr>
</tbody>
</table>

#### Capital and surplus:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common stock, $1,000 par value, authorized, issued and outstanding 5,000 shares</td>
<td>$5,000,000</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>Gross paid-in and contributed surplus</td>
<td>$34,300,000</td>
<td>$15,000,000</td>
</tr>
<tr>
<td>Special surplus</td>
<td>—</td>
<td>$8,665,090</td>
</tr>
<tr>
<td>Unassigned surplus</td>
<td>$25,176,343</td>
<td>$12,615,212</td>
</tr>
<tr>
<td><strong>Total capital and surplus</strong></td>
<td><strong>$64,476,343</strong></td>
<td><strong>$41,280,302</strong></td>
</tr>
<tr>
<td><strong>Total liabilities and capital and surplus</strong></td>
<td><strong>$174,721,657</strong></td>
<td><strong>$154,802,343</strong></td>
</tr>
</tbody>
</table>

See accompanying notes to statutory financial statements.
TRILLIUM COMMUNITY HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of Centene Corporation)

Statutory Statements of Revenue and Expenses
Years ended December 31, 2016 and 2015

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium income</td>
<td>$499,888,764</td>
<td>492,403,518</td>
</tr>
<tr>
<td>Other health care related revenues</td>
<td>19,848,299</td>
<td>30,478,210</td>
</tr>
<tr>
<td>Total revenue</td>
<td>519,737,063</td>
<td>522,881,728</td>
</tr>
<tr>
<td>Expenses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical and hospital expenses</td>
<td>324,935,014</td>
<td>293,721,070</td>
</tr>
<tr>
<td>Other professional services</td>
<td>51,017,452</td>
<td>45,925,954</td>
</tr>
<tr>
<td>Emergency room</td>
<td>32,317,241</td>
<td>37,561,750</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>69,132,767</td>
<td>59,788,837</td>
</tr>
<tr>
<td>Incentive pool and bonus amounts</td>
<td>(5,390,186)</td>
<td>4,771,681</td>
</tr>
<tr>
<td>Reinsurance recoveries</td>
<td>(2,148,065)</td>
<td>(7,545,682)</td>
</tr>
<tr>
<td>Total medical and hospital expenses</td>
<td>469,864,223</td>
<td>434,223,610</td>
</tr>
<tr>
<td>Claims adjustment expense</td>
<td>4,395,676</td>
<td>21,633,005</td>
</tr>
<tr>
<td>General administrative expenses</td>
<td>42,952,194</td>
<td>33,966,484</td>
</tr>
<tr>
<td>Increase (decrease) in premium deficiency reserve</td>
<td>(3,105,092)</td>
<td>5,133,625</td>
</tr>
<tr>
<td>Total expenses</td>
<td>514,107,001</td>
<td>494,956,724</td>
</tr>
<tr>
<td>Investment income:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net investment income</td>
<td>1,144,013</td>
<td>844,940</td>
</tr>
<tr>
<td>Net realized capital losses (net of tax expense of $17,432 and $15,677 respectively)</td>
<td>32,371</td>
<td>38,357</td>
</tr>
<tr>
<td>Total investment income</td>
<td>1,176,384</td>
<td>883,307</td>
</tr>
<tr>
<td>Net loss from agents’ or premium balances charged off</td>
<td>—</td>
<td>(82)</td>
</tr>
<tr>
<td>Income before federal income taxes</td>
<td>6,806,446</td>
<td>28,808,219</td>
</tr>
<tr>
<td>Federal income tax expense</td>
<td>1,783,944</td>
<td>14,686,196</td>
</tr>
<tr>
<td>Net income</td>
<td>$5,022,502</td>
<td>14,122,023</td>
</tr>
</tbody>
</table>

See accompanying notes to statutory financial statements.
TRILLIUM COMMUNITY HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of Centene Corporation)

Statutory Statements of Changes in Capital and Surplus
Years ended December 31, 2016 and 2015

<table>
<thead>
<tr>
<th></th>
<th>Common stock</th>
<th>Special surplus</th>
<th>Unassigned surplus</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance, December 31, 2014</td>
<td>$ 15,000,000</td>
<td>—</td>
<td>5,005,722</td>
<td>43,454,699</td>
</tr>
<tr>
<td>Net income</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>14,122,024</td>
</tr>
<tr>
<td>Change in net unrealized capital gains (losses)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>(261,342)</td>
</tr>
<tr>
<td>Change in net deferred income tax</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>1,186,000</td>
</tr>
<tr>
<td>Change in nonadmitted assets</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>(41,084)</td>
</tr>
<tr>
<td>Dividends to stockholders</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>(22,179,995)</td>
</tr>
<tr>
<td>Transferred from capital to surplus</td>
<td>(10,000,000)</td>
<td>10,000,000</td>
<td>—</td>
<td>(22,179,995)</td>
</tr>
<tr>
<td>Paid-in surplus</td>
<td>—</td>
<td>5,000,000</td>
<td>—</td>
<td>5,000,000</td>
</tr>
<tr>
<td>Change in special surplus</td>
<td>—</td>
<td>—</td>
<td>3,659,368</td>
<td>(3,659,368)</td>
</tr>
<tr>
<td>Balance, December 31, 2015</td>
<td>5,000,000</td>
<td>15,000,000</td>
<td>8,665,090</td>
<td>41,280,302</td>
</tr>
<tr>
<td>Net income</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>5,022,502</td>
</tr>
<tr>
<td>Change in net unrealized capital gains (losses)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>11,315</td>
</tr>
<tr>
<td>Change in net deferred income tax</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>77,327</td>
</tr>
<tr>
<td>Change in nonadmitted assets</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>(1,215,103)</td>
</tr>
<tr>
<td>Dividends to stockholders</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Transferred from capital to surplus</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Paid-in surplus</td>
<td>—</td>
<td>19,300,000</td>
<td>—</td>
<td>19,300,000</td>
</tr>
<tr>
<td>Change in special surplus</td>
<td>—</td>
<td>—</td>
<td>(8,665,090)</td>
<td>(8,665,090)</td>
</tr>
<tr>
<td>Balance, December 31, 2016</td>
<td>$ 5,000,000</td>
<td>34,300,000</td>
<td>—</td>
<td>64,476,343</td>
</tr>
</tbody>
</table>

See accompanying notes to statutory financial statements.
TRILLIUM COMMUNITY HEALTH PLAN, INC.  
(A Wholly Owned Subsidiary of Centene Corporation)  
Statutory Statements of Cash Flow  
Years ended December 31, 2016 and 2015

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash from operating activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premiums collected net of reinsurance</td>
<td>$495,830,543</td>
<td>480,149,416</td>
</tr>
<tr>
<td>Net investment income</td>
<td>1,103,876</td>
<td>998,032</td>
</tr>
<tr>
<td>Miscellaneous income</td>
<td>19,848,299</td>
<td>30,478,210</td>
</tr>
<tr>
<td>Benefit and loss related payments</td>
<td>(462,550,513)</td>
<td>(406,618,979)</td>
</tr>
<tr>
<td>General, administrative, and claims adjustment expenses paid</td>
<td>(44,957,603)</td>
<td>(58,207,771)</td>
</tr>
<tr>
<td>Federal income taxes paid</td>
<td>(11,437,947)</td>
<td>(10,693,061)</td>
</tr>
<tr>
<td>Net cash (used in) provided by operations</td>
<td>(2,163,345)</td>
<td>36,105,847</td>
</tr>
<tr>
<td>Cash from investing activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from investments sold, matured, or repaid</td>
<td>36,730,751</td>
<td>11,240,802</td>
</tr>
<tr>
<td>Cost of investments acquired</td>
<td>(106,431,776)</td>
<td>(11,736,618)</td>
</tr>
<tr>
<td>Net cash used in investments</td>
<td>(69,701,025)</td>
<td>(495,816)</td>
</tr>
<tr>
<td>Cash from financing and miscellaneous activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid-in surplus</td>
<td>19,300,000</td>
<td>5,000,000</td>
</tr>
<tr>
<td>Dividends to stockholders</td>
<td>—</td>
<td>(22,179,995)</td>
</tr>
<tr>
<td>Net cash provided by (used in) financing and miscellaneous sources</td>
<td>19,300,000</td>
<td>(17,179,995)</td>
</tr>
<tr>
<td>Net change in cash, cash equivalents, and short-term investments</td>
<td>(52,564,370)</td>
<td>18,430,036</td>
</tr>
<tr>
<td>Cash, cash equivalents, and short-term investments, beginning of year</td>
<td>105,111,295</td>
<td>86,681,259</td>
</tr>
<tr>
<td>Cash, cash equivalents, and short-term investments, end of year</td>
<td>$52,546,925</td>
<td>105,111,295</td>
</tr>
</tbody>
</table>

See accompanying notes to statutory financial statements.
(1) Organization and Operations

Trillium Community Health Plan, Inc. (the Company) is a wholly owned subsidiary of Centene Corporation (Centene), a Delaware stock corporation. Centene owns all of the issued and outstanding shares of the Company’s stock through Centene’s wholly owned subsidiary Agate Resources, Inc. (Agate), an Oregon corporation. The Company is owned 40% and 60% by Agate and Lane Individual Practice Association, Inc. (LIPA), respectively. LIPA is a wholly owned subsidiary of Agate.

The Company was incorporated in 2006 as a for-profit health care service contractor for the Centers for Medicare and Medicaid Services (CMS), offering a Medicare Advantage plan. In 2012, the Company became licensed to provide Medicaid coverage under a new type of healthcare delivery system called a Coordinated Care Organization (CCO) by the Oregon Health Authority (OHA). The Company also offers individual insurance policies, including comprehensive medical and stand-alone dental, through the Oregon Health Insurance Marketplace.

(2) Basis of Presentation and Significant Accounting Policies

The statutory financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation (ODCBS – DFR) for determining and reporting the financial condition and the results of operations of an insurance company and for determining its solvency under Oregon insurance law.

The State of Oregon has adopted the accounting policies found in the revised National Association of Insurance Commissioners (NAIC) Accounting Practices and Procedures Manual (NAIC SAP), subject to any deviations prescribed or permitted by the Department (SAP). SAP differs in certain respects from U.S. generally accepted accounting principles (GAAP) followed by other types of enterprises in determining their financial position, results of operations and cash flows. The most significant variances are as follows:

A. Under SAP, certain assets designated as “nonadmitted assets” are excluded from the statutory statements of admitted assets, liabilities, and capital and surplus and are charged to unassigned surplus as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums and considerations</td>
<td>$ —</td>
<td>1,772</td>
</tr>
<tr>
<td>Deferred tax asset</td>
<td>56,315</td>
<td>128,002</td>
</tr>
<tr>
<td>Health care and other receivables</td>
<td>1,617,769</td>
<td>222,711</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>16,532</td>
<td>123,028</td>
</tr>
<tr>
<td><strong>Total nonadmitted assets</strong></td>
<td><strong>$ 1,690,616</strong></td>
<td><strong>475,513</strong></td>
</tr>
</tbody>
</table>

Under GAAP, such assets are included in the balance sheet subject to impairment and allowances.

B. The statutory financial statements reflect certain assets and liabilities net of ceded reinsurance.
C. Under SAP, debt securities are carried at amortized cost. Under GAAP, debt securities are carried at amortized cost only if there is both a positive intent and ability to hold to maturity. Otherwise, they are carried at fair value with unrealized gains and losses recognized within income or accumulated other comprehensive income according to prescribed rules.

D. Under SAP, the statements of cash flow reconcile to changes in cash, cash equivalents, and short-term investments with original maturities of one year or less. Under GAAP, the statements of cash flow reconcile to changes in cash and cash equivalents with a remaining maturity period of three months or less. The statutory statements of cash flow are presented in a specified format, which differs from the format prescribed by GAAP.

E. Under SAP, net deferred income tax assets are admitted following the application of certain criteria, with the resulting change in admitted deferred tax asset amount being credited directly to capital and surplus. Under GAAP, deferred income tax assets and liabilities are recorded for temporary differences between the reported amounts of assets and liabilities and those in the Company’s income tax return. Changes to deferred income tax assets and liabilities are recorded in current operations under GAAP and directly to surplus under SAP.

F. Comprehensive income is not determined for statutory reporting purposes and there is no statement reflecting accumulated other comprehensive income.

The aggregate effect of the foregoing differences between SAP and GAAP has not been determined, but is presumed to be material.

(a) Management’s Estimates
The preparation of statutory financial statements in conformity with SAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in the evaluation, as considered necessary. Actual results could differ from those estimates.

(b) Fair Value Measurements
In the normal course of business, the Company invests in various financial assets and incurs various financial liabilities. Fair values are disclosed for all financial instruments, whether or not such values are recognized in the statutory statements of admitted assets, liabilities, and capital and surplus. Management obtains quoted market prices or other observable inputs for these disclosures. The carrying amounts reported in the statutory statements of admitted assets, liabilities, and capital and surplus for cash and cash equivalents, premiums receivable, general expenses due and accrued, and certain other current assets and liabilities are carried at cost, which approximates fair value because of their short-term nature.
(c) **Bonds**

Bonds are valued as prescribed by the NAIC and are generally carried at amortized cost with the accretion of discounts and amortization of premiums being computed under the scientific method. Realized gains and losses are calculated using the specific-identification method. Asset-backed securities are revalued using currently estimated cash flows and prepayment assumptions. A prospective adjustment methodology is used for all asset-backed securities.

The Company evaluates all of its bonds for impairment based on current market prices, economic conditions and the financial condition of the issuer. Investments that have declines in NAIC fair value below cost, which are judged to be other-than-temporary, are written down to estimated NAIC fair value. Factors considered in evaluating whether a decline in value is other-than-temporary include: (1) whether the decline is substantial, (2) the Company’s ability and intent to retain the investment for a period of time sufficient to allow for an anticipated recovery in value, (3) the duration and extent to which the fair value has been less than cost, and (4) the financial condition and near-term prospects of the issuer in relation to the anticipated recovery period. During 2016 and 2015, the Company recorded no charges related to other-than-temporary impairments.

Investment securities are exposed to various risks, such as interest rate, market and credit. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in risks in the near term would materially affect the amounts reported in the statutory statements of admitted assets, liabilities, and capital and surplus or the statutory statements of revenue and expenses.

(d) **Cash, Cash Equivalents and Short-Term Investments**

Cash, cash equivalents and short-term investments consist of cash on deposit and investments with an original maturity of one year or less.

(e) **Restricted Assets**

Under Oregon Statutes 731.604 – 731.652, the Company is required to maintain an insolvency deposit with a minimum market value of $260,000, representing a $250,000 minimum statutory market value and an additional $10,000 to cover market value fluctuations, in a custodial account for the protection of enrollees. The Company is entitled to receive interest income on these deposits. The restricted amounts are included in cash, cash equivalents and short-term investments on the statutory statements of admitted assets, liabilities, and capital and surplus. At December 31, 2016 and 2015, the carrying value of the deposit was $260,000.

(f) **Investment Income Due and Accrued**

The Company recognizes investment income when earned. Investment income due and accrued is recorded for investment income earned as of the reporting date but collected in a subsequent period. The Company performs an evaluation of these receivables to determine whether an impairment exists. No impairment charges were recorded during 2016 or 2015.
(g) **Premium Income and Premiums Receivable**

Premium income is recognized in the period in which members are entitled to receive covered services. Premiums collected in advance of the month for which coverage applies are deferred and recorded as premiums received in advance. Premiums due to the Company are recorded as premium receivables and are recorded net of an allowance based on management’s judgment on the collectability of these accounts. As of December 31, 2016 and 2015, an allowance of $6,816 and $0, respectively, was recorded related to member premiums for the Company’s Health Insurance Marketplace operations.

During 2016 and 2015, the Company earned premium revenues, net of ceded reinsurance premiums, of $499,888,764 and $492,403,518, respectively, under contracts with OHA, CMS and operations in the Oregon Health Insurance Marketplace. The Company is currently contracted with OHA through December 2018 and CMS through December 2017. Effective January 2017, the Company will no longer offer insurance policies through the Oregon Health Insurance Marketplace. Substantially all premiums are based on a fixed amount per eligible enrolled member per month. In addition, a portion of the premiums are subject to an adjustment, or risk score, based on the acuity of the Company’s membership relative to the enrolled population of other health organizations.

Under the Company’s contract with OHA it is eligible to receive additional funding for meeting or exceeding specified quality benchmarks. The Company estimates the likelihood of achieving its target based on communication with the State, available information and historical outcomes which is recorded as other health care related revenues in the statement of revenue and expenses. For 2016 and 2015, the Company recorded revenues of $19,848,299 and $30,478,210, respectively, related to this program. The Company distributes 100% of the additional funding received to providers with a portion paid to Agate for the management fee.

Premiums receivable consist primarily of amounts receivable from OHA and CMS. Amounts receivable under government insured plans, including amounts over 90 days due, which qualify as accident and health contracts are admitted assets under SAP. Amounts receivable under government insured plans include, but are not limited to, receivables under Medicare, Medicaid, and similarly funded government insured plans. As of December 31, 2016 and 2015, the Company had $0 in premiums receivable over 90 days, included in admitted assets.

(h) **Amounts Due from (to) Affiliates**

Amounts due from (to) affiliates generally consist of amounts receivable (payable) from (to) related parties under various service agreements as well as parent contribution receivables. See note 7 for detailed amounts due from (to) affiliates.

(i) **Income Taxes**

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the statutory financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled.
Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

For the year ended December 31, 2016 and the post-acquisition period of September 1, 2015 – December 31, 2015, the Company was included in the consolidated federal income tax return of Centene and its other subsidiaries. In accordance with the group’s tax allocation agreement, the subsidiaries reimburse or recover from Centene their portion of the income taxes as calculated on a separate company basis.

(j) **Claims Payable and Unpaid Claims Adjustment Expenses**

Claims payable includes claims reported but not yet paid, or inventory, and estimates for claims incurred but not reported, or IBNR. Unpaid claims adjustment expense includes estimates for the costs necessary to process unpaid claims. In 2016, the Company elected to report some costs in general administrative expenses that had historically been reported in claims adjustment expense. This resulted in $4,395,676 of claims adjustment expenses for 2016 as compared to $21,633,005 in claims adjustment expenses for 2015. The Company estimates its medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that claims payable estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. The Company includes in its IBNR an estimate for claims payable under moderately adverse conditions, which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

The Company uses its judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions it considers when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

The Company’s development of the medical claims liability estimate is a continuous process, which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. The Company consistently applies its reserving methodology from period to period. As additional
information becomes known, it adjusts the actuarial model accordingly to establish medical claims liability estimates. Management believes the amount of medical claims payable is reasonable and adequate to cover the Company’s liability for unpaid claims as of December 31, 2016 and 2015; however, actual claim payments may differ from established estimates.

(k) **Accrued Medical Incentive Pool and Bonus Amounts**

The Company participates in physician incentive plans with certain contracted providers. The plans are designed to encourage the delivery of quality care to members.

(l) **Premium Deficiency Reserve**

Premium deficiency reserves are recognized when expected incurred costs, claim adjustment expenses, and administration costs exceed the premiums to be collected for the remainder of a contract period. Premium deficiency reserves of $2,028,533 and $5,133,625 were recorded at December 31, 2016 and 2015, respectively, based on the Company’s expectations regarding the profitability of contracts in force at December 31, 2016 and 2015. The Company considered anticipated investment income when calculating its premium deficiency reserve. The adequacy of reserve requirements is continually reviewed by management, with any reductions in the reserve being recorded as a beneficial effect in the statutory statements of revenue and expenses.

