# FORMAL APPLICATION
# AND RESPONSE TO
# THE OREGON HEALTH AUTHORITY'S RFA-3402
# FOR
# COORDINATED CARE ORGANIZATIONS (CCOs)

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Respectfully Submitted To:
Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
250 Winter Street NE, Third Floor
Salem, Oregon 97301
503.947.5298

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By
Phil Greenhill
Chief Executive Officer
Southwest Oregon Independent Practice Association, Inc.
On Behalf Of
**WESTERN OREGON ADVANCED HEALTH, LLC**
Post Office Box 1096
Coos Bay, Oregon 97420
541.269.7400 x 115
pgreenhill@docshp.com

## Table of Contents

## I. APPLICATION COVER SHEET
## RFA-3402

| | | | |
|---|---|---|---|
| **Applicant Name** | : | Southwest Oregon Independent Practice Association<br>On Behalf Of **Western Oregon Advanced Health, LLC** | |
| **Form of Legal Entity** | : | Domestic Corporation | |
| **State of Domicile** | : | Oregon | |
| **Primary Contact Person** | : | Phil Greenhill | |
| **Title** | : | Chief Executive Officer | |
| **Address** | : | 750 Central Ave, Suite 202<br>Coos Bay, OR 97420 | Post Office Box 1096<br>Coos Bay, OR 97420 |
| **Telephone** | : | 541.269.7400 x 115 | |
| **Fax** | : | 541.269.7789 | |
| **E-Mail** | : | pgreenhill@docshp.com | |

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

Phil Greenhill
Chief Executive Officer

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

1. Applicant does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, sex, disability, sexual orientation, or national origin, nor has Applicant or will Applicant discriminate against a subcontractor in the awarding of a subcontract because the subcontractor is a minority, woman, or emerging small business enterprise certified under ORS 200.055.
2. Information and costs included in this Application will remain valid for 180 days after the Application due date or until a Contract is approved, whichever shall first occur.
3. The statements contained in this Application are true and, so far as is relevant to the Application, complete. Applicant accepts as a condition of the Contract, the obligation to comply with the applicable state and federal requirements, policies, standards, and regulations.
4. The undersigned recognizes this is a public document and will become open to public inspection, except as described in Section 7.8.

5. Applicant has followed the instructions provided and has identified any deviations from specifications within its Response. Applicant confirms that any instructions or specifications that it felt were unclear have been questioned in advance of this Application.

6. Applicant acknowledges receipt of all addenda issued under this RFA, as listed on OHA's web portal.

7. If awarded a Contract, Applicant will be required to complete, and will be bound by, a Contract described in this RFA. Applicant agrees to the Core Contract terms and conditions in Appendix G, except to the extent Applicant has timely requested a change or clarification or filed a protest in accordance with this RFA.

8. If awarded a Contract, Applicant will meet the highest standards prevalent among Medicaid health plans in Oregon.

9. Applicant and its Affiliates complied with the Code of Conduct in Section 7.15 of the RFA in connection with the RFA.

10. Applicant accepts the terms and conditions for OHA's web portal, as posted on the web portal.

11. Applicant will negotiate in good faith regarding the statement of work for the Contract.

| | | |
|---|---|---|
| **Signature** | : | *Phil Greenhill*<br>[Signed Electronically – See Exhibit I] |
| **Name Printed** | : | Phil Greenhill |
| **Title** | : | Chief Executive Officer and Authorized Official |
| **Date** | : | 28 April 2012 |

## II. ATTESTATIONS, ASSURANCES, AND REPRESENTATIONS

**Applicant Name** : **Southwest Oregon Independent Practice Association, Inc., dba DOCS**
**On Behalf Of WESTERN OREGON ADVANCED HEALTH, LLC**

**Instructions:** For each attestation, assurance, or descriptive representation below, Applicant will check *yes* or *no* or *qualified*. On attestations and assurances, a *yes* answer is normal, and an explanation will be furnished if Applicant's response is *no* or *qualified*. On informational representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all attestations, assurances, and informational representations. The table headings indicate if an item is an attestation, assurance, or informational representation. These attestations, assurances, and informational representations must be signed by one or more representatives of the Applicant who have knowledge of them after due inquiry. They may be signed in multiple counterparts, with different representatives of Applicant signing different counterparts. Unless a particular item is expressly effective at the time of Application, each attestation, assurance, or informational representation is effective starting at the time of readiness review and continuing throughout the term of the Contract.

### Attestations for Appendix A

| Attestation | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **A-1.** Applicant will have an individual accountable for each of the following operational functions (by the readiness review date of 3 July 2012): | | | | |
| • Contract administration | Yes | | | |
| • Outcomes and evaluation | Yes | | | |
| • Performance measures | Yes | | | |
| • Health management and care coordination activities | Yes | | | |
| • System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO | Yes | | | |
| • Mental health and addiction coordination and system management | Yes | | | |
| • Communications management to providers and Members | Yes | | | |
| • Provider relations and network management, including credentialing | Yes | | | |
| • Health information technology and medical records | Yes | | | |
| • Privacy officer | Yes | | | |
| • Compliance officer | Yes | | | |

## Attestations for Appendix A, Continued

| Attestation | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **A-2.** Applicant will participate in the learning collaborative required by ORS 442.210 | Yes | | | |
| **A-3.** Applicant will collect, maintain, and analyze race, ethnicity, and primary language data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities. | Yes | | | |

## Attestations for Appendix B

| Attestation | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-1.** Applicant will, as demonstrated with policies and procedures: (a) authorize the provision of a drug requested by the Primary Care Physician or referral Provider, if the approved prescriber certifies medically necessity for the drug (e.g., the formulary's equivalent has been ineffective in the treatment of the formulary's drug causes, or is reasonably expected to cause adverse or harmful reactions to the Member); and, (b) reimburse providers for dispensing a 72-hour supply of a drug that requires prior authorization in accordance with OAR 410-141-0070. | Yes | | | |
| **B-2.** Applicant will comply with all applicable provider requirements of Medicaid law under 42 CFR Part 438, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. | Yes | | | |
| **B-3.** Applicant will assure that all provider and supplier contracts or agreements contain the required contract provisions that are described in the Contract. | Yes | | | |
| **B-4.** Applicant will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested service area. | Yes | | | |

## Attestations for Appendix B, Continued

| Attestation | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-5.** Applicant will have all provider contracts or agreements available upon request. | Yes | | | |
| **B-6.** As Applicant implements, acquires, or upgrades health information technology (HIT) systems, where available, the HIT systems and products will meet standards and implementation specifications adopted under Section 3004 of the Public Health Services Act, as added by Section 13101 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5. | Yes | | | |
| **B-7.** Applicant's contracts for administrative and management services will contain the OHA required contract provisions. | Yes | | | |
| **B-8.** Applicant will establish, maintain, and monitor the performance of a comprehensive network of providers to assure sufficient access to Medicaid Covered Services as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO. Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines. | Yes | | | |
| **B-9.** Applicant will have executed written agreements with providers (first tier, downstream, or related entity instrument) structured in compliance with OHA regulations and guidelines. | Yes | | | |
| **B-12.** Applicant will have verified that contracted providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified providers in the future. | Yes | | | |
| **B-13.** Applicant will provide all services covered by Medicaid and comply with OHA coverage determinations. | Yes | | | |

## Attestations for Appendix B, Continued

| Attestation | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-10.** Applicant, through its contracted or deemed Participating Provider network, along with other specialists outside the network, community resources or social services within CCO's service area, will provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through:<br>• Prompt, convenient, and appropriate access to Covered Services by enrollees, 24 hours per day, seven days per week;<br>• The coordination of the individual care needs of enrollees in accordance with policies and procedures established by the Applicant;<br>• Enrollee involvement in decision-making regarding treatment, proper education on treatment options, and the coordination of follow-up care;<br>• Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and,<br>• Addressing diverse patient populations in a culturally competent manner. | Yes<br>Yes<br>Yes | | Yes<br>Yes | (1) The development of comprehensive policies and procedures required to support care coordination and integration will not be completed until 31 December 2013.<br>(2) The formal policy and procedure statements, referenced above, will specifically address issues related to enrollee compliance with prescribed treatment protocols. |
| **B-11.** Applicant will establish policies, procedures, and standards that:<br>• Assure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;<br>• Ensure access to medically necessary care and the development of medically necessary individualized care plans for enrollees;<br>• Promptly and efficiently coordinate and facilitate access to clinical information by all providers involved in delivering the individualized care plan of the enrollee;<br>• Communicate and enforce compliance by providers with medical necessity determination; and,<br>• Do not discriminate against Medicaid enrollees, including providing services to individuals with disabilities in the most integrated setting appropriate to the needs of these individuals. | Yes<br>Yes<br>Yes<br>Yes | | Yes | Full development of the CCO's Clinical Information System, through its envisioned Health Information Exchange, may not occur during the Contract period. Under such a circumstance, the existing policies and procedures of Southwest Oregon Independent Practice Association, Inc.(SWOIPA) for the prompt exchange of clinical information shall be binding. |

## Attestations for Appendix B, Continued

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

## Medicaid Assurances for Appendix B

| Assurance | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-1. Emergency and Urgent Care Services.** Applicant will have written policies and procedures and monitoring systems that provide for emergency and urgent services for all Members on a 24-hour, seven-day-per-week basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure provider compliance. [42 CFR 438.114 and OAR 410-141-3140] | | | Yes | (1) Emergency and urgent services for Members will be fully available as of the Contract effective date.<br>(2) Corresponding written policies and procedures, with included compliance, monitoring, and corrective action statements, may not be fully developed until 31 December 2012.<br>(3) SWOIPA's existing policies and procedures will be binding until replaced by the CCO's policies and procedures. |

## Medicaid Assurances for Appendix B, Continued

| Assurance | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-2. Continuity of Care.** Applicant will have written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking, and documentation of all referrals and prior authorizations to other providers. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure provider compliance. [42 CFR 438.208 and OAR 410-141-3160] | | | Yes | (1) A system for the coordination of care, tracking, documentation, and monitoring will be fully available as of the Contract effective date.<br>(2) Corresponding written policies and procedures, with included compliance, monitoring, and corrective action statements, may not be fully developed until 31 December 2012.<br>(3) SWOIPA's existing policies and procedures will be binding until replaced by the CCO's policies and procedures. |
| **B-3.** Applicant will have written policies and procedures that ensure maintenance of a record-keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC, 1320 et seq., and the federal regulations implementing the Act, and complete clinical records that document the care received by Members from the Applicant's primary care and referral providers. Applicants will communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures, and take any corrective action necessary to ensure Participating Provider compliance. Applicants will document all monitoring and corrective action activities. Such policies and procedures will ensure that records are secured, safeguarded, and stored in accordance with applicable law. [45 CFR Parts 160-164; 2 CFR 438.242; ORS 414.679; and OAR 410-141-3180] | | | Yes | (1)Fully compliant clinical records systems will be in effect as of the date of the Contract effective date.<br>(2) Corresponding written policies and procedures, with included compliance, monitoring, and corrective action statements, may not be fully developed until 31 December 2012.<br>(3) SWOIPA's existing policies and procedures will be binding until replaced by the CCO's policies and procedures. |

## Medicaid Assurances for Appendix B, Continued

| Assurance | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-4.** Applicant will have ongoing quality performance improvement program for the services it furnishes to its Members. The program will include an internal Quality Improvement program based on written policies, standards, and procedures that are designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and non-clinical care areas 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. [42 CFR 438.200 and 438.240; OAR 410-141-0200] | | | Yes | Southwest Oregon Independent Practice Association's Quality Improvement Program will be binding until replaced by new written policies and procedures for same, under the auspices of the Clinical Advisory Panel, on or before 30 June 2013. |
| **B-5.** Applicant will make Coordinated Care Services available to enrolled Members. The Applicant will not discriminate between Members and non-Members as it relates to benefits to which they are both entitled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure provider compliance. [42 CFR 438.206 to 438.210; and OAR 410-141-3220] | | | Yes | Southwest Oregon Independent Practice Association's policies and procedures for Coordinated Care and non-discrimination will be binding until replaced by the CCO's written policies and procedures for same, on or before 31 December 2012. |
| **B-6.** Applicant will have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and appeals from Members or their representatives that are consistent with Exhibit 1 of Appendix G, *Core Contract*. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure provider compliance. [42 CFR 438.228, 438.400-438.424; and OAR 410-141-3260 to 3266] | | | Yes | Southwest Oregon Independent Practice Association's Grievance and Appeals Program will be binding until replaced by the CCO's written policies and procedures for same, on or before 31 December 2012. |
| **B-7.** Applicant will develop and distribute informational materials to potential Members that meet the language and alternative format requirements of potential Members. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure provider compliance. [42 CFR 438.10; OAR 410-141-3280] | | | Yes | Southwest Oregon Independent Practice Association's Informational Member Materials will be used until replaced by the CCO's Informational Member Materials, on or before 31 October 2012. |

## Medicaid Assurances for Appendix B, Continued

| Assurance | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-8.** Applicant will have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant, Member handbook, health education, availability of intensive care coordination for Members who are aged, blind, and/or disabled, and appropriate use of emergency facilities and urgent care. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure provider compliance. [42 CFR 438.10; and OAR 410-141-3300] | | | Yes | Southwest Oregon Independent Practice Association's Informational Member Materials will be used until replaced by the CCO's Informational Member Materials, on or before 31 October 2012. |
| **B-9.** Applicant will have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Attachment 4, Core Contract. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure provider compliance. [42 CFR 438.100; ORS 414.635 and OAR 410-141-3320] | Yes | | | |
| **B-10.** Applicant will provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination) to Members who are Aged, Blind, or Disabled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure provider compliance. [42 CFR 438.208 and OAR 410-141-3405] | | | Yes | (1) A system for Intensive Care Coordination will be fully available to Members as of the Contract effective date.<br>(2) Corresponding written policies and procedures, with included compliance, monitoring, and corrective action statements, may not be fully developed until 31 December 2012.<br>(3) SWOIPA's existing policies and procedures will be binding until replaced by the CCO's policies and procedures. |

## Medicaid Assurances for Appendix B, Continued

| Assurance | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-11.** Applicant will maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules, and OHA Provider Guides. The Applicant and its providers will not hold Members responsible for the Applicant's or providers' debt(s) if the entity becomes insolvent. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure provider compliance. [42 CFR 447.46 and OAR 410-141-0420] | | | Yes | Southwest Oregon Independent Practice Association is currently characterized by efficient, compliant, and accurate fiscal systems, policies, and procedures that will need to be modified to reflect new CCO nuances. This work will be completed by 31 October 2012. |
| **B-12.** Applicant will participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards. Applicant has executed all necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules, and OHA Provider Guides. The Applicant will have a monitoring system 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. [45 CFR Part 162; OAR 943-120-0100 to 943-120-0200] | Yes | | | Southwest Oregon Independent Practice Association currently meets these requirements, and will perform trading partner functions on behalf of Western Oregon Advanced Health. |
| **B-13.** Applicant will maintain an efficient and accurate system for capturing encounter data, timely reporting the encounter data to OHA, and validating the encounter data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules, and OHA Provider Guides. The Applicant will have a monitoring system 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. [42 CFR 438.242; and the Contract] | Yes | | | Southwest Oregon Independent Practice Association currently meets these requirements, and will perform these functions on behalf of Western Oregon Advanced Health. |

## Medicaid Assurances for Appendix B, Continued

| Assurance | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-14.** Applicant will maintain an efficient and accurate process that can be used to validate Member enrollment and disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules, and OHA Provider Guides. . The Applicant will have a monitoring system 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. [42 CFFR 438.242 and 438.604; and the Contract] | Yes | | | Southwest Oregon Independent Practice Association currently meets these requirements, and will perform these functions on behalf of Western Oregon Advanced Health. |

## Informational Representations for Appendix B

| Informational Representation | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-1.** Applicant will have contracts with related entities, contractors, and subcontractors to perform, implement, or operate any aspect of the CCO operations for the CCO Contract. | Yes | | | Western Oregon Advanced Health will contract with Southwestern Oregon Independent Practice Association for all operational functions by the Readiness Review date of 3 July 2012 |
| **B-2.** Applicant has an administrative or management contract with a delegated entity to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program. | Yes | | | Western Oregon Advanced Health will contract with Southwest Oregon Independent Practice Association for all staffing functions by the Readiness Review date of 3 July 2012 |
| **B-3.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the systems or information technology to operate the CCO program for the Applicant. | Yes | | | Western Oregon Advanced Health will contract with Southwest Oregon Independent Practice Association for all or a portion of the CCO's information technology systems by the Readiness Review date of 3 July 2012 |
| **B-4.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the claims administration, processing, and/or adjudication functions. | Yes | | | Western Oregon Advanced Health will contract with Southwest Oregon Independent Practice Association for claims administration, processing, and adjudication functions by the Readiness Review date of 3 July 2012 |

## Informational Representations for Appendix B, Continued

| Informational Representation | Yes | No | Qualified Yes | Explanation if *No or Qualified* |
|---|---|---|---|---|
| **B-5.** The Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Enrollment, Disenrollment, and membership functions. | Yes | | | Western Oregon Advanced Health will contract with Southwest Oregon Independent Practice Association for all Enrollment, Disenrollment, and membership functions by the Readiness Review date of 3 July 2012 |
| **B-6.** The Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the credentialing function. | Yes | | | Western Oregon Advanced Health will contract with Southwest Oregon Independent Practice Association for all credentialing functions by the Readiness Review date of 3 July 2012 |
| **B-7.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the utilization operations management function. | Yes | | | Western Oregon Advanced Health will contract with Southwest Oregon Independent Practice Association for the utilization management function by the Readiness Review date of 3 July 2012 |
| **B-8.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Quality Improvement operation. | Yes | | | Western Oregon Advanced Health will contract with Southwest Oregon Independent Practice Association for the Quality Improvement function of the CCO by the Readiness Review date of 3 July 2012 |
| **B-9.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of its call center operations. | Yes | | | Western Oregon Advanced Health will contract with Southwest Oregon Independent Practice Association for the operation of a call center by the Readiness Review date of 3 July 2012 |
| **B-10.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the financial services. | Yes | | | Western Oregon Advanced Health will contract with Southwest Oregon Independent Practice Association for the operation of the CCO's financial services by the Readiness Review date of 3 July 2012 |
| **B-11.** 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. | | | Yes | (1) All clinical contracts with Providers will be executed by Readiness Review date of 3 July 2012. (2) All ancillary contracts will be executed by Medicaid Contract Effective Date of 1 August 2012. |

**Informational Representations for Appendix B, Continued**

| Informational Representation | Yes | No | Qualified Yes | Explanation if *No or Qualified* |
|---|---|---|---|---|
| **B-11.** Applicant will have an administrative or management contract with a delegated entity to delegate all or a portion of other services that are not listed. | | | Yes | Western Oregon Advanced Health may enter into a limited contractual agreement with Southwest Oregon Independent Practice Association for the provision of other services that are not listed. |

**Signature** : *Phil Greenhill*
[Signed Electronically – See Exhibit I]

**Name Printed** : Phil Greenhill

**Title** : Chief Executive Officer and Authorized Official

**Date** : 28 April 2012

## III. TECHNICAL APPLICATION CHECKLIST

| Included | | | |
|---|---|---|---|
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| Yes | II. | Attestations, Assurances, and Representations | Page 5 |
| Yes | III. | Technical Application Checklist | Page 17 |
| Yes | IV. | Letters of Support from Key Community Stakeholders | Page 18 |
| Yes | | Resumes for Key Leadership Personnel | Exhibit C |
| Yes | V. | Organizational Chart | Page 19 |
| Yes | VI. | Service Area Request | Page 20 |
| Yes | VII. | CCO Criteria Questionnaire | Page 21 |
| Yes | VIII. | Provider Participation & Operations Questionnaire<br>Service Area and Capacity Table<br>Participating Provider Table<br>Publicly Funded Health Care & Service Program Table | Page 70<br>Exhibit J.1<br>Exhibit J.2<br>Exhibit J.3 |
| Yes | IX. | Accountability Questionnaire | Page 78 |
| Yes | X. | Medicaid/Medicare Alignment Questionnaire | Page 87 |
| Yes | XI. | [Optional] Transformation Scope Elements | Page 88 |
| Yes | XII. | Applicant's Designation of Confidential Materials | Page 92 |

## IV. LETTERS OF SUPPORT FROM KEY COMMUNITY STAKEHOLDERS

In an effort to maintain the required text-readability of this Portable Document Format (PDF) Application, letters of support from key community stakeholders appear in Exhibit A.

In early 2011, the Board of Curry County Commissioners authorized an independent feasibility study to determine the efficacy of transferring public health and/or public mental health services to the Curry Health District. The feasibility study was completed in November of 2011, and concluded that such a transfer was feasible. However, after a review of fiscal matters, the Curry Health District determined that, in the face of uncertain cash flow for its primary function, Curry General Hospital, the Curry Health District could not accept the transfer of public health and/or public health responsibilities, unless those entities came through the door with at least $200,000 in financial reserves. To this end, in late February, 2012, the Board of Curry County Commissioners submitted a formal letter to Governor Kitzhaber, notifying him of the potential insolvency of the Curry County's publicly funded mental health program, and the potential need to transfer that program to the State, effective 30 June 2012. [As evidence, the letter from the Board of Curry County Commissioners to Governor Kitzhaber appears as the final letter in Exhibit A.]

Separately, at its meeting of 7 March 2012, Curry County Commissioners formally resolved to "transfer its public health and mental health programs to any willing and worthy provider." The current mental health program is under the leadership of an interim contracted administrator, and Jan Kaplan, previously the administrator for the merged public and mental health programs, is now overseeing only public health functions. Curry County public health tested the waters for a merger with Coos County Public Health, with no favorable result, and is now considering a merger with Josephine County Public Health. The Applicant will facilitate a community-lead solution to these issues, and, in its response to Appendix H, will request *flexibilities* in this regard. The leadership of both the Curry Health Network and Western Oregon Advanced Health are mid-course in the resolution of these issues, as verified by Curry Health Network's letter of support.

March 28, 2012

**Adapt**

*an oregon leader in the prevention and treatment of addictions since 1971*

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Fax (541) 673-5642

www.adaptoregon.org

Mr. Phil Greenhill
Chief Executive Officer
Southwest Oregon Independent Practice Association
Post Office Box 1096
Coos Bay, Oregon 97420

Bruce Goldberg, M.D.
Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, Oregon 97301-1097

Dear Gentlemen:

Adapt is a Federally Qualified Health Center, with a 40 year history of providing behavioral health services and conducting NIH sponsored clinical research. Our presence in Coos County, and the Southern Oregon coast, primarily focuses on delivering integrated behavioral health services. In addition to our continuum of outpatient services, residents have since 1982 relied upon our adult and adolescent regional residential services.

We have thus been pleased from the beginning to be included in the development of the Coordinated Care Organization in Coos and Curry Counties, in partnership with Southwest Oregon Independent Practice Association, and other community partners. We look forward to continuing our participation as an at-risk partner, as a major component of the health care delivery system, and as part of the CCO governance, pending final local decision-making.

We have a particular interest in delivering behavioral health services as an embedded feature of *private practice* primary care. Our experience using this model over the past 6 years has demonstrated increased patient access, satisfaction, and noteworthy cost-savings. CCO implementation will create new opportunity to extend these outcomes.

We are confident that working together, we will establish an exemplary Coordinated Care Organization, meeting the goals of the recently enacted Oregon legislation.

Sincerely,

Bruce Piper
CEO

*Advantage Dental Services, LLC*
The Advantage Community

April 25, 2012

Tammy Hurst, Contract Specialist
Office of Contracts and Procurement
250 Winter Street, NE, 3rd Floor
Salem, Oregon 97301

***Re: Non-Binding Letter of Support for Western Oregon Advanced Health's CCO Application***

As CEO/President of Advantage Dental Services, LLC ("Advantage"), it is with great enthusiasm that I submit this letter of support to the Oregon Health Authority in support of Western Oregon Advanced Health's CCO application.

Advantage is a dental care organization (DCO) that has been working to enhance dental care in Oregon communities since its formation. Advantage is a statewide independent practice association with over 300 dentists organized in a cooperative. Advantage currently provides oral health services to over 185,000 Medicaid patients under the Oregon Health Plan. Advantage also provides oral health services to the uninsured and underinsured through its 24 clinics located throughout Oregon. During the last year, Advantage has been involved in numerous community outreach projects to improve the oral health in communities by having dental hygienists screen children in the HeadStart, Women Infants and Children (WIC) program, and other programs for cavities, general oral health care, and medical management of caries.

Please accept this letter from Advantage in support of Western Oregon Advanced Health. Advantage believes that it will best serve the residents of its individual communities through collaborative efforts in developing a CCO. Advantage supports the formation of CCOs to achieve the triple aim and through efficiency and quality improvements reduce medical cost inflation and coordinate health care for each community member by providing the right care, at the right time, in the right place.

*Advantage Dental Services, LLC*
The Advantage Community

Advantage is excited to be part of this challenging and important work. We look forward to working with Western Oregon Advanced Health in the formation of the CCOs and coordinating care for its community members.

Sincerely,

R. Mike Shirtcliff, DMD
President/CEO
Advantage Dental Services, LLC

Bay Area Hospital

March 26, 2012

Mr. Paul Janke
Chief Executive Officer
Bay Area Hospital
1775 Thompson Road
Coos Bay, Oregon 97420

Bruce Goldberg, M.D.
Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, Oregon 97301-1097

Dear Gentlemen:

By this letter, please be formally advised of Bay Area Hospital's support for the Application that is being submitted pursuant to RFA-3402 for the creation of a fully compliant Coordinated Care Organization in Coos and Curry Counties, in partnership with Southwest Oregon Independent Practice Association, or its affiliate or subsidiary entity, or other independent corporation. Bay Area Hospital has participated in the local Coordinated Care Organization planning process since October of 2011, and will participate in the evolving Coordinated Care Organization model and structure, either as an at-risk partner or as a *major component of the health care delivery system*, pending final local decision-making regarding contractual language, fiscal arrangements, and governance determinations.

As the Medical Center for Oregon's South Coast, Bay Area Hospital offers a comprehensive range of diagnostic and therapeutic services. The hospital's inpatient and outpatient services include medical, surgical, behavioral health, pediatric, critical care, home health, outpatient psychiatric, oncology, obstetrical, and other specialties. Our mission is to improve the health of our community every day.

Working together, we believe that we can establish an exemplary Coordinated Care Organization that will improve health outcomes and service delivery systems while concurrently constraining the pace of health care cost inflation.

Respectfully submitted,

Paul Janke

1775 Thompson Road, Coos Bay, OR 97420
(541) 269-8111 · www.bayareahospital.org

BCHC Bandon Community Health Center
*Better Care for a Healthy Community*

PO Box. 423 Bandon, Oregon 97411 Ph: (541) 347-2529 Fax: (541) 347-9196

March 30, 2012

Mr. Phil Greenhill
Chief Executive Officer
Southwest Oregon Independent Practice Association
Post Office Box 1096
Coos Bay, Oregon 97420

Bruce Goldberg, M.D.
Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, Oregon 97301-1097

Dear Gentlemen:

By this letter, please be formally advised of Bandon Community Health Center's support for the Application that is being submitted pursuant to RFA-3402 for the creation of a fully compliant Coordinated Care Organization in Coos and Curry Counties, in partnership with Southwest Oregon Independent Practice Association, or its affiliate or subsidiary entity, or other independent corporation. Bandon Community Health Center has participated in the local Coordinated Care Organization planning process since October of 2011, and will participate in the evolving Coordinated Care Organization model and structure, either as an at-risk partner or as a *major component of the health care delivery system*, pending final local decision-making regarding contractual language, fiscal arrangements, and governance determinations.

The mission of Bandon Community Health Center is to provide high quality, affordable primary health care services for all residents of Bandon and the surrounding areas regardless of their ability to pay. We are an independent, non-profit Federally Qualified Rural Health Center established January 1, 2010 and we collaborate closely with the Southwest Oregon Independent Practice Association in serving the interests of Oregon Health Plan patients with their primary health care needs. We appreciate the strong leadership and inclusive decision making which has occurred in our community and support the direction being taken to establish an efficient model of health care delivery for the southern Oregon coast.

Working together, we believe that we can establish an exemplary Coordinated Care Organization that will improve health outcomes and service delivery systems while concurrently constraining the pace of health care cost inflation.

Respectfully submitted,

Linda S. Maxon
Executive Director

Dr. Gail McClave
Medical Director

# CURRY HEALTH NETWORK

**Curry Hospital**
94220 Fourth Street
Gold Beach, Oregon 97444
541.247.3000

**Curry Medical Center**
500 5th Street
Brookings, Oregon 97415
541.412.2000

**Curry Family Medical**
525 Madrona Street
Port Orford, Oregon 97465
541.332.3861

**Curry Outpatient Surgery Center**
648 Chetco Avenue
Brookings, Oregon 97415
541.412.2070

**Curry Women's Health Clinic**
94239 Fourth Street
Gold Beach, Oregon 97444
541.247.3506

**Curry Medical Annex**
94244 Fourth Street
Gold Beach, Oregon 97444
541.247.3155

Toll-Free: 800.445.8085
*CurryHealthNetwork.com*

**MISSION**

*To provide healthcare of the highest quality with genuine caring and compassion.*

**VISION**

*That our doctors, staff and facilities will be recognized by our patients and potential patients as the preferred health care system because of our quality, ease of access and range of services.*

30 March 2012

Mr. Phil Greenhill
Chief Executive Officer
Southwest Oregon Independent Practice Association
Post Office Box 1096
Coos Bay, Oregon 97420

Bruce Goldberg, M.D.
Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, Oregon 97301-1097

Dear Gentlemen:

By this letter, please be formally advised of **Curry Health District, dba Curry Health Network's (Curry)** support for the Application that is being submitted pursuant to RFA-3402 for the creation of a fully compliant Coordinated Care Organization in Coos and Curry Counties, in partnership with Southwest Oregon Independent Practice Association, or its affiliate or subsidiary entity, or other independent corporation. **Curry** has participated in the local Coordinated Care Organization planning process since October of 2011, and will participate in the evolving Coordinated Care Organization model and structure, either as an at-risk partner or as a *major component of the health care delivery system*, pending final local decision-making regarding contractual language, fiscal arrangements, and governance determinations.

Curry is the health care network in Curry county, operating a Critical Access Hospital in Gold Beach, a Rural Health Clinic in Port Orford, and an ambulatory care facility in Brookings with medical offices, full imaging , lab and an urgent care. Curry provides primary care services using physicians, physician assistants and nurse practitioners. Curry also provides General and Orthopedic surgery (including joint replacement), OB/ GYN and Urology

Working together, we believe that we can establish an exemplary Coordinated Care Organization that will improve health outcomes and service delivery systems while concurrently constraining the pace of health care cost inflation.

Respectfully submitted,

William T McMillan, FACHE
CEO

# BOARD OF COMMISSIONERS

250 N. Baxter Street, Coquille, Oregon 97423
(541) 396-3121 Ext.225
FAX (541) 396-4861 / TDD (800) 735-2900
E-Mail: bbrooks@co.coos.or.us

Fred Messerle  Cam Parry  Robert "Bob" Main


April 20, 2012

Mr. Phil Greenhill
Chief Executive Officer
Southwest Oregon Independent Practice Association
PO Box 1096
Coos Bay, OR 97420

Bruce Goldberg, M.D.
Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301-1097

Dear Sirs:

The Coos County Board of Commissioners are writing in support of the application that is being submitted by Southwest Oregon Independent Practice Association, pursuant to RFA-3402, for the creation of the coordinated care organization, *Western Oregon Advanced Health*. The Coos County Board of Commissioners, who also serve as the Local Public Health Authority and the Local Mental Health Authority, support the collaborative efforts of our health system partners in working towards the goal of improved health of our Medicaid population, which includes some of the most vulnerable of our constituents.

Coos County has been represented and involved in the planning process for the development of this CCO since October of 2011. In accordance with ORS 414.625, Coos County will be represented on the governance board of *Western Oregon Advanced Health* by both the Mental Health Director and the Public Health Administrator, as Coos County contributes significantly to our community's health care delivery system, and is at risk in our provision of services to Medicaid members and the uninsured.