(m) **Return of Premium Payable**

The Company is required to pay a rebate to OHA in the event profits exceed established levels. The Company estimates the minimum loss ratio rebate. Amounts are estimated monthly and settled with OHA after conclusion of the measurement period. As such, the Company may report an aggregate health policy reserve, contingent upon (a) the Company’s financial performance during the measurement period and (b) any experience rebate payments made to the State during the reporting period. The estimates made throughout the reporting period are reported as changes in return of premium payable. At December 31, 2016 and 2015, the Company recorded liabilities of $4,454,530 and $4,888,455, respectively.

(n) **Medicare Part D**

The Company offers a Medicare Part D benefit as a fully insured product to Medicare members. The Part D benefit consists of pharmacy benefits for Medicare beneficiaries. Part D offers two types of plans: Prescription Drug Plan (PDP) and Medicare Advantage Plus Prescription Drug (MAPD). PDP covers only prescription drugs and can be combined with traditional Medicare, certain Medicare Advantage Plans or Medicare supplemental plans. MAPD covers both prescription drugs and medical care. The Company only participates in the MAPD plan. The Company has a contract with CMS to participate as a Medicare Advantage Organization.

The recognition of the revenue and cost reimbursement components under Part D is described below:

CMS Premium Direct Subsidy – The Company receives a monthly premium from CMS based on an original bid amount. This payment for each individual is a fixed amount per member for the entire plan year and is based upon that individual’s risk score status. The CMS premium is recognized evenly over the contract period and reported as part of premiums.
Low-Income Premium Subsidy – For qualifying low-income members, CMS will reimburse the Company, on the member’s behalf, some or all of the monthly member premium depending on the member’s income level in relation to the Federal Poverty Level. The low-income premium subsidy is recognized over the contract period and reported as part of premiums.

Catastrophic Reinsurance Subsidy – CMS will reimburse the Company for 80% of drug costs after a member reaches his or her out-of-pocket catastrophic threshold. The CMS prospective payment, a flat PMPM cost reimbursement estimate, is received monthly based on the original CMS bid. After the year is complete, a settlement is made based on actual experience. The catastrophic reinsurance subsidy is accounted for as deposit accounting.

Low-Income Member Cost Sharing Subsidy – For qualifying low-income members, CMS will reimburse the Company, on the member’s behalf, some or all of a member’s cost sharing amounts (e.g., deductible, co-pay/coinsurance). The amount paid for the member by CMS is dependent on the member’s income level in relation to the Federal Poverty Level. The Company receives prospective payments on a monthly basis, and they represent a cost reimbursement that is finalized and settled after the end of the year. Low-income member cost sharing subsidy is accounted for as deposit accounting.

CMS Risk Share – Premiums from CMS are subject to risk corridor provisions which compare costs targeted in the Company’s annual bids to actual prescription drug costs, limited to actual costs that would be incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums the Company received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain. The risk share adjustment, if any, is recorded as an adjustment to premiums.

(o) Reinsurance
The Company limits its risk of certain catastrophic losses by maintaining reinsurance coverage. Premium income is recorded net of ceded reinsurance premiums. Total medical and hospital expenses are recorded net of reinsurance recoveries.

(p) Medical and Hospital Expenses
The Company contracts with various healthcare providers for the provision of certain medical care to its members. Medical claims are submitted by providers and processed in accordance with the terms of the contract. Additionally, the Company compensates some providers on a capitation basis. The amount of the capitation payments and the frequency of the distributions to the provider are based on contractual arrangements.

The cost of other healthcare services provided or contracted for is accrued in the period in which it is provided to a member based in part on estimates, including an accrual for medical services provided but not reported.
(q) **General Administrative Expenses**

The Company has a management services agreement with Agate Resources Inc. (Agate). Under the agreement, the Company pays Agate a fee based on a percentage of its monthly revenues, for which Agate provides the services necessary to manage the business operations of the Company and assumes responsibility for all associated costs. Agate assumes responsibility for program planning and development, management information systems, financial systems and services, facilities arrangement, claims administration, provider and enrollee services and records, case management, care coordination, utilization and peer review, and quality assurance/quality improvement. In addition, under the agreement, the Company pays other direct costs associated with the business not covered by the management services agreement.

(r) **Hospital Reimbursement Adjustments**

The Company excludes amounts received from the Oregon Health Authority under its CCO contract for Hospital Reimbursement Adjustments (HRAs) from premium income and medical and hospital expenses in the statutory statements of revenue and expenses. This treatment was approved by the ODCBS – DFR. HRAs of $64,616,026 and $59,858,105 have been excluded from premium income and medical and hospital expenses for the years ended December 31, 2016 and 2015, respectively.

(s) **Dividend Restrictions**

Dividends are paid as determined by the board of directors with the approval of the Commissioner of the ODCBS – DFR, as long as the Company meets or exceeds minimum capital and surplus requirements. During 2016 and 2015, the Company paid dividends of $0 and $22,179,995, respectively.

(t) **Reclassifications**

Certain reclassifications have been made to prior year amounts to conform to the current year presentation.

(3) **Bonds**

The amortized cost and estimated statutory fair values of investments in bonds at December 31, 2016 and 2015 are as follows:

<table>
<thead>
<tr>
<th>Bond Type</th>
<th>December 31, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amortized cost</td>
</tr>
<tr>
<td>U.S. government obligations</td>
<td>$1,042,874</td>
</tr>
<tr>
<td>Pol sub, states, terr. and poss.</td>
<td>13,589,348</td>
</tr>
<tr>
<td>Spec. revenue and assessments</td>
<td>43,806,403</td>
</tr>
<tr>
<td>Industrial and miscellaneous</td>
<td>34,834,334</td>
</tr>
<tr>
<td>Mortgage-backed securities</td>
<td>2,329,450</td>
</tr>
<tr>
<td><strong>Total bonds</strong></td>
<td><strong>$95,402,409</strong></td>
</tr>
</tbody>
</table>
The above table excludes short-term bonds reported in cash, cash equivalents and short-term investments at December 31, 2016 and 2015 of $3,759,822 and $3,000,549, respectively.

The fair values of the Company’s bonds are evaluated based on NAIC designations set forth by the Securities Valuation Office (SVO). The SVO does not provide fair market values for certain of the Company’s bonds. As such, the Company utilizes independent pricing services to estimate fair value for bonds which are not actively traded on the measurement date or for which the SVO does not provide fair market values.

The following tables illustrate the gross unrealized losses included in the Company’s investment portfolio aggregated by investment category. The tables also illustrate the length of time the securities have been in an unrealized loss position as of December 31, 2016 and December 31, 2015.
The Company views the decrease in value of all of the securities with unrealized capital losses at December 31, 2016 and 2015 as temporary, expects recovery in fair value, anticipates continued payments under the terms of the securities, and has the intent and ability to hold these securities until maturity or a recovery in fair value occurs. Therefore, no impairment of these securities was recorded at December 31, 2016 and 2015, or for the years then ended.

The amortized cost and statutory fair value of debt securities at December 31, 2016, by contractual maturity, are shown below. Actual maturities may differ due to call or prepayment options.

<table>
<thead>
<tr>
<th>Due in one year or less</th>
<th>Amortized value</th>
<th>Statutory fair value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$8,116,661</td>
<td>8,107,089</td>
</tr>
<tr>
<td>Due in one to five years</td>
<td>55,565,044</td>
<td>55,097,014</td>
</tr>
<tr>
<td>Due in five to ten years</td>
<td>30,670,795</td>
<td>29,777,631</td>
</tr>
<tr>
<td>Due after ten years</td>
<td>1,049,909</td>
<td>1,058,664</td>
</tr>
<tr>
<td>Total</td>
<td>$95,402,409</td>
<td>94,040,398</td>
</tr>
</tbody>
</table>

Proceeds from sales of investments in debt securities during 2016 and 2015 were $9,446,663 and $3,167,301, respectively. Proceeds from maturities, repayments and other disposals of investments in debt securities during 2016 and 2015 were $845,000 and $2,191,521, respectively. Gross realized gains for the years ended December 31, 2016 and 2015 were $91,786 and $3,696, respectively. Gross realized losses for the years ended December 31, 2016 and 2015 were $23,835 and $13,999, respectively.

Net investment income for the years ended December 31, 2016 and 2015 was as follows:

<table>
<thead>
<tr>
<th>Interest income:</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds</td>
<td>$1,011,016</td>
<td>687,259</td>
</tr>
<tr>
<td>Cash, cash equivalents and short-term investments</td>
<td>188,480</td>
<td>158,970</td>
</tr>
<tr>
<td>Investment expenses</td>
<td>(55,483)</td>
<td>(1,289)</td>
</tr>
<tr>
<td>Total net investment income</td>
<td>$1,144,013</td>
<td>844,940</td>
</tr>
</tbody>
</table>

(4) Reinsurance

During 2016 and 2015, the Company obtained reinsurance coverage from both affiliated and unaffiliated insurance companies.

For hospital inpatient services incurred during 2016, the Company obtained reinsurance coverage for members insured under its OHA contract from an affiliated entity equal to 90% of expenses in excess of $200,000 per covered person per agreement term, up to $4,600,000 per covered person per agreement term.
The Company obtained reinsurance coverage for Medicare Advantage and Health Insurance Marketplace members at varying attachment points.

The affiliated reinsurance agreement also provides for certain coverage in the event of the insolvency of the Company, as defined in the reinsurance agreement. The reinsurer agrees to continue benefits to the Company’s members who are hospitalized at the time of the insolvency until the earlier of the member’s discharge from the hospital or the date the covered person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program. The reinsurer will also continue benefits for any member for medical services incurred after the date of insolvency until the end of the period for which the applicable premium was received. Coverage for such medical services will continue after the Company becomes insolvent. The reinsurer’s aggregate maximum liability under this provision of the reinsurance agreement will not exceed $4,600,000 in 2016.

Under these agreements, the Company recorded ceded premiums of $2,673,603 and $2,962,569 during the years ended December 31, 2016 and 2015, respectively, in the statutory statements of revenue and expenses, and reinsurance recoveries of $792,000 as of December 31, 2016 as a reduction to claims unpaid in the statutory statements of admitted assets, liabilities, and capital and surplus.

(5) Income Taxes

The December 31, 2016 and 2015 tax balances and related disclosures are calculated and presented pursuant to Statements on Statutory Accounting Principles No. 101. The net deferred tax asset at December 31 and the changes from the prior year are comprised of the following components:

<table>
<thead>
<tr>
<th>2016</th>
<th>Ordinary</th>
<th>Capital</th>
<th>Total</th>
<th>2015</th>
<th>Ordinary</th>
<th>Capital</th>
<th>Total</th>
<th>Change</th>
<th>Ordinary</th>
<th>Capital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total gross deferred tax assets</td>
<td>2,441,329</td>
<td>—</td>
<td>2,441,329</td>
<td>2,364,002</td>
<td>—</td>
<td>2,364,002</td>
<td>77,327</td>
<td>—</td>
<td>77,327</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valuation allowance adjustment</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Adjusted gross deferred tax assets</td>
<td>2,441,329</td>
<td>—</td>
<td>2,441,329</td>
<td>2,364,002</td>
<td>—</td>
<td>2,364,002</td>
<td>77,327</td>
<td>—</td>
<td>77,327</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total gross deferred tax liabilities</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Net deferred tax assets (liabilities)</td>
<td>2,441,329</td>
<td>—</td>
<td>2,441,329</td>
<td>2,364,002</td>
<td>—</td>
<td>2,364,002</td>
<td>77,327</td>
<td>—</td>
<td>77,327</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total deferred tax assets nonadmitted</td>
<td>(56,315)</td>
<td>—</td>
<td>(56,315)</td>
<td>(128,002)</td>
<td>—</td>
<td>(128,002)</td>
<td>71,687</td>
<td>—</td>
<td>71,687</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net admitted deferred tax assets (liabilities)</td>
<td>$2,385,014</td>
<td>—</td>
<td>2,385,014</td>
<td>2,236,000</td>
<td>—</td>
<td>2,236,000</td>
<td>149,014</td>
<td>—</td>
<td>149,014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net change in total deferred tax assets nonadmitted</td>
<td>$ —</td>
<td>—</td>
<td>$ —</td>
<td>$ —</td>
<td>—</td>
<td>$ —</td>
<td>$ —</td>
<td>—</td>
<td>$ —</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The amount of adjusted gross deferred tax assets admitted is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th></th>
<th>2015</th>
<th></th>
<th>Change</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ordinary</td>
<td>Capital</td>
<td>Total</td>
<td>Ordinary</td>
<td>Capital</td>
<td>Total</td>
</tr>
<tr>
<td>Expected to be realized (lesser of i. or ii.):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Expected to be realized</td>
<td>28,161</td>
<td>—</td>
<td>28,161</td>
<td>—</td>
<td>2,236,000</td>
<td>—</td>
</tr>
<tr>
<td>ii. Surplus limitation</td>
<td>9,317,924</td>
<td>—</td>
<td>9,317,924</td>
<td>—</td>
<td>2,236,000</td>
<td>—</td>
</tr>
<tr>
<td>Deferred tax liability offset</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Total admitted under 11.a.–11.c.</td>
<td>2,385,014</td>
<td>—</td>
<td>2,385,014</td>
<td>2,236,000</td>
<td>—</td>
<td>2,236,000</td>
</tr>
<tr>
<td>Deferred tax liabilities</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Net admitted deferred tax asset (liability) under 11.a.–11.c.</td>
<td>2,385,014</td>
<td>—</td>
<td>2,385,014</td>
<td>2,236,000</td>
<td>—</td>
<td>2,236,000</td>
</tr>
</tbody>
</table>

Information used in the “expected to be realized” calculation consists of the following:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorized control level risk-based capital ratio without deferred tax assets</td>
<td>395 %</td>
<td>243 %</td>
</tr>
<tr>
<td>Adjusted capital and surplus</td>
<td>$ 62,091,332</td>
<td>39,044,302</td>
</tr>
</tbody>
</table>

The impact of tax planning strategies is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th></th>
<th>2015</th>
<th></th>
<th>Change</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ordinary</td>
<td>Capital</td>
<td>Total</td>
<td>Ordinary</td>
<td>Capital</td>
<td>Total</td>
</tr>
<tr>
<td>Adjusted gross DTAs – Amount</td>
<td>$ 2,386</td>
<td>—</td>
<td>2,386</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Adjusted gross DTAs – Percentage</td>
<td>— %</td>
<td>— %</td>
<td>— %</td>
<td>— %</td>
<td>— %</td>
<td>— %</td>
</tr>
<tr>
<td>Net admitted DTAs – Amount</td>
<td>$ 2,386</td>
<td>—</td>
<td>2,386</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Net admitted DTAs – Percentage</td>
<td>— %</td>
<td>— %</td>
<td>— %</td>
<td>— %</td>
<td>— %</td>
<td>— %</td>
</tr>
</tbody>
</table>

The Company has no temporary differences for which tax liabilities have not been established.

Current income taxes incurred consist of the following major components:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th></th>
<th>2015</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current year tax expense/(benefit)</td>
<td>$ 4,785,877</td>
<td>14,697,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement of IRS audit</td>
<td>94,123</td>
<td>—</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior year adjustments</td>
<td>(3,078,624)</td>
<td>(313,741)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current income tax expense/(benefit)</td>
<td>$ 1,801,376</td>
<td>14,383,259</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
Deferred income tax assets and liabilities consist of the following major components:

<table>
<thead>
<tr>
<th>Component</th>
<th>2016</th>
<th></th>
<th>2015</th>
<th></th>
<th>Change</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ordinary</td>
<td>Capital</td>
<td>Total</td>
<td></td>
<td>Ordinary</td>
<td>Capital</td>
</tr>
<tr>
<td>Loss reserve discounting</td>
<td>$989,079</td>
<td></td>
<td>989,079</td>
<td></td>
<td>438,724</td>
<td></td>
</tr>
<tr>
<td>Fixed assets</td>
<td>140,791</td>
<td></td>
<td>127,688</td>
<td></td>
<td>127,688</td>
<td></td>
</tr>
<tr>
<td>Premium-deficiency reserve</td>
<td>709,987</td>
<td></td>
<td>1,796,769</td>
<td></td>
<td>1,796,769</td>
<td></td>
</tr>
<tr>
<td>Nonadmitted assets</td>
<td>572,005</td>
<td></td>
<td>572,005</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>29,467</td>
<td></td>
<td>29,467</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total adjusted gross deferred tax assets</td>
<td>2,441,329</td>
</tr>
<tr>
<td>Valuation allowance adjustment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total adjusted gross deferred tax assets</td>
<td>2,441,329</td>
</tr>
<tr>
<td>Nonadmitted deferred tax assets</td>
<td>(56,315)</td>
<td></td>
<td>(56,315)</td>
<td></td>
<td>(128,002)</td>
<td></td>
</tr>
<tr>
<td>Admitted deferred tax assets</td>
<td>2,385,014</td>
<td></td>
<td>2,385,014</td>
<td></td>
<td>2,236,000</td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total deferred tax liabilities</td>
<td></td>
</tr>
<tr>
<td>Net admitted tax asset deferred</td>
<td>2,385,014</td>
<td></td>
<td>2,385,014</td>
<td></td>
<td>2,236,000</td>
<td></td>
</tr>
</tbody>
</table>

The valuation allowance adjustment to gross deferred tax assets as of December 31, 2016 and 2015 was $0. The net change in the total valuation allowance adjustments for the year ended December 31, 2016 was $0.
The Company’s income tax incurred and change in deferred income tax differs from the amount obtained by applying the federal statutory rate of 35% to income before income taxes as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current income taxes incurred</td>
<td>$1,801,376</td>
<td>14,697,000</td>
</tr>
<tr>
<td>Change in deferred income tax (without tax on unrealized gains and losses)</td>
<td>(77,327)</td>
<td>(1,105,000)</td>
</tr>
<tr>
<td>Total income tax expense reported</td>
<td>$1,724,049</td>
<td>13,592,000</td>
</tr>
<tr>
<td>Income before taxes</td>
<td>$6,823,878</td>
<td>31,895,888</td>
</tr>
<tr>
<td>Expected income tax expense at 35% statutory rate</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Decrease in actual tax reported resulting from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Tax-exempt income</td>
<td>(100,935)</td>
<td>—</td>
</tr>
<tr>
<td>b. Change in deferred taxes on nonadmitted assets</td>
<td>(572,005)</td>
<td>—</td>
</tr>
<tr>
<td>c. Meals and entertainment, penalties, etc.</td>
<td>9,273</td>
<td>—</td>
</tr>
<tr>
<td>d. Health insurer fee</td>
<td>3,120,758</td>
<td>2,446,749</td>
</tr>
<tr>
<td>e. Change in estimate associated with prior year tax allocation</td>
<td>(3,654,382)</td>
<td>—</td>
</tr>
<tr>
<td>f. Other</td>
<td>532,983</td>
<td>(18,310)</td>
</tr>
<tr>
<td>Total income tax expense reported</td>
<td>$1,724,049</td>
<td>13,592,000</td>
</tr>
</tbody>
</table>

As of December 31, 2016, the Company had no operating loss or tax credit carryforwards available for tax purposes.

The amount of income tax expense that is available for recoupment in the event of future net losses is:

<table>
<thead>
<tr>
<th></th>
<th>Ordinary</th>
<th>Capital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>$14,959,014</td>
<td>—</td>
<td>14,959,014</td>
</tr>
<tr>
<td>2016</td>
<td>4,880,000</td>
<td>—</td>
<td>4,880,000</td>
</tr>
<tr>
<td>Total</td>
<td>$19,839,014</td>
<td>—</td>
<td>19,839,014</td>
</tr>
</tbody>
</table>

The aggregate amount of deposits admitted under Section 6603 of the Internal Revenue Code is $0.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.
The Company's federal income tax return is consolidated with:

<table>
<thead>
<tr>
<th>Company Name</th>
<th>Company Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute Total Care, Inc.</td>
<td>Home State Health Plan, Inc.</td>
</tr>
<tr>
<td>Bankers Reserve Life Insurance Company of Wisconsin</td>
<td>IlliniCare Health Plan, Inc.</td>
</tr>
<tr>
<td>Buckeye Community Health Plan, Inc.</td>
<td>Kentucky Spirit Health Plan, Inc.</td>
</tr>
<tr>
<td>California Health and Wellness Plan</td>
<td>Louisiana Healthcare Connections, Inc.</td>
</tr>
<tr>
<td>CeltiCare Health Plan of Massachusetts, Inc.</td>
<td>Magnolia Health Plan Inc.</td>
</tr>
<tr>
<td>Cenpatico of Arizona Inc.</td>
<td>Managed Health Services Insurance Corp.</td>
</tr>
<tr>
<td>Coordinated Care Corporation</td>
<td>Nebraska Total Care, Inc.</td>
</tr>
<tr>
<td>Coordinated Care of Washington, Inc.</td>
<td>Peach State Health Plan, Inc.</td>
</tr>
<tr>
<td>Envolve Vision of Texas, Inc.</td>
<td>Sunflower State Health Plan, Inc.</td>
</tr>
<tr>
<td>Fidelis SecureCare of Michigan Inc.</td>
<td>Sunshine Health Community Solutions, Inc.</td>
</tr>
<tr>
<td>Granite State Health Plan, Inc.</td>
<td>Sunshine State Health Plan, Inc.</td>
</tr>
<tr>
<td>Hallmark Life Insurance Co.</td>
<td>Superior HealthPlan, Inc.</td>
</tr>
</tbody>
</table>

The method of allocation among companies is subject to a written agreement whereby allocation is made primarily on a separate company basis using the percentage method pursuant to provisions of Internal Revenue Code (IRC) Sections 1502 and 1552 and Treasury Regulations 1.1502 and 1.1552. This percentage method allocates a tax asset (i.e., intercompany receivable) for any benefit derived by the consolidated group for the member’s losses or credits that offset consolidated taxable income. In accordance with the tax sharing agreement, each member shall pay to Centene or receive from Centene the amount of tax liability or benefit reported on each member’s pro forma federal income tax return within 90 days of the date Centene files its consolidated federal income tax return.
(6) Claims Payable

Following is a summary of claims-related expenses and payments during 2016 and 2015:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at January 1, net of reinsurance ceded of $0 and $0, respectively</td>
<td>$82,192,295</td>
<td>54,448,800</td>
</tr>
<tr>
<td>Incurred related to current year</td>
<td>470,740,340</td>
<td>443,761,805</td>
</tr>
<tr>
<td>Incurred related to prior years</td>
<td>(876,117)</td>
<td>(9,622,045)</td>
</tr>
<tr>
<td>Total incurred</td>
<td>469,864,223</td>
<td>434,139,760</td>
</tr>
<tr>
<td>Paid related to current year</td>
<td>381,155,694</td>
<td>361,585,476</td>
</tr>
<tr>
<td>Paid related to prior years</td>
<td>79,942,486</td>
<td>44,810,789</td>
</tr>
<tr>
<td>Total paid</td>
<td>461,098,180</td>
<td>406,396,265</td>
</tr>
<tr>
<td>Balance at December 31, net of reinsurance ceded of $792,000 and $0, respectively</td>
<td>90,958,338</td>
<td>82,192,295</td>
</tr>
<tr>
<td>Less accrued medical incentive pool and bonus amounts</td>
<td>1,032,302</td>
<td>9,180,934</td>
</tr>
<tr>
<td>Net balance at December 31</td>
<td>$89,926,036</td>
<td>73,011,361</td>
</tr>
</tbody>
</table>

The incurred amounts related to prior years represent the variations between the Company’s estimated expense for prior years’ claims reserving under moderately adverse conditions and the actual amounts required to satisfy such claims. During 2016 and 2015, the Company experienced $876,117 and $9,622,045, respectively, of favorable development on prior year claims generally as a result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims.
(7) Related-Party Transactions

In addition to the reinsurance agreement in note 4 to the statutory financial statements, the Company’s transactions and amount due to related parties in exchange for services provided for the years ended December 31, 2016 and 2015 are as follows:

<table>
<thead>
<tr>
<th>Affiliate</th>
<th>Expense 2016</th>
<th>Expense 2015</th>
<th>Amount due to/(from) 2016</th>
<th>Amount due to/(from) 2015</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agate Resources, Inc.</td>
<td>$36,761,364</td>
<td>41,096,591</td>
<td>7,299,439</td>
<td>4,858,083</td>
<td>General management services</td>
</tr>
<tr>
<td>Envolve PeopleCare, Inc.</td>
<td>176,466</td>
<td>—</td>
<td>(478)</td>
<td>—</td>
<td>Nurse-line triage, life and health management</td>
</tr>
<tr>
<td>Envolve Vision, Inc.</td>
<td>174,643</td>
<td>—</td>
<td>(10,265)</td>
<td>—</td>
<td>Managed vision</td>
</tr>
<tr>
<td>Envolve Dental, Inc.</td>
<td>120,000</td>
<td>—</td>
<td>1,197</td>
<td>2,582,758</td>
<td>Managed dental*</td>
</tr>
</tbody>
</table>

* Amount due to affiliates reflected in claims payable on the statutory statements of admitted assets, liabilities, and capital and surplus as of December 31, 2016.

The Company recorded surplus contributions totaling $19,300,000 and $5,000,000 from Centene Corporation for the periods ended December 31, 2016 and 2015, respectively.

(8) Statutory Net Worth

The Company is required by Oregon statute 731.554 to maintain minimum capital reserves of 50% of its average monthly claims incurred during the last 12 months, to a maximum of $2,500,000. Mandatory reserves at December 31, 2016 and 2015 were $2,500,000. At December 31, 2016, the Company was in compliance with the minimum statutory surplus requirements.

(9) Contingencies

From time to time, the Company is involved in litigation arising in the ordinary course of operations. While the results of litigation cannot be predicted with certainty, management is of the opinion, after reviewing these matters with legal counsel, that the final outcome of such litigation, if any, will not have a material adverse effect on the Company’s financial position.
(10) Fair Value of Financial Instruments

Assets and liabilities recorded at fair value in the statutory statements of admitted assets, liabilities, and capital and surplus are categorized based upon the extent to which the fair value estimates are based upon observable or unobservable inputs. Level inputs are as follows:

<table>
<thead>
<tr>
<th>Level input</th>
<th>Input definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.</td>
</tr>
<tr>
<td>Level II</td>
<td>Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.</td>
</tr>
<tr>
<td>Level III</td>
<td>Unobservable inputs that reflect management’s best estimate of what market participants would use in pricing the asset or liability at the measurement date.</td>
</tr>
</tbody>
</table>

The carrying values and estimated fair values of the Company’s financial instruments at December 31, 2016 and 2015 were as follows:

**December 31, 2016**

<table>
<thead>
<tr>
<th>Aggregation</th>
<th>Admitted assets</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Not practicable (carrying value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>24,309,884</td>
<td>24,309,884</td>
<td>24,309,884</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Short-term investments</td>
<td>28,237,041</td>
<td>28,237,041</td>
<td>26,856,570</td>
<td>1,380,471</td>
<td>—</td>
</tr>
<tr>
<td>Bonds</td>
<td>94,040,398</td>
<td>95,402,409</td>
<td>94,040,398</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

**December 31, 2015**

<table>
<thead>
<tr>
<th>Aggregation</th>
<th>Admitted assets</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Not practicable (carrying value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>102,110,747</td>
<td>102,110,747</td>
<td>102,110,747</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Short-term investments</td>
<td>3,009,976</td>
<td>3,000,548</td>
<td>3,009,976</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Common stock</td>
<td>6,806,438</td>
<td>6,806,438</td>
<td>6,806,438</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Bonds</td>
<td>17,502,965</td>
<td>17,452,254</td>
<td>12,926,264</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>
(11) Risks and Uncertainties

The Company's profitability depends in large part on accurately predicting and effectively managing medical service costs. The Company continually reviews its premium and benefit structure to reflect its underlying claims experience and revised actuarial data; however, several factors could adversely affect the medical service costs. Certain of these factors, which include changes in healthcare practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond any health plan's control and could adversely affect the Company's ability to accurately predict and effectively control healthcare costs. Costs in excess of those anticipated could have a material adverse effect on the Company's results of operations.

(12) Subsequent Events

In connection with the preparation of the statutory financial statements, the Company evaluated subsequent events after the statutory statements of admitted assets, liabilities, and capital and surplus date of December 31, 2016 through May 26, 2017, which was the date the statutory financial statements were issued.

The Company is subject to an annual fee under Section 9010 of the Affordable Care Act (ACA). This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity’s net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. During the year ended December 31, 2016, the Company recorded $8,916,450 for nondeductible expense for the ACA annual health insurer fee based on net assessable premium of $499,028,438, which was paid on September 30, 2016. The Consolidated Appropriations Act, 2016 amended the effective date of Section 9010 of the ACA to apply to those calendar years beginning after December 31, 2013 and ending before January 1, 2017, as well as those calendar years beginning after December 31, 2017.

<table>
<thead>
<tr>
<th>Current year</th>
<th>Prior year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the federal Affordable Care Act (YES/NO)?</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>B. ACA fee assessment payable for the upcoming year</strong></td>
<td>$ —</td>
</tr>
<tr>
<td><strong>C. ACA fee assessment paid</strong></td>
<td>8,916,450</td>
</tr>
<tr>
<td><strong>D. Premium written subject to ACA 9010 assessment</strong></td>
<td>—</td>
</tr>
<tr>
<td><strong>E. Total adjusted capital before surplus adjustment</strong></td>
<td>—</td>
</tr>
<tr>
<td><strong>F. Total adjusted capital after surplus adjustment</strong></td>
<td>—</td>
</tr>
<tr>
<td><strong>G. Authorized control level</strong></td>
<td>—</td>
</tr>
</tbody>
</table>

H. Would reporting the ACA assessment as of December 31, 2016, have triggered an RBC action level (YES/NO)? N/A
Gross investments, and investments which are classified as admitted assets, consist of the following at December 31, 2016:

<table>
<thead>
<tr>
<th>Gross investment holdings</th>
<th>Admitted assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds:</td>
<td></td>
</tr>
<tr>
<td>U.S. government sponsored agencies</td>
<td>$1,042,874</td>
</tr>
<tr>
<td>Mortgage-backed securities</td>
<td>2,329,450</td>
</tr>
<tr>
<td>Securities issued by states, territories, possessions and political subdivisions in the U.S.:</td>
<td></td>
</tr>
<tr>
<td>States and Political subdivisions of states, territories and possessions</td>
<td>13,589,348</td>
</tr>
<tr>
<td>Revenue and assessment obligations</td>
<td>42,031,831</td>
</tr>
<tr>
<td>Industrial development and similar obligations</td>
<td>1,774,572</td>
</tr>
<tr>
<td>Other debt and other fixed income securities:</td>
<td></td>
</tr>
<tr>
<td>Unaffiliated domestic securities</td>
<td>25,456,345</td>
</tr>
<tr>
<td>Unaffiliated non-U.S. securities</td>
<td>9,177,989</td>
</tr>
<tr>
<td>Equity interests:</td>
<td></td>
</tr>
<tr>
<td>Investments in mutual funds</td>
<td>—</td>
</tr>
<tr>
<td>Cash, cash equivalents, and short-term investments</td>
<td>52,546,925</td>
</tr>
<tr>
<td>Total invested assets</td>
<td>$147,949,334</td>
</tr>
</tbody>
</table>

See accompanying independent auditors’ report.
1. The Company’s total admitted assets as of December 31, 2016 were: $ 174,721,657

2. The following are the 10 largest exposures to a single issuer, excluding U.S. government, U.S. government agency securities and U.S. government money market funds:

<table>
<thead>
<tr>
<th>Issuer</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pacific Continental Bank</td>
<td>23,700,141</td>
<td>13.6%</td>
</tr>
<tr>
<td>2. Oregon, State of</td>
<td>11,786,605</td>
<td>6.7%</td>
</tr>
<tr>
<td>3. Portland, City of</td>
<td>7,030,160</td>
<td>2.1%</td>
</tr>
<tr>
<td>4. Lane Community College</td>
<td>2,756,593</td>
<td>1.6%</td>
</tr>
<tr>
<td>5. Hillsboro School District 1J</td>
<td>2,492,787</td>
<td>1.4%</td>
</tr>
<tr>
<td>6. Washington, County of</td>
<td>2,151,584</td>
<td>1.2%</td>
</tr>
<tr>
<td>7. Marion County School District 103</td>
<td>1,781,318</td>
<td>1.0%</td>
</tr>
<tr>
<td>8. Clackamas, County of</td>
<td>1,760,143</td>
<td>1.0%</td>
</tr>
<tr>
<td>9. Chicago, City of</td>
<td>1,348,482</td>
<td>0.8%</td>
</tr>
<tr>
<td>10. Cargill, Incorporated</td>
<td>1,313,636</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

3. The amounts and percentages of the Company’s total admitted assets held in bonds by NAIC rating are as follows:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAIC-1</td>
<td>84,349,141</td>
<td>48.3%</td>
</tr>
<tr>
<td>NAIC-2</td>
<td>15,173,014</td>
<td>8.7%</td>
</tr>
<tr>
<td>NAIC-3</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>NAIC-4</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>NAIC-5</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

4. The amounts and percentages of the Company’s total admitted assets held in foreign investments are as follows:

<table>
<thead>
<tr>
<th>Foreign investments</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7,868,403</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countries rated NAIC-1</td>
<td>7,868,403</td>
<td>4.5%</td>
</tr>
<tr>
<td>Countries rated NAIC-2</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

6. Largest foreign investment exposures by country, categorized by the country’s NAIC sovereign rating:

<table>
<thead>
<tr>
<th>Country</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>2,192,422</td>
<td>1.3%</td>
</tr>
<tr>
<td>Germany</td>
<td>1,517,989</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

7. Aggregate unhedged foreign currency exposures: N/A

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating: N/A

9. Largest unhedged foreign currency exposures by country, categorized by the country’s NAIC sovereign rating: N/A

10. Ten largest nonsovereign (i.e. nongovernmental) foreign issues:

<table>
<thead>
<tr>
<th>Issuer</th>
<th>NAIC rating</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prudential Public Limited Company</td>
<td>NAIC-1</td>
<td>1,230,195</td>
<td>0.7%</td>
</tr>
<tr>
<td>2. Credit Suisse Group AG</td>
<td>NAIC-1/NAIC-2</td>
<td>824,995</td>
<td>0.5%</td>
</tr>
<tr>
<td>3. Bayerische Motoren Werke Aktiengesellschaft</td>
<td>NAIC-1</td>
<td>598,380</td>
<td>0.3%</td>
</tr>
<tr>
<td>4. Bayer Aktiengesellschaft</td>
<td>NAIC-1</td>
<td>717,632</td>
<td>0.4%</td>
</tr>
<tr>
<td>5. Hyundai Motor Company</td>
<td>NAIC-1</td>
<td>599,195</td>
<td>0.3%</td>
</tr>
<tr>
<td>6. Nordia Bank AB</td>
<td>NAIC-1</td>
<td>522,552</td>
<td>0.3%</td>
</tr>
<tr>
<td>7. Royal Dutch Shell PLC</td>
<td>NAIC-1</td>
<td>506,229</td>
<td>0.3%</td>
</tr>
<tr>
<td>8. UBS Group AG</td>
<td>NAIC-1</td>
<td>407,257</td>
<td>0.2%</td>
</tr>
<tr>
<td>9. Perrigo Company Public Limited Company</td>
<td>NAIC-1</td>
<td>373,932</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

All other interrogatories in Section 2 of Appendix A-001 to the NAIC Accounting Practices and Procedures Manual have not been disclosed as they are not applicable.

See accompanying independent auditors’ report.
Independent Auditors’ Report on Supplementary Information

The Board of Directors
Trillium Community Health Plan, Inc.:

We have audited the financial statements of Trillium Community Health Plan, Inc. (Trillium) as of and for the year ended December 31, 2016, and have issued our report thereon dated May 26, 2017. Our report relating to Trillium’s financial statements dated May 26, 2017 states that Trillium prepared the financial statements using statutory accounting practices prescribed or permitted by Trillium Community Health Plan, Inc. (statutory accounting practices), which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, our report states that Trillium’s financial statements do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of Coordinated Care Corporation as of December 31, 2016, or the results of its operations or its cash flows for the year then ended in accordance with U.S. generally accepted accounting principles and further states that those statements are presented fairly, in all material respects, in accordance with statutory accounting practices. We have not performed any procedures with respect to the audited financial statements subsequent to May 26, 2017.

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying annual schedule of segregated premiums for 2016 is presented to comply with the requirements of the Trillium Community Health Plan, Inc. as indicated in Oregon Administrative Rule 836-011-0050 and for the purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements in accordance with statutory accounting practices prescribed or permitted by the Trillium Community Health Plan, Inc. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the statutory basis financial statements as a whole.

St. Louis, Missouri
May 26, 2017
### Legal name of entity | NAIC no. | Year
--- | --- | ---
Trillium Community Health | 12559 | 2016

### Supplemental information:

<table>
<thead>
<tr>
<th>Segregated account</th>
<th>Beginning balance</th>
<th>Receipts +</th>
<th>Disbursements -</th>
<th>Ending balance =</th>
</tr>
</thead>
<tbody>
<tr>
<td>21000-00-000</td>
<td>$356.00</td>
<td>$697.00</td>
<td>$0</td>
<td>$1,053.00</td>
</tr>
</tbody>
</table>

### Product | Amount of segregated premiums | Number of enrollees
--- | --- | ---
Exchange Membership | $697.00 | 58

☐ Yes  ☐ No  The company is certified as a qualified issuer through the Exchange and will continue to administer the accounting system to segregate funds.

### Legal name of entity | NAIC no. | Year
--- | --- | ---
Trillium Community Health Plan | 12559 | 2016

### Officer's affirmation
I attest that the financial accounting systems, including accounting documentation and internal controls, of the segregated account(s) covered by the annual supplemental information meet the requirements under the Affordable Care Act.

Signed ___________________________  Date 4/23/17
Chief executive officer

Signed ___________________________  Date 2/24/17
Chief financial officer

Brandie Whitten
Finance Director
ATTACHMENT 12 - COST AND FINANCIAL QUESTIONNAIRE

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Page limits for this Cost and Financial Questionnaire is 25 pages. Items that are excluded from the page limit will be noted in that requirement.

A. EVALUATE CCO PERFORMANCE TO INFORM CCO-SPECIFIC PROFIT MARGIN BEGINNING IN CY 2022

OHA will implement a provision of its current waiver that requires the state to vary the profit load in CCO capitation rates based on an evaluation of CCO performance. The goal of the policy is to encourage CCOs to provide financial incentives for CCOs to improve the delivery of benefits to CCO Members. This includes more efficient use of Medical Services, increased delivery of high-value services, and an increased use of Health-Related Services when appropriate. The ability to increase the profit load for high-performing CCOs is designed to alleviate concerns that CCO investments that reduce costs and use of Medical Services will lead to capitation rate reductions that threaten CCO ability to maintain access to Health-Related Services and other programs that improve value and efficiency.

1. Does Applicant have internal measures of clinical value and efficiency that will inform delivery of services to Members? If so, please describe.

IMPROVING VALUE AND EFFICIENCY

It is a goal of Trillium Community Health Plan (Trillium) to continuously improve quality and outcomes while bringing value to the State and the communities we serve. We achieve this goal through our quality and medical management programs and fully support the alignment of quality measures and CCO performance with capitation rates. We have well-established programs and processes to measure quality and value across our system and will work directly with OHA to tailor these activities to reflect the needs of the state in alignment with our approved Transformation and Quality Strategy (TQS), Exhibit B of the Sample Contract, and related administrative rules and other formal guidance from OHA.