Also, because Coos County must meet the mandates of Oregon law in the provision of mental health and public health safety net services, we are pleased that our partners in *Western Oregon Advanced Health* have agreed to negotiate fiscal arrangements and distribution of resources which will enable Coos County to continue to serve Medicaid

members, as we have historically done for many years. These Medicaid resources are critical to the infrastructure for our County's mental health and public health services, and enable us to continue to meet our mandated obligations for those who are not covered by the global budget.

Coos County has much to contribute to the governance of *Western Oregon Advanced Health*. Public health can assist by coordinating the community health assessment and development of the public health improvement plan, as described in OAR 410-141-3145. Public health has been working with community health and social service agencies for many years on prevention efforts and coordination of services to vulnerable populations. Coos County Mental Health was selected in 1995 as one of the OHP pilot projects for the State to provide mental health services under a capitated budget. Coos County Mental Health has developed regional and local partnerships for the past 17 years to effectively address the three aims of HB 3026.

Coos County is committed to working towards an exemplary system that will improve health outcomes for Oregon Health Plan members in an efficient and effective way, and which will be achieved through transparency and collaboration with our partners in our governance structure, and with guidance from our consumers.

Fred R. Messerle

Fred Messerle
Coos County Board of Commissioners, Chair

Ginger Swan

Ginger Swan
Coos County Mental Health Director

Frances Smith

Frances Smith
Coos County Public Health Administrator

**COQUILLE VALLEY HOSPITAL**

"Improving lives through exceptional healthcare"

940 E. Fifth • Coquille, Oregon 97423 • (541) 396-3101 • Fax (541) 396-5760 • www.cvhospital,org

April 14, 2012

Mr. Phil Greenhill, Chief Executive Officer
Southwest Oregon Independent Practice Association
Post Office Box 1096
Coos Bay, Oregon 97420

Bruce Goldberg, M.D., Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, Oregon 97301-1097

Gentlemen:

Please accept this correspondence as formal notification that the Coquille Valley Hospital District, Coquille, OR supports the Application of Southwest Oregon Independent Practice Association, or its affiliate(s) or subsidiary entity(ies), or other independent corporation(s) that is being submitted pursuant to RFA-3402 for the creation of a fully compliant Coordinated Care Organization in Coos and Curry Counties. Coquille Valley Hospital District is familiar with and has engaged in dialogue through the local Coordinated Care Organization planning process toward this end, and fully expects to participate in the evolving Coordinated Care Organization model and structure, either as an at-risk partner or as a significant component of the health care delivery system, pending final local decision-making regarding contractual language, fiscal arrangements, and governance determinations.

Coquille Valley Hospital is a designated Critical Access hospital located in Coquille, OR serving the rural regional Coquille River Valley with a population of 13-14,000. Coquille Valley Hospital offers a broad and comprehensive range of health and hospital services including: inpatient and family medicine, inpatient and outpatient/ambulatory surgical services including: general surgery, orthopedic and joint replacement surgery, podiatric surgery, ophthalmologic and lens replacement, and ENT and pain management procedures, obstetrics/labor-delivery and newborn nursery care, Level IV Trauma certified Emergency Services - clinical laboratory, medical imaging, pharmacy, cardiopulmonary services (respiratory therapy), rehabilitative medicine, and support services, including Swing-bed and Home Health care.

Together with other provider organizations in the emerging CCO/system, we believe that we can establish an exemplary Coordinated Care Organization that will improve health outcomes and service delivery while concurrently constraining health care costs.

Respectfully submitted,

Dennis G. Zielinski, CEO
Coquille Valley Hospital District

NBMC
MEDICAL CENTERS

March 30, 2012

Phil Greenhill
Chief Executive Officer
Southwest Oregon IPA, Inc.
Post Office Box 1096
Coos Bay, Oregon 97420

Bruce Goldberg, M.D.
Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, Oregon 97301-1097

Dear Gentlemen:

By this letter, please be formally advised that North Bend Medical Center, Inc. (NBMC) supports the Application that is being submitted pursuant to RFA-3402 for the creation of a fully compliant Coordinated Care Organization (CCO) in Coos and Curry Counties. NBMC, along with a broad-based network of community health and service providers, has participated in a local CCO planning process since October of 2011 under the leadership of Southwest Oregon IPA, Inc. NBMC understands that the RFA Application is being submitted by Southwest Oregon IPA, Inc. on behalf of this community-wide effort. NBMC currently plans to participate in the evolving local CCO model and structure, either as an at-risk partner or as a major component of the health care delivery system, subject to reaching agreement on the local CCO's corporate and organizational structure, contractual language, fiscal arrangements, and governance determinations.

North Bend Medical Center (NBMC) operates five primary care and specialty clinics in the southwest Oregon communities of Coos Bay/North Bend, Coquille, Myrtle Point, Bandon and Gold Beach. NBMC's provider base includes over 70 primary care, specialty and mid-level providers. NBMC also provides ancillary services that include lab, radiology, day surgery and a "walk-in" clinic. NBMC has participated in the Oregon Health Plan (OHP) since its inception, including approximately 7,300 (63% of the) currently enrolled OHP members that reside in our local service area. NBMC also provides ongoing medical services to approximately 9,000 (60% of the) Medicare recipients in our community.

Working together with other community partners, we believe that we can establish an exemplary Coordinated Care Organization that will improve health outcomes and service delivery systems while concurrently constraining the pace of health care cost inflation.

Sincerely,

William H. Murray
Chief Executive Officer

*North Bend Medical Centers, Inc.*
*william.murray@nbmconline.com*
*1900 Woodland Drive*
*Coos Bay, Oregon 97420*

*Telephone 541-267-5151 Ext. 1599*
*Toll Free 1-800-234-1231 Ext. 1599*
*Fax 541-266-4525*

# Waterfall Community Health Center

30 March 2012

Mr. Phil Greenhill
Chief Executive Officer
Southwest Oregon Independent Practice Association
Post Office Box 1096
Coos Bay, Oregon 97420

Bruce Goldberg, M.D.
Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, Oregon 97301-1097

Dear Gentlemen:

By this letter, please be formally advised of Waterfall Community Health Center's support for the Application that is being submitted pursuant to RFA-3402 for the creation of a fully compliant Coordinated Care Organization in Coos and Curry Counties, in partnership with Southwest Oregon Independent Practice Association, or its affiliate or subsidiary entity, or other independent corporation. Waterfall Community Health Center has participated in the local Coordinated Care Organization planning process since October of 2011, and will participate in the evolving Coordinated Care Organization model and structure, either as an at-risk partner or as a *major component of the health care delivery system*, pending final local decision-making regarding contractual language, fiscal arrangements, and governance determinations.

Waterfall Community Health Center's origins in the late 1990's were truly born of a collaborative volunteer effort by a concerned and caring group of Coos County citizens striving to meet the need for access to health care for the uninsured and working poor. Today, Waterfall is designated as a Federally Qualified Health Center providing integrated health care in three distinct locations; at the main site in North Bend; in Coos Bay as a school based health center for the Coos Bay School District (soon to expand to a new facility serving a combination of community members and students); and thirdly in the remote region of Powers as an Oregon accredited school based health center. The clinic's mission is *"to promote access to quality integrated health services that meet the needs of individuals with barriers to care on the Southern Oregon Coast".*

Working together, we believe that we can establish an exemplary Coordinated Care Organization that will improve health outcomes and service delivery systems while concurrently constraining the pace of health care cost inflation.

Respectfully submitted,

Kathryn Laird

Kathryn Laird, RN, MN
Chief Executive Officer

1890 Waite St. Suite No. 1, North Bend, OR 97459 Phone (541) 756-6232 - Fax (541) 756-6234
http://www.wfall.org

**Curry County**
**Board of Commissioners**

David G. Itzen, *Chair*
Bill Waddle, *Vice Chair*
George Rhodes, *Commissioner*

94235 Moore Street, P.O. Box 746
Gold Beach, OR 97444
541-247-3296, 541-247-2718 Fax

February 15, 2012

Governor John Kitzhaber
900 Court St. N.E. #254
Salem, OR 97301

Re: Returning County Services to the State of Oregon

Dear Governor Kitzhaber:

Curry County is at a critical juncture in its long and storied history. If Curry County does not soon receive additional revenues to maintain services, a downward spiral of events will unfold. First, the County would have to cut an additional base amount of approximately $2,000,000 from the discretionary resources portion of the General Fund Budget of $5,100,000 effective July 1, 2012. In order to achieve budget requirements, Curry County would actually have to set aside an additional $1,000,000 in the budget because of unfunded unemployment benefits. Approximately 40 employees out of the approximately 78 funded by the General Fund and Administrative Fund would need to be terminated effective July 1, 2012. The level of services provided by Curry County for fiscal year 2012-2013 would be so drastically reduced that many essential functions could not possibly be performed. It would only get worse for fiscal year 2013-2014 for which the Board of Curry County Commissioners would have to cut approximately an additional $1,500,000 from the already drastically reduced previous year's budget.

Under the above-referenced scenario, Curry County would have to return to the State of Oregon many shared services as early as July 1, 2012. This is your notice of that very real possibility or even likelihood. Some of the services to be returned to the State of Oregon could include, but are not limited to, mental health services, public health services, alcohol and drug prevention,

environmental health, elections, building permits and inspection, sanitation, and assessment and taxation.

Curry County has been exploring local solutions. It has considered spinning off certain programs to private non-profit entities. In addition, Curry County has formed a Citizen's Committee to identify and explore all viable revenue and expenditure opportunities to achieve fiscal solvency and stability for Curry County government now and in the future. The Committee has recently submitted to the Board of Commissioners nineteen total recommendations, and they are all now being studied. Of course, it is unknown at this time as to whether any of the recommendations for increased revenue will be able to be successfully implemented. It is also possible that some opportunities for increased revenue might arise but at a later date in a time subsequent to the upcoming budget process. Under these circumstances, we invite the State of Oregon to provide assistance and partnering to the County in resolving the financial crisis. A successful partnering with the State of Oregon should actually ease the burden on the State of Oregon in light of the many County services that could be returned to the State of Oregon.

Thank you very much for your consideration of this letter.

Sincerely,

BOARD OF CURRY COUNTY COMMISSIONERS

David G. Itzen, Chair

Bill Waddle, Vice Chair

George Rhodes, Commissioner

cc: Michael Jordan
Representative Peter Buckley
Representative Dennis Richardson
Representative Bruce Hanna
Representative Arnie Roblan
Senator Peter Courtney
Senator Diane Rosenbaum
Senator Jeff Kruse
Representative Wayne Krieger
Mike McArthur

INTRODUCING

# Philip V. Greenhill

## CHIEF EXECUTIVE OFFICER

**Summary of Qualifications**

A talented health care executive with over twenty years of progressive management, marketing, finance, and technology experience. Demonstrated success in multiple health care facility operations, project management, large employee/physician systems, and eBusiness strategies. Proven track record in financial management, census development, marketing/business development, strategic planning, managing multiple projects, and forging collaborative relationships among diverse parties. Successful in developing and closing on new business to generate significant revenue and profitability growth in competitive markets. Experienced in long-term acute care hospitals, behavioral hospital settings, physician practice management, integrated delivery systems, and managed care.

**Educational Background**

- Masters in Higher Education, Morehead State University, Morehead, Kentucky
- Bachelor of Science, Morehead State University, Morehead, Kentucky

**Professional Experience**

| | |
|---|---|
| 2009 - Present | Chief Executive Officer, Southern Oregon Independent Practice Association<br>Coos Bay, Oregon |
| 2007 - 2009 | Chief Executive Officer, Tahoe Pacific Hospitals, Reno, Nevada |
| 2003 - 2007 | Chief Executive Officer, Select Specialty Hospital, Atlanta, Georgia |
| 2002 - 2003 | Health Care Management Consultant, Diversified Health Solutions<br>Nashville, Tennessee |
| 1998 - 2002 | Director, North American Medical Management, Emeryville, California |
| 1995 - 1997 | Independent Consultant, Greenhill and Associates Consulting, Napa, California |
| 1992 - 1994 | Chief Executive Officer, Solano Park Hospital, Fairfield, California |
| 1989 - 1992 | Director, Life Center, Inc., Sun Valley, Idaho |
| 1988 - 1989 | Regional Administrator, Comprehensive Addiction Programs<br>Kennett Square, Pennsylvania |
| 1987 - 1988 | Director of Physician Joint Ventures, Health Field Services, Atlanta, Georgia |
| 1983 - 1987 | Chief Executive Officer, Charter Medical Corporation, Atlanta, Georgia |

# Theresa A. Muday, MD

Southwest Oregon IPA, Inc.
d/b/a Doctors of the Oregon Coast South (DOCS)
750 Central Avenue, Suite 202, Coos Bay, Oregon 97420
541-269-7400 ext. 114

## EXPERIENCE

**Southwest Oregon IPA, Inc.** — **Coos Bay, Oregon**
**2007-Current** — **Medical Director**

- Responsible for the arrangement, coordination, monitoring, management and the effective outcome of the prior authorization, referrals, utilization review, case management, ENCC, disease management, prevention programs, claims, encounter data and stop loss activities of organization.

**North Bend Medical Center** — **Coos Bay, Oregon**
**2000-2007** — **Physician - Group Practice**

- Family Practice: full time primary care physician

**Saginaw Cooperative Hospitals, Inc** — **Saginaw, Michigan**
**Michigan State University College of Medicine**
**1999** — **Assistant Program Director**

- Full time faculty member, responsible for teaching and supervision of residents and medical students in inpatient, outpatient, and procedural medicine while maintaining an active clinical practice.

**Coney Island Community Support System** — **Brooklyn, New York**
**Jewish Board of Family and Children's Services**
**1990-1992** — **Case Associate**

- Worked as part of a multidisciplinary team caring for over one hundred chronically mentally ill adults. Performed ongoing basic psychiatric evaluation and case management, ran didactic and therapeutic groups, participated in psychiatric case conferences, and provided individual counseling for program clients.

## LICENSURE AND CERTIFICATION

| | |
|---|---|
| 2000 – Current | Licensure, Oregon Board of Medical Examiners |
| 1996-2003 | Licensure, Michigan Board of Medicine |
| 1999-2006 | Diplomate, American Board of Family Practice |
| 1998-2003 | Advanced Life Support in Obstetrics, American Academy of Family Physicians |
| 1998-2000 | Neonatal Resuscitation, American Academy of Pediatrics and American Heart Association |
| 1998-2000 | Advanced Cardiac Life Support, American Heart Association |
| 1998-2000 | Basic Life Support, American Heart Association |
| 1999 | Physician's Office Laboratory Course. Meets CLIA certification requirements. |

## EDUCATION

1996-1999 **Family Practice Residency, Saginaw Cooperative Hospitals, Inc. Saginaw, Michigan.** June 30, 1999

1992-1996 **College of Human Medicine, Michigan State University, East Lansing, Michigan.** Doctor of Medicine May 3, 1996.

1986-1990 **Williams College, Williamstown, Massachusetts.** Bachelor of Arts, Cum Laude, June 3, 1990. Major in Psychology.

## HONORS AND AWARDS

1999 **Alpha Omega Alpha Honor Medical Society.** Michigan State University, College of Human Medicine, Gamma Chapter.

1999 **Top Resident in Colposcopy and The Study of Lower Genital Tract Disease.** American Society of Colposcopy and Cervical Pathology.

1998 **Louis E. Zeile Award, Covenant Health Care Foundation.** Outstanding Junior Resident in Family Practice.

## PUBLICATIONS AND PRESENTATIONS

1999 **Variability of Code Selection Using the 1995 and 1998 HCFA Guidelines for Office Services.** Zuber, T., Rhody, C., Muday, T., Jackson, E., Rupke, S. Accepted for publication in Journal of Family Practice.

1999 **Common Herbal Medicinals.** Grand rounds presentation, SCHI Department of Family Practice.

1998 **Management of the Abnormal Pap: Atypical Squamous Cells of Undetermined Significance and Atypical Glandular Cells of Undetermined Significance.** Part of Colposcopy Review, CME course sponsored by SCHI Department of Family Practice.

1994 **The Reproductive System.** Soo Hills Elementary and Hermansville Elementary Schools, Delta County, Michigan. Presented in conjunction with the Michigan Model for Health Education for fifth graders.

# John V Sevier

1965 Grant St, North Bend OR, 97459 ♦ johns@docshp.com ♦ 541-269-7400

## Information Technology Manager

The Information Technology Manager maintains and upgrades all systems hardware and software, plans and schedules system related projects, is responsible for system and data security and integrity, manages IT staff and user support of hardware and software.

### Areas of Expertise:

- √ SQL Server development programming and administration
- √ 16 years of experience with EZCAP Software
- √ Programming in SQL, Basic, C++, Dbase/Foxpro, PHP, HTML, COBOL, Crystal reports
- √ Network administration
- √ HIPAA security compliance
- √ Business software

## Employment History

**IT Manager,** Southwest Oregon IPA, Inc. Coos Bay, OR **1996 - Present**

- Network and systems maintenance and upgrades
- Plan and schedule system related projects
- Database administration
- Develop and run reports
- Provide support for encounter data, fee schedules and capitation
- Manage system backup and maintenance
- Responsible for HIPAA Security compliance
- Provides hardware and software support for users

**Business/IT Support** Sevier/Siskowic Engineering, Inc. San Diego, CA **1980 - 1996**

- Network and systems installation and maintenance
- Accounting software installation maintenance
- CAD systems installation and maintenance
- Office software support
- Accounting responsibilities including payroll, project billing, receivables, payables and tax reporting

## Education

Grossmont College, El Cajon, CA 1982 - 1990
Business/Accounting, Systems Analysis and Networking

# Karen Gannon

Southwest Oregon IPA, Inc.
d/b/a Doctors of the Oregon Coast South (DOCS)
750 Central Avenue, Suite 202, Coos Bay, Oregon 97420
541-269-7400 ext. 118


## EXPERIENCE

**Southwest Oregon IPA, Inc.** — **Coos Bay, Oregon**
**2004-Current** — **Compliance Officer/Operations**

- Responsible for directing and coordinating Company efforts to ensure compliance with federal and state laws, regulations, and policies that govern its Medicaid business.
- Works with operational leadership to provide adequate information to ensure that they and their employees have the requisite information and knowledge of federal and state regulatory issues and requirements to carry out their responsibilities in a lawful and ethical manner.
- Coordinates, with the direction of CEO, the organization's Fraud and Abuse Identification and Reporting Plan on behalf of all organizational departments.
- Perform periodic audits of compliance with organization's written policies and procedures and any other activities that affect compliance with laws and regulations covered by compliance program and will assure that appropriate corrective action is undertaken as may be required.
- Responsible for direct over site of Customer Service Department and Provider Relations. Which includes system maintenance of provider network and provider set-up.
- Works closely with CEO in securing and maintaining contracted provider network.
- Supports CEO as needed on special project assignments.
- Responsible for ensuring timely processing of pended Encounter Data.

**Financial Analyst**

- Responsible for conducting research and analysis on varies types of information to aid in the support of the organization's compliance with contractual and regulatory obligations. This position is a support staff member to the CEO and aids the CEO as indicated below.

**South Coast Orthopaedic Associates/South Coast Surgery Center**
**2003-2004** — **Billing Manager/Contracts Manager**

- Directly oversaw the daily operations of service billings, including but not limited to, billings, accounts receivables, and resolution of customer billing errors.
- Resolved internal and external customer issues related to services billings, revenue, and 3rd party expenditures.
- Responsible for preliminary contract negotiations with insurance companies and preparation of final contracts.
- Worked closely with services operation, patient services, and technology team to continual improve the service billing operation.
- Managed, trained, and developed staff directly and indirectly reporting to this position.

**Southwest Oregon IPA, Inc.**
**2001-2003** — **Coordinator - Provider Affairs/Encounter Data Liaison**

- Responsible for handling provider inquiries, while maintaining customer goodwill. Utilized a variety of systems to research and resolve provider issues. Demonstrating drive and enthusiasm while handling provider questions, complaint intake and member benefit inquiries.
- Worked to maintain Provider Network, which included initial negotiations with network providers, compliance and maintenance of State required reporting system, provider and staff education, and responsible for timely credentialing and recredentialing of contracted provider panel.

- Responsible for insuring the accuracy, completeness and timeliness of Encounter Data submissions and resubmissions to State Medicaid System in compliance with all state and federal laws, rules, regulations, and contract provisions related to Encounter Data services.

**Southwest Oregon IPA, Inc.**
**1997-2001** **Specialist III – Claims Processing**

- Ensured the timely processing of all claims and monthly capitation payments to providers in compliance with all laws, rules, regulations and contract provisions related to claims processing. Reviewed and resolved claims problems and aided in organization's provider appeal process. Worked effectively with organization's contacted health plan partners and sub-contractors in areas related to claims processing.

**Lower Umpqua Hospital District** **Reedsport, Oregon**
**1996-1998** **Specialty Clinic Manager**

- Responsible for all aspects of clinic business matters
- Handling of multiple physicians schedules that used the clinic
- Scheduling of patients
- Responsible for coding all orthopedic claims
- Responsible for billing of orthopedic claims, posting of receivables and balancing of accounts
- Maintained patient accounts and collecting of those accounts
- Responsible for providing clinic revenue and aged reports to Accounting Department

## LICENSES

- Licensed Insurance Producer since 2006
- Notary Public

## EDUCATION

| | |
|---|---|
| 1990 – Current | Multiple Coding and Reimbursement Seminars |
| 1999 – 2000 | Mt. Hood Community College - Medical Terminology |
| 1987 | Hartnell Junior College, Salinas, CA - Business Mgmt |
| 1986 | Watsonville Adult Education, Watsonville, CA – Accounting |
| 1984 | Watsonville High School, Watsonville, CA – Graduate |

**Caryn Caswell Mickelson**
2522 Troy Lane
North Bend, Oregon 97459
(541) 297-4792
carynmickelson@gmail.com

## Professional Experience

**Director of Medical Management and Clinical Pharmacist,** Southwest Oregon IPA
Coos Bay, Oregon
June 2011 to present
Responsibilities: Clinical evaluation of authorization requests, formulary management promoting cost-effective utilization of drug therapy, effectively communicating with health care providers and community partners, and promoting development and reorganization of the Medical Management department.

**Pharmacy Manager,** Safeway Pharmacy #4711, North Bend Medical Center
Coos Bay, Oregon
May 2010 to May 2011
Responsibilities: Researched physician and patient drug inquiries, executed corporate inventory management program, conducted travel health consultations, and effectively managed staff to maximize workflow efficiency.

**Staff Pharmacist,** Safeway Pharmacy #4711, North Bend Medical Center
Coos Bay, Oregon
January 2009 to May 2010
Responsibilities: Implemented vaccine administration program, presented Zostavax informational power-point to seniors, organized off-site influenza clinics, and performed daily pharmacy operations including accurate filling and dispensing of prescription medications.

**Pharmacy Manager,** Bi-Mart Pharmacy #607
North Bend, Oregon
September 2005 to January 2009
Responsibilities: Operated a profitable pharmacy, hired and trained pharmacy personnel, conducted annual performance appraisals, inventory management, vaccine administration, and cholesterol screening.

**Staff Pharmacist,** Bi-Mart Pharmacy #607
North Bend, Oregon
June 2003 to September 2005
Responsibilities: Implemented vaccine administration program, accurate filling and dispensing of prescriptions, communicated with physicians and patients to enhance therapy compliance. Gained experience with problem solving, customer service, and conflict resolution.

## Academic Degrees

**Doctor of Pharmacy,** June 2003
Oregon State University College of Pharmacy, Corvallis, Oregon
Oregon Health and Science University, Portland, Oregon

Academic Degrees Continued

**Bachelor of Science**, General Sciences, June 2000
Oregon State University, Corvallis, Oregon

Professional Affiliations

**Academy of Managed Care Pharmacists,** 2011 to present

**Oregon State Pharmacy Association**, 1999 to 2006
Board of Directors, Southern Region Representative, 2004 to 2006
OSPA Annual Convention Planning Committee, 2000 to 2002

**Rho Chi Honor Society,** 2002 to present

**Golden Key National Honor Society**, 1999 to present

**American Pharmacist Association-Academy of Students of Pharmacy**,1999 to 2003
Chapter President, 2000 to 2001
Bristol Meyers and Squibb Summer Leadership Institute, 2000

Awards and Honors

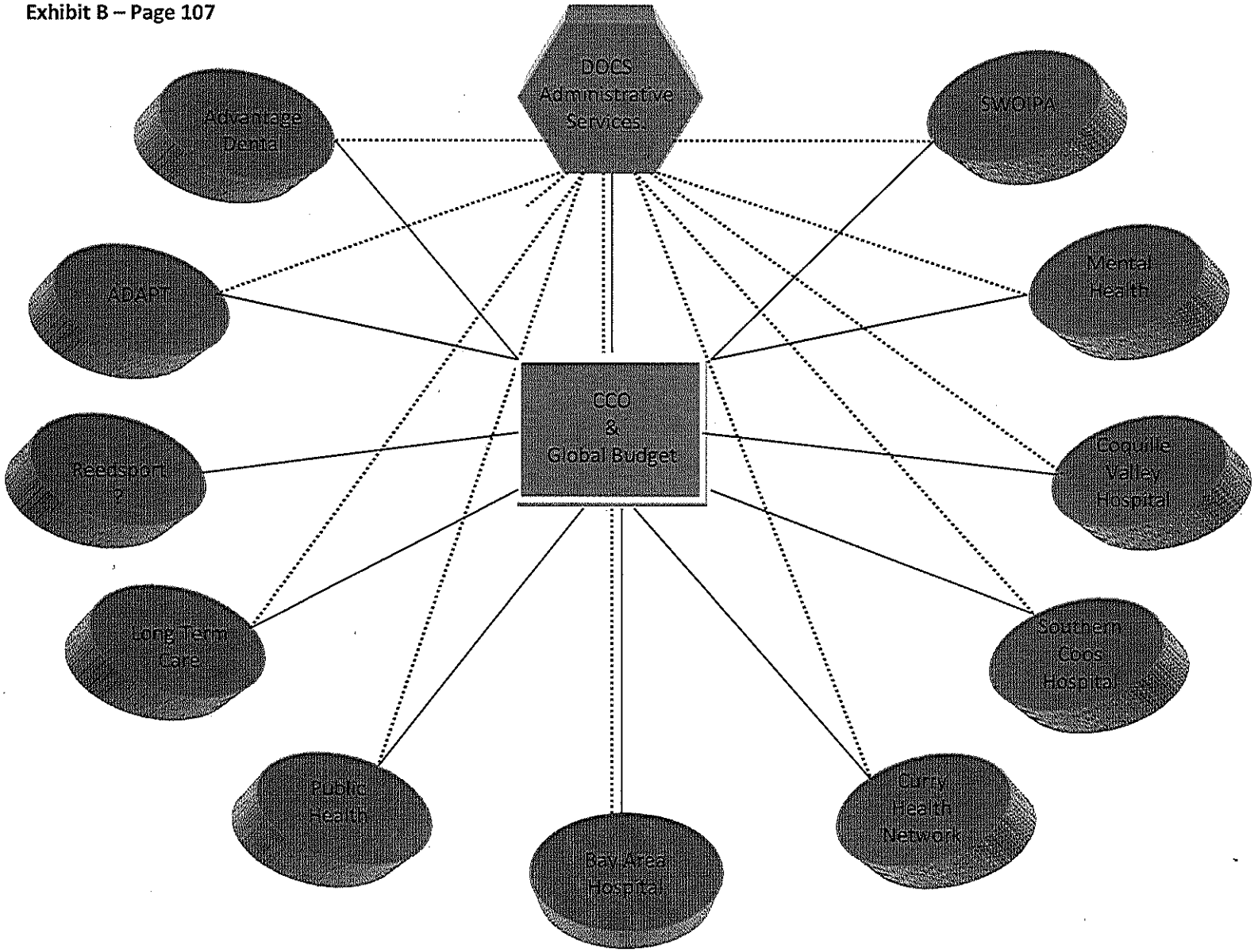
**Immunization Improvement Award**, Safeway, 2010
**Outcomes Pharmacist**, Featured Encounter 2010
**Customer Satisfaction All-Star**, Bi-Mart Corporation, 2003 to 2008
**Mortar and Pestle Professionalism Award**, Oregon State University, 2003

## V. ORGANIZATIONAL CHART

In an effort to maintain the required text-readability of this Portable Document Format (PDF) Application, the organizational chart appears in Exhibit B.

# Western Oregon Advanced Health - CCO – Organizational Chart

**Exhibit B – Page 107**



## VI. SERVICE AREA REQUEST

This application, as submitted by Western Oregon Advanced Health, requests a service delivery area that includes the entire range of Coos and Curry Counties in Oregon. The specific zip codes of interest appear in Table 1, and represent all zip codes assigned by the U.S. Postal Service in Coos and Curry Counties, Oregon.

**Table 1**
**SERVICE AREA, DEFINED BY ZIP CODES**

| County | City or Community | Zip Code | County | City or Community | Zip Code |
|---|---|---|---|---|---|
| Curry | Agness | 97406 | Coos | Lakeside | 97449 |
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| Curry | Brookings | 97415 | Coos | Norway | 97460 |
| Coos | Charleston | 97420 | Curry | Pistol River | 97444 |
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| Coos | Coquille | 97423 | Curry | Port Orford | 97465 |
| Curry | Gold Beach | 97444 | Coos | Powers | 97466 |
| Curry | Harbor | 97415 | Curry | Sixes | 97476 |

The communities of Winchester Bay (97467), Reedsport (97467), and Gardiner (97441) are within Douglas County but are geographically more proximal to Coos Bay than to the Douglas County population and medical center in Roseburg. Douglas County is contiguous to Coos County, and Western Oregon Advanced Health is willing to enroll Members from these zip codes.

## III. TECHNICAL APPLICATION CHECKLIST

| Included | | | |
|---|---|---|---|
| Yes | I. | Application Cover Sheet | Page 3 |
| Yes | II. | Attestations, Assurances, and Representations | Page 5 |
| Yes | III. | Technical Application Checklist | Page 17 |
| Yes | IV. | Letters of Support from Key Community Stakeholders | Page 18 |
| Yes | | Resumes for Key Leadership Personnel | Exhibit C |
| Yes | V. | Organizational Chart | Page 19 |
| Yes | VI. | Service Area Request | Page 20 |
| Yes | VII. | CCO Criteria Questionnaire | Page 21 |
| Yes | VIII. | Provider Participation & Operations Questionnaire<br>Service Area and Capacity Table<br>Participating Provider Table<br>Publicly Funded Health Care & Service Program Table | Page 70<br>Exhibit J.1<br>Exhibit J.2<br>Exhibit J.3 |
| Yes | IX. | Accountability Questionnaire | Page 78 |
| Yes | X. | Medicaid/Medicare Alignment Questionnaire | Page 87 |
| Yes | XI. | [Optional] Transformation Scope Elements | Page 88 |
| Yes | XII. | Applicant's Designation of Confidential Materials | Page 92 |

## IV. LETTERS OF SUPPORT FROM KEY COMMUNITY STAKEHOLDERS

In an effort to maintain the required text-readability of this Portable Document Format (PDF) Application, letters of support from key community stakeholders appear in Exhibit A.

In early 2011, the Board of Curry County Commissioners authorized an independent feasibility study to determine the efficacy of transferring public health and/or public mental health services to the Curry Health District. The feasibility study was completed in November of 2011, and concluded that such a transfer was feasible. However, after a review of fiscal matters, the Curry Health District determined that, in the face of uncertain cash flow for its primary function, Curry General Hospital, the Curry Health District could not accept the transfer of public health and/or public health responsibilities, unless those entities came through the door with at least $200,000 in financial reserves. To this end, in late February, 2012, the Board of Curry County Commissioners submitted a formal letter to Governor Kitzhaber, notifying him of the potential insolvency of the Curry County's publicly funded mental health program, and the potential need to transfer that program to the State, effective 30 June 2012. [As evidence, the letter from the Board of Curry County Commissioners to Governor Kitzhaber appears as the final letter in Exhibit A.]