Internal Measures of Clinical Value and Efficiency. As outlined in our 2018 and 2019 TQS, Trillium actively measures and monitors clinical value and efficiency today through our Quality Management and Improvement Program (QMI Program). As a data-driven organization, this information is used to design and implement programs and initiatives to support both the Triple Aim and Quadruple Aim of improved outcomes, member and provider experience, and efficiencies. The QMI Program employs a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement. Examples of internal measures include:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Aims</th>
<th>Quality Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Service</td>
<td>Value or excellence of healthcare work performed by the health plan, providers, and others involved in care for member. Assesses healthcare services accessibility, availability, cultural consideration, validation of services rendered, and member experience and perception of services rendered.</td>
<td>CAHPS®; HEDIS and HEDIS-like measures; Network Adequacy; Access &amp; Availability; Plan Performance Metrics (e.g. Call Center, Care Coordination); Credentialing</td>
</tr>
<tr>
<td>Quality of Clinical Care</td>
<td>Healthcare services provided with professional, evidence-based, and current knowledge. Assesses care quality and appropriateness, under- and overutilization, compliance with evidence-based knowledge, appropriate documentation of member care provided, coordination of care, and member experience and perception of services rendered.</td>
<td>CAHPS®; HEDIS and HEDIS-like measures; Care Gap Closures; Health Disparities; Medical Record Review Audit; Quality of Care events; Complaints and Grievances; Over- and Underutilization</td>
</tr>
<tr>
<td>Safety of Care</td>
<td>Avoidance or reduction to acceptable limits of actual or potential harm. Measures healthcare management or environment where</td>
<td>Complaints and sentinel event monitoring; Grievances and</td>
</tr>
</tbody>
</table>
Examples of Internal Measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Aims</th>
<th>Quality Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Experience</td>
<td>Interactions shaped by an organization’s culture that influences member perceptions across the continuum of care. Measures member experience with care provided by health plan, providers, and others involved in care, including transportation services and cultural competency across the system.</td>
<td>Appeals; Utilization Data; Adverse Events; and Hospital Acquired Conditions (HACs)</td>
</tr>
<tr>
<td>Provider Experience</td>
<td>Interactions shaped by an organization’s culture that influences practitioner perceptions across the continuum of care. Measures practitioner experience with service provided by health plan and others they interact with when providing care to members.</td>
<td>CAHPS®; Care Coordination Satisfaction Surveys; Grievance and Appeals; Access &amp; Availability; Input from Community Advisory Council (CAC); Utilization Data</td>
</tr>
<tr>
<td>Impact of Health-Related Services (HRS)</td>
<td>HRS offered as alternatives to Covered Services to address SDOH and improve member outcomes and delivery system efficiency. Measures impact of HRS in improving outcomes and/or efficiency.</td>
<td>Changes in Health Outcomes; Changes in Costs; Changes in Utilization of Covered Services; Member Quality of Life</td>
</tr>
<tr>
<td>Social Determinants - Health Equities (SDOH-HE)</td>
<td>SDOH-HE are addressed through whole-person health, CC, and the provision of HRS. Measures the impact of social services on health outcomes.</td>
<td>Reduction in Health Disparities; Improvements in Health Outcomes; Improved Member Satisfaction</td>
</tr>
</tbody>
</table>

In addition to industry standard (e.g. CAHPS, HEDIS) and other current CCO measures selected by OHA, examples of utilization measures monitored through our QMI Program include:

<table>
<thead>
<tr>
<th>Sample Utilization Measures to Measure Clinical Value and Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient physical and behavioral health (PH/BH) measures</strong></td>
</tr>
<tr>
<td>Days, admissions and readmissions per 1,000 members</td>
</tr>
<tr>
<td>Average length of stay, overall and by diagnosis</td>
</tr>
<tr>
<td>Recidivism</td>
</tr>
<tr>
<td><strong>Routine outpatient PH, BH and oral health (OH) measures</strong></td>
</tr>
<tr>
<td>Post-hospitalization follow-up visits</td>
</tr>
<tr>
<td>Emergency department (ED) visits per 1,000 members</td>
</tr>
<tr>
<td>Care gap closures (in accordance with clinical practice and preventive care guidelines)</td>
</tr>
<tr>
<td>Utilization related to provider preventable conditions</td>
</tr>
<tr>
<td>Annual dental visits per 1,000 members</td>
</tr>
<tr>
<td><strong>Quality of service indicators</strong></td>
</tr>
<tr>
<td>The rate of out-of-network and out-of-area care</td>
</tr>
<tr>
<td>Potentially preventable events (PPEs)</td>
</tr>
<tr>
<td>Members in Care Coordination (CC)</td>
</tr>
</tbody>
</table>

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?

**Improving Value and Efficiency.** Trillium takes a learning approach to identification of opportunities to improve value and efficiency, using all tools at our disposal, including the TQS, to support OHA’s goals. We monitor and identify trends by 1) stratifying our population into risk groups based on cost and need, 2) regularly reporting on utilization and quality outliers, and 3) tracking indicators for fraud, waste, and abuse, as further described below.

**Risk Stratification.** Risk stratification allows Trillium and our providers to quickly identify and implement tailored interventions before members become high risk and high utilizers. Our proactive approach to stratification and predictive modeling focuses on the whole person, providing an integrated risk score based on clinical and social factors. The methodology leverages our Centelligence® health informatics, analytics and predictive modeling software, pulling data from PH, BH, and oral health (OH) claims, including Z-codes which indicate the presence of social determinants of health (SDOH); authorizations; screening and assessments; and
other internal and external data sources to create a risk score. Based on all available data, our integrated risk stratification identifies areas for improvement using the following quadrants to match with the appropriate systemic member and provider interventions:

<table>
<thead>
<tr>
<th>Low Need/High Cost</th>
<th>High Need/High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on appropriate utilization. Reduce the use of duplicative and/or ineffective services while maintaining member whole health (e.g., educating on the appropriate ED use; incentives for appropriate preventive care and screenings)</td>
<td>Focus on engaging members to meet their health goals; stabilize and decrease use of high intensity services where appropriate using best practices to meet member needs (e.g., applying Housing First principles as part of a member’s care plan)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Need/Low Cost</th>
<th>High Need/Low Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on prevention to keep members in this quadrant. Part of the risk information we share with providers includes prevention gaps such as the need for validated PH and BH screenings (e.g. care gap alerts available through the Member, Provider and Community Partner Portal)</td>
<td>Focus on members that may not be receiving adequate services to address their needs. Utilize targeted engagement in the community to assess member needs, connect them to services, and follow up to ensure continued stabilization and control of chronic conditions (e.g. engaging members in Disease Management)</td>
</tr>
</tbody>
</table>

**Alignment towards the Same Goals.** By driving our CC strategy, value-based purchasing contracts, quality improvement initiatives, and cost savings efforts based on this risk stratification, we are aligning our plan, members, and provider network towards the same goal of meeting members’ integrated PH, BH, OH, and SDOH-HE needs while reducing waste. Our risk stratification is further supplemented by condition-specific algorithms to help identify opportunities and target outreach and interventions. For example, our proprietary SUD Segmentation Model uses evidence-based criteria and claims data to conduct risk stratification on and early detection of members who may be living with substance use disorder (SUD). The model places identified members into one of six risk segments and offers clinical and business intelligence that provides both member and population-based analytics to prioritize members for provider and CC engagement. Similarly, we plan to implement a Schizophrenia Inpatient Model (SIM) that utilizes administrative claims data to identify members with an increased risk of relapse that may result in schizophrenia-related hospitalizations. Identified administrative claims data estimates the instability among members with schizophrenia and increases our opportunity to identify members needing treatment intervention to prevent future negative member outcomes such as relapses in medication and/or frequent hospitalizations.

**Utilization and Quality Trend Reports.** Centileigence® compiles data to measure progress on our TQS and produce reports on PH, BH, OH, and pharmacy utilization and SDOH outcomes. Example metrics include length of stay, ED visits, admissions/discharges, readmissions, PCP visits, pharmaceutical and poly-pharmacy use, referral to ancillary providers, referral to social services, preventive screening rates, and over- and under-utilization. Trillium reviews a variety of “snapshots” at aggregate and detail levels including by member, provider or facility, provider specialty, type of service, diagnosis, place of service, and by comparing services authorized to services received. The data is reviewed against industry benchmarks, affiliate plan performance, and Oregon-specific standards to put outliers into context.

**Review and Act on Reports.** Staff from Finance and Medical Management review reports monthly to identify needed interventions. On a quarterly basis, the Quality Improvement Committee (QIC) reviews utilization and quality data to monitor progress on interventions and initiatives, further isolate trends that require action, and recognize successes that should be spread. For example, our monthly Finance Advisory Committee examines cost drivers and develops recommendations in coordination and collaboration with cross-functional departments. Based on approval of the appropriate quality committee or subcommittee, recommendations are turned into initiatives with appropriate actions steps, timelines, and accountability. For example, the Finance Advisory Committee recently identified ED utilization as an area of
focus based on increased utilization. As a result, Trillium developed and implemented the following action items and activities:

<table>
<thead>
<tr>
<th>Action Items and Activities to Reduce ED Utilization</th>
<th>Recommendations</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) ED workgroup convened and identified two areas of focus: <strong>Intervention</strong> and <strong>Prevention</strong>.</td>
<td>April 2018</td>
<td></td>
</tr>
<tr>
<td>2) <strong>Intervention</strong> for high utilizers includes: PreManage community-wide workflows and use; same-day PCP appointments; Chronic Pain Program; coordination with transportation providers; and embedded health navigators in the ED. Recommendation from BH cost forum: Increase urgent care access by opening a 24/7 clinic.</td>
<td>9/1/2018 – 12/31/2018</td>
<td></td>
</tr>
<tr>
<td>3) <strong>Prevention</strong> and member experience: PCP after-hours messaging; dissemination of ED packets to the community, telemedicine in rural and BH offices; preventive care at BH clinics; trusted relationships with peer support for navigation; member incentives; Community Health Worker Collaborative, and urgent care education.</td>
<td>8/1/2018 – 10/31/2018</td>
<td></td>
</tr>
</tbody>
</table>

**Fraud, Waste, and Abuse (FWA) Monitoring.** Based on national experience and emerging fraud trends, our Program Integrity and Special Investigative Unit, led by Trillium’s parent company, in collaboration with Trillium’s Compliance Officer, jointly develop an annual plan for payment integrity and FWA. We utilize a two-pillar approach, similar to that used by CMS, which leverages both prospective and retrospective fraud detection methods. For example, we use specialized algorithms designed by industry experts to detect FWA in high-risk specialties such as providers with cycle/auto billing activities, providers offering durable medical equipment (DME), home health, BH, and transportation services. Through our Service Verification process, 1.5% of all members are selected each month to receive a service verification form to validate that billed services were received and instructed to call if there are discrepancies. We perform regular auditing and review monthly reporting from the Program Integrity and Special Investigative Unit to track and trend FWA.

$3.6 MILLION

Trillium’s 2018 program integrity savings totaled more than $3.6 million.

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.**

**PROMOTION AND USE OF HEALTH-RELATED SERVICES (HRS)**

Trillium is committed to the continued and expanded use of Health-Related Services (HRS) to improve health outcomes and reduce avoidable health care services utilization and cost. We have developed an HRS policy in accordance with OAR 410-141-3150, 45 CFR 158.150 and 45 CFR 158.151 to promote and ensure the delivery and payment of HRS that are consistent with achieving member wellness and the objectives of an individualized care plan or improving population health and health care quality as identified through the Community Health Assessment (CHA).

**HRS to Meet Individual Member Needs.** All HRS requests submitted by members or providers on the member’s behalf will be considered using OHA-approved criteria. Members and providers are trained on the availability of HRS through orientations and onboarding activities, the Member Handbook and the Provider Manual, with updates and reinforcing information in Member and Provider Newsletters. Care Coordinators will also be trained on the availability of HRS and will leverage these services to meet member goals through the care planning process, documenting HRS referrals in the member’s plan of care for appropriate facilitation and follow up. Examples of individual requests Trillium has approved in our current membership are hotel stays, weight scales, and air conditioners.

**HRS to Meet Population Health Needs.** Trillium may initiate and provide HRS on a community-based level. Such activities may include programs to improve the general community health, e.g., farmers’ market in the “food desert” or classes on healthy meal preparation. Community-based initiatives are identified and selected based on the local CHA. Example of population-based initiatives implemented in our current Service Area include prevention services such as tobacco education, childhood obesity and prenatal care, in addition to access to food and member incentives.
Proposed HRS Criteria. For both HRS submitted by members or by a provider on the member’s behalf, or HRS initiated by Trillium on a community-based level, the following criteria must be met. HRS are intended to:

- Improve health delivery, member health, and outcomes
- Be cost-effective alternatives to covered benefits
- Generate savings and lower costs
- Effectively treat or prevent PH, BH, and/or OH conditions
- Prevent or delay health deterioration
- Be consistent with the member’s treatment plan as developed by the member’s care team (individual)

4. What is the Applicant’s strategy for spending on Health-Related Services to create efficiency and improved quality in service delivery?

HRS Spending. Trillium’s strategy for HRS expenditures centers around our commitment to invest in prevention, healthy behaviors, and social determinants of health and health equity (SDOH-HE). HRS spending is used as an internal strategy to help meet the Triple Aim of improved outcomes and experience and reduced costs. HRS spending includes both flexible spending on individual services to improve outcomes in a more efficient and member-centric manner, and community investments in population health. The specific areas of community investment in HRS will be driven by the Community Advisory Council (CAC) with final approval by the Trillium Board, in full alignment with the CHA and CCO 2.0 goals and objectives. Trillium will solicit funding requests from the community and evaluate based on established and public community benefit criteria. Flexible spending decisions are made through the multi-disciplinary HRS Committee led by Medical Management based on individual need and evaluated against established and public individual member criteria. The Finance Advisory Committee is responsible for monitoring spending, including flexible services and community benefit initiatives, and reporting this information to the CAC and QIC quarterly to monitor impact on efficiency and quality in service delivery and member outcomes and experience.

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?

HRS Evaluation Process. Trillium evaluates the effectiveness and impact of HRS on SDOH-HE through our QMI Program, further described in Section 12.A above. To test and analyze the effectiveness of HRS and SDOH-HE specific spending, we will use our cost and utilization macro tool, as further described in Attachment 10.B. HRS-related outcomes are produced by our Data and Analytics team and reviewed by the CAC and QIC. This will include an annual presentation of our SDOH-HE Outcomes Report to combine, track, and trend outcomes impacted by HRS and SDOH-HE spending and initiatives. The CAC is responsible for establishing and ongoing review of HRS criteria, approving global/community requests, and monitoring effectiveness of investments to inform future spending. The QIC oversees the HRS program and makes recommendations for improvements. Specifically evaluating the impact of HRS and other initiatives designed to address SDOH-HE, we are also adding a Health Equity Council who will be responsible for monitoring impact and making additional recommendations to the QIC.

HRS Evaluation Measures. Approved HRS shall be evaluated no less than quarterly for:

- Changes in health outcomes
- Changes in costs
- Changes in covered service utilization
- Changes in utilization of HRS
- Member/provider experience
- Other key performance indicators as identified by the committee when HRS are approved
B. QUALIFIED DIRECTED PAYMENTS TO PROVIDERS

Beginning in 2020, OHA will develop a program of qualified directed payments (QDP) for the repayment of most provider taxes paid by Hospitals in Oregon. The specific parameters and methodology of the QDPs for fiscal year 2020 will be determined following completion of the 2019-21 Legislatively Adopted Budget and will rely on input from a variety of stakeholders. OHA will promulgate administrative rules to include a Quality and Access pool for Hospitals reimbursed by Medicare based on diagnostic-related groups (aka, DRG Hospitals).

1. Does Applicant currently measure, track, or evaluate quality or value of Hospital services provided to its enrollees? If so, please describe.

Trillium monitors the quality, value, and safety of hospital services through our Quality and Medical Management programs and Finance Department. This includes evaluating for trends, improvement and education opportunities, and identifying and addressing concerns.

Quality Management and Improvement Program (QMI Program). Measuring, tracking and evaluating the quality and value of hospital services is a function of our QMI Program. We take a multi-faceted approach to identifying and understanding quality and value in our programs and services, including a compilation of satisfaction survey results; grievance and appeal trends; quality of care (QOC) issues and adverse events; HEDIS and other clinical quality measures; and trends in under-, over-, and inappropriate utilization. For example, we measure, track, and evaluate utilization measures – such as days per 1000, admits per 1000, readmissions, and average length of stay – by hospital and by condition to identify trends or opportunities for improvement or intervention. Trends and patterns may indicate potential quality issues or inefficiencies. Figure 12.B is one example of a hospital reporting view.

Hospital services data is evaluated by our Finance and Medical Management teams and reported up through the QIC. As indicated through identified trends or concerns, additional ad-hoc workgroups are convened to address specific topics and report back to the QIC on a regular basis.

Quality and Safety. Monitoring and promoting patient safety is integrated throughout many activities across Trillium but primarily through identification of potential and/or actual QOC issues or adverse events. Trillium staff (i.e. Medical Management, Member Services, Provider Services, Appeals and Grievances, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors, or the Board may advise the QMI Department of potential QOC issues. Adverse events may also be identified through claims-based reporting. Potential QOC issues or events require investigation of the factors surrounding the event to determine severity and the need for corrective action up to and including review by the Peer Review Committee as indicated. Potential QOC issues received in the QMI Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level. While an individual adverse event may not necessarily constitute a significant QOC issue, Trillium monitors and tracks these occurrences for trends in type, location, and provider to monitor patient safety and investigates further and/or requests a corrective action plan at any time a QOC issue is definitively identified.

Medical Management. The quality and value of hospital services is also actively monitored and evaluated by our Medical Management teams, including Utilization Management (UM) and Care Coordination (CC). For
example, UM monitors appropriateness of services through concurrent review. The concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization or for ongoing care, facilitates the implementation of the practitioner’s plan of care and promotes timely care, determines the appropriateness of treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. For members in CC, the Care Coordinators closely follow any hospital stays to ensure member needs are being met and members are ready to be transitioned upon discharge. Throughout the UM and CC process, if quality issues or concerns are identified, they are reported to the QMI Department for follow up. Furthermore, if Finance identifies clinical cost drivers, they engage UM and CC to develop and implement interventions and monitor success through monthly Financial Advisory Committee reporting.

**PreManage.** Our CC and analytics team also use the PreManage tool to track and trend utilization and develop actions around course correcting. For example, in response to increased NICU utilization at one facility, Trillium completed case-by-case review to audit appropriate utilization and identified that a high volume of babies were born at other local hospitals and transferred to that facility due to high NICU availability and level of care needs. Trillium determined the increased NICU utilization was appropriate based on the level of care available at that facility, and not an indication of the quality of labor and delivery services.

**Future State.** To further support our hospital quality efforts and align with OHA value-based payment (VBP) requirements, Trillium plans to work with network hospitals to develop hospital case rates and VBP. This will include a hospital quality program in Year 3, leveraging the work of our affiliate health plan in California. As part of their process, the plan compiled a list of 21 potential incentive measures for consideration. The list was reviewed internally and externally, including buy-in from the California Hospital Association, and narrowed down to 7 measures based on meaningfulness, data availability, and operational ease.

### C. QUALITY POOL OPERATION AND REPORTING

OHA will adjust the funding mechanism of the quality incentive pool from a bonus to a withhold of a portion of CCO capitation rates. This allows CCO expenditures of Quality Pool funds to be considered in capitation rate development and be included in the Medical Loss Ratio (MLR) requirements that apply to the CCOs. This change is intended to motivate CCOs to make timely investments in their communities and the providers and partners that enable their achievement of metrics associated with the incentive program. Including CCO spending of incentive pool earnings in capitation rate development increases the transparency of the program while retaining significant flexibility for CCOs in how they utilize their Global Budget.