Separately, at its meeting of 7 March 2012, Curry County Commissioners formally resolved to "transfer its public health and mental health programs to any willing and worthy provider." The current mental health program is under the leadership of an interim contracted administrator, and Jan Kaplan, previously the administrator for the merged public and mental health programs, is now overseeing only public health functions. Curry County public health tested the waters for a merger with Coos County Public Health, with no favorable result, and is now considering a merger with Josephine County Public Health. The Applicant will facilitate a community-lead solution to these issues, and, in its response to Appendix H, will request *flexibilities* in this regard. The leadership of both the Curry Health Network and Western Oregon Advanced Health are mid-course in the resolution of these issues, as verified by Curry Health Network's letter of support.

## V. ORGANIZATIONAL CHART

In an effort to maintain the required text-readability of this Portable Document Format (PDF) Application, the organizational chart appears in Exhibit B.

## VI. SERVICE AREA REQUEST

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The communities of Winchester Bay (97467), Reedsport (97467), and Gardiner (97441) are within Douglas County but are geographically more proximal to Coos Bay than to the Douglas County population and medical center in Roseburg. Douglas County is contiguous to Coos County, and Western Oregon Advanced Health is willing to enroll Members from these zip codes.

## VII. COORDINATED CARE ORGANIZATION CRITERIA QUESTIONNAIRE
**[FROM APENDIX A]**

### Part I: Background Information about the Applicant

**a. Description of the Applicant's Legal Entity Status and Where Domiciled:** Southwest Oregon Independent Practice Association, a Domestic Corporation incorporated in 1994, doing business as Doctors of Oregon's Coast South (DOCS), domiciled in Coos County, Oregon, is serving as the official applicant on behalf of Western Oregon Advanced Health, which is in the process of forming a Limited Liability Company, also domiciled in Coos County, Oregon.

**b. Description of the Applicant's Affiliates as Relevant to the Contract:** Western Oregon Advanced Health's board of directors will enter into a contractual agreement with Southwestern Oregon Independent Practice Association, Inc., wherein Southwestern Oregon Independent Practice Association will provide core management and fiscal functions on behalf of Western Oregon Advanced Health's Coordinated Care Organization (CCO). To this end, Southwestern Oregon Independent Practice Association, and the approximately 110 physicians that it represents, will serve as the Applicant's primary affiliate. Other essential affiliates include, but are not limited to:

- ADAPT, a publicly funded and not-for-profit chemical dependency treatment program with offices in Coos County;
- Advantage Dental, a Dental Care Organization (DCO), representing 38 dental professionals who are located in Coos and Curry Counties;
- Bandon Community Health Center, a not-for-profit corporation and participating Rural Health Act clinic that serves low-income, medically uninsured, Medicaid, and Medicare beneficiaries in southern Coos County;
- Bay Area Hospital, a Diagnostic Resource Group (DRG) regional referral and tertiary hospital, located in Coos County;
- Bay Clinic, a primary and multi-specialty medical group practice located in Coos County;
- Coos County Mental Health, the publicly funded mental health program operating in Coos County;
- Coos County Public Health, the publicly funded population-based public health agency operating in Coos County;
- Coquille Valley Hospital District, a Type B Critical Access Hospital (CAH), located in Coos County;
- Curry General Hospital, a Type A Critical Access Hospital (CAH), located in Curry County;

- Curry Health District, a publicly chartered special district that owns and operates Curry General Hospital in Curry County;
- Curry Health Network, an informal rural health network that is comprised of all primary, secondary, and tertiary medical providers and facilities in Curry County;
- North Bend Medical Centers, a primary and multi-specialty medical group practice, with offices located in Coos and Curry Counties;
- Oregon Department of Health and Human Services, Seniors and People with Disabilities Program, for the coordination of care for Members in long-term care facilities, for both Coos and Curry Counties;
- PacificSource, Southwestern Oregon Independent Practice Association's partner in the provision and delivery of Medicare Advantage services in Coos County, effective 1 January 2013;
- Powers Health District, a publicly chartered special district that owns and operates the Powers Health Clinic, which has been closed for the past two years, but which is receiving technical assistance and support from Waterfall Community Health Center;
- South Coast Hospice, a not-for-profit hospice program that operates in Coos County;
- South Coast Orthopedic Associates, a multi-physician orthopedic medical specialty practice with offices in Coos and Curry Counties;
- Southern Coos Hospital and Health Center, a Type B Critical Access Hospital (CAH) and attached outpatient clinic, located in Bandon in Coos County; and,
- Waterfall Community Health Center, a federally qualified health center serving low-income, medically uninsured, Medicaid, Medicare, and other vulnerable populations, with offices located in Coos Bay, North Bend, and Powers, in Coos County.

**c. Applicant's Intended Effective Date for Serving Medicaid Populations:** 1 August 2012

**d. Is Applicant Invoking Alternate Dispute Resolutions?** No. Applicant is requesting *flexibility*.

**e. Does Applicant Request Changes to, or Desire to Negotiate, Any Terms and Conditions in the Contract, Other than Those Mandated by Medicaid or Medicare?** Kindly refer to Section XI, (optional) responses to the RFA's Exhibit H.

**f. Proposed Service Area by Zip Codes:** Table 1 summarizes all zip codes assigned in Coos and Curry Counties by the U.S. Postal Service, and comprises the Applicant's proposed service delivery area. In addition to the specific zip codes that appear in Table 1, Western Oregon Advanced Health is willing to enroll Members from the contiguous communities of Winchester Bay and Reedsport (97467) and Gardiner (97441). These communities are located in Douglas County, but are more geographically proximal to Coos Bay than to the Douglas County population (and medical) center in Roseburg.

**Table 1**
**SERVICE AREA, DEFINED BY ZIP CODES**

| County | City or Community | Zip Code | County | City or Community | Zip Code |
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| Curry | Gold Beach | 97444 | Coos | Powers | 97466 |
| Curry | Harbor | 97415 | Curry | Sixes | 97476 |

**g. Location of Applicant's Primary Administrative Office:** 750 Central Ave, Suite 202
Coos Bay, Oregon 97420

**h. Counties or Portions of Counties Served, and Arrangements to Coordinate with County Governments:** The service delivery area is wholly and exclusively comprised of Coos and Curry Counties in southwestern Oregon.

In Coos County, the administrator for the Public Health Department (Frances Smith), and the director for the County Mental Health Department (Ginger Swan), have participated as active members of the CCO Planning Committee since that Committee was first convened in October of 2011. The Committee has met on a regular monthly basis since that time, and increased the frequency of meetings to a semi-monthly basis beginning in March of 2012. Effective with the 2 February 2012 meeting, Coos County Commissioner Fred Messerle joined the CCO Planning Committee. One Coos County Commissioner will serve as a member of the Coos County Community Advisory Committee, and the panel of Coos County Commissioners will appoint the membership of the Coos County Community Advisory Committee. A delegate of the Board of Commissioners for Coos County serves as a member of the governing board of Western Oregon Advanced Health. Letters of support from the Coos County Public Health Department and Coos County Mental Health Department appear in Exhibit A. Western Oregon Advanced Health envisions entering into a contractual relationship with Coos County for the provision of public health and mental health services by not later than 1 August 2012.

In Curry County, the director for the Curry County Public Health Department (Jan Kaplan) commenced participation in the CCO Planning Committee effective with the 2 February 2012 meeting, although a series of face-to-face visits and dialogues preceded that date. One Curry County Commissioner will serve as a member of the Curry County Community Advisory Committee, and the panel of Curry County Commissioners will appoint the membership of

the Curry County Community Advisory Committee. A delegate of the Board of Commissioners for Curry County may serve as a member of the governing board of Western Oregon Advanced Health. As of the date of this Application's submission, the public health and mental health programs operated by Curry County were facing insolvency, as is evidenced by a letter submitted by the Board of County Commissioners for Curry County to Oregon's Governor in late February, notifying the Governor that the County may return public health and mental health services to the control of the State. Simultaneously, Curry County's public health and mental health department is undergoing a Medicaid audit and the results are not yet known.

In November of 2011, the Curry County Board of Commissioners received the results of an independent and commissioned feasibility study, the purpose of which was to determine whether public health and/or public mental health services could be transferred to the Curry Health District. While the feasibility study concluded that such a transfer was possible, at least for public health services, Curry Health District has been unwilling to accept the transfer of public health functions unless those functions can *come through the door* with adequate cash reserves to offset anticipated losses for the first twelve-month operating period. The ability of Curry County Public Health to generate the required $200,000 by the proposed effective date of 1 July 2012 is questionable. Thus, at its regularly scheduled meeting of 7 March 2012, the Board of County Commissioners for Curry County adopted a resolution to transfer public health, public mental health, and addiction treatment services to any qualified entity. Southwest Oregon Independent Practice Association is engaged in discussions, and perhaps negotiations, with the Curry Health District regarding the transfer or acquisition of public health services, and is working to identify a qualified vendor for public mental health and addiction treatment services. At the same time, Curry County Public Health is engaged in discussions with Josephine County Public Health regarding the creation, by merger or otherwise, of a regional public health entity. For each of these reasons, as of the submission date of this Application, there is no lawful or solvent entity within Curry County with whom to contract for the provision of public health, public mental health, and addiction treatment services.

**i. Prior History as a Managed Care Organization with the Oregon Health Authority:** Western Oregon Advanced Health, as a newly created entity for the purposes of the CCO program, has no prior history as a Managed Care Organization (MCO) with the Oregon Health Authority (OHA). However, Western Oregon Advanced Health's managing partner, Southwest Oregon Independent Practice Association, has an extensive history of providing managed care services to the Medicaid population in Coos and Curry Counties, and holds a current contract with the Oregon Health Authority (OHA) as a Managed Care Organization (MCO). Southwest Oregon Independent Practice Association's MCO contract is considered to be that of a *Fully Capitated Health Plan.*

Coos County Mental Health, and Curry County Mental Health, have been participating with Jefferson Behavioral Health under the latter's contract with the Oregon Health Authority as a Mental Health Organization (MHO), and as such, have experience with managed care tenets relative to the provision of mental health services to the Medicaid population.

Advantage Dental, one of Western Oregon Advanced Health's affiliates, has been operating a Dental Care Organization (DCO) in concert with the Oregon Health Authority, and as such, has extensive experience with managed care tenets relative to the provision of dental health services to the Medicaid population.

**j. Is Applicant the Identical Organization Holding a Current MCO Contract?** Yes. Western Oregon Advanced Health is a newly created organization for the purposes of the CCO model, but the applicant organization, managing partner, and fiscal agent will be Southwestern Oregon Independent Practice Association, Inc., dba DOCS. It is the latter organization, Southwestern Oregon Independent Practice Association, Inc., that currently holds an MCO contract with the OHA.

**k. Does the Applicant Include More than One MCO?** No.

- Southwest Oregon Independent Practice Association holds a current contract with the Oregon Health Authority (OHA) as a Managed Care Organization (MCO) for the provision of services to the Medicaid population in Coos and Curry Counties.

- Coos County Mental Health, and Curry County Mental Health, have been participating with Jefferson Behavioral Health under the latter's contract with the Oregon Health Authority as a Mental Health Organization (MHO).

- Advantage Dental, one of Western Oregon Advanced Health's affiliates, has been operating a Dental Care Organization (DCO) in concert with the Oregon Health Authority that includes services to the Medicaid population in Coos and Curry Counties (in addition to multiple other Oregon counties).

**l. Does the Current MCO Make this Application for the Identical Service Area?** Yes.

- The service area for Western Oregon Advanced Health is identical to that described in Southwest Oregon Independent Practice Association's current MCO contract, specifically, Coos and Curry Counties.

- The service delivery area for Jefferson Behavioral Health's current MHO contract includes Coos, Curry, Jackson, Josephine, and Klamath Counties. This CCO Application is for a sub-set of the current MHO contract, specifically, for Coos and Curry Counties.

- The service delivery area for Advantage Dental's current DCO contract involves a multiplicity of Oregon counties. This CCO Application is for a sub-set of the current DCO contract, specifically for Coos and Curry Counties.

**m. Does Applicant have Any Contract with OHA as a Licensed Insurer or Health Plan Third-Party Administrator for the Oregon Medical Insurance Pool, *Healthy Kids Connect*, Public Employees Benefit Board, Oregon Educators Benefit Board, or Adult Mental Health Initiative?** No.

**n. Does the Applicant have Experience as a Medicare Advantage Contractor?** Southwestern Oregon Independent Practice Association has provided Medicare Advantage services under contract with CareSource and ATRIO. Effective 1 January 2013, Southwestern Oregon Independent Practice Association, Curry Health Network, and Bay Area Hospital will provide Medicare Advantage services under an affiliation agreement with PacificSource. None of the participating entities have held a direct contract with the Centers for Medicaid and Medicare Services (CMS) for Medicare Advantage services. The service delivery area for the Medicare Advantage affiliation with PacificSource comprises Coos and Curry Counties.

**o. Does the Applicant Hold a Current Certificate of Insurance with the State of Oregon, Department of Consumer and Business Services, Insurance Division?** No.

**p. Description of Applicant's Demonstrated Experience and Capacity for:**

**Developing and Implementing Alternative Payment Methodologies Based on Health Care Quality and Improved Health Outcomes:** According to the OHA's Office for Oregon Health Plan Policy and Research (November, 2010), thirty percent (30%) of all services provided to patients is either unnecessary or inappropriate. Many health care professionals and institutions lack the information and infrastructure needed to assess whether the health care services provided actually improve the health of patients. Moreover, the fee-for-service payment system fails to link payment to the attainment of desired outcomes: it pays for units of service, and not for improving health status or delivering efficient and superior quality care. It rewards hospital admissions and expensive procedures, but does not reimburse for care coordination, discharge planning, and other activities that are critical to keeping people healthy.

Southwestern Oregon Independent Practice Association has long understood the correlates between alternative payment methodologies and the delivery of high-quality health care services that produce improved health outcomes. But, like most health-serving organizations, Southwestern Oregon Independent Practice Association has lacked some of the informatics and infrastructure needed to use payment methodologies as an incentive for the delivery of high-quality health care services that result in measurable improvements in health outcomes, although some significant improvements have been made, over time, in

this regard. For example, Southwestern Oregon Independent Practice Association uses a robust system of prior approvals for elective hospitalizations and expensive procedures, and has, over the past year, worked diligently to reduce inappropriate over-utilization of prescribed narcotic agents. In this latter initiative, the number of patients who receive (costly) prescriptions for narcotic agents has been reduced by greater than one-half, but more importantly, those patients have been assisted in enrolling in alternative pain management programs, sponsored by Southwestern Oregon Independent Practice Association, that have measurably improved both quality of life and health outcomes.

Southwestern Oregon Independent Practice Association is working, in the current calendar year, on a new initiative that will specifically link provider payment with patient retention. It is the first true alternative payment methodology that has been authorized by Southwestern Oregon Independent Practice Association's board of directors.

A member of Southwestern Oregon Independent Practice Association, William Murray, served on the Payment Reform Subcommittee of the Health Incentives and Outcomes Committee, convened by the Oregon Health Policy Board that submitted its recommendations in November of 2010, long before HB 3650 was introduced to the 2011 Oregon Legislative Assembly. Since that time, Southwestern Oregon Independent Practice Association has embraced the Committee's recommendations and has been developing the capacity toward a transformational delivery system that will:

- Foster provider accountability through a mature measurement infrastructure that provides meaningful, accurate, and actionable data on performance at the provider, practice, and institutional levels;
- Measure health outcomes and cost metrics relative to historical performance, peer performance, and explicit benchmarks; and,
- Pay for care in a way that initially rewards performance and ultimately is tied to a budgeted cost for efficient provision of necessary care.

Key to attaining these transformational aims and capacity, Southwestern Oregon Independent Practice Association, as the managing partner for Western Oregon Advanced Health, will:

- Move forward decisively to transform the primary care delivery system, recognizing that a robust system, of primary care is fundamental to achieving the Triple Aim, and that the widespread implementation of primary care homes should begin as soon as possible;
- Focus measurement and payment efforts in areas of significant cost impact or significant defects in the quality of care, where the potential for improvement is the greatest (e.g., significant issues of infant mortality and low birth weight infants in the communities of Gold Beach and Port Orford in Curry County);

- Require the local service delivery system to become more patient- and family-centered, in the belief that engaged patients are far more likely to practice health prevention, engage in self-care for the management of chronic illness, appropriately use primary health care services, and avoid the inappropriately utilization of highly expensive emergency department services; and,
- Initiate the use of new payment incentives and methodologies, including pay-for-performance, episode (bundled) payment, gain-sharing schemes, and piloted new payment programs that incent providers to coordinate care, eliminate care deficits, and drive unnecessary costs out of the system, as approved by Western Oregon Advanced Health's board of directors.

Certain of Western Oregon Advanced Health's affiliates have amassed additional acumen and capacity with respect to improving health outcomes that, in turn, decrease the costs of health care services. Coquille Valley, Curry General, and Southern Coos Hospitals have been participating for three years in a quality improvement project that is jointly sponsored by the federal Office of Rural Health Policy and the Oregon Office of Rural Health. Metrics under analysis include medication errors, pressure ulcers, and unattended in-facility accidental falls. Reductions in these adverse events save downstream health care dollars while at the same time improving health outcomes for patients. Waterfall Community Health Center and the Powers Health District participated in a three-year project in concert with the Health Resources and Services Administration's (HRSA's) Office of Rural Health Policy to effectively increase the proportion of adult diabetic patients whose blood glucose levels were under good control over a sustained period of time, the impact of which reduced health care spending while improving health outcomes. Moreover, Waterfall Community Health Center and ADAPT, as federally qualified health centers, are also participating with HRSA in cross-site clinical performance evaluations that are purposed at reducing costs and improving health outcomes for pre-natal patients, infants, and those who are diagnosed with hypertension, asthma, obesity, tobacco addiction, and diabetes.

**Coordinating the Delivery of Physical Health Care, Mental Health Care, Chemical Dependency Treatment Services, Oral Health Care, and Long-Term Care Services:** As a relatively new entity, Western Oregon Advanced Health cannot claim any significant experience in the coordination of health care delivery across all service sectors, but it can state that it has been specifically designed to support the development of that capacity within a founding philosophy that embraces the true coordination of integrated care. The truth is, of course, that caring and attentive providers have always coordinated care for their patients, albeit they often lack the tools and infrastructure to do so efficiently. Dentists and oral surgeons coordinate with cardiac patients' cardiologists before undertaking invasive procedures. Mental health therapists coordinate with primary care providers both to obviate physical diagnoses that could produce mental symptoms and to coordinate medication regimes. Physicians refer to, and consult with, addiction treatment personnel, particularly in those circumstances in which the addiction arises as the result of a prescribed

substance. In smaller communities and geographies, there is a naturally occurring interplay among and between the professions, all in the interests of patient safety, improved outcomes, and coordinated care delivery. In smaller communities and geographies, there is a naturally occurring interplay among and between the professions, all in the interests of patient safety, improved outcomes, and coordinated care delivery. Nonetheless, the CCO's affiliates can point to multiple successful care coordination projects that have been undertaken over time.

For a four-year period ending in 2010, and in a single-county initiative, many of Western Oregon Advanced Health's affiliates engaged in a formalized system of care coordination and case management. Under this demonstration project, Bay Area Hospital identified 185 distinct individuals for their propensity to inappropriately utilize emergency department services. These patients were somewhat evenly divided between persons who were low-income and medically uninsured and patients with confirmed psychiatric diagnoses. Using resources provided by Bay Area Hospital and Southwest Oregon Independent Practice Association, a special needs case management nurse was retained and assigned to Waterfall Community Health Center to interface with, and coordinate care for, those patients who were medically uninsured, and a corresponding special needs case manager was deployed at Coos County Mental Health to provide exceptional needs care coordination for those targeted patients who were diagnosed with psychiatric illnesses. As the two case managers undertook their work, they discovered the need for greater coordination across social service systems and care providers and began to convene regular monthly meetings of these facilitators. Partners in these monthly meetings included: multiple local offices from within the Oregon Department of Health and Human Services; Coos County Mental Health; Coos County Public Health; Coos Elderly Services; Oregon Coast Community Action; Southwest Oregon Independent Practice Association; ADAPT; Bay Area Hospital; and Waterfall Community Health Center. Despite the fact that the demonstration project was successful in reducing inappropriate emergency department utilization among the targeted sub-population by 50 percent, the project ended in 2010 because it lacked the sustaining resources to continue.

South Coast Ruralhealth Integrated Provider Team (SCRIPT) was founded in 1990 as an Oregon, membership, not-for-profit corporation that enjoys IRS tax-exempt status. The exclusive charitable mission of SCRIPT is to support the unique role of not-for-profit health care delivery systems in Coos and Curry Counties, as those systems work to increase health care access and eliminate health disparities. The founding members of SCRIPT included: Curry County Public Health; Curry General Hospital; Coos County Public Health; Coquille Valley Hospital; the Powers Health District and Rural Health Clinic; and Waterfall Community Health Center. From 1990 to 1994, in partnership with HRSA's Bureau of Primary Health Care, SCRIPT operated a $750,000 per year project, the dual purposes of which were to enroll eligible persons in publicly funded health insurance programs and provide care coordination and case management services. Through this initiative, seven registered nurses

were employed and out-stationed at each of SCRIPT's member organizations, in what represented the two counties' earliest efforts at care coordination. Nurse case managers met on a semi-monthly basis to learn from one another, identify barriers to care, engage in problem-solving, and overcome challenges on behalf of the patients for whom they were coordinating care.

Based on the successes of SCRIPT's first project, from 1995 to 1998, the entity received a three-year *Rural Health Network Development* grant from HRSA's Office of Rural Health Policy to continue its work in care coordination and case management. As the direct result of cross-discipline care planning, the project was once again successful in increasing the number of medically uninsured patients who had access to a permanent *medical home*, while reducing the rate of inappropriate emergency department utilization. However, the lack of a uniform assessment tool and patient registry were identified as significant obstacles. Today, many of Western Oregon Advanced Health's affiliates continue to participate in SCRIPT. In addition to the six founding members of SCRIPT, listed above, the following organizational members have been added: Coos County Mental Health; ADAPT; Advantage Dental; Bandon Community Health Center; Southern Coos Hospital; Southwest Oregon Independent Practice Association; and Southern Oregon Adolescent Study and Treatment Center.

In a separate two-county initiative, *Ready to Smile*, school-based oral health screening, the application of dental varnishes and sealants, and referrals for restorative care is provided through a collaborative mechanism, lead by the Coos County Public Health. Partners in this oral health care coordination effort include Curry County Public Health, Waterfall Community Health Center, Bandon Community Health Center, Advantage Dental, and all public school districts.

Western Oregon Advanced Health's CCO planning process commenced in October of 2011, at which time, multiple work groups were tasked with developing various components for an effective CCO system of care. By far, the most active work group was that of Integrated Care Coordination, chaired by Ginger Swan, director of Coos County Mental Health. That work group identified multiple and diverse systems of care coordination and case management in operation throughout the two-county region: (1) Both the Coos and Curry County Public

Health agencies provide multiple models of case management and care coordination for pregnant women, mothers, infants, and families; (2) Both the Coos and Curry County Mental Health agencies provide a robust and extensive menu of case management and care coordination for patients who are diagnoses with chronic and persistent mental illness and for those who are transitioning from one level of care (e.g., outpatient, residential, inpatient) to another; (3) Southwestern Oregon Independent Practice Association employs an exceptional needs case management nurse; (4) Local offices of the Oregon Department of Health and Human Services employ a diversity of case managers to assist low-income

families, youth who reside in foster care, seniors, and persons with disabilities; (5) Additional case management services are available through regional providers who specialize in services for those diagnosed with developmental disabilities; (6) Most of the largest medical practices (e.g., North Bend Medical Centers; Waterfall Community Health Center) employ case management nurses who work with patients who are diagnosed with chronic diseases, or those with multiple morbidities; (7) The Maslow Project provides case management to homeless youth; (8) At least two hospitals (e.g., Bay Area Hospital; Curry General Hospital) employ case management nurses to work with specific populations, while all hospitals employ either medical social workers or discharge planners; and, (9) Coos Elderly Services performs legal guardian and conservator services for highly vulnerable seniors, many of whom are confined to long-term care facilities or group foster homes. It was the finding of the Integrated Care Coordination work group that the two counties are not lacking for qualified and experienced case management and care coordination personnel, but rather that there remains a need for increasingly *lean* care coordination strategies that employ the use of *super case managers*, common assessment procedures and tools, shared treatment and case management plans, and greater information flow through such strategies as a Health Information Exchange. It is these precise strategies that reside at the core of this CCO Application, and through the CCO model and shared governance, the project's planners will achieve measurably increased capacity to fully coordinate and integrate care across all disciplines and sectors. The Community Behavioral Health Association's *Four Quadrant Model*, as later described, will serve as the overarching theoretical base for this work.

**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:** Southwest Oregon Independent Practice Association, along with local public health agencies, has played a leadership role in engaging community members and health care providers in improving the health of the community. Significant population-level initiatives have included tobacco cessation, diabetes prevention, and pediatric oral health prevention. In partnership with Western Oregon Advanced Health's provider panel, the Coos County Public Health Department offers Stanford University's evidence-based best practice model for *Chronic Disease Self-Management*.

Several of Western Oregon Advanced Health's affiliates have amassed considerable expertise in deploying consumer-driven and community-based initiatives. Bandon Community Health Center and Waterfall Community health center are characterized by consumer-majority board of directors who have worked effectively to create service delivery systems during non-traditional hours and to implement sliding-fee schedules and affordable access to diagnostic medical laboratory and pharmacy services. Coos County Mental Health has long been characterized by a very active consumer advocacy group (CAOS) that actively implements consumer-designed programming and makes use of peer wellness specialists.

The Curry County Public Health agency is also characterized by a consumer-majority Public Health Advisory Committee. Finally, the Coos and Curry County Community Needs Assessment Study was vetted by two focus groups, one comprised entirely of consumers, and the other comprised of consumer advocates.

Coos and Curry Counties are characterized by a significantly homogeneous population of Caucasians of European ancestry. Racial and ethnic minorities, in combination, comprise less than six percent (5.88%) of the total population, and of these, Hispanics are in the majority at 2.90 percent ($\underline{N}$ = 2,448). Although 400 migrant and seasonal farm workers will frequent Coos and Curry Counties during the annual cranberry harvest, local public school districts no longer offer migrant education programs, and the number of children enrolled in Second Language Learner (formerly, English as a Second Language, or ESL) programs has steadily declined. Nonetheless, on an annual basis, the Office of Oregon Health Plan Policy and Research estimates that 119 persons living in Coos and Curry Counties are eligible for Citizen/Alien-Waived Emergent Care (CAWEM). Of interest, a recent study estimated that fully one-half of all undocumented aliens in Coos and Curry Counties are from Canada. In this regard, Waterfall Community Health Center participated with the Oregon Health Authority in a *safety net primary care demonstration project*, the purpose of which was to enroll alien children in a Medicaid-like health insurance plan, and eligible children of alien parents in the Oregon Health Plan. Western Oregon Advanced Health's largest affiliates (e.g., Coos County Public and Mental Health; Curry County Public and Mental Health; North Bend Medical Centers; Bay Area Hospital; and Waterfall Community Health Center) have access to bi-lingual, bi-cultural, and bi-literate personnel, including medical interpreters and translators, and those who are fluent in American Sign Language.

The most significant health disparities in Coos and Curry Counties are not borne by those who are of racial or ethnic minority status, but rather by those who live in poverty, the majority of whom are enrolled in the Medicaid program and who comprise the target population for the Coordinated Care Organization. In certain target communities (e.g., Coquille and Port Orford) inadequate access to primary health care services results in socioeconomic health disparities. Five rural communities in Coos and Curry County evidence Ambulatory Care Sensitive Condition (ACS) Ratios that are two standard deviations above Oregon's mean, in descending order of severity: Bandon; Gold Beach; Powers; Coos Bay; and Port Orford. Low-income persons suffer from higher incidences of infectious and parasitic diseases, malignant neoplasms, chronic lower respiratory disease, chronic liver disease, suicide, alcohol-induced deaths, and drug-induced deaths. As a direct result, Comparative Mortality Ratios (CMR) are elevated, in descending order of severity, in: Bandon; Powers; Port Orford; Brookings; Gold Beach; and Coquille. Three-year averaged Infant Mortality Rates (IMR) rates in Gold Beach and Port Orford are 2.5 times state and national norms. Among those beneficiaries who are currently enrolled in Southwestern Oregon Independent Practice Association's managed care plan for Medicaid Members, there are disproportionately high rates for the occurrence of post-traumatic stress disorder,

borderline personality disorder, and bipolar illness, than occur in the statewide cohort of Medicaid enrollees. In Coos and Curry Counties, when the population on "open medical cards" is combined with the population enrolled in Medicaid managed care, one out of every two adult Medicaid beneficiaries will be found to carry a formal psychiatric diagnosis.

In Coos and Curry Counties, chronic disease, and in particular chronic and persistent mental illness, is interconnected with poverty in a vicious cycle. Chronic mental illness often precludes gainful employment or contributes to low earning capacity, thereby drawing individuals into a downward spiral of worsening disease and poverty. Persons living in poverty are more vulnerable to chronic disease, including greater exposure to inherited and other risk factors, and decreased access to health services. In short, the chronic disease burden is concentrated among the poor, and in Coos and Curry Counties, the burden of chronic disease is now visiting the third and fourth generation of those who have lived in chronic poverty. It is this interplay between poverty and chronic illness that results in the single greatest health inequities in Coos and Curry Counties. These health inequities are reflected in length of life, quality of life, rates of disease, rates of disability, rates of death, severity of disease, and access to treatment. The overarching goal of Western Oregon Advanced Health's Coordinated Care Organization is to achieve health equity by eliminating health disparities while achieving the Triple Aim, particularly among the Member population that is characterized by multi-generational poverty and chronic disease. The Coordinated Care Organization, and each of its affiliates, brings differing levels of acumen and experience, but remains, overall, committed to this end. Chief among Western Oregon Advanced Health's priorities is the development and implementation of a Coordinated Care Organization that will develop new capacities and capabilities in the attainment of health equity for all Members.

**q. Identify and Furnish Resumes for Key Leadership Personnel:** The following individuals comprise the key leadership team for Western Oregon Advanced Health's Coordinated Care Organization:

| | | |
|---|---|---|
| Chief Executive Officer | : | Phil Greenhill |
| Chief Financial Officer | : | Lance Brant, CPA (by contract) |
| Chief Medical Officer | : | Tracy Muday, M.D. |
| Chief Information Officer | : | John Sevier |
| Chief Operations Officer | : | Karen Gannon |
| Medical Management Director | : | Caryn Mickelson, PharmD |

Collectively, Western Oregon Advanced Health's key leadership team has amassed more than sixty years of progressively responsible and successful executive experience in the health sector. In an effort to maintain the required text-readability of this Application, resumes for directly employed key personnel appear in Exhibit C.

**r. Organizational Chart:** In an effort to maintain the required text-readability of this Portable Document Format (PDF) Application, the organizational chart appears in Exhibit B.

**s. Is Applicant Deferring Submission of Any Supporting Documents, Tables, or Data that are a Part of the Technical Application until the Readiness Review Date?** (1) Please refer to certain *Explanations* in the preceding Attestation, Assurances, and Descriptive Representation document, pages 5 to 16 of this Application. (2) Because of insolvency questions related to the public health and mental health departments in Curry County, certain supporting documents from these, or substitute, entities will not be available until the readiness review date. (3) The MOA with DHS for LTC services will not be available until the readiness review date of 3 July 2012.

## Part II: Community Engagement in Application Development

The CCO planning process commenced in earnest in October, 2011, with the seating of a CCO Planning Committee that met on a regular monthly basis from October, 2011, to February, 2011, and then escalated its meeting schedule to that of semi-monthly. An average of 24 persons, drawn largely from the health sector, has attended each meeting. In Coos County, County Commissioner Cam Perry, who serves as the liaison to the Coos County Departments of Mental and Public Health, was originally seated as a member of the CCO Planning Committee, but was unable to participate because of a protracted family health emergency. County Commissioner Fred Messerle joined the CCO Planning Committee at its meeting of 2 February 2012 and has participated in all meetings since that time. Curry County Commissioners appointed Jan Kaplan, Director of Curry County Public Health, as their delegate representative, and Mr. Kaplan has participated in all CCO Planning Committee meetings since 2 February 2012.