QUALITY POOL OPERATION AND REPORTING

Trillium has historically supported quality incentives and acknowledges the transition from a bonus to a withhold as an effort to further expand these programs while promoting flexibility and transparency. Since the original OHA quality incentive started in 2013, Trillium has traditionally earned bonus funds based on quality performance, as demonstrated in the table below.

*Exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.*

Trillium has shared incentive awards with primary care physicians (PCPs) based on clinic and individual performance since 2013, expanding to include behavioral health (BH) providers and specialists beginning in 2017.
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.

Supporting Public Health Partners and Non-Clinical Providers. Trillium commits to distributing Quality Pool earnings to public health and non-clinical providers. Today, Trillium uses a portion of our Quality Pool earnings to fund innovation proposals submitted by the community as part of the Trillium Innovation Fund. In 2018, the amount was $600,000 and for 2019 it is $500,000 (for a total of $1 million including $500,000 from Trillium profit). Innovation proposals can be used to address SDOH-HE partners and other Health-Related Services (HRS) providers. For example, working with Lane County Health and Human Services, Trillium helped implement the Frequent Users System Engagement (FUSE) initiative to assist homeless members who frequently utilize health, social, and government services. The positive results of the FUSE program have resulted in additional Trillium investment to expand the project. While we have not explicitly allocated Quality Pool funds to support these specific interests, this would align with our Community Health Assessment (CHA) and will be considered as part of the new contract. Types of organizations and providers are envisioned to include those that address housing and food insecurity as well as those that provide transportation, Traditional Health Workers (THWs), and health related items such as diapers and other baby/child care items. We will work closely with our Quality and Advisory Committees, including the CAC (and CAC subcommittees such as the SDOH Workgroup), Rural Advisory Council (RAC), Health Equity Council, and Tribal Advisory Council to develop a model that includes public health and non-clinical providers as part of our funding distribution, in alignment with our VBP initiatives, Transformation and Quality Strategy (TQS), OHA goals, Exhibit B of the Sample Contract, and the local CHA.

2. How much of the Quality Pool earnings does the Applicant 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.

Investing in the Community. The most recent Quality Pool distribution (2017 paid in 2018) was $600,000 to the Innovation Fund, $17.6 million to providers (92%) and $1 million to Trillium (8%). Our current method for distributing funds to non-clinical providers is through our Innovation Fund. We will work directly with our Advisory Councils and Subcommittees (e.g. Health Equity Council and CAC subcommittee such as the SDOH Workgroup) to determine the approach for distributing additional or targeted funds to non-clinical providers through the Quality Pool via Innovation or HRS funds. The goal is to drive funds to those areas, clinical or non-clinical, with the greatest impact on health outcomes, member experience and cost efficiency, pulling in guidance from OHA and our TQS. We will continue to support a portion of the Quality Pool to the Innovation Fund. By moving to a withhold, the distribution methodology described will change, but the intent is to keep the dollar amounts similar based on provider performance and community direction.

3. How much of the Quality Pool earnings does the Applicant plan on investing outside its own organization? On what would Applicant make such investments?

Exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.
**Investing Outside of Trillium.** Today, 92% of Quality Pool earnings are invested outside of our organization. These funds are distributed to providers and the Innovation Fund. Moving forward we will align Quality Pool funds with our VBP programs, re-investing in our delivery system through payments directly tied to quality and the delivery of holistic care. Again, based on moving to a withhold the distribution methodology will change, but the intent is to keep the dollar amounts similar based on performance and working toward a 3.4% growth target.

**4. How will the Applicant decide and govern its spending of the Quality Pool earnings?**

**Quality Pool Governance.** Each local Trillium Compensation Committee, comprised of plan leadership, County and DCO representatives, major PCP groups, and other community providers, including specialists and BH providers, makes recommendations regarding Quality Pool spending to the Trillium Board. Supporting these recommendations is a workgroup of each Compensation Committee led by our Chief Medical Officer and our Quality and Analytics team. As we work to expand the scope of these funds, we will engage the local CAC and RAC as described above. These advisors will provide direct input into the model for spending allocations and specific initiatives to be supported in the region, with final approval by the Board, in alignment with our TQS, CHA, and Community Health Improvement Plan (CHP).

**5. When will Applicant invest its Quality Pool earnings, compared with when these earning are received?**

**Quality Pool Payouts.** Quality Pool earnings are paid out in the year they are received. For example, the 2017 Quality Pool earnings were received in July of 2018 and reimbursed to providers in October of 2018.

**6. Does the Applicant have sufficient cash resources to be able to manage a withhold of a portion of its Capitation Payments?**

**Managing Withholds.** We have and will continue to maintain sufficient cash resources to efficiently and effectively manage our business. The new mechanism by which the Quality Pools will be funded will not have a material impact on our operations or continued ability to manage. Notwithstanding, Trillium has the full backing of our parent company, Centene Corporation, in the event of needed cash infusions. Centene, a Fortune 100 Company, has a successful history of starting up, funding, and managing health plans. Currently, Centene has over $10 billion of liquid assets and an additional $1.5 billion revolving credit agreement upon which it can rely for any health plan capital requirements.

**D. TRANSPARENCY IN PHARMACY BENEFIT MANAGEMENT CONTRACTS**

OHA seeks to address increasing pharmacy costs by increasing the transparency of CCO relationships with Pharmacy Benefit Managers (PBMs) and requiring no-spread contracts between CCOs and PBMs. CCOs will be required to ensure they are receiving competitive pricing from their PBMs by obtaining 3rd party market checks audits.

1. **Please describe the PBM arrangements Applicant will use for its CCO Members.**

Trillium is committed to supporting OHA’s Health System Transformation goals, including transparent network contracting. We are implementing a transparent contracting model with our affiliated pharmacy benefits manager (PBM), Envolve Pharmacy, in conformance with the Standards for PBM Contracting Regarding CCO 2.0 and Oregon Health Policy Board (OHPB) Policy #14. Trillium contracts with Envolve Pharmacy to administer certain pharmacy management functions, including claims and encounter processing, network management, and rebate negotiations. Envolve Pharmacy will continue to administer these functions seamlessly during the CCO 2.0 contract period. Effective May 1, 2019, Trillium’s contracting arrangements are fully transparent with 100% pass through of manufacturer rebates. Envolve Pharmacy will charge Trillium for exactly what they paid a pharmacy (drug ingredient cost plus a dispensing fee) and an administrative fee.

2. **Does 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 would be undertaken.**
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)

Trillium currently has a “spread” arrangement but is moving to a “no-spread” arrangement with our PBM effective May 1, 2019.

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?

Trillium does not currently obtain a third-party market check or audit of our PBM arrangement for competitive pricing. However, we are including third-party market checks and audit provisions in our contract amendment with Envolve Pharmacy effective January 1, 2020. The contract amendment language will comply with the requirements outlined in Exhibit B of the Sample Contract with respect to amendments based upon market check results. We plan to contract with a third-party vendor in 2020 for a market check and rebate audit in the second quarter of 2021 (and in the second quarter annually thereafter). This will allow for a full year of claims under the transparent contract. In the second quarter, the market check will include a comparison of industry pricing trends for programs that have a single statewide PDL and transparent pricing. Based upon those results, we will work with our PBM to ensure our pricing meets current industry trends. Additionally, our third-party vendor will audit our PBM’s rebate pass to determine if any rebates were retained by the PBM. Any retained rebates will be remitted to Trillium per our contract arrangement. These activities will be completed no later than July 1 of each year. Trillium will share the third party reports with OHA within seven days of delivery.

4. Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements?

Trillium does not plan to use the Oregon Prescription Drug Program to meet requirements.

E. ALIGNMENT PREFERRED DRUG LISTS (PDLs) AND PRIOR AUTHORIZATION CRITERIA

OHA seeks to address increasing pharmacy costs by increasing the alignment of CCO preferred drug lists (PDLs) with the PDL used by OHA for the fee-for-service program with a particular focus on high-cost drugs and on alignment strategies that reduce overall program costs and/or improve the pharmacy benefit for OHP Members. OHA will work in conjunction with Successful Applicants to establish initial PDL alignment criteria and will take additional steps to modify alignment criteria over time. As part of this requirement, CCOs will be expected to make public and accessible their PDLs as well as the coverage and Prior Authorization criteria for all pharmaceutical products.

1. Does 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. Trillium does and will continue to publish our preferred drug list (PDL) on our website.

2. Does 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.

Trillium publishes changes to the PDL and Prior Authorization criteria 30 days in advance of the effective date of the change. We communicate changes on our website and through written communications to members, prescribers, and pharmacies.
3. To what extent is 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

Trillium conducted a comparison of our formulary preferred drugs to the fee-for-service (FFS) PDL preferred drugs, limiting our analysis to brand drugs due to their high cost. Our comparison revealed a 60% match between our formulary and the FFS PDL. PDLs are developed based upon negotiating supplemental rebates for a drug’s preferred placement. We believe that the 40% difference between our PDL and the FFS PDL is due to our supplemental rebate agreements differing from OHA’s rebate agreements.

4. Does the Applicant plan to fully align its PDL with the fee-for-service PDL? If not, please describe exceptions.

Yes. Trillium will fully align our formulary with the FFS PDL.

F. FINANCIAL REPORTING TOOLS AND REQUIREMENTS

OHA will enhance financial reporting and solvency evaluation tools by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk Based Capital (RBC) tool to evaluate carrier solvency, along with supplemental schedules as requested by OHA (identified in Exhibit L of the Contract). CCOs will file required NAIC reports using Statutory Accounting Principles (SAP). A financial hardship exemption will be available for Year 1 for CCOs with a demonstrated financial hardship related to converting to SAP and filing reports through NAIC. Additional reporting through the Exhibit L Financial Reporting Template will be required. OHA will promulgate administrative rules describing regulatory interventions based on RBC level.

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.

Trillium (since 2012) and our affiliate health plans nationwide report using NAIC forms. We are all related through our parent company, Centene.

2. Does the Applicant currently participate and file financial statements with the NAIC?

Yes. Implemented in 2012, Trillium currently files financial statements with the NAIC.

3. Has Applicant prepared a financial statement which includes a RBC calculation? If so, please submit.

Yes. Please see Att.12 Financial Statement for our March 1, 2019 filing.

4. Does the Applicant currently have experience reporting in SAP either directly or through any Affiliate of Applicant?

Yes, Trillium has direct experience reporting in SAP.

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.

No, Trillium will not seek an exemption from SAP and NAIC reporting for 2020.

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.

Please see Att. 12 UCAA Form 13H Best, Att. 12 UCAA Form 13H Minimum, Att. 12 UCAA Form 13H Maximum, Att. 12 NAIC Biographical Affidavits, Att. 12 UCAA Supplemental Financial Analysis, and Att.12

**REQUIRED DOCUMENTATION**

<table>
<thead>
<tr>
<th>REQUIRED DOCUMENTATION</th>
<th>ATTACHMENT 12</th>
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<tbody>
<tr>
<td>• Completed Pro Forma Workbook Templates (NAIC Form 13H)</td>
<td>• Att. 12 UCAA Form 13H Best</td>
</tr>
<tr>
<td>• Completed NAIC Biographical Affidavit (NAIC Form 11)</td>
<td>• Att. 12 NAIC Biographical Affidavits</td>
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<tr>
<td>• Completed UCAA Supplemental Financial Analysis Workbook Template</td>
<td>• Att. 12 UCAA Supplemental Financial Analysis</td>
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<tr>
<td>• Three years of Audited Financial Reports</td>
<td>• Att.12 2015 Audited Financial Reports</td>
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<td>• Att.12 2016 Audited Financial Reports</td>
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<td>• Att.12 2017 Audited Financial Reports</td>
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**G. ACCOUNTABILITY TO OREGON’S SUSTAINABLE GROWTH TARGETS**

OHA seeks to improve the connection between CCO Contracts and the sustainable growth targets established in Oregon’s Medicaid waiver and the legislatively enacted budget.

1. **What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year?**

**STRAATEGIES TO ALIGN WITH STATE MEDICAID WAIVER AND BUDGET**

As an experienced CCO with local and national expertise, Trillium invests in key strategies to mitigate cost drivers and achieve sustainable growth targets, including:

- Care Coordination and Disease Management programs, including early identification, risk stratification and predictive modeling; ED Diversion; and Transitions of Care
- Well-designed and robust Quality Management and Improvement (QMI) Program
- Promotion of Clinical Practice Guidelines and Evidence-Based Practices
- Appropriate care administered at the right time, by the correct provider, in the most appropriate setting (Utilization Management)
- Pharmacy Management Programs
- Member Education and Engagement including care gap closures and quality incentives
- Provider Engagement including actionable data at the point of care
- Value-Based Purchasing (VBP) and Alternative Payment Models
- Administrative Simplification
- Annual Budgeting
- Oversight and Accountability, including Subcontractor Oversight
- Robust Data Analytics and Tools
- Robust Fraud, Waste, and Abuse Program

New initiatives we are exploring and building include: inclusion of the 3.4% sustainable growth target in our VBP programs, an efficiency fund to reward providers for addressing cost drivers, leveraging Prometheus Analytic logic, and new care management models such as the Intensive Community Care Management (ICCM) model described in Attachment 7.6.A(5).

2. **How will the CCO allocate and monitor expenditures across all categories of services?**

**ALLOCATING AND MONITORING EXPENDITURES**

As part of our culture of continuous quality improvement, we constantly monitor both clinical and administrative expenditures to assure we have the appropriate level of service and support to care for our membership and deliver on our contract without incurring waste. Each department is accountable for their functional area, and on a monthly basis, our Senior Leadership Team reviews expenditures across all categories of services for appropriate intervention.

**Budget Allocation.** The annual budget and quarterly forecasting are developed by the leadership team with input from across functional areas and analysis and recommendations from the Finance Committee and local
Finance Advisory Committees (FAC). The FAC looks at year-over-year local trends by cost category on a monthly basis. Our analysis and reporting processes inform budget allocations by category of service, quarterly forecasting, and quality and process improvement initiatives to positively impact negative trends.

**Monitoring Expenditures.** Financial reporting is presented and analyzed at both the Finance Committee and the Trillium Board, with local cost drivers and trends reviewed at each FAC. Monthly and quarterly financial reports include a review of statutory pre-tax income (examining revenue, medical expenses, claims liability, and administration); gross margin and membership (including medical loss ratio [MLR]); risk pool and quality metrics; actuarial opinion and audit; cost drivers; cost and quality initiatives (evaluating outcomes and effectiveness); and investments. Medical costs are broken down by hospital inpatient and outpatient; emergency department (ED); primary care; specialty care; pharmacy; capitation; direct medical (non-claims based); and reinsurance. In addition to monitoring at the cost category, each medical cost category and MLR is evaluated at the product level, including TANF, Expansion, SSI Dual and SSI Non-Dual.

### 3. What strategies will the Applicant utilize related to Value-Based Payment arrangements to achieve a sustainable expenditure growth?

**VALUE-BASED PAYMENTS**

VBP is a core pillar in our sustainability strategy. As fully described in our response to Att. 8, Trillium will leverage our existing provider partnerships and our experience rewarding our provider community for their performance against CCO quality metrics as the foundation for achieving OHA’s CCO 2.0 VBP targets. The additional service types where we will focus our VBP efforts include hospital care, maternity care, children’s health care, BH care, and dental care. We will offer a portfolio of VBP arrangements that include a broad range of HCP-LAN categories to ensure we have an arrangement in place that aligns with every provider’s capabilities, with a focus on HCP-LAN Category 2.C and 3.A.

To ensure providers engage in our VBP programs and successfully move along the continuum, Trillium will deploy a specialized Provider Partnership Management. Our Provider Partnership Management Team will be responsible for engaging providers on how to improve quality, control costs, and ensure continued access for our members, leading to VBP and provider success. We will bring analytic expertise and experience in financial analysis; quality and HEDIS reporting; and managing MLR, expenditure growth and risk sharing agreements.

### 4. What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members?

**STRATEGIES TO CONTAIN COSTS WHILE MAINTAINING QUALITY**

Our programs and services are designed around the Quadruple Aim of improved outcomes, improved member and provider experience, and improved efficiencies and reduced costs. To help achieve the Quadruple Aim, high-level cost drivers and interventions include:

<table>
<thead>
<tr>
<th>Cost Driver</th>
<th>Trillium in Action</th>
</tr>
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<tbody>
<tr>
<td>Improving access to preventive and primary care</td>
<td>Trillium has invested $6.3 million since the start of the CCO program on efforts to expand access to care for OHP members.</td>
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<tr>
<td>Member outreach and education initiatives to promote utilization of preventive services and healthy behaviors</td>
<td>MyHealthPays is Trillium’s expanded member incentive program that offers financial rewards to members actively engaged in healthy behaviors and decision-making. In 2018, Trillium’s member incentive program funded and distributed 3,399 gift cards totaling over $84,975.</td>
</tr>
<tr>
<td>Providing a medical home to an individual and utilizing a physician’s expertise to refer patients to the appropriate place in the system</td>
<td>Trillium maintains a robust network of 60 PCPCHs in our current Service Area and have contracts and LOAs with 92 PCPCHs in the Tri-County Region that embrace a whole-person, patient and family-centered approach. Our Member Engagement team outreaches to all new members to connect with an appropriate medical home and educate on how to access services to avoid unnecessary ED use. Over 90% of Trillium members are assigned to a certified PCPCH.</td>
</tr>
<tr>
<td>Providing individualized Care</td>
<td>Our integrated CC and DM programs are designed to identify and intervene early to prevent</td>
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<table>
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<tr>
<th>Cost Driver</th>
<th>Trillium in Action</th>
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<tbody>
<tr>
<td>Coordination (CC) services and disease management (DM) services</td>
<td>escalation of risk, leading to higher cost care, as further described in Att. 7 and Att. 11. In January 2019, we launched the Intensive Community Care Management (ICCM) program to serve over 300 high-cost complex members who have five or more chronic physical conditions and at least one BH condition.</td>
</tr>
<tr>
<td>Channeling care to providers who practice in a cost-effective manner</td>
<td>Trillium recently entered into total cost of care risk-sharing arrangements with three PCPCHs representing approximately half of our membership where we provide performance data to drive appropriate steerage within each group.</td>
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| Using lower cost services and products where such services and products are available and clinically appropriate, driven by medical management programs and protocols | In response to increased ED utilization, an ED workgroup was convened and identified two areas of focus: Intervention and Prevention. Examples of initiatives implemented in Q4 2018 to reduce inappropriate ED use include:  
  ▶ **Intervention:** PreManage community-wide workflows and use, same-day PCP appointments, Chronic Pain Program, coordination with transportation providers, embedded health navigators in the ED  
  ▶ **Prevention:** PCP after-hours messaging, dissemination of ED packets to the community, telemedicine in rural and BH offices, preventive care at BH clinics, and relationships with the peer support Community Health Worker Collaborative |
| Conducting provider profiling and enhancing provider accountability for quality and cost-effectiveness through value-based purchasing | In 2019, Trillium launched an innovative VBP program for ICCM in partnership with the Center for Family Development (CFD). In addition to meeting all current CCO metrics, ICCM providers are held accountable for several other performance metrics and are subject to a withhold that can be earned back if savings targets are achieved and performance metrics are met.                                                                                                                                                                                                                                                                                                                                                   |

5. Has the Applicant achieved per-Member expenditure growth target of 3.4% per year in the past? Please specify time periods.

**Expenditure Growth Rate.** Trillium has not met the 3.4% goal, as detailed in **Figure 12 below**, but did fall below the average for CY17/CY16.

**Figure 12 Historical Rate of Growth by CCO: CY2014-2015 to CY2016-2017**

![Figure 12](image_url)
H. POTENTIAL ESTABLISHMENT OF PROGRAM-WIDE REINSURANCE PROGRAM IN FUTURE YEARS

OHA seeks to establish a statewide reinsurance program to better control costs related to high-cost medical conditions, treatments, and patients.

While Trillium currently holds a reinsurance policy under a direct contract, we remain open to a statewide reinsurance program as directed by the State.

1. What type of reinsurance policy does the Applicant plan on holding for 2020? Please include the specifics. (e.g. attachment points, coinsurance, etc.)

Consistent with our current coverage, Trillium plans on holding a Specific Excess loss policy covering inpatient claims in 2020 and beyond. Our current plans include an attachment point of $500,000 per member per contract year with a reimbursement percentage of 90% once the deductible is met, which we expect to maintain.

2. What is the Applicant’s reasoning for selecting the reinsurance policy described above?

The terms of the policy described allows us to manage and retain an appropriate amount of risk while at the same time conceding extremely high dollar cases to a third party.

3. What aspects of its reinsurance policy are the most important to the Applicant?

As mentioned above, Trillium finds the policy is commensurate with our appetite for risk. Further, there is no credit risk regarding collection of recoveries from the assuming entity.

4. Does existing or previous reinsurance contract allow specific conditions or patients to be excluded, exempted, or lasered out from being covered?

Our current policy covers inpatient hospital claims. Our current or past reinsurance contracts do not allow specific conditions or patients to be excluded, exempted, or lasered out from being covered for inpatient hospital claims.

5. Is Applicant able to leave or modify existing reinsurance arrangements at any time or is Applicant committed to existing arrangements for a set period of time? If so, for how long is Applicant committed to existing arrangements? Are there early cancelation penalties?

The duration of our contract is one year (calendar year). Any changes to the agreement would have to be negotiated with the reinsurer. Trillium can precipitate the termination of the agreement by ceasing to pay its premiums in a timely manner. There is no financial penalty for a termination resulting from premium non-payment.

I. CCO SOLVENCY STANDARDS AND OHA TOOLS TO REGULATE AND MITIGATE INSOLVENCY RISK

OHA seeks to ensure continued financial viability of the CCO program as a whole so as to ensure OHP Members are protected from potential access barriers that could come with a CCO insolvency event. In addition, OHA may implement new solvency regulation tools that are similar to those utilized by DCBS in its regulation of commercial carriers that would allow OHA to prevent or meliorate insolvency events.

1. Please describe Applicant’s past sources of capital.

Trillium’s past sources of capital have been its results of operations and funding from our parent company, Centene, if needed.

2. Please describe Applicant’s possible future sources of capital.

Trillium anticipates continued profitability going forward. In addition, Trillium has the full backing of its parent company for any potential future capital needs. Currently, Centene has over $10 billion of liquid assets and an additional $1.5 billion revolving credit agreement.

3. What strategies will the Applicant use to ensure solvency thresholds are maintained?

Trillium closely monitors its capital and surplus levels as reported to the NAIC on a quarterly basis to ensure compliance with both OR Statute 731.554 and the standard benchmark of 200% of the Authorized Control Level established by NAIC’s Risk Based Capital model for determining appropriate minimum capital and surplus levels.
Any indication of risk to thresholds would be escalated to Centene for immediate remedial action or cash infusion as indicated. **Trillium’s capital and surplus level is well in excess of both these benchmarks.**

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.**

Trillium’s parent company, Centene, will serve as a resource in the event Trillium requires additional capital. Centene, a Fortune 100 company, has a successful history of starting up, funding and managing health plans across the county. Currently, Centene has over $10 billion of liquid assets and an additional $1.5 billion revolving credit agreement upon which it can rely for Trillium capital requirements as necessary.

**J. ENCOUNTER DATA VALIDATION STUDY**

1. **Please describe Applicant’s capacity to perform regular Provider audits and claims review to ensure the timeliness, correctness, and accuracy of Encounter Data.**

**ENCOUNTER QUALITY STARTS FROM PROVIDER CLAIMS QUALITY**

Trillium recognizes the importance of OHA’s encounter data validation studies to identify opportunities for technical assistance and establish a baseline error rate. Serving the state of Oregon for over two decades, we have developed a rigorous process to ensure the encounter data Trillium provides to OHA is timely, correct, accurate, and complete. We have organized our systems, processes, and staff around an end-to-end view of encounter data production: from the provider’s claim submission on the front end to our submission of corresponding encounter record data to OHA via our Encounter Data System, with the capacity to monitor encounter production at every step. We view our ability to receive correct and accurate claims from providers as a critical factor in ensuring timely, correct, and accurate encounter data production. Our claims processing is efficient, effective, and accurate to support downstream encounter data production through provider claims audits, as well as claims review and editing. Our claims and encounters data validation processes and procedures have resulted in an encounter completeness rate of over 99%. All of Trillium’s claims and encounters processes and controls are aligned with claims and encounters requirements in Exhibit B, Part 8 of the Sample Contract, and the administrative rule concepts outlined in OHPB Policy #31.

**Inbound Claims Edits.** Our Health Information System (HIS) applies HIPAA compliance checks to inbound electronic claims and validates the submitter, member, and provider information on the claim to ensure compliance with HIPAA federal mandates and Companion Guides. Paper claims are processed with the same data validation edits as electronically submitted claims in appropriate HIPAA-compliant formats to ensure the downstream encounter data we produce meets and/or exceeds OHA standards.

**Edits and Audits Performed During Adjudication and Payment.** Once our HIS reviews submitted claims for HIPAA compliance, completion and validity, those claims are electronically loaded into our claims processing system for adjudication. Our claims processing system automatically verifies service coverage and member eligibility for dates of service on the claim, matching of claim to service authorizations (if applicable), provider network status, provider eligibility to render the services on the claim, that the provider is not excluded from providing Medicaid services, and the application of appropriate fee schedule. Once claims are adjudicated, our centralized Encounter Business Operations Team uses our Encounter Data System to apply additional validation edits, create encounter submission files, load inbound response files from OHA, and track encounter data status. The Encounter Data System applies custom, OHA-specific edits to adjudicated claims data to ensure all critical data elements are present and accurate. We identify any issues with an inbound claim and work with providers, if needed, to correct and reprocess the claim. Our Encounter Business Operations Team also monitors encounter accuracy by regularly validating a random sample of encounter records against the source claims data in our HIS. Trillium’s Encounter Data System submits encounter files, including both paid and denied claims, to OHA for both initial submissions and adjustments using the Encounter Data System automated scheduler. We also
use the Encounter Data System to correct and track encounters failing quality standards as a mechanism to resubmit in an expeditious manner and within OHA required timeframes. We will conduct data transactions in accordance with required timeframes, OHA Electronic Data Transaction Rules, OAR 943-120-0100 through 943-120-0200, supply all required Encounter Data and Pharmacy Expense Reports, and will work with OHA’s Encounter Data Liaison to resolve encounter data issues.

**Ensuring Timeliness.** Trillium measures claims timeliness from submission date to payment date (paper check date or EFT notification date), or date of electronic or paper denial notice. Our HIS System applies date and time stamps upon receipt of all claims (electronic or paper), allowing us to maintain metrics on the timeliness of our claims processing and payment. From claim receipt to provider payment, our HIS System retains and displays a complete claim processing history, enabling us to focus on any claims that risk exceeding timeliness standards. Our claims staff also monitor our online Claim Status Dashboards (Dashboard) with drill down capabilities. The Dashboard displays the volume of claims receipt, auto-adjudication rates, paid and denied claim statistics, pends, adjudication inventory, voids, and rejects.

**Ongoing Monitoring, Audits, and Reviews.** Trillium’s centralized Claims Audit Department—which is independent of our Claims Department—provides continuous feedback to management on processing, payment, and financial accuracy of claims payment and system configuration. This team performs continuous audits to assess multiple attributes including outliers/ unusual practices, claim payment recalculation in the audit sample based on underlying source documents (i.e. RFA requirements, Trillium’s contract with OHA; or provider contracts), accuracy of claim data entry, and verification that claims coding was consistent with provider credentials. The statistically valid audits are based on random samples of all paid, denied, and adjusted claims. The Claims Audit Department staff document audit results for each attribute reviewed in our claim audit software. When an error is found, we document the specific error reason and, if applicable, the dollar amount incorrectly processed for both over- and underpayments. The Claims Audit Department staff communicate errors in real-time to the responsible department. Results are summarized on a monthly basis through claims quality dashboard reports posted to our secured internal intranet. Trillium also utilizes the following ongoing monitoring and auditing approaches:

- **Automated Pre-Payment Claims Edits.** Our claim code editing software, integrated with AMISYS, analyzes claims real-time against coding standards set by the State of Oregon, National Correct Coding Initiative, American Medical Association, and medical specialty organizations to ensure provider-coding accuracy. Our claim code editing software has thousands of edits to assess claims coding accuracy and reduce waste.

- **Clinical Reviews.** We review for clinical appropriateness and publish policies which are followed during the claims payment process. Clinical review is an additional screening of clinical billing discrepancies on a prepayment basis. Our Clinical and Payment policies consider clinical appropriateness, spend, and trends in fraud, waste, and abuse (FWA).

- **Targeted High Dollar Audits.** We review 100% of claims prior to check cycle that exceed an allowed amount of $20,000 for facility and $5,000 for professional. Claims are reviewed against OHA, state, and federal contracts and guidelines to ensure accuracy. If systematic errors are found, corrective action is taken to uphold payment integrity.

- **Routine Validation of Claims and Encounter Data.** We validate all data upon receipt, which includes checks for all applicable claims data fields. Billed services are validated through focus studies, annual provider medical record reviews, provider profiling, detail encounter data reconciliation, and targeted utilization review of specific provider claims.

- **Check Run Audits.** To help identify trends and patterns of non-payment, especially for providers new to Trillium, we conduct weekly reviews of all adjudicated claims for denial patterns, such as by procedure,
denial codes, and/or individual provider. We identify systematic trends and formulate appropriate solutions, including provider education, individualized technical assistance, and system configuration enhancements.

**Data Mining Activities.** Post-payment, our Payment Integrity Department identifies any overpayments made by using data mining processes. Our Program Integrity Department has in-house solutions as well as multiple partners reviewing paid claims data to ensure proper payments were made.

**Quality Control Audits.** We conduct quality control audits by reviewing various reports on a regular basis. Examples of these reports include providers with a high number of referrals, providers providing outdated treatment, and member emergency department utilization.

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.**

**Medical Record Audit of Services Provided.** Trillium leverages a defined claims data validation process to verify that our claims data accurately reflects the services provided, including chart audit. This Medical Record Audit of Services Provided reviews the timeliness, correctness, and accuracy of claims and encounter data against the provider’s medical record. At least annually, Trillium analytics staff select a random sample of claims to review against providers’ medical records. Trillium Clinical Performance Assistants have access to many of our provider Electronic Health Record systems from which they can pull medical records. Certified coders validate that submitted claims data is supported by the medical record by confirming that the event is present in the data; that medical record, diagnosis codes, and descriptions match; and that the procedure codes and descriptions match. If a billing issue is found, the provider is reported to Provider Network Management and/or Compliance to determine next steps, which may include corrective action and/or additional training. We also have the flexibility to perform more targeted analysis on a specific sample of claims, if we are seeing consistent billing errors from providers.

**Pre- and Post-Payment Clinical Reviews.** We use automated FWA detection software as an additional level of claim edit processing to further detect clinical coding errors. When a provider is billing differently than peers by at least 2.5 standard deviations, they are flagged for review. Once we determine the provider’s claims data is inappropriate, we request medical records to conduct a clinical review and/or deny the claim if the medical record does not match the claim. Program Integrity also conducts post-payment audits to validate that services billed by providers match those in the medical records. We reference provider medical records to validate the billing and identify any potential upcoding. We validate the Diagnosis Related Group, and the Resource Utilization Group level billed for nursing facilities. The audits also assess if documentation is complete and accurate for home health and DME claims. If the audit shows a service was incorrectly billed, we notify the provider, and adjust the payment accordingly.

**Special Investigative Unit Investigations.** Upon reception of information regarding a provider who may have incorrectly or inappropriately billed for services, our centralized Special Investigative Unit reviews and takes appropriate action. This may include reviewing for suspicious indicators based on state/federal laws, regulations, provider claims, and provider contracts. This initial review determines the need for a formal investigation. A component of the investigation is a Clinical Record Review. Investigators may request a random sample of medical records for review by trained clinical nurses against submitted claims. Based on the findings, next steps may include provider/member education, recoupment, corrective action plans, and/or a state or federal referral.
K. COST AND FINANCE REFERENCE DOCUMENTS

<table>
<thead>
<tr>
<th>Reference Document</th>
<th>Trillium’s Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhibit L Financial Reporting</td>
<td>Trillium has reviewed the <strong>Exhibit L Financial Reporting</strong> reference document and will comply with all requirements.</td>
</tr>
<tr>
<td>Exhibit L Financial Reporting Supplemental SE</td>
<td>Trillium has reviewed the <strong>Exhibit L Financial Reporting Supplemental SE</strong> reference document and will comply with all requirements.</td>
</tr>
<tr>
<td>2020 Minimum Medical Loss Ratio Rebate Calculation Report Instructions</td>
<td>Trillium has reviewed the <strong>2020 Minimum Medical Loss Ratio Rebate Calculation Report Instructions</strong> reference document and will comply with all requirements.</td>
</tr>
<tr>
<td>2020 Minimum Medical Loss Ratio Template</td>
<td>Trillium has reviewed the <strong>2020 Minimum Medical Loss Ratio Template</strong> reference document and will comply with all requirements.</td>
</tr>
</tbody>
</table>

L. EXHIBITS TO THIS ATTACHMENT 12

<table>
<thead>
<tr>
<th>Exhibit</th>
<th>Trillium’s Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon CY20 Procurement Rate Methodology</td>
<td>Trillium has reviewed the <strong>CCO 2.0 Procurement Rate Methodology</strong> exhibit, which has informed our response to Attachment 12 – Cost and Financial Questionnaire.</td>
</tr>
<tr>
<td>CCO 2.0 Procurement Rate Methodology Appendix I</td>
<td>Trillium has reviewed the <strong>CCO 2.0 Procurement Rate Methodology Appendix I</strong> exhibit, which has informed our response to Attachment 12 – Cost and Financial Questionnaire.</td>
</tr>
<tr>
<td>RFA Pro Forma Reference Document</td>
<td>Trillium has reviewed the <strong>RFA Pro Forma Reference Document</strong> exhibit, which has informed our response to Attachment 12 – Cost and Financial Questionnaire.</td>
</tr>
<tr>
<td>UCAA Supplemental Financial Analysis</td>
<td><strong>Att. 12 UCAA Supplemental Financial Analysis</strong></td>
</tr>
<tr>
<td>CCO RFA Enrollment Forecast</td>
<td>Trillium has reviewed the <strong>CCO RFA Enrollment Forecast</strong> exhibit, which has informed our response to Attachment 12 – Cost and Financial Questionnaire.</td>
</tr>
</tbody>
</table>
This information is exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.
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Attachment 13 — Attestations

Applicant Name: Trillium Community Health Plan, Inc.

Authorizing Signature: [Signature]

Printed Name: Chris Ellertson

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:

T. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration? Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities).

☑ 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: ________________________________________

   ________________________________________
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: _____________________________________________

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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: _____________________________________________

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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: _____________________________________________

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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: _____________________________________________

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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: _____________________________________________
j. 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: ______________________________________

k. 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: ______________________________________

l. 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: ______________________________________

m. 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: ______________________________________


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. 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: __________________________________________

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: ________________________________

g. For services that are not captured on encounter claims, is Applicant willing to track and document Member interactions with THWs?
   ☑ 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: _______________________________________
s. 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: ____________________________

   _____________________________________________________________

   t. 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: ____________________________

   _____________________________________________________________

   u. 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: ____________________________

   _____________________________________________________________

   v. Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?
   ☑ Yes ☐ No
   If “no” please provide explanation: ____________________________

   _____________________________________________________________

   w. Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?
   ☑ Yes ☐ No
   If “no” please provide explanation: ____________________________

   _____________________________________________________________

   x. 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: ____________________________

   _____________________________________________________________

   y. 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 Vonttract, 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 Vonttract, 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:

__________________________


g. Will Applicant make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment?

☑ 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 LTCP, will Applicant request a LTCP determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTCP 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 LTCP, will Applicant request a LTCP determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTCP 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 LTCP 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: ____________________________________________________________
p. 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: ____________________________________________

q. 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: ____________________________________________

r. 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: ____________________________________________

s. 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: ____________________________________________

t. Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________________________

u. 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: ________________________________
II. 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: ____________________________________________
n. Will Applicant screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at the link below and in Wraparound Service OARs? [http://www.oregon.gov/oha/hsd/amb/pages/index.aspx.]
   ☑ Yes ☐ No
   If “no” please provide explanation: ____________________________________________

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] 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: ____________________________________________

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: ____________________________________________

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: ____________________________________________

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: ____________________________________________

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 6.

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________
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: ____________________________________________
Attachment 14 — Assurances

Applicant Name: Trillium Community Health Plan, Inc. (Trillium)

Authorizing Signature: [Signature]

Printed Name: Chris Ellerton

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:
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 CoordinationCare 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:

   *Trillium complies with 42 CFR § 438.206, as well as contractually requires compliance from our providers.*

b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.
   *Trillium ensures compliance with 42 CFR § 438.207 through reporting in state-specified formats on a frequency as designated by the state of Oregon.*

c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.
   *Trillium complies with 42 CFR § 438.208. We follow established procedures to coordinate services provided to our members with services they may receive from other vendors, including dental. Upon notification that one of our members needs or is accessing services provided by another vendor, we will immediately initiate those procedures to communicate with other vendors serving the member and coordinate services to ensure continuity of care and that services are not duplicated.*

d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.
   *Trillium ensures compliance with 42 CFR § 438.210 through coverage, authorization of services, written notification, and adequate timing to meet all related requirements.*

   *Patient safety and positive health outcomes are our top priority and depend on services being rendered by qualified and appropriately credentialed providers. We will demonstrate that our providers are credentialed, as required by 42 CFR 438.214 and this RFA, and we follow the State’s established uniform credentialing and recredentialing policies and our credentialing policies.*

   *Trillium ensures adherence to 42 CFR § 438.224 and contractually require confidentiality regarding all medical records and any other identifying health and enrollment information.*


g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.
   *Trillium's Grievance and Appeal system complies with 42 CFR § 438.228 and is governed by policies and procedures that are reviewed annually and more frequently as needed.*

h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.
   *Trillium ensures our subcontractual relationships and delegation meet the requirements of 42 CFR § 438.230. We maintain ultimate responsibility for adhering to and fully complying with the Sample Contract, and contractually require subcontractors to follow all applicable laws and regulations.*

i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.
   *Trillium adheres to 42 CFR § 438.236 by adopting, disseminating, and applying practice guidelines based on valid, reliable clinical evidence in consideration of our members.*

j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.
   *In accordance with 42 CFR § 438.242, Trillium maintains and updates a Management Information System (Health Information System) that collects, validates, integrates, tracks, trends, analyzes, and reports data to our providers, stakeholders, members, and State clients.*
Attachment 15 — Representations

Applicant Name: Trillium Community Health Plan Inc. (Trillium)

Authorizing Signature: [Signature]

Printed Name: Chris Ellerson, President & CEO

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: To manage local staffing needs with regards to the CCO program, Trillium employs a local director of human resources. Our managed services agreement with Centene Management Company, LLC (CMC) includes additional human resources support.

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: Trillium has a managed services agreement with CMC that includes information technology systems (claims processing, enrollment, provider data management, call center system, financial system) to support local operations of the CCO program.

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: To support our local claims and analytic teams, Trillium has a managed services agreement with CMC that includes claims administration, processing and adjudication functions.