Beginning in February, the CCO Planning Committee appointed an Integrated Care Coordination and Case Management work group, under the leadership of Ginger Swan, Director of Coos County Mental Health. This group has met a minimum of eight times as of this writing, and has expanded to include a wide diversity of non-health-serving and non-affiliates who either serve, or directly advocate for, under-served populations who are defined by age, ethnicity, race, economic status, or other defining characteristics. These direct service and advocacy groups have provided considerable input and involvement in the CCO planning process, leading to the development of this Application.

In addition to the Care Coordination work group, a separate work group on Governance and Structure was appointed in February, 2012. County Commissioners and their leadership employees serve as members of the Governance and Structure work group.

Western Oregon Advanced Health's *Community Needs Assessment Study* was vetted in December of 2011 by two focus groups: one comprised of Medicaid beneficiaries; and the other comprised of advocates for under-served populations who are defined by age, ethnicity, race, economic status, health disparities, or other defining characteristics.

## Section 1 – Governance and Organizational Relationships

### 1. Governance

**Description of the Proposed Governance Structure:**

ORS 414.625 requires that each Coordinated Care Organization must seat a governing board that includes: *a majority comprised of those persons who are risk-holders (at least two of whom must be practicing providers, one of whom must be a physician or nurse practitioner); major components of the health care delivery system; a mental health or chemical dependency treatment provider; at least two members of the community-at-large; and at least one member of the Community Advisory Council.* Western Oregon Advanced Health finds that those *persons* who are risk-holders are, in fact, the individual physicians who comprise Southwestern Oregon Independent Practice Association, and has therefore organized its governance structure such that physicians are in the majority. While Western Oregon Advanced Health would have defined hospitals, dental care organizations, mental health, and chemical dependency treatment providers to have been major *components* of the health care delivery system, mental health and chemical dependency were treated separately by the relevant statute. For that reason, hospitals and a single dental care organization are seated as members of the local CCO governing board as *major components of the health care delivery system*, while mental health and/or chemical dependency treatment are allocated a separate and distinct seat on the governing board. As a matter of internally adopted policy, one member of each County Community Advisory Council serves on the governing board. In specific, the governance structure for Western Oregon Advanced Health will be comprised of the following:

- Physicians (or their designated administrators) will comprise at least 60 percent of the membership of the board of directors, but in no case, less than six (6) members, two of whom must be primary care providers, and two of whom must be physicians practicing in medical specialty areas;

- Two representatives from hospitals;
- A single representative from community mental health;
- A single representative from county public health;
- A single representative from contracted addiction treatment services;
- A single representative from Advantage Dental;
- The chairperson of the Community Advisory Council; and,
- At least two members from the community-at-large.

**Community Advisory Councils:** Western Oregon Advanced Care will seat a Community Advisory Council in each separate county in which it operates. The overarching purpose of the Community Advisory Council is to ensure that the health care needs of the CCO's Members and the community are being addressed. The Community Advisory Council will: maintain a consumer-majority while including representatives of the community and each county government served by Western Oregon Advanced Care; meet no less frequently than once every three months; and, have its membership selected by a committee comprised of equal numbers of county representatives (county commissioners) from each county served by Western Oregon Advanced Care and members of Western Oregon Advanced Care's governing body. As of the date of the submission of this Application, the Community Advisory Councils have not yet been seated. The Community Advisory Council for Coos County will be seated by 10 June 2012. The Applicant will request *flexibility* in the seating of the Community Advisory Council for Curry County for reasons referenced on pages 18, 38, and 39. Western Oregon Advanced Care has formally adopted preliminary policies and procedures governing Community Advisory Councils, and these are appended as Exhibit D.

**Relationship of the Governance Structure with the Community Advisory Councils:** The duties of the Community Advisory Councils include, but are not limited to: identifying and advocating for preventative care practices to be implemented by Western Oregon Advanced Health; overseeing a community health needs assessment and adopting a community health improvement plan to serve as the strategic, population-based, health care system service plan for the specific communities to be served by Western Oregon Advanced Health; and, annually publishing a report on the progress of the community health improvement plan. The community health improvement plan, as adopted by the Community Advisory Councils, will describe the scope of the activities, services, and responsibilities that Western Oregon Advanced Health will consider upon implementation of the plan, including, but not limited to: analysis and development of public and private resources, capacities, and metrics;

priority-setting; health policy; systems design; outcome and quality improvement; integration of service delivery; and, workforce development.

In the interests of transparency, all meetings of the Community Advisory Council will be convened pursuant to Oregon's public meeting laws and will be announced in advance and made open to the general public, thereby creating a forum at which Member input may be provided. Moreover, under Western Oregon Advanced Health's plan, Community Advisory Councils will play a role in resolving consumer complaints. In each county, Western Oregon Advanced Health will enter into a contractual agreement with the local Public Health agency to provide facilitation and staff support to the Community Advisory Councils. The purposes of these contractual arrangements are threefold: (1) It is believed that public health authorities are in the best position to lend counsel to Community Advisory Councils regarding matters of prevention and population-based wellness; (2) Public health authorities are already charged with annually undertaking comprehensive needs assessment studies, and these arrangements will avoid redundancy, save costs, and aggregate efforts; and, (3) By empowering public health authorities to work in this manner, the undertakings of the Community Advisory Councils are at *arms' length* from the influence of the CCO's board of directors, thereby permitting greater independence for Community Advisory Councils. Community Advisory Councils will thus be presented with multiple options for advancing recommendations to the CCO's governing board: directly through the chairperson of the Community Advisory Council who holds a seat on Western Oregon Advanced Health's board of directors; or through the public health director, to the County Commissioner, who directly serves on the board of directors, or appoints a delegate to serve on the board of directors. To assure that no recommendation of the Community Advisory Council goes unaddressed, the board of directors will be required to respond, in writing, to every recommendation of the Community Advisory Councils within ninety (90) days of their receipt.

**2. Clinical Advisory Panel**

Western Oregon Advanced Health will seat a Clinical Advisory Panel. The board of directors will annually solicit nominations for the Clinical Advisory Panel from providers, who are expected to nominate their peers who have displayed advanced clinical skills. The overarching purposes of the Clinical Advisory Panel are to oversee the Coordinated Care Organization's clinical quality assurance and improvement programs, and to advance evidence-based best practices and standards for uniform adoption throughout the Coordinated Care Organization. The Clinical Advisory Panel will forward such recommendations to Western Oregon Advanced Health's board of directors, through Southwestern Oregon Independent Practice Association's Chief Medical Officer, who will chair the Clinical Advisory Panel. As with the Community Advisory Councils, all recommendations of the Clinical Advisory Panel must be acted upon by the board of directors, in writing, within ninety (90) days. Additional detail about the Clinical Advisory Panel appears in Exhibit E.

**3. Agreements with Oregon DHS Offices for Seniors and People with Disabilities**

Mr. Michael Marchant, District Manager for Seniors and People with Disabilities, of the Oregon Department of Health and Human Services in Coos and Curry Counties, has been an active participant in both the CCO Planning Committee and its Integrated Care Coordination and Case Management work group since February, 2012. A copy of the Memorandum of Understanding, related to the coordination of care for Members who are placed in long-term care facilities, is under negotiation and will be available as of 3 July 2012.

**4. Agreements with Local Mental Health Authorities and Community Mental Health**

In Coos County, an evolving and good faith effort has been extended between Western Oregon Advanced Health and the Coos County Department of Mental Health. The latter entity has served as a member of the CCO Planning Committee since October of 2011, and its director, Ginger Swan, has chaired the local work group on Integrated Care Coordination and Case Management. Western Oregon Advanced Health envisions entering into a contractual relationship with Coos County for the provision of the full spectrum of comprehensive and coordinated mental health services, based on a sub-global payment rate (as well as for a delimited menu of mental health services that are not included under the global budget). The contractual document will detail provisions, and provide supporting resources, for meeting the health and mental health needs of mental health patients who are transitioning from one level of care to another (e.g., outpatient, residential, inpatient), as well as coordination with community emergency service agencies to assure an appropriate response to Members (and other community residents) who experience mental health crises. Coos County may, or may not, elect to contract with Jefferson Behavioral Health for some administrative, support, and residential services. Coos County Mental Health is the appropriate agency to perform each of these tasks, as they fall within the current scope of practice for community mental health programs, and the local mental health agency has amassed decades of experience in this regard. Moreover, Coos County Mental Health plays an active leadership role in the Local Public Safety Committee and provides 24-hour support to the community, as well as the services of a licensed mental health professional to corrections personnel. The contractual document with Coos County Mental Health is under development and negotiation, but will be available by the time of the readiness review date of 3 July 2012.

In early 2011, the Board of Curry County Commissioners authorized an independent feasibility study to determine the efficacy of transferring public health and/or public mental health services to the Curry Health District. The feasibility study was completed in November of 2011, and concluded that such a transfer was feasible. However, after a review of fiscal matters, the Curry Health District determined that, in the face of uncertain cash flow for its primary function, Curry General Hospital, the Curry Health District could not

accept the transfer of public health and/or public health responsibilities, unless those entities came through the door with at least $200,000 in financial reserves. To this end, in late February, 2012, the Board of Curry County Commissioners submitted a formal letter to Governor Kitzhaber, notifying him of the potential insolvency of the Curry County's publicly funded mental health program, and the potential need to transfer that program to the State, effective 30 June 2012.

Separately, at its meeting of 7 March 2012, Curry County Commissioners formally resolved to "transfer its public health and mental health programs to any willing and worthy provider." The current mental health program is under the leadership of an interim contracted administrator, and Jan Kaplan, previously the administrator for the merged public and mental health programs, is now overseeing only public health functions. Curry County public health tested the waters for a merger with Coos County Public Health, with no favorable result, and is now considering a merger with Josephine County Public Health. The Applicant is facilitating a community-lead solution to these issues, and, in its response to Appendix H, will request *flexibilities* in this regard.

**5. Social and Support Services**

In an effort to carry out, and achieve, the Triple Aim, Western Oregon Advanced Health, directly and through its affiliates, has established meaningful relationships with social and support services present in Coos and Curry Counties.

- ORegon Coast Community Action (ORCCA) is the designated community action agency for Coos and Curry Counties, and as such is purposed at alleviating poverty and addressing its root causes. ORCCA serves as the housing authority for Coos and Curry Counties, operates Head Start programs in these communities, and is the local member of the Oregon Food Bank. Because the overarching goal of Western Oregon Advanced Health's Coordinated Care Organization is to achieve health equity by eliminating health disparities, particularly among the Member population that is characterized by multi-generational poverty, ORCCA is an essential partner in the attainment of this goal. To this end, ORCCA will fill one seat on the Community Advisory Council, and may receive annual grants-in-aid for cooperative undertakings that are purposed at addressing the root causes of poverty.
- Western Oregon Advanced Health is directly engaged with multiple programs and offices of the Oregon Department of Health and Human Services, and is negotiating a Memorandum of Understanding with the Office for Seniors and Persons with Disabilities, and later in this Application will describe an innovative model for care delivery for children under the control of Child Protective Services. The local Office of Adult and Family Services is a primary contact and enrollment point for persons who are eligible for inclusion in Medicaid, and the project's community outreach and eligibility assistance workers coordinate their efforts with this office.

- Western Oregon Advanced Health's primary interface with state and local corrections, law enforcement, county juvenile departments, and court systems is through its affiliates, ADAPT and County Mental Health. County Mental Health agencies are represented on each County's state-mandated Local Public Safety Committees, and through that participation arrange for 24-hour emergency services, mental health assessments, pre-sentencing assessments, mandatory episodes of treatment, and mental health programs purposed at juvenile diversion. There are no problem-solving courts in the service area.

- Interface with the Oregon Youth Authority has proven to be difficult. Oregon Youth Authority's facilities are located out-of-county, and youthful offenders, upon release from OYA facilities, are discharged to the home community with no advance notice, care coordination, or community-based plans for care.

- Interface with school districts occurs primarily through pediatricians and multiple affiliates of Western Oregon Advanced Health. Waterfall Community Health Center provides school-based health centers within the Powers and Coos Bay School Districts. Bandon Community Health Center directly interfaces with the Bandon and Port Orford School Districts. Coos County Public Health, in partnership with Curry County Public Health, provides oral health screening in all public school districts in Coos and Curry Counties. ADAPT operates prevention and early intervention programs in Coos County schools, while Curry County Mental Health operates these programs in Curry County schools. Waterfall Community Health Center provides a significant volume of sliding-fee-scheduled primary health care services to medically uninsured students who are enrolled at Southwestern Oregon Community College.

- The Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw operates an Indian Health Services Clinic, and an Indian Dental Clinic, in Coos Bay. The Tribes and their clinic regularly refer tribal members, including eligible Alaska Natives and non-member Native Americans, for a wide array of health services, including medical specialty care, hospital-based care, mental health services, and oral surgery, and in all cases pre-authorize those services and provide prompt and reasonable reimbursement. Tribal members do not participate in the Oregon Health Plan.

- Programming for persons with developmental disabilities in Coos and Curry Counties is far from robust. Multiple non-profit agencies provide case management, housing, employment, and other assistances to these individuals, and frequently arrange for their health care services through affiliates of Western Oregon Advanced Health. On many occasions, case managers for the developmentally disabled will accompany their clients to medical appointments. Coos Elderly Services also provides some guardian and conservator services on behalf of adults with developmental

disabilities, and when Coos Elderly Services assumes these responsibilities, they also become the medical conservator of record.

**6. Community Health Assessment and Community Health Improvement Plan**

Western Oregon Advanced Health has completed its preliminary *Community Health Assessment Study for Coos and Curry Counties*. The *Study* was completed under independent contract, and relied upon publicly available data sets, including those generated by the U.S. Bureau of Census, the federal Health Resources and Services Administration, the federal Substance Abuse and Mental Health Services Administration, The Kaiser Foundation, The Robert Wood Johnson Foundation, Oregon's Office of Rural Health, Oregon Health & Science University, Oregon Office of Epidemiology, Oregon Office for Health Plan Policy and Research, Oregon Health Authority, Coos County Mental Health, Coos County Public Health, Curry County Mental Health, and Curry County Public Health, among others. The *Study* was intended as a beginning point for the purposes of CCO planning, and will be updated on an annual basis by the Community Advisory Councils with the assistance of relevant local public health agencies.

Western Oregon Advanced Health's *Community Health Assessment Study* was vetted in December of 2011 by two focus groups: one comprised of Medicaid beneficiaries; and the other comprised of advocates for under-served populations who are defined by age, ethnicity, race, economic status, health disparities, or other defining characteristics.

On a biennial basis, the Community Advisory Councils will sample data from the *Community Health Assessment Study*, as well as input from Members and diverse populations, including those who reside in long-term care facilities and those who are served through mental health programs, to develop the *Community Health Improvement Plan.* Early considerations for the first *Community Health Improvement Plan* are referenced within the initial *Community Health Assessment Study for Coos and Curry Counties*, which is submitted in its entirety as Exhibit G.

## Section 2 – Member Engagement and Activation

**Ways in Which Members are Meaningfully Engaged:** Western Oregon Advanced Health has embrace the patient-centered primary care medical home as a promising model that aims to strengthen the health care system by reorganizing the ay primary practices provide care (American Academy of Family Physicians, 2007; Rittenhouse, et al, 2009). Many, including Western Oregon Advanced Health, believe that the patient-centered primary care medical

home model can achieve its objectives only by fully engaging patients. However, patients, and their family members and advocates, are unlikely to be familiar with this model of care and may think that the medical home is simply a primary care gatekeeper with a different name. Western Oregon Advanced Health will support, and over time require, primary care practices to engage patients at three levels: involvement in their own care; quality improvement in the primary care practice; and, policy and research development and implementation, according to guidelines that have been advanced by the Agency for Healthcare Research and Quality (*The Patient-Centered Medical Home: Strategies to Put Patients at the Center of Primary Care*, 2011).

Primary care practices will actively engage patients and their families and caregivers in the management or improvement of their health in four ways: (1) *Communicating* with patients about how the medical home model works, the role of patients and providers, and what each can expect of the other in this new model of care; (2) Supporting patients in *self-care*, including assisting all patients to reduce risk factors while also helping patients with chronic illnesses to develop and update self-care goals; (3) Partnering with patients in formal and informal *decision-making* by presenting patients with evidence-based (formal) decision aids to understand the likely outcomes of different treatment options, and seeking to understand patient preferences, thereby collaborating in (informal) decisions that can improve a variety of health care decisions; and, (4) Improving *patient safety* by giving patients access to their medical records so they can detect and prevent errors, and by actively including patients in such areas as safe medication use, infection control initiatives, and reporting complications or errors.

Western Oregon Advanced Health's primary care practices will engage patients in ongoing quality improvement efforts in a variety of ways, including soliciting regular feedback through surveys, gathering additional information on patient perspectives through the Community Advisory Council process, and inviting individual patients and consumer advocacy organizations to contribute to quality improvement activities. According to the Agency for Healthcare Research and Quality (loc cit), *little evidence is available regarding the effects of engaging patients in practice-level quality improvement, although useful examples do exist.*

Western Oregon Advanced Health's board of directors and Clinical Advisory Panel can engage patients, families, and consumer advocacy organizations in policy and research, such that any local studies of the efficacies of the medical home model will reflect patient perspectives. Without the explicit inclusion of patients to articulate their needs, even the best-intentioned medical home policy, design, and research may miss the mark, resulting in system- and provider-centered care, rather than patient-centered care.

In working toward active patient engagement, Western Oregon Advanced Health stands prepared to:

- Adopt payment strategies (e.g., bundled payments; performance bonuses) that compensate and incentivize practices to demonstrate patient engagement in self-management and shared decision-making, or to reward practices for implementing processes that engage patients in practice-level quality improvement, recognizing that these engagement processes may require additional costs as well as changes in practice culture.
- Provide practices with technical assistance, tools, and shared resources to assess current patient-engagement practices, develop improvement plans, engage patients in discussions of what they can expect and what will be expected of them under the medical home model, assess the readiness of classifications or groups of patients for participation in diagnosis-specific self-care management support that may be provided through the coordinated care organization, provide motivational interviewing and cultural relevancy training for all providers and staff members, support shared decision-making, promulgate printed materials that are compliant with health literacy standards, and obtain and use patient feedback in the quality improvement process.
- Develop and implement compliance and monitoring protocols to attain these ends.

**How Applicant will Support a Comprehensive Communication Program:** Central to the effective engagement of patients in their own care is a comprehensive and consistent communication program that promotes patient engagement at every level. Efforts to engage patients in their own care may require a change in practice culture by taking the time, at every encounter, to simply ask patients what matters most to them. There is *no one-size-fits-all solution, and patient engagement will look very different for different practices, patient populations, and individual patient-provider interactions* [Agency for Healthcare Research and Quality, *Engaging Patients and Families in the Medical Home,* 2010]. Both providers and patients will need new skills for this partnership, and for this reason, Western Oregon Advanced Health will provide and require, within one year of attaining certification as a coordinated care organization, all providers and affiliates, who have not already done so, to complete a four-hour course in motivational interviewing. Motivational interviewing is an evidence-based best practice and solid tool for motivating patients to become engaged in their own care. Motivational interviewing will serve as the foundation for all verbal communication between providers, members of their staff, and patients, and for this reason, the requirement for formal motivational interviewing training will be incumbent upon not only providers, but all members of their office and practice staff. It is through the provider-patient relationship that engagement and motivation will occur, and it is primarily through a peak level of motivation that patients, supported by their primary care providers, will best be able to address the social determinants of health.

Western Oregon Advanced Health has among its provider panel individuals who are bi-cultural, bi-lingual, and bi-literate. Every reasonable effort will be made to assign patients with limited English proficiency to a geographically proximal provider who is bi-lingual

and/or bi-cultural. To facilitate the engagement of all patients in manners that are culturally and linguistically appropriate, Western Oregon Advanced Health will require, within one year of attaining certification as a coordinated care organization, all providers and affiliates, and their staff members and employees, to complete the Health Resources and Services Administration's five-hour, on-line, training program in health literacy and cultural competency. This specific program is designed for health care workers and professionals and covers a wide range of issues and needs, including cultural considerations that are not often evident, e.g., the culture of poverty or the culture of chronic illness.

Western Oregon Advanced Health will place two documents into publication. The first document will be a very simple brochure that explains the co-occurring concepts of patient engagement within the context of a primary-care patient-centered medical home. These brochures will be written at the eighth-grade (or lower) level, made available in both English and Spanish, and slightly modified from site-to-site to be site-specific. As patients enter the primary care medical home for the first time after January 1, 2013, they will be given a copy of the brochure by a member of the primary health care team, who will not only hand it to them, but explain the concepts to them and use the opportunity to negotiate at least one way in which each adult patient can become engaged in their own wellness or self-management. The back panel of the brochure will be designed in such a way as to list the individuals who comprise the patient's medical team (e.g., physician, mid-level practitioner, registered nurse or case management nurse, navigator, social worker, wellness specialist) for continuing reference, but the top name in each patient's list will be his or her own to underscore the fact that the patient is the most important member of the primary health care team.

The second publication, available after January 1, 2013, in both English and Spanish, will be a simple patient handbook that again emphasizes the concurrent concepts of patient engagement within a patient-centered primary-care medical home. The handbook, written at the eighth-grade level or lower, will inform patients about: how to navigate the health care system operated by the coordinated care organization; how to access advocates; what they should expect from the coordinated care organization; what the coordinated care organization will expect of them; patient rights; patient responsibilities; patient choice; grievance procedures; personal wellness planning; and how to access services including patient navigation and peer wellness assistance. These publications will be made available in reception areas and posted on the website for Western Oregon Advanced Health.

The Community Advisory Council will be comprised, in the majority, of patient-members, and will be charged with the responsibility of monitoring and measuring patient engagement and activation. Technical assistance will be provided to the Community Advisory Council by Western Oregon Advanced Health, and it is envisioned that a survey tool will be developed with consumer input for the purposes of soliciting, monitoring, and evaluating patient engagement.

## Section 3 – Transforming Models of Care

### 1. Patient-Centered Primary Care Medical Homes

Ninety-five percent (95%) of all primary care providers within Western Oregon Advanced Health's coordinated care organization are clustered in five practice arrangements: (1) North Bend Medical Clinics is comprised of primary care providers and a full panel of medical specialists, and operates practice locations in North Bend, the Coquille Valley, and Bandon (in Coos County), and Gold Beach and Brookings (in Curry County). (2) Bay Clinic is comprised of primary care providers and a panel of medical specialists, and serves the population center of Coos Bay and North Bend (Coos County). (3) Waterfall Community Health Center is a federally qualified health center with practice locations in North Bend, Coos Bay, and Powers (Coos County). Waterfall Community Health Center operates state-certified school-based health centers on the campus of Marshfield High School (Coos Bay) and the Powers School District. (4) Bandon Community Health Center is a participating Rural Health Act Clinic (Coos County), and is currently working with the Port Orford School District to provide student health services. (5) Curry Health District directly employs primary care physicians, and several medical specialists, who practice in the District's critical access clinics in Port Orford, Gold Beach, and Brookings (Curry County).

North Bend Medical Clinics either has submitted, or will soon submit, its application to OHA for registration as a Patient-Centered Primary Care Medical Home at the Tier 3 level. Waterfall Community Health Center entered into a letter of intent with the Health Resources and Services Administration to work toward national NCQA recognition as a Patient-Centered Primary Care Medical Home, and has been involved in that effort for over one year. In the intervening time, the Oregon Health Authority announced a patient-centered primary-care medical home registration process that was far less rigorous than the NCQA national model, and Waterfall Community Health Center either has submitted, or will soon submit, its application to OHA for registration at the Tier 3 level. In addition, Waterfall Community Health Center is engaged with CMS in a primary-care patient-centered medical home demonstration project for Medicare patients.

Waterfall Community Health Center has engaged the services of an executive nurse, Lonnie Scarborough, RN, to guide the organization through its National Council on Quality Assurance (NCQA) recognition process. In this capacity, Ms Scarborough has been afforded the opportunity to participate in state, multi-state, and national training activities related to the primary-care patient-centered medical home, and is currently participating in a statewide collaborative sponsored by the Oregon Primary Care Association. Western Oregon Advanced Health has made arrangements to supplement Ms Scarborough's compensation package at Waterfall Community Health Center, in order to make Ms Scarborough's technical assistance services available to Bay Clinic, Bandon Community

Health Center, and the Curry Health District as those entities work toward the attainment of primary-care patient-centered medical home registration or recognition status. Between the capacities of North Bend Medical Centers and Waterfall Community Health Center, Western Oregon Advanced Health estimates that forty percent of all patients will be enrolled in a recognized primary care patient centered medical home on 1 August 2012. Bandon Community Health Center, Bay Clinic, and the Curry Health District will attain recognition by not later than 31 July 2013, at which time, ninety-five percent (95%) of all Medicaid Members will be served in a recognized patient-centered primary-care medical home, and one hundred percent (100%) of the federally qualified health centers, rural health clinics, and school-based health centers in Coos and Curry Counties will be captured under the patient-centered primary-care medical home model. Moreover, because the two largest practices (North Bend Medical Clinics and Bay Clinic) retain the lion's share of the coordinated care organization's medical specialists, most members will receive care in a combined primary-care/medical-specialty-care patient-centered medical home.

Western Oregon Advanced Health will support its provider network, and their respective patient-centered primary-care medical homes, by: (1) Providing technical assistance in the person of Ms Scarborough; (2) Disseminating training and tools for care coordination within the context of a medical home model, through Ms Scarborough and the unique resources that are availed to her, that are currently being developed by the Oregon Primary Care Association's collaborative on medical homes, the Qualis Project (in partnership with The Commonwealth Fund), and the National Council on Quality Assurance; (3) Managing provider concerns through dedicated personnel; and, (4) Managing the coordinated care organization's relevant member databases.

The CCO Planning Committee is continuing its exploration of the preferred methodologies for providing fully coordinated care services for Members who are confined to DHS Medicaid-funded Long-Term Care facilities. The current thinking as that Western Oregon Advanced Health will directly retain the services of two nurse practitioners, one in each of Coos and Curry Counties, who will make daily rounds at each Long-Term Care facility and perform coordination functions with each Member's assigned patient-centered primary-care medical home. In an alternate scenario, a dedicated Long-Term Care registered nurse from each of the major practice groups (North Bend Medical Centers, Bay Clinic, and Curry Health District), who is directly employed by those groups, would serve as the identified liaison between Long-Term Care facilities and the patient-centered primary-care medical home.

Communication and care coordination elements, beyond those that occur within the primary care medical home, are discussed under Section 5 of this narrative.

## 2. Other Models of Patient-Centered Primary Health Care

Western Oregon Advanced Health is not proposing to use other models of patient-centered primary health care in addition to, or as a substitute for, the patient-centered primary-care medical home model. However, embedded within this model, and in direct support of the model, Western Oregon Advanced Health is proposing two innovations.

In the first innovation, Western Oregon Advanced Health will explore the feasibility of establishing a formalized patient-centered primary-/behavioral-health medical home model for those patients who are diagnosed with chronic and persistent mental illness, and who elect to be served in a medical behavioral health care home. It is envisioned that this model may be implemented in any one of multiple ways: by embedding a primary health care team at Coos County Mental Health; by embedding a primary health care team at Coos County Public Health to provide comprehensive services to Coos County Mental Health, building upon the co-location of these two entities; or through a co-location arrangement that involves Coos County Mental Health and Waterfall Community Health Center. Western Oregon Advanced Health will complete a feasibility study for the development of a patient-centered primary-/behavioral-health medical home model for patients who are persistently mentally ill by not later than 31 December 2012, and if the feasibility study proves promising and financially feasible, the model will be implemented by not later than 31 December 2013.

In the second innovation, all children and adolescents who are placed in foster care services will be assigned to a single pediatrician, Carla McKelvey, M.D., who will be assigned on a provisional basis at Waterfall Community Health Center. Waterfall Community Health Center has developed a state-of-the art, EPIC-based system of certified electronic health records, in partnership with the Oregon Community Health Information Network (OCHIN) that includes patient access through *MyChart*. [*MyChart* is limited in scope to summarized data including patient problem lists, current diagnoses, allergies, prescribed medications, and next scheduled office or diagnostic appointments, and permits registered patients to communicate with their primary care team by e-mail.] Because foster children are frequently moved from one foster family to another, or are initially placed with a foster family on a short-term basis under emergent circumstances until a permanent foster home can be identified, foster parents traditionally receive limited information about the child's medical needs and all-too-frequently, these children fall through the cracks of the health care system. By consolidating the medical care for all foster children in one location that is supported by *MyChart*, foster parents can, upon receiving a new foster child placement, immediately login to the *MyChart* system, learn of any allergies, medical conditions, and/or current prescription medications, communicate with the care team by e-mail, and be aware of the child's next scheduled medical visit. In an effort to support a permanent medical home model for all foster children within Coos County, Western Oregon Advanced Health will examine alternative payment methodologies for these specific services that may include

an adjustment to the capitation rate, a fee-for-service arrangement beyond the capitation rate, or case rate reimbursement depending on volume.

**3. Access**

**Geographic Locations:** Coos County is characterized by three population centers. The largest population center is comprised of the adjoining cities of Coos Bay and North Bend, and supports over one-half of all County residents. The secondary population center occurs in the county seat of Coquille, and at eight miles distance, the smaller community of Myrtle Point. The third, and smallest, population cluster is in the community of Bandon. Two additional areas within Coos County are considered to be remote and sparsely populated: Lakeside and Powers. Patient-centered primary-care medical homes, with adequate capacity, will be available through Western Oregon Advanced Health at locations in Coos Bay, North Bend, Coquille, Myrtle Point, Bandon, and Powers, leaving only Lakeside without immediate access to primary health care services. Lakeside is located at eleven miles to the north of North Bend along the U.S. 101 transportation corridor. The population of Lakeside is too few to support the permanent presence of a primary health care provider or team. Given the distribution of patient-centered primary-care medical homes in Coos County, it is estimated that no Member will be more than fifteen (15) miles from a medical home. Transportation assistance will be provided on an *as needed* basis.

Curry County is characterized by three population centers: Port Orford in North County; Gold Beach in Central County; and Brookings-Harbor in South County. The community of Agness is considered to be remote and sparsely populated, with a population base of < 400. Patient-centered primary-care medical homes, with adequate capacity, will be available in all three population centers: Port Orford; Gold Beach; and Brookings-Harbor. Persons living in Agness may be as many as thirty miles from the nearest source of primary health care services, and Members living in this community will be provided with transportation assistance on an *as needed* basis.

**Non-Traditional Hours:** All patient-centered primary-care medical homes will offer non-traditional practice hours, including evening and/or week-end appointing, as required by Tier 3 registration.

**Non-Traditional Settings:** Western Oregon Advanced Care will retain the services of generalist and indigenous community health outreach workers who are demographically similar to the Member population to whom they are assigned. County Mental Health Agencies will retain the services of specialist, yet indigenous, community health outreach workers who are demographically and diagnostically similar to the Member population to whom they are assigned. All community health outreach workers will work through community-based and non-traditional settings to effect outreach, education, engagement,

and re-engagement of Members who live in diverse communities or who are too-often medically under-served.

Community health outreach workers receive engagement, motivational interviewing, cultural competency, health literacy, and eligibility assistance training prior to deployment in indigenous settings frequented by members of the target population, e.g., coin-operated laundry facilities; community-based food banks; and un-registered migrant farm labor camps. Community health outreach workers are selected on the basis of their community-specific indigenous status, demographic similarity with members of the target population, and inherent *natural helper* characteristics. Community health outreach workers are present to: inform members of the target community about Medicaid programs; support care coordination; assist with Medicaid enrollment; provide informal education regarding patient engagement and the concept of a patient-centered primary-care medical home; arrange transportation assistance; re-engage targeted Members who may be avoiding care or having difficulty with self-care management plans; remove barriers to self-care; directly provide or refer Members and persons eligible to become Members to systems navigators and advocates; and, specifically work to identify pregnant women who become eligible for Medicaid services under *expanded criteria* such that these women enter pre-natal care during the first trimester of pregnancy.