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: Trillium has a managed services agreement with CMC that includes information technology and system support for Enrollment, Disenrollment and membership functions. To support these services Trillium has local operations which include enrollment and membership functions.
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: Trillium has a managed services agreement with CMC to perform credentialing functions, and provider data management. Additionally, Trillium's management agreements with Dental Care Organizations (DCOs) include delegation of credentialing functions for oral health providers.

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: Trillium will manage the utilization operations of the CCO program locally. Trillium has an administrative services agreement with Lane County (Trillium Behavioral Health) to perform utilization operations management for behavioral health services.

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: Trillium will perform all Quality Improvement operations.

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: Trillium operates a local member and provider call center to perform call center operations. We have a managed services contract with our affiliated subcontractor, Envolve PeopleCare, who will administer the Nurse Advice Line.

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: Trillium employs local financial staff, including our Chief Financial Officer, to manage the financial services of the CCO program locally, with additional financial services support through our managed services agreement with CMC.
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: Trillium does not have a management contract with a contractor to delegate all or a portion of other services that are not listed.

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: Trillium delegates the following services to our affiliated and non affiliated major subcontractors listed below:

* Lane County Oregon (Trillium Behavioral Health) will provide select Behavioral Health Services
* Lane Transit District (current), GridWorks, MTM, and Logisticare (expected) will provide non-emergency transportation services
* Advantage Dental Services LLC, Capital Dental Care, ODS Community Dental Inc., and Willamette Dental will provide dental services
* Envolve PeopleCare will administer disease management and wellness assessments
* Envolve Pharmacy Solutions will provide the pharmacy benefit management services
* Envolve Vision will provide vision management services
* National Imaging Associates will provide radiology services
* Linguavna Interpreters, Inc. will provide language interpretation and translation services.

12. Other then 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: Trillium will provide sub-capitated payments to DCOs through agreements that include quality based performance metrics. Trillium recognizes that payments attributable to a VBP contract held by a CCO with an entity to whom dental services are delegated will not count as a VBP arrangement.

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: Health Plan Services Contract - CCO Contract #143121-14
ATTACHMENT 16 — MEMBER TRANSITION PLAN

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Page limits for this Member Transition Plan is 10 pages. Items that are excluded from the page limit will be noted in that requirement.

1. BACKGROUND AND SUPPORTING SOURCES
As described in Section 5.8 Member Enrollment, OHA will hold an Open Enrollment period for Members in Choice Areas of the state. Members in these areas may move from their current plan to another plan during the Open Enrollment period. For purposes of its Application, the Applicant should assume that all of its service areas will be Choice Areas.

The Member Transition Plan should describe both the process for the safe and orderly transfer of Members to another CCO and how members will be received from another CCO during the Open Enrollment period. This plan should also clearly outline how the plan will maximize and maintain continuity of care for members. The level of detail that should be encompassed, at a minimum, includes continuity of care with primary and specialty care providers, primary care and Behavioral Health Homes, plans of care, prior authorizations, prescription medications, medical care coordination, and transportation.

The Member Transition Plan should include specific processes for members who may suffer serious detriment to their physical and mental health or who are at-risk of hospitalization or institutionalization, if any breakdown in service provisions or access to care were to occur, including services provided by providers that may not be contracted with the new CCO. OHA considers these populations to include, but not limited to:

- Prioritized populations
- Medically fragile children
- Members undergoing Breast and Cervical Cancer Treatment
- Members receiving CareAssist assistance due to HIV/AIDS
- Members receiving services for end-stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services
- Members discharged from the Oregon State Hospital or Medicaid funded residential Behavioral Health programs in the last 12 calendar months
- Members 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 (HCBS) under these federal authorities. These individuals are at risk of institutionalization or would require services in an institution within 30 days. Institution is defined as Hospital, Nursing Facility or intermediate care facility for individuals with intellectual disabilities.

A successful Member Transition Plan will result in a seamless transition experience for members changing CCOs during the open enrollment period, with minimal and ideally no disruptions of care. OHA will inform applicants, in connection with RFA awards, which of its service areas are likely to be Choice Areas. In light of that information, applicants are expected to submit a complete Member Transition Plan, gain OHA approval of its plan, and update the plan as part of negotiation activities, contracting, and open enrollment period processes.

Attachment 16
1
2. PLAN CONTENTS

A. COORDINATION BETWEEN TRANSFERRING AND RECEIVING CCOS

OHA expects the Transferring and Receiving CCOS to work together and cooperate to achieve a successful transition for Members who change CCO during the Open Enrollment period. This section should describe the Applicant’s plan to coordinate with other CCOS as the Transferring and/or Receiving CCO. This includes but is not limited to establishing working relationships and agreements between CCOS to facilitate data sharing and validation, Member Prior Authorization history, Provider matching and Assignment, continuity of care and customer support.

TRILLIUM’S PLAN FOR CCO COORDINATION FOR TRANSITIONING MEMBERS

Continuity of care, coordination across disparate systems, and timely access to services are core health plan functions. Trillium is committed to coordinating with other CCOS as the transferring and/or receiving CCO to effectively maintain these functions throughout a member’s tenure and transition. We will continue to focus our continuity efforts on helping make any transition as smooth as possible for members and providers, whether a single member moving into our Service Area, Open Enrollment, or a contract transition contemplated by CCO 2.0. Regardless of which side we fall on, we will coordinate directly with each CCO to provider or receive member information to create a seamless experience for all.

Trillium Accountability. We will establish a Continuity Coordinator accountable for Trillium’s compliance with and leadership role in the provided reference document OAR 410-141-3061 Transition of Care Requirements, the Oregon Health Plan Administrative Rulebook, and other OHA guidance on member transitions. Their role will be to develop partnerships and protocols with other CCOS to deliver on these requirements and serve as a single point of contact for the other CCOS as well as the State for any transition-related activities, questions, or coordination needs. In addition, to support the technical requirements for data sharing and validation, we will designate a HIT Liaison as the CCO technical contact and facilitator of CCO data sharing and validation that will work with our Continuity Coordinator.

Proposed Approach for CCO Coordination. Driven by the Continuity Coordinator, our initial proposal for CCO coordination under CCO 2.0 is as follows:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to collaborate with OHA on state-wide Member Transition of Care (ToC) Workgroup</td>
<td>Upon reinstatement of this group, all CCOS should be required to participate and elect a representative for the ToC Workgroup. Trillium is available to take a lead role in coordinating and developing protocols and materials for reaction, input, and final ToC and OHA approval. Trillium’s Continuity Coordinator will be the designated lead with additional support from the HIT Liaison and other functional areas such as Care Coordination, Utilization Management and Provider Relations.</td>
</tr>
<tr>
<td>Establish written protocols with CCOS</td>
<td>Draft protocols to drive and oversee the member transition process. Review at ToC Workgroup for additional input, with feedback and approval from OHA. Protocols will include, at a minimum: data to be shared/exchanged (e.g. claims and authorization history, members in Care Coordination, and care plans); method for data sharing and validation; PCP and treating provider matching and assignment; customer support including list of contacts; and continuity of care requirements as driven by individual member needs, OHA, and Contract requirements.</td>
</tr>
<tr>
<td>Define HIPAA compliant technical mechanisms for coordinating/sharing data</td>
<td>CCOS to agree on a common set of data sharing requirements (e.g., HL7, FHIR, CCD) and transfer methods (e.g., SFTP, secure portal, HIE or other potential channels).</td>
</tr>
<tr>
<td>Create a CCO Member Transition checklist</td>
<td>Draft a checklist and facilitate a ToC Workgroup discussion. The checklist would be completed by each receiving CCO and presented to the transferring CCO to outline transition needs and promote consistency.</td>
</tr>
<tr>
<td>Form CCO contact list and</td>
<td>All CCOS to contribute to a shared contact list to ensure coordination with assigned</td>
</tr>
<tr>
<td>Activity</td>
<td>Method</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>supporting information</td>
<td>Continuity Coordinator or other designee at each CCO.</td>
</tr>
<tr>
<td>Explore Oregon Transition of</td>
<td>Determine possibility of establishing a ToC Hub for purposes of sharing between CCOs using a common and repeatable method, system and/or data repository.</td>
</tr>
<tr>
<td>Care (ToC) Hub Model</td>
<td></td>
</tr>
</tbody>
</table>

**Member Transition Plan.** Upon RFA award, we will provide OHA with a completed Member Transition Plan and will revise this plan based on further conversations with OHA and partnering CCOs to implement an agreed upon plan for CCO 2.0.

**Lessons Learned.** Our Continuity Coordinator will leverage local knowledge and relationships combined with the experience of our affiliate plans to recommend and adopt similar methods proven to be effective and applicable to supporting Oregon Health Plan members. For example:

**Example #1.** In 2017, our Texas affiliate collaborated with partnering health plans to formalize operational procedures for member health plan changes. This group jointly developed a Transfer Process, including a Transfer Checklist, Contact Information Roster, and Authorization Data File Format to cover instances when a member is newly enrolled or is changing health plans with or without active service authorizations. This group defined the data Transfer Process, where the sending health plan must provide to the receiving health plan the member’s care plan and applicable forms, waiver services used, identification information on the member’s existing providers, and active authorizations no later than 15 business days from the receipt of the state’s eligibility file. Our affiliate plan sends or receives this information, based on whether losing or gaining the member, via secure e-mail or Secure File Transfer Protocol (SFTP), which depends on the capabilities of the receiving or sending health plan. The Transfer Process also includes a secure electronic mailbox for each health plan to share related information.

**Example #2.** In 2016, our Georgia affiliate partnered with the Georgia Department of Community Health (DCH) and participating health plans to best address the transition of care process and define effective data sharing methods. They formed a working group to define the process, including how to identify transitioning members, identify risks and technical challenges, and define data file requirements and method of transfer. Their decision was to utilize the HL7 Consolidated Clinical Document Architecture (C-CDA) format, which would be generated by each health plan and distributed to the Georgia HIE (GaHIN). The GaHIN now serves as a secure centralized hub to collect and distribute all C-CDA files between the health plans for all transitioning members. This approach provided all health plans with an agreed upon standard and process for creating and receiving secure member information, through the same delivery channel, which reduced complexity and minimized risks.

**B. TRANSFERRING CCOS WITH OUTGOING MEMBERS**

This section of the Member Transition Plan is required if Applicant (1) has a 2019 CCO contract, (2) is a risk-accepting entity or Affiliate of a 2019 CCO, or (3) has a management services agreement with or is under common management with a 2019 CCO.

(1) DATA SHARING

This section should describe the plan to compile and share electronic health information regarding the Member, their treatment and services. Include data elements to be shared, formatting and transmittal methods, and staffing/resource plans to facilitate data transfers to the Receiving CCO(s).

**PROPOSED PROCESS FOR SUPPORTING OUTGOING MEMBER TRANSITIONS**

Upon notification that a member is transitioning to another CCO, we will collect the data needed by the receiving CCO to ensure continuity of care and non-disruption of services. We will leverage our integrated Health Information Technology (HIT) platforms to collate all necessary data elements to create and distribute a...
Continuity of Care Document (CCD) for each impacted member. The flexibility of a CCD will allow Trillium to compile and share all agreed upon health information regarding the member including the care plan, treatment, services and prior authorizations. *Figure 16. Trillium HIT Platform Overview* depicts our data collection approach. We will pull and format information from our source systems into a CCD containing all agreed upon data elements, as described below and finalized through the ToC Workgroup. Once the CCD is created, we will distribute this securely to the receiving CCO using an agreed upon method such as secure email, SFTP or via our proposed *Oregon Transition of Care (ToC) Hub*, once established.

*Figure 16. Trillium HIT Platform Overview*

The data and file exchange backbone (A) of our HIT will provide us with the structure to collect, format, and share the data elements needed for effective transitions. Today, our Electronic Data Interchange (EDI) capabilities provide HIPAA and non-HIPAA secure file exchanges with state agencies, including OHA, providers, subcontractors, and Health Information Exchanges (HIEs). We support standards-based data interchanges, including HL7 Admission, Discharge, Transfer (ADT)/FHIR, CCD, and other forms of health information transactions to further facilitate the sharing of clinical data. Our Centelligence® Platform (B) analyzes and integrates transactional data from internal and external sources, into the Enterprise Data Warehouse (EDW) and is responsible for routing data to and from our core processing platforms (C).

*Proposed Data Elements to be Shared.* To create the CCD, the ToC Workgroup will work collaboratively to define the data fields that are common across all entities and what the CCD should include. The table below outlines the suggested CCD segment data elements and the HIT Core Processing Platforms (C) that we will use as the source for this information in order to generate a CCD and ensure an effective member transition between CCOs. This is intended only as an example of potential data fields to initiate discussions with OHA and partnering CCOs.
## Proposed CCD Data Elements

<table>
<thead>
<tr>
<th>CCDs Segment Data Element</th>
<th>Trillium’s Source for Information</th>
<th>CCDs Segment Data Element</th>
<th>Trillium’s Source for Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID</td>
<td>Unified Member View (UMV) (member data management system)</td>
<td>Care Plan and Associated Data Elements</td>
<td>TruCare (care management system)</td>
</tr>
<tr>
<td>Member Name</td>
<td>UMV</td>
<td>Screenings and Assessments</td>
<td>TruCare</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>UMV</td>
<td>Open Authorizations (including date range, provider, codes, units, etc)</td>
<td>TruCare</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>UMV</td>
<td>Historical Authorizations</td>
<td>TruCare</td>
</tr>
<tr>
<td>Gender</td>
<td>UMV</td>
<td>Historical Claims and Accumulators</td>
<td>Claims Processing System</td>
</tr>
<tr>
<td>Member Address/Phone</td>
<td>UMV</td>
<td>Advance Directives</td>
<td>TruCare</td>
</tr>
<tr>
<td>Preferred Language</td>
<td>UMV</td>
<td>Laboratory Values/Results</td>
<td>Supplemental Files</td>
</tr>
<tr>
<td>PCP name and NPI</td>
<td>UMV &amp; Provider Data Management (PDM)</td>
<td>Medication History</td>
<td>Pharmacy System</td>
</tr>
<tr>
<td>Other active provider name and NPI (e.g. behavioral health (BH) provider or specialist)</td>
<td>UMV &amp; PDM</td>
<td>Diagnosis</td>
<td>Claims System</td>
</tr>
<tr>
<td>Provider Contact Info</td>
<td>UMV &amp; PDM</td>
<td>Transportation Needs</td>
<td>TruCare</td>
</tr>
<tr>
<td>Current DCO</td>
<td>UMV</td>
<td>Other Accommodations</td>
<td>TruCare</td>
</tr>
<tr>
<td>Allergies</td>
<td>TruCare</td>
<td>SDOH Information</td>
<td>TruCare</td>
</tr>
</tbody>
</table>

**Formatting and Transmitting.** Through the use of our integrated HIT and EDI capabilities, we propose using the industry standard HL7 CCD format to generate and transfer this data in a reusable and repeatable fashion ensuring that the quality of data transferred is maintained and is useable by the recipient. As mentioned above, we are prepared to distribute this securely to the receiving CCO using an agreed upon method that meets their specifications.

**Staffing Support.** We will leverage our HIT Liaison and Data Transfer staff along with support from our Corporate IT department to ensure all systems contain the necessary data elements, and that we follow a repeatable process to create a common data file such as a CCD. This team will also ensure that all data transmissions between CCOs occur timely and without error.

**(2) PROVIDER MATCHING**

*This section should describe the methods for identifying Members’ primary care and Behavioral Health home Providers and any specialty Providers, and transmitting that information to the Receiving CCO(s).*

All Trillium members are assigned a PCP during the onboarding process, which is stored for each individual member in our UMV system. The PCP may be a PCPCH or BH home. We can also identify active providers associated with any given member through our claims and authorization systems. We will pull all available information (e.g., TIN, NPI, name, address and office information) for each PCP, BH, or specialty providers that a member is seeing at the time of transition and make this information available via the CCD that we provide to the new CCO.
(3) CONTINUITY OF CARE

This section should describe plans to support Member continuity of care, including but not limited to Prior Authorizations, prescription medications, medical Case Management Services, and Transportation. This section should include all Members regardless of health status with specific details to address those Members at risk as described in Section (1).

Our role as a CCO is to ensure seamless access to services for all of our members. To facilitate continuity of care for members transitioning out of Trillium, we will provide the necessary data and information to the receiving CCO and appropriately educate our members, providers, and staff on our Continuity of Care policies, in accordance with CCO 2.0 and the new transition of care rule (OAR 410-141-3061).

Timely Data to Support Continuity of Care. Trillium will comply with requests from a receiving CCO for historical utilization data in a complete and timely manner in compliance with applicable State and Federal Laws. Standard data to be provided to the receiving CCO will include open authorizations, including date ranges, codes, providers, and units; medication history and prescription medications; care plans, care planning notes, and screenings and assessments; and scheduled transports. Information will be provided as soon as possible post notification, but no later than 30 days after disenrollment for open authorizations. We will also appropriately identify members at risk as described in Section (1) as part of the data elements provided to the receiving CCO.

Education and Training. Critical to ensuring continuity of care is ongoing education and notifying and outreaching to members and providers to assist with transitions, explain rights and responsibilities, and ensure they know how to reach, access, and get paid for services under the receiving CCO. This includes education and training for our staff on how to support members and providers during a transition. For members with high-risk and complex health care needs, our staff will outreach to the receiving CCO to perform a warm-handoff and provide additional information around a member’s needs, as appropriate. Additional information on how we work directly with outgoing members and their providers to facilitate seamless care and transitions is included in Section C below.

C. MEMBER/PROVIDER OUTREACH FOR TRANSITION ACTIVITIES

This section should describe plans to work directly with outgoing Members and their Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping Members and Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Receiving CCO to ensure a seamless transition of care for the Member.

As part of our member transition plan, supporting our Continuity Coordinator are our Care Coordination Team (CC Team), Call Center, Member Concierge Team and Provider Engagement staff, who will all continue to support members as they transition to or from other CCOs. These teams are available via our Call Center to support members, providers, and partnering CCOs with any questions they may have with transitioning. We have found through our experience that a phone call with the member, the family, providers or others involved in the transition process can be invaluable, ensuring there is a full understanding of the member’s health and social needs and how best to use the information available. Other ways we work directly with outgoing members and their providers, including members with special health care needs, are described below.

Member Education and Outreach. All members are made aware of our continuity of care policies and procedures, including the continuity of care time period and exceptions, through the Member Handbook and on our public website. Members can also contact our Call Center for assistance with continuity of care or transition
needs. Members at risk as described in Section (1) identified for transition will be contacted by their Care Coordinator to walk through the transition process, make necessary care plan updates, and educate on their rights and how to ensure seamless access to care. The Care Coordinator will offer to do a warm handoff with the receiving CCO Care Coordinator to ensure continuity in the care planning process. During this call, we will discuss current care needs, future (post-transition) appointments, interpreter services, or needed transportation services, the current care plan, and how that plan will be seamlessly transitioned over to the new CCO. This call will provide the member with an opportunity to ensure that their questions are answered prior to the transition thus easing their transition. Our staff will also provide resources for the receiving CCOs, such as contact numbers and website information, which a member may need to contact their new CCO. This information, along with other resources such as Frequently Asked Questions (FAQs), will be made available to members in our Member Handbook and on a new Transitions of Care Resource Page to be located on our public website. As part of the transition, the Care Coordinator will ensure necessary authorizations are in place so as not to delay care upon transition. The Care Coordinator will also ensure all non-covered services are adequately documented in the care plan and members are aware that they can continue to receive community-based services regardless of their CCO. For Health-Related Services not covered by the receiving CCO, the Care Coordinator will work with the member to identify other community resources to fulfill the service needs in the community.