**Contract Start Date Barriers:** Western Oregon Advanced Health does not anticipate any barriers with regard to having sufficient access to coordinated care services for all covered populations by the Contract Start Date.

**Member Engagement in Transitioning to Coordinated Care Organization Model of Care:** Community health outreach workers will play an essential role in providing informal, one-on-one and small group, education to Members and persons eligible for membership, regarding the essential concepts of patient engagement in the patient-centered primary care medical home, features of the new coordinated care organization model and why this model is important to the Member, what to expect from the coordinated care organization, and what the coordinated care organization will expect from its Members. As Members make actual contact with their patient-centered primary-care medical homes, the medical home becomes responsible for sustaining patient engagement and continuing to provide sufficient coaching to enable Members to derive the maximum value from the coordinated care organization and the medical home model.

## 4. Provider Network Development and Contracts

**Building on Existing Provider Networks:** Western Oregon Advanced Health is a new corporation developed for the specific purpose of establishing a compliant coordinated care organization. Western Oregon Advanced Health, in turn, will contract with Southwestern Oregon Independent Practice Association, which currently operates as a Managed Care Organization for the State's physical health Medicaid program, for the provision of management services to the coordinated care organization. Under this arrangement, Western Oregon Advanced Health will inherit or acquire Southwestern Oregon Independent Practice Association's provider panel, with includes virtually all physicians practicing in Coos and Curry Counties, along with contractual agreements with three Critical Access Hospitals (Curry General; Southern Coos; Coquille Valley) and one DRG hospital (Bay Area).

The primary care providers are largely clustered among five organizations: North Bend Medical Centers; Bay Clinic; Curry Health Network; Waterfall Community Health Center; and Bandon Community Health Center. Of these, North Bend Medical Centers and Waterfall Community Health Center are already steeped in the concept of coordinated and team-based care, as is evident from their Tier 3 registration as Oregon patient-centered primary-care medical homes. Bandon Community Health Center also practices as a patient-centered primary care medical home as a function of its current *Federally Qualified Health Center Planning Project*, funded by HRSA's Bureau of Primary Health Care, which strongly encourages its grantees to adopt coordinated and team-based care approaches. As Bay Clinic and Curry Health Network move toward the attainment of Oregon registration as patient-centered primary-care medical homes, they will simultaneously establish internal procedures that directly support coordinated and team-based care. At the outset of Member enrollment, at least one-half of all Members will be served by coordinated and team-based care, and by 31 December 2013, virtually all members will be served in recognized care coordination and team-based models.

Southwestern Oregon Independent Practice Association directly retains the services of a special needs case management nurse who is responsible for arranging all out-of-plan care for those medical services that are not available in Coos and Curry Counties. At present, Coos County does not enjoy the services of a cardiologist, and cardiology represents the single greatest need for out-of-plan care. Bay Area Hospital is currently constructing a cardiac care facility with a cardiac catheterization laboratory, and upon completion will recruit a cardiology practice to Coos County.

**Mental Health and Chemical Dependency Service Alternates:** Western Oregon Advanced Health will enter into contractual agreements with Coos County Public Health for the provision of a comprehensive array of mental health services in Coos County, including alternatives to unnecessary inpatient utilization for children and adults, including addictive disorders. It is anticipated that Coos County Public Health, in turn, will contract with

Jefferson Behavioral Health, a regional Behavioral Health Organization, for certain management services, including contractual relationships with a variety of alternative providers, such as crisis-respite or short-stay facilities. For example, Coos County Mental Health contracts with Bay Area First Step that operates a sober transitional housing unit. Similarly, Coos County Mental Health, in collaboration with its contracted community partners, operates Pony Creek, a children's respite and sub-acute care hospital diversion and step-down facility, and the Crisis Resolution Center, which is a six-bed, short-stay, adult respite and sub-acute care hospital diversion and step-down program.

At the time of this writing, Western Oregon Advanced Health is uncertain as to the entity that will provide public mental health services in Curry County. The current program is under contracted temporary management and facing fiscal insolvency, and the Board of County Commissioners is looking for an alternate provider. Potential alternate providers include Josephine County Public Health, Curry Health District, ADAPT, and Jefferson Behavioral Health. Western Oregon Advanced Health is in dialogue with all parties. Regardless of what entity actually assumes responsibility for public mental health services in Curry County, including the potential that Western Oregon Advanced Health may do so directly as a default position, it is likely that the entity will contract with Jefferson Behavioral Health for the full range of children's and adult's hospital diversion and step-down programs. Patients who require psychiatric hospitalization from Curry County are transported to Bay Area Hospital in Coos County, which permits a second chance for the coordinated care organization to divert patients to the Pony Creek and Crisis Resolution Centers, mentioned above, thereby extending these resources beyond that of a single county.

Since the time of the Crisis Resolution Center's inception in 2004, total admissions to acute care beds at Bay Area Hospital have decreased by 74 percent, from 1,168 bed days in 2003, to 341 bed days in 2011. In a further effort to divert unnecessary and/or inappropriate admissions to acute care beds, both county public health agencies offer walk-in services during normal business hours for patients who are in crisis, as well as 24/7 after-hours coverage.

Pursuant to contracts negotiated with Coos County Mental Health, the successor organization to Curry County Mental Health, and/or Jefferson Behavioral Health, Western Oregon Advanced Health will sustain a behavioral health provider network that is already in place to support Members in the most appropriate and independent setting, including their own homes, or independent or supported living. Case workers are assigned to all patients with persistent, chronic, or acute mental illness to assist them in independent living skills and/or arrangements and to provide care coordination and navigation services for these individuals. In support of these activities, the county mental health agencies operate, under contract with residential providers: a 21-unit apartment complex for independent living; a

10-unit transitional housing apartment complex; a five-unit apartment complex for semi-independent living; a four-bed homeless shelter; a five-bed Psychiatric Security Review Board home; four adult foster homes with a capacity for 20 persons; and in-home personal care services.

## 5. Coordination, Transition, and Care Management

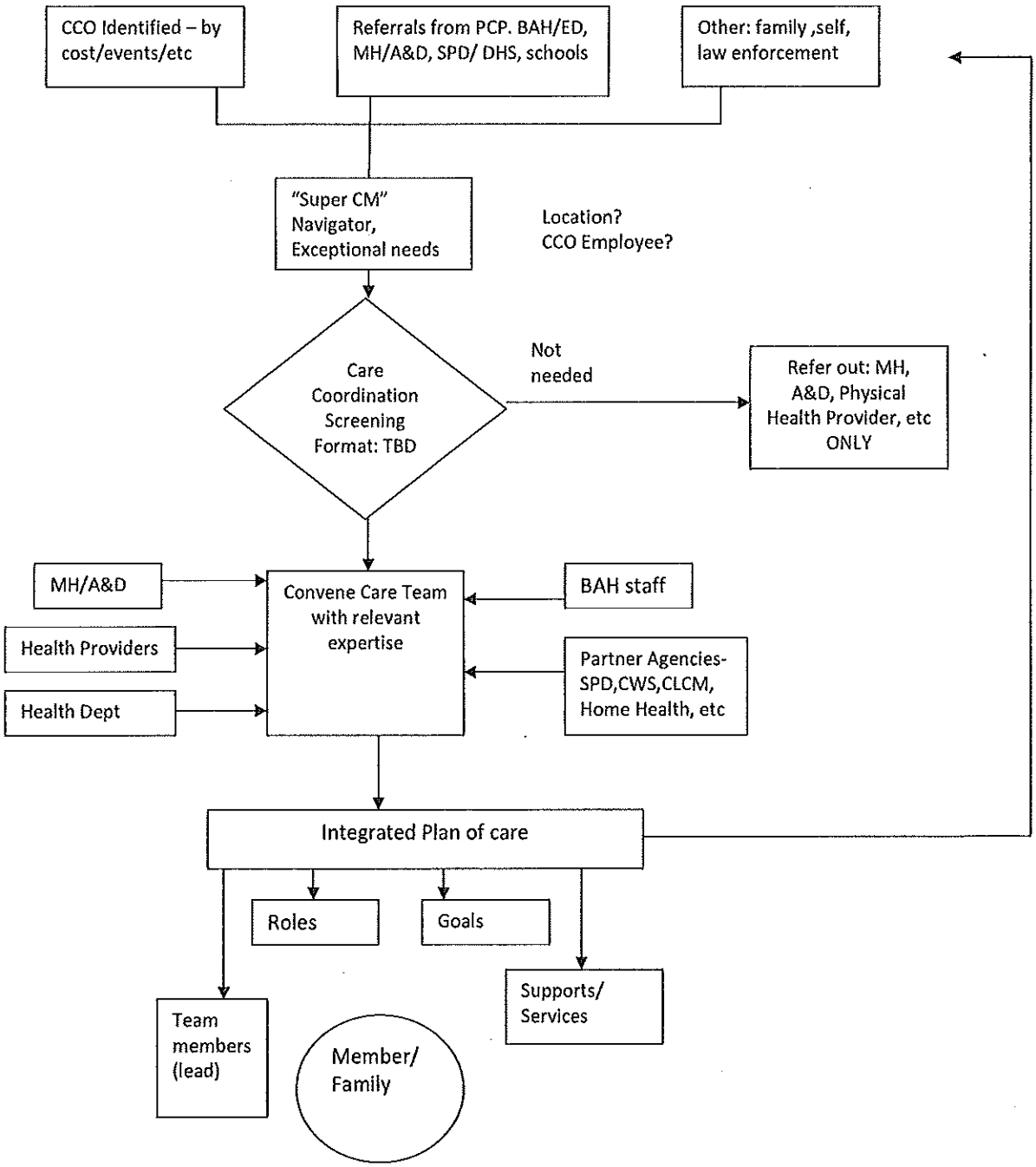
### Care Coordination:

**Flow of Information:** Over time, Western Oregon Advanced Health will achieve the full, effective, and efficient flow of information for all Members, regardless of diagnostic category or care setting, through the development of a robust Health Information Exchange. At the outset of coordinated care organizational implementation, the development of a Health Information Exchange is beyond the fiscal capabilities of Western Oregon Advanced Health. Accordingly, until such time as the Health Information Exchange can be established, all providers, including general medical, Long-Term Care facilities, mental health, home health, and community-based services, will be reliant upon Western Oregon Advanced Health's *Model for Care Coordination*, as is illustrated in Figure 1 on page 53, following. The *Model* incorporates a team-based approach with unique and specialized teams being assembled, according to discipline, for each Member who is in need of such services.

**Necessary Partnerships:** Since early February, 2012, a local Care Coordination Work Group has been meeting on a bi-monthly basis. The Work Group is comprised of all DHS and community-based human service agencies, the local DHS manager for Long-Term Care for both Coos and Curry Counties, public mental health agencies, public health agencies, representative physicians, hospital discharge planners and medical social workers, the local federally qualified health center and other *safety net* clinics, representatives from Advantage Dental, and Southwest Oregon Independent Practice Association's special needs and out-of-plan case management nurse(s). To date, the Work Group has developed a *Point of Contact* list for all medical, social, and human service organizations and agencies, and the *Point of Contact* person for each organization or agency has agreed to be responsible for coordinating the delivery of services within that agency, and to provide a *warm hand-off* to the person within their agency who will provide direct services to the Member. The *Point of Contact* person for each agency will be the initial care team for referred Members. This team, in turn, will develop working relationships and information-sharing, and will be responsible for the coordination of care within their respective agencies. The findings of screening instruments and resultant coordinated (integrated) care plans will be provided to case managers at the patient-centered primary care medical home for those Members for whom the preponderance of interventions are community-based.

**Figure 1**
**Model for Care Coordination**

Target Population(s): High Medical/Mental Health Needs; Complex Care; High-Cost Members; Members Residing in Long-Term Care or Publicly Supported Housing Arrangements



**Communication Tool:** Western Oregon Advanced Health will place two documents into publication. The first document will be a very simple brochure that explains the co-occurring concepts of patient engagement within the context of a primary-care patient-centered medical home. These brochures will be written at the eighth-grade (or lower) level, made available in both English and Spanish, and slightly modified from site-to-site to be site-specific. As patients enter the primary care medical home for the first time after January 1, 2013, they will be given a copy of the brochure by a member of the primary health care team, who will not only hand it to them, but explain the concepts to them and use the opportunity to negotiate at least one way in which each adult patient can become engaged in their own wellness or self-management. The back panel of the brochure will be designed in such a way as to list the individuals who comprise the patient's medical team (e.g., physician, mid-level practitioner, registered nurse or case management nurse, navigator, social worker, wellness specialist) for continuing reference, but the top name in each patient's list will be his or her own to underscore the fact that the patient is the most important member of the primary health care team.

The second publication, available after January 1, 2013, in both English and Spanish, will be a simple patient handbook that again emphasizes the concurrent concepts of patient engagement within a patient-centered primary-care medical home. The handbook, written at the eighth-grade level or lower, will inform patients about: how to navigate the health care system operated by the coordinated care organization; how to access advocates; what they should expect from the coordinated care organization; what the coordinated care organization will expect of them; patient rights; patient responsibilities; patient choice; grievance procedures; personal wellness planning; and how to access services including patient navigation and peer wellness assistance. These publications will be made available in reception areas and posted on the website for Western Oregon Advanced Health.

**Uniform Methods of Identifying Members for Formal Care Coordination:** A universal screening tool has been developed by the local Coordinated Care Work Group, and will be used in all health, mental health, dental, developmental disability, and social service settings within Western Oregon Advanced Health's service delivery area. The universal screening tool is specifically purposed at Members who have multiple morbidities, are diagnosed with acute or persistent mental illness or developmental disabilities, are medically complex or difficult to manage, reside in publicly supported facilities or Long-Term Care arrangements, or who represent high levels of utilization and/or cost. The results arising from the application of the screening tool will be disseminated to those entities, on a *need to know basis*, who will be directly involved in the Member's coordinated care, and to the designated case manager at the Member's patient-centered primary-care medical home. This case manager, located at the patient-centered primary-care medical home, is the individual who is ultimately responsible for assuring that

a care team (comprised of representatives from each entity or agency that will be involved in the Member's direct service delivery) develops a plan of care on behalf of, and in concert with, each Member and, if wanted or warranted, his or her family or representative. The case manager at the Member's patient-centered primary-care medical home is charged with the responsibility for monitoring the plan of care, determining when formalized care coordination is no longer required, assembling the care team to modify or revise the plan of care, and leveraging the social resources of outreach workers, peer wellness specialists, and navigators when these services are indicated. The Coordinated Care Work Group is in the process of developing the format for a universal care plan that will be characterized by a *wrap-around* approach. Similarly, the Work Group is in the process of developing position descriptions for case managers who are employed by patient-centered primary-care medical homes. Consistency of position descriptions across the two-county region will be essential to assuring that each case manager's duties and responsibilities are consistent and complementary.

**State Goals and Expectations for Members with Severe and Persistent Mental Illness:** At the outset of coordinated care organizational implementation, certain Medicaid-funded services, including those for Members who reside in Long-Term Care facilities, or who are diagnosed with severe and persistent mental illness and receiving in-patient care at the State hospital, will continue to be the responsibility of the State. Over time, however, these responsibilities may be devolved from the State to local coordinated care organizations, and Western Oregon Advanced Health is aware of this potential trend, as it is aware of the need to support public mental health services at critical and essential levels that have previously received Medicaid reimbursement directly from the State. Western Oregon Advanced Health is fully cognizant that these Medicaid beneficiaries remain Members of Western Oregon Advanced Health, regardless of their inpatient status at the State hospital or Long-Term Care facilities, and thus Western Oregon Advanced Care is highly committed to the seamless and coordinated delivery of physical, mental, behavioral, and oral health care services for these Members. When residing in the community or in Long-Term Care facilities, the model for care coordination for these Members will be precisely as described above, using universal screening tools, plan of care templates, care coordination teams, wraparound services, and an assigned case manager at the Member's patient-centered primary care medical home.

In this regard, the public mental health agencies (or, in the case of Curry County, the successor agency), in partnership with Western Oregon Advanced Care, will continue to participate in the *Enhanced Care Services* program to provide integrated mental, physical, and oral health care services to persons who are either living in, or transitioning from, the state hospital, Long-Term Care facilities, foster homes, and semi-independent living arrangements. Similarly, the public health agencies, in partnership with Western Oregon Advanced Care, will continue to participate in the *Dual Response Team Program for Seniors and Persons with Disabilities*, which is a locally developed program that provides an

integrated and team-based approach to responding to the needs of seniors and persons with disabilities to: access necessary medical treatment; reduce emergency medical service needs; access mental health treatment and medication; and, successfully maintain independent or semi-independent living. Western Oregon Advanced Health, within the context of the global budget, will fully allocate funds to the *Enhanced Care Services* and *Dual Response Team* programs.

**Evidence-Based Practices:** The *wrap-around* model for care coordination is considered an evidence-based practice, and was used to guide and inform Western Oregon Advanced Health's care coordination service elements for all age and diagnostic groups. Non-traditional health workers who will be deployed throughout the system of care coordination will include peer counselors, peer wellness specialists, and personal health navigators.

**Assignment of Responsibility and Accountability:** Every Member of Western Oregon Advanced Health will be assigned to a primary care provider at the time of enrollment, and it is this primary care provider, working through his or her care teams and case managers, who is ultimately responsible for care coordination throughout the life cycle and all related transitions. Because most Members will have been previously enrolled with Southwestern Oregon Independent Practice Association's Managed Care Organization, and because Southwestern Oregon Independent Practice Association will serve as the managing entity and its provider panel will become Western Oregon Advanced Health's provider panel, current Members will be immediately engaged at the appropriate level of care at the time of enrollment. Even those Medicaid beneficiaries who are currently on *open medical cards* are apt to have established care with one of Western Oregon Advanced Health's patient-centered primary-care medical homes, as all such medical homes, with the exception of one group practice in Brookings-Harbor (Curry County) have been captured among the coordinated care organization's provider panel. However, during the first thirty (30) days following the initial enrollment of Members who are transitioning from *open medical cards*, Western Oregon Advanced Health will conduct a cross-check to identify any new Members who have not established a medical home among panel members, and will effect outreach to these new Members to assure that the appropriate level of care is currently in place.

The uniform screening tool, as previously discussed, will be used across all settings to assess individual care needs and to determine if needed levels of care are being appropriately provided. The uniform screening process will be made culturally and linguistically appropriate through the inclusion of bilingual, bicultural, and bi-literate panel members and health care workers, and by requiring cultural competency training for all providers and members of their office staffs. Among anticipated Members, the needs assessment study will confirm that there are more persons who are diagnosed with mental illness than there are persons of ethnic minority extraction. Accordingly, the most

predominant non-majority culture will be that of the *culture of mental illness* which is often superimposed on a *culture of poverty* as the two characteristics are so inexplicably interlinked. It is for this reason that Western Oregon Advanced Health is proposing to conduct a study, for completion prior to 31 December 2012, to determine the feasibility of developing a patient-centered primary-/behavioral-care medical home model for those patients who are diagnosed with mental illness and who may prefer this model or be better served through this model.

**Comprehensive Transitional Care:** Priority populations for comprehensive transitional care planning and coordination include: persons exiting all hospital settings, including skilled care facilities and the State hospital; hospice patients; medically complex persons with co-morbidities; persons diagnosed with severe and persistent mental illness; persons diagnosed with developmental disabilities; persons entering or exiting Long-Term Care facilities; adults and children residing in foster care; persons transitioning from residential treatment programs for mental health and chemical dependency treatment; and any other vulnerable or elderly patient for whom special assistance may be appropriate, or whose family has requested special assistance.

For those patients who are exiting a standard hospital setting and who have no other special or priority needs, the assigned primary care provider and his or her team is responsible for transitional care planning and implementation, regardless of the patient's age. For hospice patients, South Coast Hospice in Coos County, and Curry County Home Health and Hospice in Curry County are ultimately responsible for transition planning and implementation, in direct consultation with the Member's primary care provider. For all other high-priority and special needs populations (enumerated above), the care coordination team, as illustrated in Figure 1, is responsible for discharge and transitional planning and implementation, under the direct supervision of the case manager who is employed by the patient-centered primary-care medical home (for medical patients), or the public mental health agency (for mental health patients), regardless of the patient's age.

All transitional planning and implementation services are fully and equally available to Members receiving DHS Medicaid-funded Long-Term Care services and supports, and communication patterns with DHS's local office pertinent to these individuals is through the comprehensive care coordination team, illustrated in Figure 1, in which DHS's local manager plays an active role.

Coos Crisis Resolution Center may be used as a short-stay transitional housing arrangement for any adult Member, while Pony Creek may serve a similar purpose for any child or adolescent. Other transitional options include: Bay-1 and Bay-2 Apartments (fifteen units), a transitional housing option for adult mental health patients, with 24/7 case management services; Cedar Bay (five units) that provides transitional housing and services for persons

being returned to the community by the Psychiatric Security Review Board; and Bay Area First Steps for persons transitioning from residential treatment for chemical dependency and addiction. The public mental health agencies provide the *Personal Care Assistant* program that provides in-home supports, up to twenty hours per month, for qualifying individuals.

On a monthly basis, DHS will provide Western Oregon Advanced Health with a roster of all Members who are currently placed in foster care, Long-Term Care facilities, or the State hospital, for the specific purposes of tracking, notification, communication, care coordination, and transitional planning, if relevant. As soon as it is known that a Member is at risk of entering, or will be entering, any type of residential, foster, or other facility, a case manager is assigned to assure the appropriate level of care, engage family members, and attend care plan meetings. For these patients, DHS convenes care plan meetings, and appropriate medical and mental health personnel from Western Oregon Advanced Health will attend and participate.

**Individual Care Plans:** The same Care Coordination Work Group that developed the universal screening tool (that factors for needs, referral relevancy, and risk assessment) for local adoption is working to develop an electronic universal *individual care plan template* as required by ORS414.625. This document will be available by the time of the readiness review on 3 July 2012. Western Oregon Advanced Care will use the individual care plans to address the therapeutic and supportive needs of all priority populations: persons admitted to, or being discharged from, the State hospital; persons placed in Long-Term Care facilities or foster care; hospice patients; medically complex persons with co-morbidities; persons diagnosed with severe and persistent mental illness; persons diagnosed with developmental disabilities; persons being treated in residential or in-patient facilities for addictive disorders; persons who represent high utilization or cost rates; and any other vulnerable or elderly patient for whom special assistance may be appropriate, or whose family or advocate has requested special assistance. As soon as a Member encounters circumstances itemized in the prior sentence, these circumstances trigger the universal screening, intensive care coordination management (both as previously and redundantly described), and individualized care planning. The Coos and Curry County offices of DHS may also immediately trigger the universal screening, intensive care coordination, and individual care planning process for any Member by simply contacting Western Oregon Advanced Health's on-call case management nurse.

Individual care plans are developed by the appropriately representative care coordination team for each Member who has been assigned to a team, and Members and/or their family members or advocates are strongly encouraged to participate and become engaged with the care coordination team and the individualized care plan. Each specialty area identified on the screening tool (e.g., mental health, physical health, oral health, DHS) contributes to the comprehensive assessment and individualized care plan. The

individualized care plan is monitored by the case manager at the patient-centered primary-care medical home, who co-signs the individualized care plan as proof that this individual has accepted ultimate responsibility for the plan. This case manager is responsible for assuring that individualized care plans are reviewed and updated at six-month or briefer intervals, or whenever significant changes occur. Each patient's care team remains active until the care plan's goals are met, the Member withdraws from participation, or the services being provided are no longer returning any benefit.

**6. Care Integration**

**Mental Health and Chemical Dependency Services and Supports:** The well-known and widely adopted *Four-Quadrant Model* is a conceptual system-wide framework for health, mental health, and behavioral health services developed by Barbara Mauer under the auspices of the National Council for Community Behavioral Healthcare. It serves as a guideline for assigning treatment responsibility between specialty mental and behavioral health agencies and primary care providers. The model divides the general treatment population into four groupings based on mental, behavioral, and physical health risks and status, and then suggests system elements to address the needs of each particular subpopulation.

Meant as a population-based planning tool, the Model recognizes that both mental and physical health needs may change over time and thus the constellation of services must be flexible enough to meet individual need at any given point in time. It also acknowledges and incorporates consumer autonomy: the patient-centered medical home should be based on consumer choice and the specifics of how the community intends to achieve collaboration and coordinated care. The primary care and specialty behavioral health systems should develop protocols, however, that spell out how acute behavioral health episodes or high-risk consumers will be handled. These tenets were addressed in the previous section of this Application related to care coordination, universal screening, case management, and care planning.

The individual quadrants in this conceptual design are as follows (as excerpted from *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities by Barbara Mauer, 2005):*

> **Quadrant I: Low Behavioral and Physical Complexity/Risk** – A population most likely to exhibit depression and anxiety, though it may include some with more severe mental disorders. If selected by the Member, this population can be served in primary care with behavioral health staff on site.

**Quadrant II: High Behavioral Health, Low Physical Health Complexity/Risk** – Most individuals with severe mental illness, children and youth with serious emotional disturbance or those with co-occurring disorders. This population would likely be served in a specialty behavioral health system that coordinates with the primary care provider, or in a more advanced integrated system that provide primary care services within the behavioral health setting. [A feasibility study to determine if this model of care can be realized for Coos and Curry Counties will be completed by 31 December 2012.]

**Quadrant III: Low Behavioral, High Physical Health Complexity or Risk** – Large percentage of patients with chronic medical illnesses (e.g., diabetes, cardiovascular conditions) that are at-risk of or have evidence of behavioral disorders (e.g., mild to moderate depression, anxiety), some of which may be related to their primary medical conditions. This population can be served in the patient-centered primary care medical home, with supporting medical specialists, and with behavioral staff on-site, coordinating with all medical care providers including disease care managers. Access to behavioral specialists with expertise in treating persons with co-morbid chronic medical illnesses is advisable.

**Quadrant IV: High Behavioral, High Physical Health Complexity or Risk** – Those with severe mental illness or emotional disturbance co-occurring with one or more complex medical condition, such as diabetes or cardiovascular problems. This population can be served in both the patient-centered primary-care medical home, supported by medical specialists, or in a more advanced primary care service within the behavioral health setting. In addition to the behavioral case manager, there may be a disease manager working in coordination.

The *Four-Quadrant Model* represents the evidence-based best practice standard that provides the philosophical underpinnings for Western Oregon Advanced Health's system of care integration, and is illustrated in Figure 2, on the following page.

**Figure 2**

***THE FOUR QUADRANT MODEL***

| | |
|---|---|
| **Quadrant II**<br>**High Behavioral and Low Physical Health Needs**<br><br>+ Behavioral health clinicians and/or case managers with responsibility for coordination with PCPs<br>+ Primary care provider and team with standard screening tools and guidelines<br>+ Out-stationed medical nurse practitioner or physician at behavioral health site, or other models for true care integration<br>+ Specialty behavioral health<br>+ Residential behavioral health<br>+ Crisis capacity<br>+ Inpatient behavioral health capacity<br>+ Other community supports | **Quadrant IV**<br>**High Behavioral and Physical Health Needs**<br><br>+ PCP with standard screening tools and guidelines<br>+ Out-stationed medical nurse practitioner or physician at behavioral health site, or other models of true care integration<br>+ Nurse case manager at behavioral health site, or other models of true care integration<br>+ Behavioral health clinician / case manager<br>+ External care manager<br>+ Specialty medical/surgical<br>+ Residential behavioral health capacity<br>+ Crisis capacity<br>+ Behavioral health and medical/surgical inpatient capacity<br>+ Other community supports |
| **Quadrant I**<br>**Low Behavioral and Physical Health Needs**<br><br>+ PCP with standard screening tools and behavioral health practice guidelines<br>+ PCP-based behavioral health consultant or care manager<br>+ Access to psychiatric consultation | **Quadrant III**<br>**Low Behavioral and High Physical Health Needs**<br><br>+ PCP with standard screening tools and behavioral practice guidelines<br>+ PCP-based behavioral health consultant or care manager<br>+ Specialty medical/surgical<br>+ Psychiatric consultation<br>+ Emergency department access<br>+ Medical/surgical inpatient<br>+ Nursing home / home-based care<br>+ Other community supports |

Western Oregon Advanced Care will utilize its series of patient-centered primary-care medical homes as the most important tool in the attainment of integrated primary, mental, and behavioral health care services and supports. While all service delivery begins within the context of the medical home, any high-utilization, high-cost, or high-risk event or characteristic may trigger care coordination, which includes universal screening, intensive care coordination management, and individualized care planning. The universal screening tool is designed to screen for all aspects of health care, including physical, mental, emotional, behavioral, and dental. In all respects, the provision of these features of care integration is precisely as described for care coordination earlier.

**Oral Health:** Western Oregon Advanced Health will enter into a contractual agreement with Advantage Dental, the dental care organization that is currently serving Medicaid enrollees in Coos and Curry Counties, with an effective date of 1 July 2012. The contractual agreement for dental and oral health services will be in full compliance with ORS 414.625, and will be available at the time of the readiness review on 3 July 2012.

At the outset of the coordinated care organization implementation period, Advantage Dental will provide a series of brief orientation and training sessions that will be made compulsory for all primary care providers, addiction treatment providers, and mental health providers who are affiliated with Western Oregon Advanced Health. For primary care providers, the training will include how to conduct simple dental and oral health screening examinations. For all provider types, the training session teach providers how to deliver brief and effective oral health prevention messages for all age levels and ethnicities, how to make referrals to Advantage Dental, and how Advantage Dental will work through care coordination and integration efforts as equal members of the coordinated care organization.

A robust program of oral health screening is currently available in all public school systems in Coos and Curry Counties, under the leadership of the Coos County Public Health Department, Curry County Public Health Department, Waterfall Community Health Center, and Bandon Community Health Center. To date and as noted by the community health needs assessment study, these efforts have not been coordinated with Advantage Dental, but clear and written plans for coordinated school-based oral health screening, and dental sealant or varnish programs, along with sustainable methods for financial support, will be negotiated among Advantage Dental, Coos County Public Health, Curry County Public Health, Waterfall Community Health Center, and Bandon Community Health Center by not later than 31 December 2012.

**Hospital and Specialty Services:** Western Oregon Advanced Health will contract with three critical access hospitals (Curry General, Coquille Valley, and Southern Coos) and one DRG hospital (Bay Area) for the provision of all required hospital services. These contractual agreements will delineate the methodologies by which patient-centered primary-care medical homes and hospitals will inter-coordinate with one another from the time of pre-admission to discharge. All Members who are in transition from the primary to the tertiary level of care, and who are in need of such services, will receive comprehensive transitional care, as previously set forth (on page 57).

Similarly, Western Oregon Advanced Health will contract with North Bend Medical Centers, Bay Clinic, and South Coast Orthopedics for the provision of medical specialty services. These contractual agreements will delineate the methodologies by which patient-centered primary-care medical homes and physicians who practice in medical specialty areas will

inter-coordinate with one another from the time of referral through discharge. All Members who are in transition from the primary to the secondary level of care, and who are in need of such services, will receive temporary transitional care through the coordinated care organization's patient health navigators.

The communities' largest practices (North Bend Medical Centers, Waterfall Community Health Center, South Coast Orthopedics, and to a lesser extent, Bay Clinic and Curry Health District) each have access to systems of electronic health records. Bay Area Hospital, and to a lesser extent the three critical access hospitals, also have access to electronic health record systems. The challenge will be to develop interoperability between and among the various systems of electronic health records to improve communication and information sharing among the entities. While there is no doubt that a robust Health Information Exchange would yield these benefits, the initial costs are too great, and it is likely that smaller interim steps will need to be taken through health information cross-walks that create greater interoperability.

**7. DHS-Funded Long-Term Care Services**

At the outset of coordinated care organizational implementation, certain Medicaid-funded services, including those for Members who reside in Long-Term Care facilities, or who are diagnosed with severe and persistent mental illness and receiving in-patient care at the State hospital, among others, will continue to be the responsibility of the State. Over time, however, these responsibilities may be devolved from the State to local coordinated care organizations, and Western Oregon Advanced Health is aware of this potential trend, as it is aware of the need to closely coordinate care with DHS in an effort to attain the Triple Aim for these Members of improved health outcomes, improved health care delivery systems, and reduced costs – in these particular circumstances – reduced costs for the State. Western Oregon Advanced Health is fully cognizant that these Medicaid beneficiaries, for whom a portion of costs are being paid by the State, remain Members of Western Oregon Advanced Health, regardless of their inpatient status at the State hospital, Long-Term Care facilities, or other settings, and thus Western Oregon Advanced Care is highly committed to the seamless and coordinated delivery of efficient and cost-effective physical, mental, behavioral, and oral health care services for these Members.

Throughout this Application document, and particularly from pages 52 to 59, the Applicant has repeatedly and redundantly communicated its understanding of the State's angst about the Members for whom it still holds financial risk and its plans to be fully present and involved in the care, coordination, integration, and management of such patients. Among the specific models to be used are the Care Coordination Model (defined by Figure 1), the Four Quadrant Model (defined by Figure 2), team-based care and care coordination approaches; and the use of nurse practitioners to make regular rounds in all congregate

living and Long-Term Care facilities, as well as to home-based patients identified to the coordinated care organization by DHS.

**8. Utilization Management**

Western Oregon Advanced Health makes utilization management decisions according to each Member's unique needs and issues of health equity. Western Oregon Advanced Health has established a program that creates collaboration among Programs for Seniors and Persons with Disabilities and primary care providers for Members who reside in adult foster care arrangements or Long-Term Care facilities, and will expand this model of reflective collaboration across other continuums of care for Members with: special health care needs; developmental and intellectual disabilities; and acute, persistent, or chronic mental illness.

Western Oregon Advanced Health will maintain a no-authorization-required list for ambulatory services to reduce both access barriers and costly paperwork burdens. Western Oregon Advanced Health does require notification for acute admissions in order to permit the Coordinated Care Organization to work with Members, Members' families, and providers for the purposes of utilization management, assuring a safe transition, and avoiding costly readmissions. Western Oregon Advanced Health monitors and analyzes utilization data on a continuous basis in an effort to identify potential or actual incidences of under/over utilization. Thresholds are determined for each of the selected areas. If trends or patterns are recognized, necessary steps are taken to investigate and address these variances. Mental Health is included in the monitoring process, and data is selected from HEDIS measures that are specifically relevant to the population. Thresholds are established using external nationally recognized sources wherever possible (e.g., Quality Compass). Utilization report analysis is incorporated into the annual evaluation for reporting purposes, inclusive of over/under utilization trends.

## Section 4 – Health Equity and Eliminating Health Disparities

**Health Equity:** The Centers for Disease Control states that *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 inequities are reflected in differences in: length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment. The overarching goal of the CDC is to achieve health equity by eliminating health disparities. The social determinants of health include poverty, unemployment, low educational attainment, rural geographies, and cultural or ethnic barriers.

**Chronic Disease and Poverty:** Chronic disease and poverty are interconnected in a vicious cycle. Chronic diseases result in lost time at work and thus create and contribute to poverty, drawing individuals and families into a downward spiral of worsening disease and poverty. Persons living in poverty are more vulnerable to chronic disease, including greater exposure to inherited and other risk factors and decreased access to health services. In short, the chronic disease burden is concentrated among the poor. In Coos and Curry Counties, the burden of chronic disease is now visiting the third and fourth generation of those who have lived in chronic poverty. Of those who are diagnosed with chronic disease states, the overwhelming majority are also characterized by mental and emotional illnesses, and these very illnesses can create barriers to care and resultant inequities.

**Cultural and Linguistic Barriers:** Although small in number, fully one-third of the community's Hispanic persons are not native English speakers, and thus will have limited English proficiency. For these individuals, complex health care systems will be difficult to navigate, thereby resulting in barriers to care and resultant inequities. For a greater number of Coos and Curry County residents, multigenerational poverty has produced a *culture of poverty* that is more inextricably linked with health inequities than those experienced by minority cultures. Over time, if not already present, health care professionals may also observe the emergence of a culture of obesity with its resultant isolation and health inequities, as well as a discrete culture of mental illness. Early research is confirming that those who are obese or mentally ill experience less degrees of acceptance within the health care system, resulting in access barriers.

**Low Educational Attainment and Literacy Skills:** One out of every four adults aged 30 to 50 in Coos and Curry Counties has failed to attain a formal high school education. These individuals may experience difficulty in reading printed patient or consumer information, following printed health care instructions, or understanding the detail sheets that accompany prescription medications. While many who are capable of solid reading and

comprehension skills will often find health literacy to be challenging, the task will be much more difficult and off-putting for those with low educational attainment.

**Geographic Barriers:** For low-income persons who live in Agness (Curry County), the nearest source of primary health care services will be at least 45 miles in a single direction. With no developed public transportation system, these individuals will be reliant on privately-owned vehicles or the good will of friends and neighbors to transport them to health services. Of interest, 12 percent of all households in Coos and Curry Counties do not own a motor vehicle.

**Health Equity:** Medicaid is, and has always been, a form of health insurance, the purpose of which is to provide *medically necessary* care. The root causes of health inequity are often, but not always, bound in complex socioeconomic conditions, the resolution of which do not fall cleanly within the parameters of *medically necessary* care or the delimitations of the federal and state Medicaid program. While it is incumbent on health care providers and planners to be cognizant of the confounding socioeconomic landscape that gives rise to the potential for health inequities, it must be understood that publicly sponsored health insurance is just that – health insurance -- and not a general funding vehicle for social change initiatives or addressing the root causes of poverty. Western Oregon Advanced Health's providers and planners can best address health inequities by addressing health disparities within the context of culturally appropriate care, consistent with the Centers for Disease Control's definition. Western Oregon Advanced Health is committed to this end, and will establish patient outcome measures, consistent with the Oregon Health Authority's metrics for coordinated care organizations, that track and report on these quality measures according to demographic factors that include race, ethnicity, primary language, mental health, and substance abuse disorder data.

## Section 5 – Payment Methodologies that Support the Triple Aim

In addition to the governing board, Community Advisory Council, and Clinical Advisory Panel, Western Oregon Advanced Care will seat a *Metrics, Measures, and Advanced Payment Methodology Advisory Council*. This latter Council will be comprised of the chief executive officer and the chief medical officer of each entity or organization that is a major component of the coordinated care organization's health care delivery system. This Council will be responsible for reviewing and analyzing metrics and measures, and based on that review and analysis, for making recommendations to the coordinated care organization's governing board regarding advanced (e.g., alternate or incentivized) payment methodologies for adoption by the coordinated care organization.

The Applicant will detail its current thinking regarding payment methodologies concurrent with its submission of the financial application in mid-May, 2012. Concepts that are currently under consideration include:

- Continuation of a (unusual) fully-capitated payment structure for Bay Area Hospital;

- Entering into a sub-global budget agreement with the Curry Health Network for the services of its hospital and directly employed physicians;

- Applying *care rate payment methodologies* for *episodes of care* for population groups who are diagnosed with chronic disease states;

- Using a consolidated provider staffing model for a chronic pain program;

- Entering into a sub-global budget arrangement, rather than a fee-for-service arrangement, with Coos County Public Health;

- Creation of a *Complex Care Center* to meet health care and intensive case management needs of Members diagnosed with multi-systemic chronic disease states (that may or may not include mental illness), particularly those who are identified as under-using or over-using health care services;

- The potential development of a fully integrated and patient-centered primary- and mental-health care home for persons diagnosed with acute and/or persistent chronic mental illness; and,

- The adoption of payment methodologies that align with *lowest cost estimates* and/or *least costly services* guidelines.

## Section 6 – Health Information Technology

**Description of Applicant's Current Capacity:** The communities' largest practices (North Bend Medical Centers, Waterfall Community Health Center, South Coast Orthopedics, and to a lesser extent, Bay Clinic and Curry Health District) each have access to systems of electronic health records. The systems in use by North Bend Medical Centers, Waterfall Community Health Center, and South Coast Orthopedics are federally ONC certified, and Waterfall Community Health Center has qualified for *meaningful use* reimbursement, and its EPIC-based system is currently supporting *MyChart* on-line access by registered Members as a patient-engagement strategy. Bay Area Hospital, and to a lesser extent the three critical access hospitals, also have access to electronic health record systems. The system in use by Bay Area Hospital is also federally ONC certified.

**Plans for Improvement:** The challenge for Western Oregon Advanced Health will be to develop interoperability between and among the various systems of electronic health records to improve communication and information sharing among the entities. While there is no doubt that a robust Health Information Exchange would yield these benefits, the initial costs are too great, and it is likely that smaller interim steps will need to be taken through health information cross-walks that create greater interoperability.

A Health Information Technology Work Group has been meeting for over one year, and is close to identifying its preferred Health Information Exchange solution, with corresponding cost estimates. A fully completed and time-framed plan for the initial implementation of cross-walks, and the ultimate adoption of a Health Information Exchange, will be completed and available to the Oregon Health Authority by 31 December 2012. This plan will set forth Western Oregon Advanced Health's strategies to: track and increase adoption rates of federally certified ONC electronic health records; migrate toward an affordable Health Information Exchange; improve Health Information Technology in the areas of data analytics and quality improvement; engage Members through such strategies as *MyChart*; ensure that every provider in the network is either registered with a statewide or Direct-enabled Health Information Services Provider or a member of an existing Health Information Organization with the ability for providers with any electronic health records system to be able to share electronic information with any other provider within the coordinated care organization.

Waterfall Community Health Center, with the assistance of the Health Resources Administration and the U.S. Department of Agriculture's *Distance Learning and Telemedicine* grant programs, will be installing a telemedicine hub at its home office in North Bend, and end-user sites at school-based health centers in Powers and Coos Bay. Western Oregon Advanced Health hopes to build upon these telemedical capabilities, and

will be partnering with Waterfall Community Health Center and Bandon Community Health Center to seek similar grant funds to establish hub sites at Bandon Community Health Center, North Bend Medical Centers, and Bay Area Hospital, to support end-user sites in Lakeside, Bandon, Port Orford, Agness, and Gold Beach.

Approximately two years ago, the Bay Area Community Health Information Alliance (BACHIA) was formed for the purposes of establishing a Health Information Exchange. Key members of the Alliance include Southwest Oregon Independent Practice Association, North Bend Medical Centers, Bay Clinic, Bay Area Hospital, and South Coast Orthopedics. Affiliate members include Coos County Public Health and Coos County Community Mental Health. To date, the Alliance has expended $600,000 in the development of a not-yet-operable and Medicity-based Health Information Exchange, and it is anticipated that an additional investment of $600,000 will be required to bring the Exchange to full fruition.

Western Oregon Advanced Health is open to discussions with the Oregon Health Authority on a gain-sharing proposal to complete the Health Information Exchange. Such an endeavor should result in cost savings, and if achieved, Western Oregon Advanced Health could agree to sharing realized savings with the Oregon Health Authority.

**[PAGE COUNT. This Section, Appendix A, is limited to 50 pages. It currently begins on page 21 and concludes on page 69, and consumes exactly 49 pages.]**

## VIII. PROVIDER PARTICIPATION AND OPERATIONS QUESTIONNAIRE
**[From Appendix B]**

### Section 1 – Service Area and Capacity

Western Oregon Advanced Health's *Service Area Table*, with noted capacities, is appended as requested as an Excel spreadsheet in Exhibit J.1. The Applicant has the capacity to serve 12,600 Members in Coos County and 3,350 Members in Curry County.

### Section 2 – Standards Related to Provider Participation

**1. <u>Standard #1 – Provision of Coordinated Care Services</u>**

Dependent upon the timely flow of global budgeting financial information from the Oregon Health Authority, Western Oregon Advanced Health predicts that contracts for the following services will be negotiated as of the readiness review date of 3 July 2012:

- Acute inpatient hospital psychiatric care;
- Addiction treatment, including Assertive Community Treatment, and a corresponding panel of chemical dependency treatment providers (for Coos County);
- Dialysis services;
- Federally qualified health centers;
- Home health;
- Hospice;
- Hospital;
- Imaging;
- Mental health services, including intensive case management, the services of certified peer wellness specialists, and a corresponding panel of mental health providers (for Coos County);
- Oral health providers;
- Primary-care patient-centered medical homes, including palliative and urgent care;
- Rural health centers;
- School-based health centers;
- Specialty physicians; and,
- Tertiary hospital services.

Western Oregon Advanced Health will also make contractual arrangements for the delivery of the following services, although these contractual documents may not be in place as of the readiness review date of 3 July 2012. In the intervening time, from August 1, 2012, until contractual agreements have been negotiated, these services will be compensated under existing, temporary, or alternate payment bases:

- Ambulance and emergency medical transportation;
- Addiction treatment, including a panel of chemical dependency treatment providers in Curry County;
- Mental health services, including intensive case management, the services of certified peer wellness specialists, and a corresponding panel of mental health providers in Curry County; and,
- Pharmacies and durable medical equipment providers.

Western Oregon Advanced Health does not envision entering into contractual agreements for or providing, the following services:

- Supported employment, and,
- Tribal and Urban Indian Health Services.

It is envisioned that community prevention services, health education services, health promotion services, and health literacy services will be provided pursuant to the Community Advisory Councils' yet-to-be-developed *Community Health Improvement Plans*.

Coos and Curry Counties are characterized by the absence of certified medical interpreters. Bilingual capabilities, in the Spanish language, are currently available at public health and mental health agencies in Coos and Curry counties, Bay Area Hospital, Curry General Hospital, Waterfall Community Health Center, and North Bend Medical Centers. All other providers and locations use telephonically assisted medical interpretation services, for Spanish and all other languages.

Western Oregon Advanced Care will either directly employ and/or contract with others for the services of Community Health Workers. The likely contracted providers for these services are Waterfall Community Health Center and Bandon Community Health Center (in Coos County), and the Curry Health District (in Curry County).

Similarly, Western Oregon Advanced Care will either directly employ and/or contract with others for the services of Health Systems Navigators. The likely contracted providers for these services are North Bend Medical Centers, Bay Clinic, and Bay Area Hospital (in Coos County), and the Curry Health District (in Curry County).

Western Oregon Advanced Health's *Participating Provider Table* is appended as requested as an Excel spreadsheet in Exhibit J.2.

**2. Standard #2 - Providers for Members with Special Health Care Needs**

Each of Western Oregon Advanced Health's primary care physicians, by virtue of their academic preparation and direct experience over the past fifteen years in providing primary health care services to Oregon Health Plan beneficiaries, have developed skills in effectively providing medical services to special populations and persons who are elderly, disabled, residing in substitute care, evidence high health care needs or costs, diagnosed with multiple chronic conditions, mentally ill, or chemically dependent. Particular expertise has been developed in this regard by Western Oregon Advanced Health's participating federally qualified and rural health centers. Western Oregon Advanced Health's local provider panel includes all required specialists and sub-specialists, with the exception of cardiology and neonatology, and out-of-area contractual arrangements are in place for those medical sub-specialties. Medical care for all children and youth residing in substitute care will be consolidated under a single pediatrician who holds advanced expertise with this population. Arrangements are being developed for on-site medical service delivery for adults residing in Long-Term Care or DHS-supported adult foster care homes. Finally, Western Oregon Advanced Health is working toward a model that will permit the development of a patient-centered combined primary- and behavioral-care medical home for Members who are diagnosed with acute or persistent mental illness.

**3. Standard #3 – Publicly-Funded Public Health and Community Mental Health Services**

The *Publicly-Funded Health Care and Service Programs Table* for Coos County appears as Exhibit J.3. Representatives from Coos County Public Health and Community Mental Health Services participated as active members of the CCO Planning Committee, commencing in November, 2011, and the director of Coos County Community Mental Health Services served as a member of a statewide CCO work group and continues to chair Western Oregon Advance Health's care coordination work group. In Curry County, the director of the Public Health Department has served as a member of the local CCO Planning Committee since 1 February 2012. The Curry County Community Mental Health Services program is under the temporary leadership of a contracted director whose services will conclude on 30 June 30 2012. Signed agreements with Coos County Public Health and Mental Health will be available as of the 3 July 2012 readiness review date. Signed agreements for publicly-funded public health and community mental health services in Curry County will be similarly available by 3 July 2012, either directly with Curry County government (unlikely) or with a (planned) successor organization that inherits these service responsibilities, as elsewhere discussed in this Application. Good-faith efforts are continuing in Curry County and will come to fruition.

**4. Standard #4 – Services for American Indian/Alaska Native Populations**

In Coos and Curry Counties, 1,367 persons identify as being Native American or Alaska Natives. For the large part, these individuals are well assimilated in the general community and local culture and do not report barriers in accessing culturally relevant coordinated care services. The local Indian Health Services Clinic easily refers its patients to Western Oregon Advanced Health's medical specialty providers and systems. The Coos County Community Mental Health program is under the direct leadership of an individual who is a Native American Indian, and coordinated care through that system is fully and entirely culturally relevant for indigenous persons.

**5. Standard #5 – Indian Health Services and Tribal 638 Facilities**

The Confederated Tribes of the Coquille, Siuslaw, Coos, and Umpqua operate an Indian Health Clinic in North Bend (Coos County) that is available without charge to all Tribal members, although travel distances do not always make the Indian Health Clinic a viable option for Native American residents of Curry County. The Indian Health Clinic offers a full array of primary, dental, and out-patient mental health services. Currently, the Indian Health Clinic makes referrals to Western Oregon Advanced Health's provider panel for all services that are beyond its capacity or medical capabilities and provides direct reimbursement for these services. To date, the Indian Health Clinic has preferred to function autonomously and independently and has not participated as a member of the Coordinated Care Organization's predecessor Managed Care Organization. Western Oregon Advanced Health respects the Indian Health Clinic's preference to remain autonomous and is aware that the Indian Health Clinic may be affiliating with the Northwest Portland Area Indian Health Board, which is advancing plans to create a statewide Coordinated Care Organization with a service area comprised of the nine federally recognized tribes within the State of Oregon, including the Confederated Tribes of the Coquille, Siuslaw, Coos, and Umpqua. Western Oregon Advanced Health has elected to stand-aside to permit the local Tribes to affiliate coordinated care options according to their discretion and preferences. Western Oregon Advanced Health will continue to provide requested medical services to Tribal members and will readily admit the Indian Health Clinic to its provider panel if requested to do so by Tribal leaders.

**6. Standard #6 – Integrated Service Array for Children and Adolescents**

Coos County Community Mental Health serves as the lead organization for the delivery of the Integrated Service Array for children and adolescents, and has developed an extensive menu of services, including intensive psychiatric day treatment, and sub-contractual relationships to support these services. Although Southern Oregon Adolescent Study and Treatment Center is the primary sub-contractor for the Integrated Service Array, other community partners include contracted therapists, school-based mental health programs,

Coos County Public Health, the Family Court program, DHS, and Juvenile Justice. All policies and procedures related to confidentiality are in place, as are the needed policies and procedures to assure that the Integrated Service Array is family-driven, strength-based, and culturally sensitive. Western Oregon Advanced Health will enter into a contractual agreement with Coos County Community Mental Health for the full spectrum of care coordination and case management services for children, adolescents, and adults, and through this agreement, will support Coos County Community Mental Health in its continued and uninterrupted delivery of the Integrated Service Array, albeit with the increased coordination with participants' primary care medical homes.

**7. Standard #7 – Mental Illness Services**

Community- and home-based mental illness services, with an emphasis on care coordination and case management, will be provided through contractual relationships with Community Mental Health agencies. Mental health treatment services will be provided through a combination of contractual agreements with Community Mental Health agencies and by patient-centered primary care medical homes that retain the services of licensed mental health professionals. As a matter of established standards for state-registered, patient-centered primary-care medical homes, primary care providers are expected and required to engage in the early detection, prevention, and identification of mental illness, especially at the time of the initial contact, on the occasion of annual comprehensive physical examinations, throughout the perinatal period, or whenever a Member shows evidence of mental illness, the symptoms of which may include non-compliance with recommended medical protocols or the over-utilization of services.

**8. Standard #8 – Chemical Dependency Services**

Community- and home-based chemical dependency services, including direct treatment, care coordination, and case management, will be provided under contractual agreement with ADAPT in Coos County, and with the successor organization to Curry County Community Mental Health in Curry County. As a matter of established standards for state-registered, patient-centered primary-care medical homes, primary care providers are expected and required to engage in the early detection, prevention, and identification of chemical dependency and addictive illness, especially at the time of the initial contact, on the occasion of annual comprehensive physical examinations, throughout the perinatal period, or whenever a Member shows evidence of mental illness, the symptoms of which may include non-compliance with recommended medical protocols or the over-utilization of services.

## 9. Standard #9 – Pharmacy Services and Medication Management

**Experience and Ability to Provide Drug Benefits for Condition/Treatment Pairs:** As a Managed Care Organization, Southwest Oregon Independent Practice Association established a prescription drug benefit using a formulary for covered medications and a prior authorization process for accessing non-formulary medications. The *Linefinder* program is in place to assure that conditions being treated are *above the line* for Oregon Health Plan coverage, and to assure whether the *co-morbid condition rule* is being met for Condition/Treatment pairs. [Not all therapeutic classes are *above the covered line,* e.g., insomnia.] Because Jefferson Behavioral Health established its own formulary, psychotropic medications are not currently included in Western Oregon Advanced Health's formulary, but will be added.

**Specifications:** As a Managed Care Organization (in transition to a Coordinated Care Organization), Southwest Oregon Independent Practice Association uses a restrictive formulary to promote the use of more cost-effective generic medications, when these are available. The applicant has a prior authorization process in place for patients and prescribers to gain access to non-formulary medications, when appropriate. The prior authorization request is reviewed by either the directly employed clinical pharmacist or medical director. The formulary includes FDA-approved medications for each therapeutic class and at least one item in each therapeutic class for over-the-counter medications sufficient to ensure the availability of covered drugs outside of the prior-approval process. Western Oregon Advanced Health's drug use criteria were developed by an internal group of physicians, based on accepted national guidelines. The formulary is currently revised on an annual basis with physician and provider input. Western Oregon Advanced Health is currently working to seat a local Pharmacy and Therapeutics work group to permit quarterly, rather than annual, revisions to the formulary. This process is staffed in-house with the use of the State Pharmacy and Therapeutics Committee's guidance, and pursuant to HERC guidelines.

**Ability to Ensure Adequate Pharmacy Network:** Southwest Oregon Independent Practice Association contracts with all pharmacies to ensure an adequate pharmacy network. This is particularly important in small rural communities that do not have access to major pharmacy chains (e.g., WalMart; RiteAid; Safeway), and is equally important to assure that small independent pharmacies remain in business in rural settings, thereby creating nearby access. Formularies are distributed to all pharmacies on an annual basis, and at the time of revision. Formularies are also distributed to all local contracted providers. Letters are sent to pharmacies and prescribers when formulary or utilization criteria are revised. The Pharmacy Benefit Manager (PBM) is a national organization, thereby creating nation-wide prescription access for Members who may be traveling. DUR messaging alerts pharmacists and prescribers when prior authorizations are required.

**Processing Pharmacy Claims:** Southwest Oregon Independent Practice Association contracts with a PBM to process pharmacy claims. The PBM uses real-time claims adjudication and captures all relevant clinical and historical data elements for claims paid in their entirety by the MCO/CCO, and when the coordination of benefits is required to bill Third Party Liability (TPL) when the MCO/CCO is the secondary coverage.

**Capacity to Process Prior Authorization:** Prior authorizations are processed in-house during normal business hours, and often later on Friday evenings in an effort to ensure that all requested authorizations are processed before the weekend. Pharmacies are able to contact the PBM helpdesk during weekends and afterhours for compassionate care over-rides for urgent and emergent medications. A five-day hospital over-ride is always granted to Members when discharging from the hospital, regardless of formulary status, to ensure there is no lapse in medication coverage.

**Contractual Arrangements with a PMB:** MedImpact serves as the contracted PMB. The contracted discount percentage from Average Wholesale Price (AWP) is -16.5 percent. The dispensing fee is $2.00. The administrative fee is $.28 per claim with certain minimums and ceilings.

**340-B Capacity:** The only 340-B Pharmacy Pricing entities that are represented on the panel of Western Oregon Advanced Health are: federally qualified health centers (i.e., Waterfall Community Health Center); disproportionate share hospitals (i.e., Bay Area Hospital); and, critical access hospitals (Coquille Valley Hospital; Curry General Hospital; and Southern Coos Hospital). Of these, only Waterfall Community Health Center participates in 340-B Pharmacy Pricing for out-patient pharmaceuticals. Southern Oregon Independent Practice Association has recently consulted with a pharmacy consulting service to aid in the greater implementation of the 340-B pharmacy pricing program.

**Medication Therapy Management (MTM):** Because in-house support for MTM services is known to be burdensome and costly, Western Oregon Advanced Health will most likely contract with a specialized entity (Outcomes Pharmaceuticals) for the provision of MTM services, dependent upon cost negotiations, and will work within the local community of pharmacists to gather interest and support for the MTM program, including a payment structure that compensates pharmacists for their time in this regard, in the firm belief that MTM greatly enhances coordination of care efforts.

**E-Prescribing:** With the exception of Waterfall Community Health Center, the entities that comprise Western Oregon Advanced Health do not have e-prescribing capabilities, although these capabilities are emerging at the 50-member-strong North Bend Medical Centers, and will become a focus for the remaining panel of providers over time.

**10. Standard #10 – Hospital Services**

All Members will have equitable access to inpatient and outpatient hospital services, at four locations: Bay Area Hospital; Coquille Valley Hospital; Curry General Hospital; and, Southern Coos Hospital. Members requiring invasive cardiology procedures and neonatal intensive care will be referred to alternate hospitals. The Member Handbook and other communication strategies, referenced on page 54, will be used to educate Members about appropriately accessing ambulance, emergency department, urgent care, and less intensive interventions. Inappropriate utilization will be tracked through Western Oregon Advanced Health's electronic encounter management and reporting systems by the medical director, and exceptions reports will be generated in order to identify Members who may benefit from increased educational or case management efforts. As a general operating principle, Western Oregon Advanced Health disallows claims for Provider Preventable Conditions, based on Medicare guidelines, for adverse events or hospital acquired conditions, but each claim may be adjudicated between the medical director and the provider on a case-by-case basis. Western Oregon Advanced Health's readmission policies are in direct compliance with the Congressional Research Service's *Medicare Hospital Readmissions Issues, Policy Options, and PPACA* guidelines (September, 2010). Although readmitting a patient to a hospital may be appropriate in some cases, policy makers and researchers agree that reducing readmission rates could help contain health care costs and improve the quality of patient care. Although several entities have attempted to define just how many readmissions might be preventable, no consensus exists on how to distinguish among those readmissions that might be avoided and those that might not. Innovative strategies that may be employed to decrease unnecessary hospital readmissions include: service delivery reform (i.e., the coordinated care model); care coordination using telehealth; initiatives to improve patient compliance; and local financing reform through the global budget process. Many of these initiatives, accompanied by greater Member education and engagement and the increasing use of less intensive interventions, could also be employed to decrease unnecessary hospital utilization.

**Section 3 – Assurance of Compliance with Medicaid Regulations and Requirements**

RFA 3402 identifies fourteen (14) Medicaid regulations and requirements and asks the Applicant to briefly state how it meets the standards. Within the strictures of the eight-page limitation for responses to Appendix B, it is not possible to state how the Applicant meets these standards on a case-by-case basis across fourteen (14) standards. In brief and general terms, Western Oregon Advanced Health complies with every standard by: developing compliant internal policies and procedures; monitoring and enforcing those policies and procedures; engaging in corrective action when it is necessary to do so; and remaining abreast of current regulations and evidence-based best practice standards and incorporating those regulations and standards in the timely promulgation of revised policies, procedures, and provider training and orientation.

## IX. ACCOUNTABILITY QUESTIONNAIRE
**[From Appendix C]**

### Section 1 – Accountability Standards

**1. Description of Existing Quality Measurement and Reporting System**

Western Oregon Advanced Health, through its management affiliation with Southwestern Oregon Independent Practice Association, has adopted the quality measurement system that is recommended by the National Committee for Quality Assurance (NCQA). Although Southwestern Oregon Independent Practice Association is not accredited by NCQA, its quality measurement system is consistent with that of entities that either are NCQA accredited, or seeking NCQA accreditation. At a minimum, the following HEDIS measures are monitored:

**Table 2**
**HEDIS MEASURES TRACKED FOR QUALITY MANAGEMENT**

| |
|---|
| Annual Monitoring for Patients on Persistent Medications (Total Rate) |
| Antidepressant Medication Management |
| Appropriate Testing for Children with Pharyngitis |
| Appropriate Treatment for Children with Upper Respiratory Infection |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis |
| Breast Cancer Screening |
| Cervical Cancer Screening |
| Childhood Immunization Status (Combination 2) |
| Chlamydia Screening in Women (Total Rate) |
| Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only) |
| Colorectal Cancer Screening |
| Comprehensive Diabetic Care [Eye Exam; LDL-C; HbA1c (> 9.0% = Poor Control); Podiatry; Nephropathy] |
| Controlling High Blood Pressure |
| Flu Shots for Adults (Ages 50-64) |
| Flu Shots for Older Adults |
| Follow-Up After Hospitalization for Mental Illness (7-Day Rate) |
| Follow-Up for Children Prescribed ADHD Medication (Both Rates) |
| Glaucoma Screening in Older Adults |
| Medical Assistance with Smoking and Tobacco Use Cessation |
| Osteoporosis Management in Women Who Had a Fracture |
| Persistence of Beta-Blocker Treatment Post Heart-Attack |
| Pneumonia Vaccination Status for Older Adults |
| Prenatal and Postpartum Care (Both Rates) |
| Use of Appropriate Medications for People with Asthma (Total Rate) |
| Use of Imaging Studies for Low Back Pain |

## 2. Participation in External Quality Measurement and Reporting

Western Oregon Advanced Care will participate in the NCQA quality measurement and reporting program and, after 1 January 2013, in the Medicare Advantage reporting system maintained by CMS.

## 3. Internal Quality Standards to Which Providers and Contractors Are Held

The internal performance expectation is to attain all HEDIS measures at the 75$^{th}$ percentile, based on NCQA Quality Compass benchmarks which are produced and updated annually.

## 4. Mechanisms for Sharing Performance Information with Providers and Contractors

Southwest Oregon Independent Practice Association has the current capacity to share performance information with all providers and contractors. At present, ongoing dialogue with providers concerning HEDIS results is accomplished by a team approach under the leadership of the medical director. These dialogues are always purposed at identifying best practices, supporting clinicians in their improvement efforts, and incorporating linguistic and cultural components.

By not later than 31 January 2012, the Applicant will develop a dashboard approach to quality metrics that displays both national performance rates and local performance rates, and compares each provider's or contractor's attained performance rates with national and local norms for selected metrics or variables.

## 5. Mechanisms for Sharing Performance Information with Members

To date, Southwest Oregon Independent Practice Association has not formally disseminated performance information to Members. Beginning in 2013, aggregate performance information will be shared with the Community Advisory Council and by 2014 with the Members-at-large via the Applicant's web page.

## 6. Plans to Use Quality Measures for Incentives or Alternate Payment Mechanisms

After the quality measure dashboard system (referenced above) has been implemented for a full twelve-month period, Western Oregon Advanced Health fully intends to provide alternate payment mechanisms (i.e., incentives) for providers who attain pre-determined

benchmarks for HEDIS and other locally-adopted metrics, such as patient retention as a measure of patient engagement. The full twelve-month period is required prior to implementation in order to present providers with sufficient time frames in which to identify and implement improvement targets.