**Provider Education and Outreach.** Providers will be made aware of continuity of care policies and procedures through the Provider Manual, provider onboarding, and on our website. It is important providers understand their ability to continue to see members during the continuity of care period and that the receiving CCO will be responsible for the costs of continuing any ongoing course of treatment and coordination of care for new enrollees transitioning into the CCO. For at-risk members, the Care Coordinator will outreach directly to providers to engage in transition planning as appropriate. As part of the CCO 2.0 transition, our Provider Relations team will hold educational sessions with providers to help them understand their role in member transitioning between CCOs and what activities they can do to help the member during this time, as well as how to ensure timely and accurate payment. Providers will be educated on the resources available to members and providers on our Transitions of Care Resource page on our public website so they can inform members of where to obtain additional information. We will notify providers that information is being provided to the member’s new CCO for continuity.

**Staff Training.** During the continuity of care period, our staff will be available to assist current and prior members with understanding their coverage, ensuring continued services are received and to answer any questions they may have. Our internal staff, including Call Center staff, are trained on and follow an established Continuity of Care Policy and Procedure which provides guidance on how best to support members during this transition period.

**D. RECEIVING CCOs WITH INCOMING MEMBERS**

(1) DATA SHARING

This section should describe the data reception plan for incoming Members, including but not limited to receiving and storing data files, front-end validation, system entry, output validation, and distribution.

**PROPOSED PROCESS FOR SUPPORTING INCOMING MEMBER TRANSITIONS**

To expand upon the capabilities we provide today, we will take CCD files from other CCOs to support seamless transition when a member is transitioning to Trillium. As depicted above in Figure 16. Trillium HIT Platform Overview we will utilize our EDI capabilities to receive and process the CCD into our EDW. Once in the EDW, we will perform a validation that the data received is formatted accurately and contains the required data elements. Following validation, we will parse the CCD file into our downstream core processing platforms such as UMV, TruCare, and Claims Processing system. To ensure accurate and timely payment, our claims and
authorization systems are configured to recognize the continuity of care period and pend before denying any prior authorizations and associated claim. The claims system will utilize the prior authorization data to validate appropriate services are rendered, process the claim and generate payments to out-of-network providers. Our goal is to ensure this information is made available to our staff in a timely and efficient manner to avoid any gaps in care. Once the information has been loaded into the appropriate system(s) our staff will begin making outreach and engaging members on their transition of care needs.

(2) PROVIDER MATCHING

"This section should describe the methods for identifying Members’ primary care and Behavioral Health home Providers and any specialty Providers, and enrolling Members with their assigned Providers. This includes contingency plans for assigning Members to appropriate Providers if they cannot be enrolled with the Provider from the Transferring CCO."

Primary Care and BH Home Providers. Upon receipt and processing of the transferring CCO’s supplied CCD file, we will update the member’s record in UMV, including assignment to the supplied PCP. If a PCP was not previously assigned, is out of network, and/or is not included in the CCD file, our Member Concierge outreach team will call the member to facilitate member choice. If a member is unsure about which provider to choose, our Concierge team will supply them with a list of provider choices in their area that align with their preferences. Our team will then follow-up as needed to support the member in selecting the best provider for their needs. If the member does not choose, our auto-assignment algorithm will search for providers in the member’s geographic area based on zip code and language preferences. The algorithm will assign a Trillium contracted provider to this member. The member will be notified of this assignment when they receive their updated Trillium ID Card, where their assigned provider will be listed. The member will also be given instructions on how to change their provider via our secure member portal or Call Center. If a member would like to remain with a non-network provider they had assigned while under the coverage of another CCO, they may continue seeing that provider throughout the continuity of care period. If the member is at high risk of being hospitalized, institutionalized or has a serious health risk, they may retain their current provider and we will work with this provider (if not currently in our network), to become a network provider or secure a single case agreement. If a servicing provider is not available in the new service area or if the member would like to continue treatment with their current provider after the transition period is completed, the provider will be required to submit an authorization, requesting services and providing rationale. As part of the prior authorization review process we will attempt to secure a contract.

Specialty Providers. For members in an active course of treatment, we will honor and be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers except as provided for in OAR 410-141-3061 or other forthcoming OHA guidance. Our systems will be configured to ensure accurate payment throughout the continuity of care period in accordance with OAR 410-141-3061 or other forthcoming OHA guidance. Concurrently, our Provider Network team will complete a crossover analysis of our network and any other CCOs in the service area and pursue contracts with any out-of-network providers actively seeing our incoming members to support continuity and member preferences past the transition period.
(3) CONTINUITY OF CARE

This section should describe plans to support Member continuity of care, including but not limited to honoring Prior Authorizations, prescription medications, and Treatment Plans from the Transferring CCO, medical Case Management Services, and Transportation. This section should address the approach for all Members regardless of health status with specific details to address those persons described in Section (1). As the receiving CCO, the plan should address how the Receiving CCO will ensure access to all medically necessary services for Members at risk of serious detriment to their physical and mental health, hospitalization, or institutionalization.

At the foundation of our continuity of care plan are written policies and procedures (P&Ps) developed in accordance with OHA requirements. Our approach is supported by our trained staff and provider and member education, outreach and materials (see 16.C above). Our focus is also on the configuration of our claims and authorization systems to ensure timely and appropriate payment for services during the transition period in accordance with continuity of care rules. As a receiving CCO, Trillium follows transition processes and protocols as described below:

- **For new members transitioning from FFS or another CCO**, Trillium will collect all available information from the former (sending) CCO, including existing care plans, transfer packets, authorizations, medication information, transportation/interpreter needs, and current providers and/or services, via CCD or other formats. We will also identify members at risk as described in Section (1) using information provided in the 834 file and included in the CCD, such as members who are homeless. Our CC Team will review this information and identify at-risk members for outreach, further assessment, and hands-on assistance.

- **We will conduct a Member Welcome Call for all new members**, making multiple (at least three) call attempts on different days at different times. As part of this call, we will complete an Initial Risk Screening to identify any immediate needs and/or active courses of treatment. For members requiring continuity of care, this information is transferred to the CC Team to ensure the appropriate prior authorization information is loaded into our system and the member has appropriate transportation and/or interpreter services in place. For example, if a member has transportation scheduled with a non-par vendor we will honor and make arrangements for payment. A Care Coordinator will be assigned to identified members for follow up including engagement in CC and care plan development for members that would benefit from CC or ICC services as specified in OAR 410-141-3170.

- **Trillium ensures that members receiving services through a prior authorization issued by another payer, or services where a prior authorization was not required but is required by Trillium, receive seamless authorization and uninterrupted services throughout the continuity of care period.**

- **Trillium takes responsibility for and ensures appropriate payment to providers**, regardless of network or prior authorization status, throughout the continuity of care period in accordance with OHA requirements, leveraging our robust claims payment system.

(4) MEMBER/PROVIDER OUTREACH FOR TRANSITION ACTIVITIES

This section should describe plans to work directly with incoming Members and their Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping Members and Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Transferring CCO to ensure a seamless transition of care for the Member.

As described in 16.C above for outgoing members, we work directly with incoming members and their providers, including members with special health care needs.
Member Education and Outreach. All transitioning members are educated on our continuity of care policy, how to access services, and resources available in our Member Handbook, public website and Member Portal. This initial education is part of our Welcome Call, as well as during the initial screening and Care Coordinator outreach for members identified at risk or needing special assistance. New members are informed of their ability to continue to see out-of-network providers in accordance with our continuity of care policy. For incoming members identified as at risk as defined in Section (1), our CC Team will perform an outreach call to the member. During this call we will discuss their current care needs, providers and services, help facilitate appointments and other accommodations, engage in care planning, and answer any questions they have about the change. As indicated, a Care Coordinator will complete a review of the member’s potential need for long-term services and supports and identify appropriate members for referrals to DHS for long-term services and supports per OAR 410-141-3160. CC staff may perform additional outreach to the prior CCO, using the contact information collected at the ToC Workgroup, to discuss the member care needs, request additional information and help gain a better understanding of what is needed for the member. In addition to outbound outreach, our Call Center staff are trained to take incoming calls to answer any questions that a member or provider who calls into Trillium has about their transition and address any concerns they may have, making a warm handoff to the CC Team for members that might benefit from CC.

Provider Education and Outreach. We educate providers on our continuity of care policy as part of our initial orientation and in ongoing provider training and materials. Initial orientation is completed for all in-network providers within 30 days of their active date. For out-of-network providers, we will outreach to the provider to educate on billing and payment and how to join our network. We will notify providers that have been assigned a new member through their member roster on the Trillium Provider Portal and in the monthly Hot-spotter Report to encourage outreach and engagement. To help facilitate the transition, our Continuity Coordinator or CC Team will be available to assist with securing member consent and transferring medical records from the prior provider(s). Our Provider Service Representatives also hold education sessions with providers to help them understand their role in transitioning members into Trillium and what activities they can do to help the member during this time. For at-risk members, the Care Coordinator will outreach directly to providers to engage in care planning and monitoring.

3. REFERENCE DOCUMENTS:

<table>
<thead>
<tr>
<th>Reference Document</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 Contract Extension, Contract Termination and Closeout Requirements</td>
<td>Trillium has reviewed and will comply with all requirements as outlined in the Reference Documents and OAR administrative rules. In addition, we have reviewed and used these documents to inform our response to Attachment 16 – Member Transition Plan.</td>
</tr>
<tr>
<td>OAR 410-141-3061 Transition of Care Requirements</td>
<td></td>
</tr>
<tr>
<td>OAR 410-141-3258 Contract Termination and Closeout Requirements</td>
<td></td>
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<tr>
<td>Oregon’s K Plan web page</td>
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<tr>
<td>Oregon’s Application for a 1915(c) HCBS Waiver</td>
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</table>
LOCALLY-BASED, COMMUNITY-ROOTED, PROVIDER-ORIENTED CCO

Local Approach. Trillium Community Health Plan (Trillium) brings over 20 years’ experience (7 years as a CCO) collaborating with community organizations, providers, county representatives, members, and families to deliver coordinated, integrated, high-quality services to nearly 90,000 members in Lane County and contiguous zip codes in Benton, Coos, Douglas, and Linn Counties (Lane Region). Being a partner, convener and innovator in the communities in which we live, work and age has served as the platform for successfully meeting CCO goals, including integration of physical, behavioral health and oral health and coordination with the long-term care (LTC) and Medicare delivery systems and continuously driving toward the Triple Aim and Quadruple Aim of improved outcomes, member and provider experience and efficiencies. As Health System Transformation evolves, Trillium is well positioned to meet CCO 2.0 goals including expanding public health and prevention efforts to address social determinants of health and health equity (SDOH-HE); ensuring sustainability and transparency and increasing quality and performance through value-based purchasing and technology solutions; continued integration and coordination; and innovation, as highlighted throughout our response.

Local Decision-Making. Trillium believes that health care is best delivered locally. We deliver this through local leadership and decision-making: local offices; local workforce and field-based staff; local governance structure; provider engagement; and hands-on community engagement efforts. Trillium augments these community-focused efforts through our parent, Centene’s, investments in health information technology, sharing of best practices and evidence-based models, and focus on improvement of health care outcomes one person at a time.

WELL-POSITIONED TO EXPAND OUR SUPPORT OF CCO 2.0

Current Success. Differentiating our CCO is a person-centered, whole-health approach to care, focusing on each unique individual and coordinating across the system of care and care continuum, all supported by robust and flexible system capabilities and strategic community investments aligned with OHA and local community goals. For example:

- Our person-centered, integrated care coordination model, staffing, and programs are evidence-based and tailored for managing and coordinating physical, behavioral, oral, LTC and SDOH-HE member needs.
- We understand that culturally competent, trauma-informed, high-touch interaction – supported by Traditional Health Workers and SDOH-HE partners – is critical to engaging members and their families to improve health and wellness and address SDOH-HE.
- We emphasize timely communication, collaboration, and transparency with providers to improve quality and efficiency and support providers along the continuum of value-based payments, electronic health record use and Patient-Centered Primary Care Homes status.

Future Opportunity. Based on current success and outcomes in the Lane Region, market presence across the State through our affiliate Health Net, and boots-on-the-ground community engagement along the I-5 corridor, Trillium believes we can add value by extending our Service Area to Clackamas, Multnomah and Washington Counties (Tri-County Region). We are actively developing a network of county support; physical, behavioral and oral health providers; and LTC and SDOH-HE partners and are confident in our ability to adopt and adapt successful programs and infrastructure, such as our Rural Advisory Council and Oral Health Collaborative, to the Tri-County Region.

Since 2012, Trillium has:
- Increased Access to Integrated Care: Invested more than $13 million to open five new clinics.
- Addressed SDOH-HE: Allocated $1.33 per member per month to fund preventive programs that address SDOH-HE.
- Provider Engagement and Sustainability: Reinvested 92% of our Quality Pool incentive funds back to providers.
- Improving Health Outcomes: From 2013 to 2018, Lane County improved in overall health outcomes from 17th out of 36 Oregon counties.
Per OHA's response to Question and Answer #58 in Addendum 5 released March 15, 2019, please see Att.7.11 for Trillium Community Health Plan's response to the "Full County Coverage Exception Request".
## Reference #1 (Current Client)

<table>
<thead>
<tr>
<th>Name of Client Firm</th>
<th>Orchid Health Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Program/Project</td>
<td>Integrated Primary Care/Behavioral Health Program</td>
</tr>
<tr>
<td>Name of Primary Reference</td>
<td>Orion Falvey, Executive Director</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Address: 47815 Highway 58 Oakridge, OR 97463</td>
</tr>
<tr>
<td></td>
<td>Phone: 503-850-8132</td>
</tr>
<tr>
<td>Time Period of Relationship</td>
<td>Start Date: January 2014   End Date: N/A; Ongoing</td>
</tr>
<tr>
<td>Description of Program / Scope of Services Provided Within the Last 5 Years</td>
<td>This program aligns with OHA’s <em>CCO 2.0 goal of improving Oregon’s behavioral health system and addressing barriers to access to and integration of care</em>. Orchid Health was founded in 2014 by two University of Oregon students, Orion Falvey and Oliver Alexander, who wanted to bring healthcare clinics in the most underserved rural communities. They found that patients living in rural communities face many social determinates of health that can cause treatable disease to spiral out of control and cause premature death. They purposely chose communities who had the largest population without primary care clinics in the area. Orion has continued to build the Clinic into a 5 STAR recognized Patient-centered Primary Care Home. Orchid offers local, comprehensive healthcare in the Oakridge community, a medically underserved rural area in the Cascade Mountains that had little primary care for OHP patients before the founding of the clinic. Through a patchwork of start-up funding from Lane County, HRSA and Trillium, the Clinic has become well respected and successful, attracting top providers and remaining responsive to the needs of the community. Nearly all of the Trillium members in their service area have opted to utilize the Clinic and are very satisfied with the services they receive there.</td>
</tr>
<tr>
<td>Innovations, Results and Value Achieved Under Contract</td>
<td>Orchid Health is one of Lane County’s most innovative rural clinics, responsive to local needs and professional support. The Clinic has fully integrated behavioral healthcare into the primary care environment, initially through partnership with a licensed mental health clinic in Cottage Grove, and then thorough their own hiring of behavioral health practitioners supported by Trillium billing. In 2018 Orchid Health was awarded a Trillium Innovation Grant to expand intensive care management using a community based model. Orchid Health continues to build strong relationship with community partners and Trillium Community Health Plan.</td>
</tr>
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</table>
Exempt from disclosure under ORS 192.311 through 192.478 and ORS 646.461 through ORS 646.47 as confidential and proprietary commercial and/or financial information.
# Reference #3 (Former Client)

<table>
<thead>
<tr>
<th><strong>Name of Client Firm</strong></th>
<th>Lane County Health and Human Services Department</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Program/Project</strong></td>
<td>Trillium Behavioral Health (TBH) Division</td>
</tr>
<tr>
<td><strong>Name of Primary Reference</strong></td>
<td>Dr. Bruce Abel, DSW</td>
</tr>
</tbody>
</table>
| **Contact Information** | **Address:** 2452 Lawrence St. Eugene Oregon 97405  
**Phone:** 541-844-5586  
**Email:** bruceabel@msn.com |
| **Time Period of Relationship** | **Start Date:** January 2012  
**End Date:** November 2017 (Retired) |

## Description of Program/Scope of Services Provided Within the Last 5 Years

This program aligns with OHA’s [CCO 2.0 goal of improving Oregon’s behavioral health system and addressing barriers to access to and integration of care](#). TBH is a department of Lane County Health and Human Services and in 2012 became a partner with Trillium to create a CCO in Lane County. Dr. Bruce Abel was the County MHO Manager for the Oregon Health Plan (OHP) mental health services funding and delivery system, and he was an important partner in the creation of the CCO model that Trillium was awarded a Contract for. He severed as the Chief Behavioral Health Officer at TBH, working closely with Trillium. Dr. Abel brought decades of experience guiding the mental health system in Lane County at the CCO, and was largely responsible for providing stability to the system as the CCO model became established, and for guiding Trillium and TBH’s system transformation with the integration on physical and behavioral health at the clinical and systems levels. Under Dr. Abel’s leadership TBH provided utilization management and care coordination for the behavioral health system; guided provider and community educational opportunities; funded crisis resources; and collaborated with the LMHA to create a strong and responsive system to address member needs.

## Innovations, Results and Value Achieved Under Contract

Dr. Abel was instrumental in the formation and growth of the Trillium CCO behavioral health integration; supported the implementation of the Children’s System of Care and Wraparound Initiative and Older Adult Behavioral Health Initiative; expanded Assertive Community Treatment (ACT) for adults with severe and persistent mental illness; established a Community Crisis Respite Program and the expansion of adequate crisis response; integrated behavioral health and primary care under the Patient Centered Primary Medical Home (PCPMH) model; supported the formation of a Certified Community Behavioral Health Clinics in Lane County; and designed value based payment models for the behavioral health contracts, to name just a few of his many accomplishments.
<table>
<thead>
<tr>
<th>Reference #4 (Former Client)</th>
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</thead>
<tbody>
<tr>
<td><strong>Name of Client Firm</strong></td>
<td>Rick Yecny, former Chief Administrative Officer for Siuslaw Hospital</td>
</tr>
<tr>
<td><strong>Name of Program/Project</strong></td>
<td>Trillium Rural Advisory Council, Trillium Board</td>
</tr>
<tr>
<td><strong>Name of Primary Reference</strong></td>
<td>Rick Yecny</td>
</tr>
</tbody>
</table>
| **Contact Information**     | Address: 06088 Mercer Lake Road, Florence, OR 97439  
Phone: (541) 999-3109  
Email: ryeeny@charter.net |
| **Time Period of Relationship** | Start Date: June 2012  
End Date: December 31, 2017 |
| **Description of Program / Scope of Services Provided Within the Last 5 Years** | This program aligns with OHA’s *CCO 2.0 goal of improving social determinants of health, particularly in Oregon’s rural communities*. Mr. Yecny served on the Trillium Rural Advisory Council (RAC) and was the RAC representative on the Trillium Board of Directors. In his role as the RAC Board representative, he advocated for the rural community by focusing on solutions to complex problems, such as health equity and access to care. |
| **Innovations, Results and Value Achieved Under Contract** | Mr. Yecny was instrumental in his role as a Trillium Rural Advisory Council member in representing the needs of rural communities. Mr. Yecny’s leadership secured a HRSA grant to fund SBHC’s in the Siuslaw and Mapleton School Districts that will include behavioral health supports. This effort involved hiring a consultant and engaging in a community collaboration that included Trillium and Lane County. We continue to build on the work that Mr. Yecny started. Additionally, Mr. Yecny assisted the Reedsport community in identifying Trillium to replace the CCO that exited their service area. He recognized the opportunity for Trillium to duplicate their success in Lane County by providing access and coordination of care to Oregon Health Plan members in Reedsport. |