### 7. Capacity to Collect and Report Accountability Quality Measures

Western Oregon Advanced Health's capacity to collect and report on the accountability quality measures established by the Oregon Health Authority is deemed to be robust, with internal capacity to integrate data from a variety of sources. Southwest Oregon Independent Practice Association has produced a spectrum of HEDIS measures over the course of multiple years, many of which cross-walk to the quality measures found in Table C-1 of RFA 3402. As Western Oregon Advanced Health works to incorporate new or additional accountability measures, it will do so from the perspective of the Members' experiences, thereby working to attain the Triple Aim. An annual Member satisfaction survey is conducted as one method for gaining insight into Members' experiences, successes, frustrations, barriers, equity issues, and sense of cultural appropriateness. Member satisfaction data are dichotomized by practice settings in order to produce results that are more actionable for both providers and Western Oregon Advanced Health.

## Section 2 – Quality Improvement Program

### 1. Quality Assurance and Performance Improvement

**Current Status:** Southwest Oregon Independent Practice Association has a well-defined process for quality improvement, based primarily on HEDIS indicators. The quality committee is chaired by the medical director and includes providers who are nominated by their peers and reflective of the diverse rural communities and Member profiles that are represented within the service delivery area. The medical director is responsible for developing the annual quality plan, and the plan is subsequently reviewed, revised, and ratified by the quality committee. The times, dates, and places for all quality committee meetings are made known to all providers, and any provider is welcome to attend, observe, and comment. Issues related to individual provider's compliance and/or needs for corrective action are handled confidentially between the medical director and the involved provider.

**Moving Forward:** Western Oregon Advanced Health believes that it has outgrown its current quality improvement program. While the current program is adequate to meet

contractual obligations as a Managed Care Organization, the quality improvement program is not one that is sufficiently robust to incorporate mental, oral, and behavioral health services, nor to continually expand to include an increasing number of accountability, transparency, and outcome metrics.

Most independent practice associations and Managed Care Organizations, including Southwestern Oregon Independent Practice Association, have traditionally delegated quality performance, management, assurance, and improvement functions to their medical directors. In retrospect, many are learning that medical directors do not necessarily have any advanced training in quality functions and may be inadequately prepared to fully lead quality management.

For these reasons, Western Oregon Advanced Health, in partnership with Southwest Oregon Independent Practice Association, will create a new employment position for a Director of Quality Management and Improvement, and will provide oversight to this individual as he or she completely revamps, updates, and upgrades the coordinated care organization's quality program. Western Oregon Advanced Health envisions a robust and state-of-the art program of quality management that transcends every aspect of organizational affairs, including clinical, fiscal, and management, and wherein quality improvement in any one aspect of organizational affairs will directly impact quality performance in all other aspects of the organization. Collectively, work that is purposed at improving clinical, fiscal, and management systems should concurrently produce measurable progress toward the attainment of the Triple Aim while also informing progress (or lack thereof) toward the elimination of health inequities, improvements in care coordination, and seamlessness of transitions between care settings. At the same time, the new quality system must remain responsive to the coordinated care organization, the Oregon Health Authority, providers, and Members. It must support quality improvement through the adoption of evidence-based best practice standards, while at the same time having sufficient dentition to engage in corrective action and progressive discipline when needed. It must further base its foci not only on the attainment of arithmetical outcome measures, but on a multiplicity of supporting quality documents – individual treatment plans, Member satisfaction surveys, provider satisfaction surveys, case management functions, and cost calculations and comparisons.

The type of quality management, assurance, and improvement program that Western Oregon Advanced Health envisions will require time to develop and in-service or external training for providers who agree to serve as members of the quality assurance committee. The quality assurance committee will be comprised of sub-committees according to discipline yet will work across disciplines to study the interrelationship of measures across physical, mental, behavioral and oral health systems. In response to Appendix H, Western Oregon Advanced Health has outlined the operational steps and sequence required to bring such a quality assurance program to fruition by not later than 30 June 2013.

## 2. Clinical Advisory Panel

Western Oregon Advanced Health will establish a Clinical Advisory Panel that will be comprised of one dental professional; one hospital representative; one mental health professional; one behavioral health professional; and five physicians, each of whom must work in discretely different employment settings, and one of whom must be a member of Western Oregon Advanced Health's governing board of directors. The charter, duties, and membership of the Clinical Advisory Panel are further detailed in Exhibit E.

## 3. Continuity of Care / Outcomes / Quality Measures / Cost

**Improving Member Outcomes:** *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.* Every written policy and procedure exists either to ethically safeguard Members or to improve their opportunities for a favorable health outcome. The minutes of every meeting of the quality committee are purposed at documenting the organization's efforts to implement evidence-based best practices and to identify emerging best practices that may be beneficial to Members. Although *innovation* was popular among publicly funded programs in the 1990s, since the turn of the century, public funds have been directed toward *evidence-based best practice models,* somewhat at the expense of *innovation.* It is difficult indeed to *innovate* in the face of 123 pages of draft administrative rules that are more focused on compliance than on innovation, or against the strictures of a 130-page legalistic contractual document that will require ever increasing fiscal expenditures for new classifications of personnel, health information systems and exchanges, staffing of newly created Councils and Panels, unwieldy governance structures, forced underwriting of outdated public sector programs, increased accountability and ever-evolving metrics, leaving little on the table with which to *innovate.*

The line in the sand for the Oregon Health Plan has been raised so high that the removal of a foreign object from a child's ear is no longer a covered benefit. While by no means *innovative,* the removal of such a foreign object is still considered to be a *medical best practice,* and at Western Oregon Advanced Care, we *innovate* by encouraging our medical providers to remove that foreign object at our own direct expense, in the belief that the potential prevention of downstream permanent hearing loss is in direct support of the Hippocratic Oath, if not the Triple Aim.

Western Oregon Advanced Health will cautiously *innovate,* understanding that not all innovation is good. Adverse innovation is responsible for price escalation among products developed under systems with unusually high research and development costs, like

pharmaceuticals (Gilbert, 2008). Innovation may be adversely impacted when regulations reduce incentives by lowering post-innovation profit margins (Gilbert, 2009), as is likely to occur under the coordinated care organizational model if funding for Medicaid programs remains unstable. Forced inter-organizational governance structures, when used to manage decision-making within the context of shared performance, have been found to have compelling adverse effects on innovation (Aggarwal, 2010).

Innovative models under consideration by Western Oregon Advanced Health include:

- Continuation of a (unusual) fully-capitated payment structure for Bay Area Hospital;
- Entering into a sub-global budget agreement with the Curry Health Network for the services of its hospital and directly employed physicians;
- Applying *care rate payment methodologies* for *episodes of care* for population groups who are diagnosed with chronic disease states;
- Using a consolidated provider staffing model for a chronic pain program;
- Entering into a sub-global budget arrangement, rather than a fee-for-service arrangement, with Coos County Public Health;
- Creation of a *Complex Care Center* to meet health care and intensive case management needs of Members diagnosed with multi-systemic chronic disease states (that may or may not include mental illness), particularly those who are identified as under-using or over-using health care services;
- The potential development of a fully integrated and patient-centered primary- and mental-health care home for persons diagnosed with acute and/or persistent chronic mental illness;
- The development of a wound care clinic; and,
- The adoption of payment methodologies that align with *lowest cost estimates* and/or *least costly services* guidelines.

**Key Quality Measures:** The key quality measures that are currently in place include the HEDIS measures that are summarized in Table 2 on page 77. Baseline data exist for the majority of these measures, against which comparisons may be made. In addition, Western Oregon Advanced Health is applying patient retention as an internal quality metric purposed at measuring patient engagement.

**Plans to Implement Wellness and Health Improvement Activities:** Western Oregon Advanced Health is committed to developing, implementing, and measuring the efficacy of wellness and health improvement activities for Members, but is hesitant to pre-define these activities in advance of giving the Community Advisory Council the opportunity to develop its unique Community Health Improvement Plan. All too often, we ask volunteers to serve on these types of important committees or councils, only to advise them that advanced decisions were made for one reason or another, thereby rendering the energy and the work of the Council somewhat meaningless or impotent. We would prefer, rather, to permit the Community Advisory Council to exercise its leadership role in developing a needs-based Community Health Improvement Plan, and then to commit resources towards those wellness and health improvement activities that are consistent with the Plan.

Southwest Oregon Independent Practice Association has previously supported evidence-based programs in tobacco cessation and self-management program for chronic diseases, as developed by Stanford University, and will continue to do so. In addition to the strategies that will be forthcoming from the Community Advisory Council, Western Oregon Advanced Health will develop web-based Member education components with a strong emphasis on wellness and links to relevant additional information or self-help tools. Western Oregon Advanced Health and its affiliates share a strong history in emphasizing health and wellness for staff and Members alike. Representative options include: ergonomic evaluations for workers; healthy vending machine options; tobacco-free workplaces; lactation rooms; flex schedules; work-from-home options for some occupational classifications; daily walking breaks; team walking; pedometers; blood drives; flu immunization campaigns; and both staffing and participating in community-based health fairs and related community-based venues.

**Data Capture:** To date, Southwest Oregon Independent Practice Association's staffing patterns, policies, procedures, and electronic practice management systems have been adequate to capture all data sets contractually required by its Managed Care Organization contract with the State of Oregon, and to analyze those data sets for evaluation and quality improvement functions. Nonetheless, as the data demands expand to include mental, behavioral, and oral health, and increase to include a broader array of transparency, performance, accountability, developmental, and outcome metrics, the Applicant's data capture needs will require careful re-assessment and the cost-conscious investment in advanced electronic systems, including hardware, firmware, and software. The investment in expanded or replacement data capture capacity will assure that quality data are available upon which to measure progress, determine outcomes, engage in corrective action, negotiate alternative payment strategies, and support decision-making – all purposed at the attainment of the Triple Aim.

**Strategies for Attaining the Triple Aim:** The entire purpose of the Coordinated Care Organization is to improve patient health outcomes, streamline the health care service delivery system, and contain the costs of care, and every component of this Application has supported these ends. Nonetheless, Western Oregon Advanced Care will undertake multiple innovation strategies that are in direct alignment with the Triple Aim, to wit:

- Work with and through the governance structure to identify, market, and implement alternative payment methodologies, inclusive of incentives that directly support the Triple Aim;

- Increasingly emphasize, and then measure and evaluate, efforts at Member engagement, including incentivizing providers for patient retention;

- Increasingly emphasizing, and ultimately requiring, the provision of primary health care services through patient-centered medical homes, and then measuring and evaluating those efforts for efficacy;

- Providing preventative and responsive on-site medical services to adults who reside in adult foster care homes or Long-Term Care facilities, with the singular goal of better managing the health of these individuals in home-based and residential, rather than inpatient, settings;

- Negotiating sub-global budget rates with local public health agencies, in the belief that so doing will stabilize their business operations (thereby promoting the public's health and assuring the presence of a critical *safety net* within the health care system), while at the same time reducing the amount of effort required to process fee-for-service claims and, where permitted, prior authorizations;

- Consolidating the care for children and youth who are in substitute care under a single pediatrician, in an federally qualified health center setting that has access to *MyChart*, thereby improving continuity of care for these children and youth, while further engaging their foster care providers and reducing duplicated diagnostic medical tests;

- To the extent determined to be feasible, working to develop a fully integrated, patient-centered, combination primary and behavioral mental health care home for Members who are diagnosed with acute, persistent, and chronic mental illness, thereby improving engagement and outcomes for these patients, while enhancing the experience of care and constraining costs; and,

- Working creatively to establish a system of public health and public mental health services in Curry County in the non-governmental sector that is purposed at patient-centeredness attained through the elimination of silos and authorities.

**Continuity of Care:** Western Oregon Advanced Health's programs for assuring continuity of care and care coordination (inclusive of tracking all referrals and prior authorizations), is theoretically based in an understanding of *clinical pathways*. Clinical pathways are multidisciplinary plans (or blueprints for a plan of care) of best clinical practice for specified groups of patients with a particular diagnosis that aid in the coordination and delivery of high quality care. They are a documented sequence of clinical interventions that help a patient with a specific condition or diagnosis move, progressively through a clinical experience to a desire outcome. Predominantly, they are management tools and clinical audit tools that are based on clinical information developed in other guidelines or parameters, and are specific to the institution, or in the case of Western Oregon Advanced Health, the interconnected system, that are using them. Originally, critical pathways began with admission to a provider or facility and ended with discharge from that provider or facility. Today, and as used by Western Oregon Advanced Care, they are interdisciplinary in focus, merging medical and nursing plans of care with those of oral health, mental health, behavioral health, long-term care, nutrition, physical therapy, hospice, and home health affiliates. They provide opportunities for collaborative practice and team-based approaches to care that can maximize the expertise of multiple disciplines while significantly improving the patient's experience of care and reducing the costs of care through duplication avoidance. Clinical pathways have four main components: a timeline; the interventions; intermediate and long-term outcome criteria; and the variance record (to allow deviations, such as prior authorizations) to be documented and analyzed. Clinical pathways differ from practice guidelines, protocols, and algorithms because they are used by a multidisciplinary team and have a focus on the quality and coordination of care. In essence, a clinical path is not a mandatory treatment plan, a standard of care, a substitute for clinical judgment, or a substitute for physician orders. Rather, the intraoperative clinical path serves as an integrated documentation tool to stabilize the intraoperative process of patient care and effectively manage clinical and financial outcomes.

# WESTERN OREGON ADVANCED HEALTH 2012
# Draft Policies for the Community Advisory Council



| Policy Title | Coordinated Care Organization's Community Advisory Council |
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| **Policy Description** | Western Oregon Advanced Health's Coordinated Care Organization (CCO) will sponsor a Community Advisory Council (CAC) pursuant to Section 13 of HB 1580-9, for the purposes of assuring that the health care needs of consumers and communities served by the CCO are being addressed in accordance with the Oregon Health Authority's regulations and initiatives. |
| **Position Statement** | Consumer participation is a core value of Western Oregon Advanced Health's Coordinated Care Organization. Sponsorship of the CAC reflects the CCO's commitment to assuring the implementation of health care transformation and the attainment of the Triple Aim. The CCO, through contracts with local public health agencies, will provide administrative and technical support for the CAC's activities as described in this policy. |
| **Overarching Strategy** | The CAC will provide independent recommendations and advice to the CCO's governance structure. Areas of focus may include, but are not limited to:<br>• The underutilization, if any, of the CCO's patient- or community-specific preventative health care services or initiatives;<br>• Providing recommendations to the CCO for its strategic planning process by annually reviewing the community health needs assessment study and preparing and recommending a strategic Community Health Improvement Plan;<br>• Monitoring policies and other variables that may interfere with equitable access to health care services, particularly for high priority patients;<br>• Policies and procedures for addressing consumer complaints;<br>• Reviewing quality, cost, outcome, and other data, as needed for the members and the public to assess the value of health care services delivered by the CCO, pursuant to the Triple Aim. |
| **Policy Goals and Objectives** | • Provide each consumer with the highest quality health care and services possible within the resources of the CCO.<br>• Assure consumer satisfaction with the quality of health care services<br>• Assist in the attainment of the Triple Aim of better population health, better patient outcomes, and lower total health care cost.<br>• Assist the CCO to expand consumer education and increase the capacity of consumers to productively engage in personal health care management and preventative practices.<br>• To recognize as tier-two consumers, and give voice to, the non-patient population who, through taxation, provides revenue for Medicaid services, and thus the CCO. |

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| **Community Advisory Council Membership** | Consistent with State CCO requirements, the Consumer Advisory Council (CAC) sponsored by the CCO will include representatives from local community organizations, local government, and consumers, with the latter comprising a majority of available seats. The chairperson of the CAC will serve on the CCO's governance structure. The membership will be comprised as follows:<br><br>• One (1) person from each County served by the CCO who is either a local elected official, or his or her designee;<br>• One (1) person who represents the CCO and/or the broader medical community;<br>• One (1) person from each County Public Health Department from each County in which the CCO operates;<br>• One (1) person who represents a publicly funded mental health or chemical dependency treatment agency or program;<br>• One (1) person who represents a rural health clinic, critical access clinic, or federally qualified health center;<br>• One (1) person who represents a local community-based social service agency or program;<br>• One (1) member-at-large; and,<br>• A sufficient number of consumers to assure a consumer-majority, with at least two consumers appointed from each County in which the CCO operates, and at least two consumers representing mental and behavioral health services.<br><br>Upon "start up," CAC nominations will be made by the ad hoc CCO Planning Committee and approved by the respective Board of County Commissioners and three persons from each County who are likely to hold positions on the CCO's governance structure. Thereafter, CAC members will be co-appointed by the respective Boards of County Commissioners and the CCO's governing board. Each appointment is for a three-year term, and no person, with the exception of the representative of the County Public Health Department, who may serve for longer than two consecutive terms. Initial appointment will be staggered, such that five members are appointed for a one-year term, five members are appointed for a two-year term, and five members are appointed for a three-year term. |
| **Community Advisory Council Operations** | The CAC shall annually elect a Council Chair and a Vice-Chair.<br><br>The Council Chair shall serve on the CCO's governance structure.<br><br>Membership in the CAC will be voluntary; however, CAC members may be reimbursed by the CCO for related travel, child care, and other reasonable and pre-approved costs associated with attendance and participation.<br><br>A minimum of eight (8) members must be present to constitute a quorum.<br><br>CAC meetings and deliberations will be conducted in a fair and effective manner, and minutes shall be maintained for all CAC meetings. |

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| **Critical Success Factors** | The following critical success factors provide the philosophical and cultural foundation of the CCO's Community Advisory Councils' operating model. The Councils' success will be achieved through:<br><br>• Substantial collaboration with consumers, providers, and the CCO;<br>• Meaningful CAC participation and input to the CCO's annual community needs assessment and strategic planning processes;<br>• The provision, by the CCO, of aggregated data requested by the CAC for evaluation and decision-making purposes;<br>• Adequate staffing of the CAC by the CCO; and,<br>• Transparency to the public represented by the CAC. |
| **Detailed Scope of Service** | **A. Consumer Protection and Engagement**<br>• Monitor underutilization and denial of services<br>• Evaluate how well the CCO's methods: encourage consumers to be active partners in self-management of their health; education consumers and communities about coordinated care; assist consumers to navigate the integrated health care delivery system; offer consumers access to patient care advocates, including peer wellness specialists, personal health navigators, and qualified community health workers; provide culturally and linguistically appropriate services; integrate wellness and prevention resources to help consumers make health lifestyle choices; and encourage consumers to work with their care coordination team in a holistic manner.<br>**B. Needs Assessment and Community Health Improvement Plan**<br>• Annually review, input, and approve the CCO's needs assessment study<br>• Annually develop a strategic Community Health Improvement Plan for submission to the CCO's board, prior to its strategic planning process<br>**C. Equitable Access**<br>• Annually review the CCO's policies and procedures governing patient access, the CCO's efforts to ameliorate access barriers, and the CCO's prioritization of special populations<br>• Make corresponding recommendations<br>**D. Consumer Complaints**<br>• Review the CCO's policies and procedures on consumer rights and protections and make corresponding recommendations<br>• As needed, coordinate with the State Ombudsman's Office<br>**E. Attainment of the Tripe Aim**<br>• Annually review quality, cost, outcome, and other data, as needed to assess the value of health care services delivered by the CCO |

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| **Community Advisory Council Implementation Schedule** | 1. Identify potential CAC appointees ..... By 05-05-2012<br>2. Vet list of potential appointees and establish final roster ..... By 05-15-2012<br>3. Present to County Commissioners and CCO Governing Board for approval ..... By 05-20-2012<br>4. Prepare and execute CAC Member Agreements ..... By 06-10-2012<br>5. Complete CAC Kick-Off Meeting ..... By 06-10-2012<br>6. Elect CAC Officers; Establish 2012-2013 CAC meeting schedule, annual agenda, and work plan ..... By 11-30-2012<br>7. CAC meeting schedule, annual agenda, and work plan submitted to CCO board for approval ..... By 12-10-2012 |
| **Recitals** | **From HB 3650:**<br>Section 4: *Each CCO convenes a community advisory council that includes representatives of the community and county government, but with consumers making up a majority of the membership, and that meets regularly to ensure that the health care needs of the consumers and the community are being addressed.*<br><br>**From SB 1580-9:**<br>Section 13: *A CCO must have a community advisory council (CAC) to ensure that the health care needs of the consumers and the community are being addressed. The CAC must: (a) Include representatives of the community and of each county government served by the CCO, but consumer representatives must constitute a majority of the membership; (b) Meet no less frequently than once every three months; and ( c) Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the CCO and members of the governing body of the CCO.*<br><br>*The duties of the CAC include, but are not limited to: (a) Identifying and advocating for preventative care practices to be utilized by the CCO; (b) Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the CCO; and ( c) Annually publish a report on the progress of the community health improvement plan.* |

These preliminary policies and procedures were submitted to Western Oregon Advanced Health's governing body and adopted by majority vote at the regularly scheduled meeting convened on __(date)__ The governing board has elected to next review these policies either two years hence, or on the date of _____(date)_____, whichever shall first occur.

_____
President of the Board

_____
Secretary of the Board

# Western Oregon Advanced Health 2012
# Draft Policies for the Clinical Advisory Panel



| Program Title | Western Oregon Advanced Health Clinical Advisory Panel |
|---|---|
| Program Description | Western Oregon Advanced Health will sponsor a Clinical Advisory Panel (CAP) to ensure that the physical, dental and mental health care needs of consumers are provided in a fashion that ensures that the best possible health care services are delivered in the most cost effective manner possible, consistent with the Triple Aim. The CAP will prepare quarterly report for review and action by Western Oregon Advanced Health's governing board. |
| Position Statement | Quality cost effective care to members is a core value of Western Oregon Advanced Health. Sponsorship of the CAP reflects Western Oregon Advanced Health's commitment to ensuring that Members and communities receive evidence-based care and optimum value from health services that are purposed at improving health outcomes while conserving health care resources.<br><br>The CAP will monitor Western Oregon Advanced Health's adherence to defined best practices for desired outcomes. It will regularly analyze data on:<br>• Integration of physical, mental and dental services<br>• Services delivered in a Patient Center Primary Care setting,<br>• Best practices developed and communicated,<br>• Flow of health information to and from care providers<br>• Cost savings achieved through integrated system.<br><br>Western Oregon Advanced Health's Clinical Advisory Panel will use industry benchmarks, internally driven performance targets, and information from other CAPs in the state to monitor and assess care coordination and desired outcomes. Western Oregon Advanced Health, through its Chief Medical Officer, will provide administrative and technical support for the Panel's activities as defined in this program description. |
| Organizational Strategy | The Clinical Advisory Panel will provide independent recommendations and advice to Western Oregon Advanced Health's board of directors on its coordination of care initiatives and internal CCO policies designed to ensure best clinical practices. Areas of focus include, but are not limited to:<br><br>• Evaluating coordination of physical, mental and dental care to determine outcomes as defined by governing board.<br>• Identifying barriers to care integration and developing working plan to address.<br>• Development of a Primary Care Patient Centered Medical Home expansion strategy to ensure the maximum number of CCO members are served by this primary care model.<br>• Reviewing the coordination of social and support services and partnerships with the primary, mental and dental providers.<br>• Monitoring of member educational initiatives used to educate them about care coordination and their responsibility in the process. |

| | |
|---|---|
| **Clinical Advisory Panel Membership** | The CAP will include: five physician members, each of whom works in a discretely different employment setting and one of whom must be a member of the board of directors for Western Oregon Advanced Health; one dental professional who works in affiliated with Advantage Dental; one hospital representative; and one or two mental health professionals. The CAP will be chaired by the chief medical officer for Southwest Oregon Independent Practice Association. There must be at least one member of the CAP from each county served by Western Oregon Advanced Health.<br><br>A single CAP will serve Western Oregon Advanced Health's Coordinated Care Organization as a whole. In consideration of the fact that Western Oregon Advanced Health's CCO service delivery area may comprise up to four counties, or portions of counties, the CAP may organize its activities according to work groups or sub-committees. Nonetheless, there will be but one standard of care, with related protocols, across the service delivery area, although provisions may be made for differences in health equity, health disparity, and provider proclivities<br><br>CAP members will be appointed by the board of directors for Western Oregon Advanced Health. Membership shall be voluntary and members may be compensated for their services.<br><br>A majority of members must be present to constitute a quorum and 67 percent of those attending must vote for an action in order for it to be forwarded to the governing board for consideration. Panel meetings and deliberations will be conducted in a fair and effective manner with minutes recorded. |

| **Implementation Work Plan** | **Timeline: No later than** |
|---|---|
| 1. Identify potential Council appointees | August 1, 2012 |
| 2. Vet list of potential appointees and establish final roster | August 15, 2012 |
| 3. Present to CCO Board of Directors for approval | August 31, 2012 |
| 4. Prepare and execute member agreement | September 15, 2012 |
| 5. Panel convenes initial meeting | October 15, 2012 |
| 6. Establish 2012 – 2013 Council meeting schedule, annual agenda, and work plan | November 30, 2012 |
| 7. Submit to CCO Board of Directors for approval | December 31, 2012 |

These preliminary policies and procedures governing the Clinical Advisory Panel were submitted to Western Oregon Advanced Care's board of directors and adopted by majority vote at the regularly scheduled meeting convened on ____(date)____, and will remain in full force an effect until the time of this policy statement's next review on ____(date)____, or two years hence, whichever shall first occur.

_____
President of the Board

_____
Secretary of the Board

Exhibit G

# COMMUNITY HEALTH NEEDS ASSESSMENT STUDY

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## Coos and Curry Counties
## Oregon

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Prepared for
Western Oregon Advanced Health

By
Kathy R. Ingram, Ph.D., Inc.

March 2012

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# COMMUNITY HEALTH NEEDS ASSESSMENT STUDY FOR COOS AND CURRY COUNTIES (OREGON)

## I. Introduction to the Target Communities

**Geographic Setting:** Coos and Curry Counties are situated in the southwestern-most corner of the State of Oregon, and encompass a geographic region that is comprised of 3,277 square miles. The two-county service delivery area is bounded the Pacific Ocean to the west, the California state border to the south, the Coastal Mountain Range to the east, and the Umpqua River drainage to the north. When the population and geographic mass of Brookings-Harbor is extracted, the balance of Curry County supports fewer than 9 persons per square mile, and meets all federal definitions for *frontier* status. The remaining reaches of Coos and Curry Counties are classified as *rural* by the U.S. Department of Transportation, U.S. Department of Commerce, and the U.S. Department of Health and Human Services' Health Resources and Services Administration.

The overall topography of Coos and Curry Counties ranges from coastal beaches, to bogs and sloughs, to small agricultural valleys, to steep and rugged mountainous terrain. Coos and Curry Counties are somewhat long and narrow. Collectively, the counties average thirty miles in width from west to east, but account for 112 miles of shoreline from north to south. Within the thirty-mile span from west to east, the elevation ascends from sea level to 5,098 feet at the summit of Pearsoll Peak within the Kalmiopsis Wilderness. The average annual precipitation is 82 inches.

When Coos and Curry Counties were first settled by early pioneers in search of gold, five communities, each separated by a full day's ride by horseback, were established along the Pacific coast. From south to north: Brookings-Harbor is situated at the southwestern-most corner of Oregon, abutting the California state line; Gold Beach is situated mid-county and serves as Curry County's county seat; Port Orford is situated at the northern-most boundary of Curry County; Bandon is located at the southern end of Coos County; and the much larger communities of Coos Bay and North Bend are thirty miles to the north. Each of these communities was originally established as an overnight stage coach rest stop, and each supports a shallow-draft port at the mouth of a west-flowing river system. The Port of Brookings is located at the mouth of the Chetco River; the Port of Gold Beach is located at the mouth of the Rogue River; the Port of Port Orford is located at the mouth of the Sixes River; the Port of Bandon is located at the mouth of the Coquille River; and, the International Port of Coos Bay, which is a deep-draft port, is located at the mouth of the Coos River. Midway between the Port of Port Orford and the Port of Bandon is Cape Blanco, which is the continental United States' western-most land mass.

**Transportation:** The targeted communities are located 350 miles to the north of San Francisco, California, and 350 miles to the south of Portland, Oregon. Both counties receive an allocation from the Oregon Department of Transportation and sub-grant these funds to a quasi-governmental organization for the operation of a very limited public transportation system. In general, this public transportation system operates within municipalities and consists of limited special transportation via handicapped-accessible vans for medical appointing. Medical transportation services operate on a demand basis and are available to Medicaid, Medicare, and TANF recipients. These county-specific and on-demand transportation systems do not cross county lines. While TANF recipients who reside in Port Orford may access the system for medical appointments scheduled thirty miles to the south in Gold Beach, they may not access the system to travel thirty miles to the north, across the county line, to Bandon.

The nearest airport that offers passenger service is in North Bend (Oregon), at an approximate distance of eighty miles from the community of Gold Beach, which is the county seat for Curry County. This airport provides passenger service for an average of eighteen passengers per day to the regional hub in San Francisco, California.

The balance of transportation for the two counties is via privately-owned and operated motor vehicles. During winter months, the nearly seven feet of annual precipitation results in extensive mud slides and road bed erosion, making travel by motor vehicle time-consuming and hazardous when the roads are navigable. On an estimated thirty days per year, and in some years for as long as ninety days per year, at least one of the major north-south or east-west roadways is closed for reasons of mud or rock slides or erosion. US 101 serves as the major north-south transit lane and is situated precariously close to the Pacific Ocean shore line and is subject to extensive erosion. Oregon 99 and 42 serve as the major west-east transit lanes and are characterized by steep ascents, narrow road beds, treacherous curves, the absence of break-down or passing lanes, and sharp drop-offs with no shoulders. The north-facing portions of Curry County are subject to dense fog for nine months out of each year, making transit by road even more problematic.

**Economy:** Two decades ago, Coos and Curry Counties' economies were primarily resource-dependent and based on timber and fisheries industries. As federal forestry and marine management practices shifted in favor of sustainable yields and species protection, timber harvests have been curtailed by a negative 30.2 percent and fishery harvests by a negative 120 percent. As a result, the service delivery area has evidenced definitive changes in its economic base. The region has experienced an out-migration of skilled laborers and an in-migration of retirees. In essence, those who could find work elsewhere have done so. Those who remain are largely unskilled. Today, only 8.8 percent of the workforce is employed in timber- and fishery-related industries. Of greater concern, 25.7 percent of the workforce is employed in retail sales and tourism-related service industries. The overwhelming majority of retail sales and tourism industry workers are employed at near-minimum-wage and often times in seasonal positions. In general, these employment settings do not offer the benefit of employer-sponsored health insurance. Over the ten-year period from 1989 to 1999, when the nation was experiencing a period of robust economic growth, the service delivery area's per capita income grew by only .86 percent per annum.

Prior to the national economic recession, in May of 2008, the number of unemployed persons in Curry County stood at 599, while the number of unemployed persons in Coos County was 1,869. As the economic recession worsened, the numbers of unemployed soared to 1,442 (February, 2009) in Curry

County, and 4,165 (March 2009) in Coos County. Today (January, 2012), a total of 1,184 workers in Curry County and 3,273 workers in Coos County remain unemployed. While national unemployment rates have dropped to 8.8 percent, and Oregon's unemployment rate to 9.6 percent, the rates in Curry and Coos County remain a 13.1 and 11.4, respectively, and are among the worst in Oregon. If it is assumed that unemployment impacts an entire household, and that the average household size is 2.7 persons [U.S. Census 2010], then 12,034 of the targeted area's 84,408 persons, have been recently and negatively impacted by unemployment. For many, the loss of employment brings with it the loss of employer-sponsored, or partially-sponsored, health insurance benefits.

**Federal Designations:** The entire range of Coos and Curry Counties is classified as a *Medically Underserved Area* (Designation 7419994114). Both counties hold classifications as *Health Professional Shortage Areas for Low-Income Persons* (Designation Number 14199941 for Coos County, and Designation Number 1419994195 for Curry County). Both counties are classified as a *Mental Health Professional Shortage Area* for all persons (Designation Number 7419994114) [hrsa.hpsafind.gov, March, 2012].

## II. Population and Demographics

**General:** Coos and Curry Counties are home to 84,408 residents [U.S. Census Update]. Of these persons: 17,749 (21 percent) are seniors, aged 65 and older, who are eligible for inclusion in the Medicare program; 17,900 (21.2 percent) are children and adolescents aged 0 to 17, 11,921 (66 percent) of whom qualify for inclusion under the expanded State Children's Health Insurance Program (SCHIP); and, 48,759 (57.7 percent) are adults between the ages of 18 to 64. Of this adult population: 16,178 (33 percent) are privately insured; 4,388 (9 percent) are significantly under-insured; and, 20,733 (42.5 percent) are medically uninsured. Of interest, of those adults who are fully and adequately insured, the preponderance are either workers, or dependents of workers, who are employed in the public sector (i.e., persons who are employed by the federal government, county governments, local city governments, port districts, school districts, and other special districts). Few persons employed in the private sector are fully or adequately insured.

**Culture, Ethnicity, and Language:** Coos and Curry Counties are comprised of an ethnically homogeneous population that is comprised, in the majority, of Caucasians of European ancestry (N = 79,445, or 94.12 percent). Table 1 presents data pertaining to ethnic minorities for the general population.

**Table 1**
**Ethnic Minorities in Coos and Curry Counties**

| Ethnicity | Number | Percent |
|---|---|---|
| Black, African-American | 110 | .13% |
| American Indian or Alaska Native | 1,367 | 1.62% |
| Asian | 202 | .24% |
| Hawaiian or Pacific Islander | 388 | .46% |
| Other, or Two or More Races | 2,887 | 3.42% |
| Hispanic of Any Race | 2,448 | 2.90% |

Bureau of Census findings report that 5.4 percent (N = 4,558) of the target population is comprised of native Spanish speakers. Local wisdom suggests that, in fear of exportation, a goodly number of undocumented residents escaped inclusion in the formal Census process. On an annual basis, the Office of Oregon Health Plan Policy and Research estimates that 119 persons living in Coos and Curry Counties are eligible for Citizen/Alien-Waived Emergent Care (CAWEM) [Oregon Health Authority, January 15, 2012]. Of interest, a recent study [Ingram, August 2010] estimated that fully one-half of all undocumented aliens in Coos and Curry Counties were from Canada.

**Migrant and Seasonal Farm Workers:** Coos and Curry Counties support extensive agricultural pursuits in floriculture, forest re-planting, and cranberries. While there are no licensed migrant and seasonal farm labor camps located within either county, data related to migrant education obtained from the Educational Service District suggests that the counties serve as the temporary home to 400 migrant and seasonal farm workers each year, the majority of whom are Mexican nationals who have illegally crossed the United States border. The migrant farm workers who travel to this area do so in the absence of their family units and are largely adult males in their twenties and thirties. They are housed in the trailer units of semi-trucks parked adjacent to the railroad, and are nearly invisible, although they can be observed laundering blue jeans and white tee shirts at coin-operated laundry facilities nearly every Saturday when the cranberry harvest is underway. When in need of legal, social, or health services, the migrant workers seek referrals from an understanding bilingual and bicultural proprietor of a local Mexican restaurant.

**Housing and Homelessness:** Locally, the housing trend has seen a significant influx of retirees who, having sold their California homes for significant profit margins, have readily-available cash with which to purchase retirement *dream homes* along the Oregon coast, thereby increasing the market value for most real property in Coos and Curry Counties. Housing costs doubled between 2002 and 2008, and then dropped, but not precipitously so, concurrent with the national economic recession from 2008 to 2011. Although there are no public housing projects within the targeted census tracts, each community supports some low-income housing units. The Coos and Curry Housing Authorities report that the average waiting period for HUD-supported public housing and/or Section 8 vouchers exceeds twenty-five months.

On an annual basis, the Oregon Department of Housing and Community Services conducts a one-night shelter count of persons who are homeless. However, because there are no shelters in Curry County, and only a single forty-bed shelter in Coos County, the one-night shelter count consistently fails to accurately enumerate the number of homeless persons in the target communities. Local school districts

report that 652 high school aged students meet Title I homelessness criteria [586 in Coos County and 66 in Curry County; Oregon Department of Education, March 2012]. If it is assumed that each homeless adolescent is a member of a family, with an average household size of 2.7 persons [U.S. Census, 2010], then it may be reliably extrapolated that there are at least 1,760 persons who are homeless in Coos and Curry Counties. Advocates for the homeless place the estimate at 900 persons in Coos County [Nancy Devereux Center, Coos Bay, March, 2012].

**Income and Poverty:** In 2008, Oregon's median family income stood at $47,800 (or $15.32 per hour, based on 1.5 FTE workers per household). Median family incomes in the targeted region are significantly lower: $34,300 ($10.99 per hour) in Coos County; and, $35,600 ($11.41 per hour) in Curry County [U.S. Housing and Urban Development, Fiscal Year 2008 Income Limits for Section 8 Fair Market Housing]. In Coos and Curry Counties, 14.03 percent of all persons live at or below 100 percent of the Federal Poverty Index, while 50.97 percent live between 101 and 200 percent of the Federal Poverty Index (ffiec.gov/census). In aggregate, 65 percent the all persons in Coos and Curry County live at or below 200 percent of the Federal Poverty Index.

**Educational Attainment:** To a large extent, the lack of family-wage employment in Coos and Curry Counties is not only a function of the paucity of employment opportunities, but also the function of poor educational attainment rates. In Oregon, fully 26.3 percent of all adults over the age of 25 have failed to attain a high school diploma or its equivalent. Once again, we find rates in Coos and Curry Counties that are substantially worse. In Coos County, 30.7 percent of all adults have failed to attain a high school education; in Curry County, that number stands at 32.1 percent.

**Gender and Age:** The service delivery area's population evidences a normal distribution with respect to gender. As is the prevailing national pattern, women tend to be higher consumers of primary health care services than men (as evidenced by insurance premiums which, until 2011, were markedly higher for women, when compared to men, until the age of senescence when premiums for the two genders achieve parity). Among local private practices, women are disproportionately higher consumers of clinic services until the attainment of Medicare age, at which time utilization trends for both genders attain parity. For the populated aged 15 to 64, women comprise seventy-three percent of all clinic users. In part, this is due to the fact that more women live in poverty than do men. [Within the targeted Counties, the average annual earnings for males employed on a full-time basis is $31,083, compared to $23,512 for females employed on a full-time basis.]

Twenty-two percent (22.5%) of the target area's population is 65 or more years of age, which is extremely disparate when compared to an Oregon statewide rate of 12.8 percent and a national rate of 12.4 percent. Moreover, the very elderly, aged 75 and older, are proportionately among the fastest-growing sub-population when compared with national age distribution norms.

## III. Description of the Local Medical Environment

**Hospitals:** Curry County is served by a single hospital, Curry General, which is a Type A Critical Access Hospital. Curry General Hospital supports 24 staffed beds. In 2010, the hospital provided 2,407

inpatient days, for an average length of stay of 3.38 days, and an occupancy rate of 27.48 percent. The hospital also supported 4,084 emergency department visits and 47,999 outpatient visits. Net patient revenue was $21,798,351, against total operating costs of $23,646,102, for an operating margin of -6.34 percent. Medicaid accounts for 12.06 percent of all hospital revenue.

Coos County is served by three hospitals: Bay Area Hospital; Coquille Valley Hospital; and Southern Coos Hospital. Bay Area Hospital is classified as a "DRG" facility. It boasts 129 staffed beds. The hospital is mid-course in a construction project that will expand its capabilities. In 2010, the hospital provided 23,019 inpatient days, for an average length of stay of 3.17 days, and an occupancy rate of 48.9 percent. The hospital also supported 21,377 emergency department visits and 73,085 outpatient visits. Net patient revenue was $130,701,420, against total operating costs of $128,061,935, for an operating margin of +3.29 percent. Medicaid accounts for 13.44 percent of all hospital revenue.

Coquille Valley Hospital is a Type B Critical Access Hospital, and supports 25 staffed beds. The Hospital is mid-course in a new construction project that will expand its capabilities. In 2010, the hospital provided 1,627 inpatient days, for an average length of stay of 3.08 days, and an occupancy rate of 17.83 percent. The hospital also supported 4,402 emergency department visits and 20,602 outpatient visits. Net patient revenue was $16,243,905, against total operating costs of $15,238,302, for an operating margin of +7.47 percent. Medicaid accounts for 10.77 percent of all hospital revenue.

Southern Coos Hospital is a Type B Critical Access Hospital, and supports 19 staffed beds. In 2010, the hospital provided 1,148 inpatient days, for an average length of stay of 3.22 days, and an occupancy rate of 16.5 percent. The hospital also supported 4,327 emergency department visits and 12,912 outpatient visits. Net patient revenue was $16,208,396, against total operating costs of $17,255,568, for an operating margin of -6.38 percent. Medicaid accounts for 7.04 percent of all hospital revenue.

**Mental Health Professionals:** The *Yellow Pages* for Coos and Curry Counties identify four clinical psychologists, 14 licensed clinical social workers, two licensed marriage and family therapists, and two licensed professional counselors. Coos County Mental Health Department directly employs a staff psychiatrist, two psychiatric nurse practitioners, one psychiatric nurse, and 26 qualified mental health professionals, several of whom are dually certified as certified alcohol and drug counselors.

**Indian Health Services Clinics:** The Confederated Tribes of the Coquille, Siuslaw, Coos, and Umpqua operate an Indian Health Clinic in North Bend (Coos County). Travel distances do not render this clinic as a viable option for most eligible persons who live in Curry County.

**Safety Net Clinics:** Curry General Hospital operates two Critical Access Clinics: one in Brookings and one in Port Orford. Coos County is served by Waterfall Community Health Center, a federally qualified health center, and by Bandon Community Health Center, a participating Rural Health Clinic. A rural health district, established in 1980 in the community of Powers, has been unable to recruit or retain a provider for the past three years, and is currently inactive. In early 2005, the National Association of Community Health Centers (NACHC) commissioned a study to identify the nation's 100 poorest counties that did not enjoy the benefit of a federally qualified health center within their boundaries. Curry County was one of five Oregon counties identified by NACHC's study.

**School-Based Health Centers:** In Curry County, school-based health centers operate on the campuses of Brookings-Harbor and Port Orford High Schools. In Coos County, school-based health centers operate on the campus of Marshfield High School (Coos Bay) and Powers Elementary School.

**Providers:** Table 2, below, summarizes the numbers and types of health care professionals and providers that serve Coos and Curry Counties, and compares the supply of providers to Oregon's population-to-practitioner ratios.

**Table 2**
**Health Providers by Type, Number, and Ratio**

| HEALTH CARE PROVIDER TYPE | Coos County NUMBER | Coos County RATIO | Curry County NUMBER | Curry County RATIO | Oregon RATIO |
|---|---|---|---|---|---|
| Primary Care Physicians | 59 | 1 : 1,069 | 16 | 1 : 790 | 1 : 930 |
| Emergency Physicians | 7 | 1 : 9,009 | 0 | | 1 : 5,820 |
| General Surgeons | 9 | 1 : 7,007 | 0 | | 1 : 10,418 |
| Obstetricians and/or Gynecologists | 8 | 1 : 4,030 | 1 | 1 : 10,918 | 1 : 3,386 |
| Psychiatrists | 6 | 1 : 10,511 | 3 | 1 : 7,113 | 1 : 6,437 |
| All Other Physician Specialties | 46 | 1 : 1,371 | 7 | 1 : 3,049 | 1 : 845 |
| Physician Assistants | 9 | 1 : 7,007 | 2 | 1 : 10,670 | 1 : 4,165 |
| Registered Nurses | 701 | 1 : 90 | 87 | 1 : 245 | 1 : 107 |
| Nurse Practitioners | 28 | 1 : 2,252 | 12 | 1 : 1,778 | 1 : 1,956 |
| Nurse Anesthetists | 16 | 1 : 3,942 | 1 | 1 : 21,340 | 1 : 12,451 |
| Clinical Nurse Specialists | 3 | 1 : 21,022 | | | 1 : 26,188 |
| Pharmacists | 25 | 1 : 2,423 | 4 | 1 : 5,335 | 1 : 1,716 |
| Physical Therapists | 31 | 1 : 2,034 | 11 | 1 : 1,940 | 1 : 1,593 |
| Dieticians | 5 | 1 : 12,613 | 1 | 1 : 21,340 | 1 : 8,478 |
| Dental Hygienists | 32 | 1 : 1,971 | 9 | 1 : 2,371 | 1 : 1,614 |
| Dentists | 34 | 1 : 1,855 | 11 | 1 : 1,940 | 1 : 1,494 |

## IV. Community-Level Health Statistics and Disparities

### A. Physical Health

**Comparative Rural Health Data:** On a biennial basis, the Oregon Office of Rural Health engages in a legislatively required study to identify and quantify areas of unmet health care needs among Oregon's 105 defined rural communities. The study is completed by researchers at Oregon Health & Science University under contract to the Oregon Office of Rural Health. The most recent study was released in November of 2011, and was for the 2011-2013 biennial period. The study examines three factors: percentage of primary care visits met; ambulatory care sensitive hospital admission ratios; and, crude mortality ratios. Crude scores are converted to V-scores, or rates, or ratios, such that adequate comparisons can be made from one community to another.

Percent of Primary Care Visits Met: This measure involves estimating the total number of primary care visits that are needed by a given population, using a complex formula that factors for gender and age. The total visits actually provided is divided by the total number of primary care visits needed, to arrive at the *percentage of primary care visits met.* In Oregon, for all rural service areas in 2011, the mean percentage of primary care visits met was 91.2 percent. In the community of Coquille, in Coos County, only 54.6 percent of all needs for primary health care visits were met, ranking this community as 80th among Oregon's 105 rural communities. The only other targeted community that scored poorly on this variable was Port Orford, where 71.3 percent of all primary health care visit needs were met.

Ambulatory Care Sensitive Conditions (ACS) Ratio: Ambulatory care sensitive conditions (also known as preventable hospitalizations) are a set of inpatient diagnostic categories that may have been preventable or unnecessary had they been treated with timely and effective primary care. These include many common conditions such as asthma, diabetes, hypertension, and pneumonia. Many studies have shown that high rates of admissions for these conditions can be indicative of serious primary health care access problems. Other studies have shown that areas with high numbers of low-income or uninsured residents tend to have higher rates of preventable hospitalizations.

For this calculation, the researchers utilized the widely-used list of (ICD-9-CM) ASCS diagnoses pioneered by John Billings. Three years' worth (2008-2010) of Oregon inpatient discharges by Zip Code were retrieved from COMPdata and averaged for a per year number. This average per year number is divided by the current population of the rural service area, and then multiplied by 1,000 to result in a rate per 1,000 members of the population. Each rural service area rate is then divided by the ASC rate for the state to produce a ratio.

$$\text{ACS Rate} = \frac{\text{One Year Average ACS Admissions}}{\text{Current Total Population}} \times 1{,}000$$

$$\text{V2} = \frac{\text{ACS Rate for Service Area}}{\text{ACS Rate for State}}$$

An ASC ratio of less than 1.00 indicates that the area has a lower preventable hospitalization rate than the state as a whole, while a value greater than 1.00 indicates above average hospitalizations for preventable conditions. The mean ACS ratio for rural service areas in Oregon is 1.25 – somewhat higher than for the state as a whole, generally indicating that rural populations have an overall greater rate of hospitalizations for preventable conditions. The following scores were assigned to designated rural communities within the five-county service delivery area:

| | | | |
|---|---|---|---|
| Bandon | 2.47 | Coos County | Rank 103 of 105 |
| Gold Beach | 2.41 | Curry County | Rank 100 of 105 |
| Powers | 2.24 | Coos County | Rank 99 of 105 |
| Coos Bay | 2.08 | Coos County | Rank 98 of 105 |
| Port Orford | 1.91 | Curry County | Rank 97 of 105 |

The two-county rural service delivery area was distinguished by attaining five of the nine worst scores in the state of Oregon with respect to negative ACS ratios. This is highly indicative of series primary health care access problems, or quality of care, or both.

Comparative Mortality Ratio: This variable compares the rural service area's crude (not age-adjusted) death rate to the death rate for the entire state. This non-age-adjusted rate is a valuable measure because it reflects a number of unique qualities that may affect rural areas (e.g., a higher proportion of elderly, a greater number of laborers in dangerous occupations, and lack of emergency medical transport systems). Three years' worth of mortality data were used, and then averaged in order to control for fluctuations that may occur annually with small numbers in some service areas.

$$\text{Crude Death Rate} = \frac{\text{One Year Average Resident Deaths}}{\text{Current Population}} \times 1{,}000$$

$$V3 = \frac{\text{Crude Death Rate for Service Area}}{\text{Crude Death Rate for State}}$$

As with the ACS ratios, the comparative mortality ratio was adjusted (or weighted) so that, for comparison purposes, 1.00 would equal the state's average. Therefore, a comparative mortality ratio of less than 1.00 would indicate that the area has a lower death rate than the state as a whole, and a value greater than 1.00 would indicate above average mortality rates. For Oregon's 105 rural communities, the mean comparative mortality ratio was 1.29, meaning, overall, mortality is greater in rural communities than for the state as a whole. Comparative mortality ratios attained by rural communities within the five-county service delivery area include:

| | | | |
|---|---|---|---|
| Bandon | 2.28 | Coos County | Rank 103 of 105 |
| Powers | 2.05 | Coos County | Rank 101 of 105 |
| Port Orford | 1.80 | Curry County | Rank 97 of 105 |
| Brookings | 1.69 | Curry County | Rank 94 of 105 |
| Gold Beach | 1.63 | Curry County | Rank 92 of 105 |
| Coquille | 1.62 | Coos County | Rank 89 of 105 |

For this variable, three local communities (Bandon, Powers, and Port Orford) attained scores that were two standard deviations above the mean, while an additional three communities attained scores that were a single deviation above the mean for all rural communities in Oregon. Simply put, six local rural communities evidence much higher rates of mortality than the state as a whole, or for other rural comparison communities.

Overall Ranking: In concluding its study on Unmet Primary Health Care Needs in Oregon's Rural Communities, the researchers weighted all three variables to arrive at a rank-order listing of those rural communities with the greatest needs. Of the 105 rural communities scattered across Oregon's thirty-six counties, the following communities were listed as evidencing the highest overall unmet health care needs in rural Oregon:

| | | | |
|---|---|---|---|
| Port Orford | 42 | Curry County | Rank 8 |
| Powers | 42 | Coos County | Rank 9 |
| Bandon | 47 | Coos County | Rank 16 |
| Coquille | 49 | Coos County | Rank 22 |

**Age-Adjusted Death Rates:** Table 3 depicts age-adjusted death rates for Coos and Curry Counties for the three-year period 2007-2009 (representing the most recent period for which certified death data are available) and contrasts these with Oregon's statewide rates.

**Table 3**
**Three-Year-Averaged, Age-Adjusted Death Rates**

| Cause of Death | State Average | Coos & Curry Counties |
|---|---|---|
| Infectious and Parasitic Disease | 14.3 | **20.6** |
| Malignant Neoplasms | 181.3 | **214.9** |
| Diabetes Mellitus | 25.9 | 22.0 |
| Major Cardiovascular Disease | 214.9 | 245.5 |
| Influenza and Pneumonia | 11.6 | 12.3 |
| Chronic Lower Respiratory Disease | 47.3 | **57.8** |
| Chronic Liver Disease | 11.4 | **17.5** |
| Symptoms and Signs of NEC | 15.3 | 20.6 |
| Unintended Injury and Accidents | 40.9 | 45.1 |
| Suicide | 15.4 | **26.6** |
| Alcohol-Induced Deaths | 13.2 | **21.6** |
| Drug-Induced Deaths | 14.4 | **17.1** |

**Notes:** (1) Rates are expressed as deaths per 100,000; (2) Rates in bold type are significantly elevated over statewide norms
**Source:** Oregon Office of Epidemiology, County Data Books, 2009, Table 6-47t

Coos and Curry Counties ranked 2nd in Oregon for the incidence rate of esophageal, lung, and bronchial cancers, 4th for oral, pharyngeal, and prostate cancer, and 5th for kidney and renal cancer. Worse, Coos and Curry Counties ranked 1st for age-adjusted deaths arising from esophageal, kidney, renal, oral, and pharyngeal cancers and leukemia. Within Coos and Curry Counties, the incidence rate for arthritis and hypertension are trending downward, while the rates for asthma, heart attack, stroke, diabetes, elevated blood cholesterol, and obesity are trending upward and are higher than statewide norms. Among eighth-grade students, 15.7 percent are considered overweight, while 10.8 percent are considered obese.

**Infant Mortality Rates:** Many authorities agree that a community's infant mortality rate is the greatest measure of the community's overall health status [World Health Organization, 2003]. A study of three-year averaged infant mortality rates for multiple three-year bands spells alarming concerns for at least one rural community in Coos and Curry Counties, as illustrated in Table 4.

**Table 4**
**Three-Year Averaged Infant Mortality Rates**

| Community | 2003-2005 | 2004-2006 | 2005-2007 | 2006-2008 |
|---|---|---|---|---|
| United States | 8.2 | 8.2 | 8.2 | 8.2 |
| Oregon | 7.2 | 7.2 | 7.2 | 7.2 |
| Bandon, Coos County | **13.4** | 6.7 | 6.5 | |
| Coos Bay, Coos County | 5.5 | 7.8 | 9.6 | 6.4 |
| Coquille, Coos County | 5.3 | 6.5 | 5.6 | 4.9 |
| North Bend, Coos County | 9.2 | 6.9 | 2.3 | 2.2 |
| Gold Beach, Curry County | 9.5 | **20.0** | **19.8** | **22.0** |
| Port Orford, Curry County | **27.8** | **55.6** | **27.8** | **26.3** |

**Note:** Rates in bold type are significantly elevated over state and national norms

**Perinatal Health:** On average, 71.9 percent of all maternity cases enter pre-natal care during the first trimester of pregnancy, and 8.7 percent receive inadequate pre-natal care [Oregon Office for Health Statistics, 2008]. The low infant birth weight rate is 68.4 per 1,000 births, and the very low infant birth weight is 7.6 per 1,000 births. By comparison, Oregon's statewide low infant birth weight rate is 61.0, and very low infant birth weight rate is 9.8. Of all pregnant women in Coos and Curry Counties, 21.5 percent report the use of tobacco products during pregnancy.

The adolescent pregnancy rate for Coos County is 7.8 per 1,000 females aged 10 to 17, and the same rate for Curry County is 6.5. These rates compare favorably against Oregon statewide adolescent pregnancy rates of 10.1 per 1,000 females aged 10 to 17. In both Coos and Curry Counties, the pregnancy rates for 18 and 19 year-olds, at 98.9 and 93.3, respectively, are higher than Oregon's mean rate of 86.8 per 1,000 females aged 18 and 19.

**Child Health:** Based on the 4:3:1:3:3 childhood immunization protocol, the rates of age appropriately immunized children in Coos and Curry Counties have steadily increased: from 71.8 percent in 2004, to 72.4 percent in 2006. Thereafter, it is not possible to track true trend data, as effective January 1, 2007, the immunization standard became 4:3:1:3:3:1, to include Varicella. As of 2010, the compliance rate with age-appropriate immunization protocols stood at 75.1 percent in Coos County, which is favorable when compared to Oregon's statewide average of 73 percent [Oregon ALERT Immunization Registry]. Nonetheless, nearly one out of every four children in the targeted counties is not age-appropriately immunized.

**Adolescent Health:** On a biennial basis, the *Oregon Youth Behavior Risk Survey* is administered to eighth- and eleventh-grade students in participating school districts throughout Oregon. The *Survey* has been normed and standardized to account for students who provide unusually favorable or fictitious results. Table 5 presents data from the responses of eleventh-grade students from Coos and Curry Counties.

**Table 5**
***Oregon Youth Behavior Risk Survey* Data: 2010**

| Variable | Curry County | Coos County |
|---|---|---|
| Percent of youth reporting "poor" or "fair" health status | 10.2 | 10.9 |
| Percent of youth reporting "poor" or "fair" mental health status | 17.0 | 20.4 |
| Percent of youth who have not visited a physician in greater than 24 months, unless ill or injured (e.g., no preventative or well-adolescent health exam) | 29.1 | 17.7 |
| Percent of youth who report that they have *unmet primary health care needs* | 20.0 | 22.1 |
| Percent of youth who report that they have *unmet mental health care needs* | 16.8 | 18.2 |
| Percent of youth who admit to frank indicators of serious depression during the past twelve months | 17.9 | 23.1 |
| Percent of youth who state they have considered suicide | 11.1 | 15.8 |
| Percent of youth who state they have attempted suicide | 5.3 | 6.7 |
| Percent of youth who have consumed alcohol on at least one occasion during the prior thirty days | 43.7 | 51.5 |

**Public Health:** During fiscal year 2010/2011, the Coos County Public Health Department identified 190 incidences of (selected) reportable diseases: 152 for Hepatitis C; 22 for Campylobacter; 7 for Giardiasis; 5 for Hepatitis B; and 2 each for Pertussis and Salmonella. The trend for all reportable diseases was downward, with the exception of Campylobacter. During the same time period, the Public Health Department engaged in partner notification for 161 cases of Chlamydia. Five possible cases of Turberculosis were investigated, with one active case identified and three latent cases treated. A total of 77 animal bites were reported, with none resulting in a confirmed case of Rabies.

**County Health Rankings:** In late March of 2010, the Robert Wood Johnson Foundation, in partnership with the University of Wisconsin Population Health Institute, released its *County Health Rankings* for Oregon. (Although Oregon has thirty-six counties, six smaller counties were combined and counted as three counties, and thus the overall rating is based on thirty-three, and not thirty-six, counties.) This nationwide project ranks counties within each state, and also compares them to national standards. Coos County was ranked 26$^{th}$ out of 33 counties with respect to health disparities and mortality rates, while Curry County was ranked 25$^{th}$. Factors that contributed to low rank status for Coos County included: high rates for premature death; tobacco use; adult obesity; fatal injuries; preventable hospital stays; and poverty. Factors that contributed to low rank status for Curry County included: high rates for premature death; motor vehicle deaths; an inadequate supply of primary care physicians; low compliance rates with cancer screening protocols; percentage of children living in poverty; and, high proportion of single-parent households.

## B. Mental and Behavioral Health

The Office of Applied Studies at the federal Substance Abuse and Mental Health Services Administration engages in annual surveys to estimate the prevalence of certain mental health conditions (i.e., generalized psychological distress and major depressive episodes) for which data are aggregated at the state level. According to the survey administered in 2009, 12 percent of all adult Oregonians reported experiencing serious psychological distress within the past year. Among persons aged 18 to 25, 22 percent of all randomly selected survey respondents reported an episode of serious psychological distress within the past year, placing Oregon at the top of state rankings for this variable. An alarming 10 percent of all adult Oregonians reported suffering from at least one major depressive episode in the past year, and Oregonians consistently scored two standard deviations above the man for this variable when compared to other states (2007 and 2009).

The Oregon Office of Epidemiology monitors very few variables that are specifically related to mental health and/or substance abuse. Within its available data sets, it is known that the three-year averaged (2007 to 2009) age-adjusted death rate for reasons of suicide in Coos and Curry Counties was 26.6, which compared negatively to a statewide rate of 15.4 per 100,000. This trend was significantly stronger for males than for females, with an age-adjusted suicide-related death rate for males of 38.1 per 100,000. Between 2000 and 2010, forty (40) Coos and Curry County children and adolescents were admitted to Curry General Hospital or Southern Coos Hospital for sufficiently serious injuries as to require emergency medical intervention and/or hospitalization arising from suicide attempts.

National and state data also testify to significant unmet substance abuse treatment needs. The Substance Abuse and Mental Health Services Administration's *National Survey on Drug Use and Mental Health* (2009) estimated that 32,000 Oregonians, aged 18 to 25, needed, but did not receive, treatment services for illicit drug addiction; of those 32,000 persons, 520 resided in Coos and Curry Counties. In Oregon, 9.62 percent of all persons aged 18 to 25 are dependent on illicit substances and not enrolled in treatment programs. Oregon, along with eight other states, scores within the second standard deviation above the mean for the proportion of substance-dependent persons who are not receiving treatment, at >9.09 percent. Three-year averaged (2007-2009) and age-adjusted death rates in Coos and Curry Counties for alcohol-induced deaths at 21.6, is nearly double the Oregon statewide average of 13.2. Drug-induced death rates are similarly elevated at 17.1, compared to an Oregon statewide rate of 14.4.

## C. Oral Health

Although community-specific data are not available, the *Oregon Smiles Survey* (2009) found that 56 percent of six-to-eight-year-old children in Oregon suffered from tooth decay, well off the mark set at 42 percent by *Healthy People 2010*. Among children eligible for the National School Lunch Program, 68 percent of Oregon's children evidenced decay, 30 percent were in need of urgent oral health treatment, and 21 percent evidenced decay in seven or more teeth. [These data compare negatively against children from moderate-to-high-income families, at 48 percent, 11 percent, and 10 percent, respectively.] Children from low-income households are at greater risk of not receiving dental care.

Only 58 percent of low-income children visited a dentist in 2001, compared to 87 percent of moderate-to-high-income children. The primary reason cited for not having been to a dentist in the last year was that the parent *could not afford it* (64 percent). Of extreme interest, when the *Oregon Smiles Survey* was repeated in 2007, the results were sobering: every major measure of oral health among Oregon's school children had worsened.

Dental decay remains a significant public health problem for Oregon's children. According to the *Oregon Smiles Survey* (2009), nearly two out of every three children in first, second, and third grades (representing 80,000 children statewide) have already had a cavity. One out of every five children in this age group (representing more than 24,000 youngsters), have rampant decay, meaning decay in seven or more teeth. One out of every six children in this age band (representing 21,000 children), have already had cavities in their permanent adult teeth. Decay in a permanent tooth requires a lifetime of re-treatment, often including larger fillings over the years, and perhaps an ultimate root canal, crown, or extraction. Decayed teeth are also not suitable for dental varnishes – a highly effective, low-cost method for preventing cavities.

The amount of productive time lost from the classroom as a result of neglected oral health care among Oregon's children is staggering. Among children enrolled in primary grades, every day, nearly one in twenty children require urgent care due to dental pain or infection. On any given day, across all age bands, more than 5,000 children in Oregon are in school and suffering from dental pain or infection. By extrapolation, it is estimated that on any given school day, 34 children enrolled in public schools in Curry and Coos Counties are in need of urgent dental care. Also by extrapolation, it is estimated that in any given school year, the community's children and adolescents will miss 2,950 days of school as the result of oral pain.

Of particular concern is the fact that children who live outside of the Portland metropolitan area, in the more rural portions of Oregon, suffer from poorer oral health. Children from the state's urban areas evidenced less untreated tooth decay and were less likely than their rural cohorts to have ever had a cavity. More than one-half of urban third-grade students have dental sealants; slightly less than one-fourth of rural children in Coos and Curry County enjoy the benefits of dental sealants.

In November of 2006, the Oregon Public Health Division released its landmark study: *The Burden of Oral Disease in Oregon*. Despite the fact that studies document that periodontal disease during pregnancy has been associated with low birth weight and pre-term deliveries (Khander, 2005), and that poor oral health during pregnancy increases the risk of early childhood dental caries among offspring (Caufield, 2004), the study found that less than one-half of Oregon's women sought dental care during pregnancy, and only one-third received education on how to care for their infant's teeth. Among children, oral disease is five times more common than asthma. Neither Coos nor Curry Counties have access to fluoridated water.

In November of 2008, Nancy Abrams, D.M.D., primary care planner for the Oregon Primary Care Office, completed an exhaustive study that culminated in a report entitled *Primary Care Dental Capacity in Oregon: Results of the 2007 Primary Care Dental Survey*. Although most (95.3 percent) of primary care dentists in Oregon are accepting new patients, nearly one half of those (45.8 percent) also reported that they were imposing some type of restriction on new Medicaid patients. Within Coos and Curry Counties, there is 1.0 FTE primary care dentist for every 2,357 members of the general population,

which compares equitably to an Oregon statewide average of 1:2,243. However, when an examination is made of the number of primary care dentists who accept Medicaid, or who agree to work out payment plans for professional services with dentally uninsured or low-income patients, the dentist-to-population ratio in Coos and Curry Counties soars to 1:6,343.

When queried as a component of the *Oregon Youth Behavior Risk Survey* (2010), 17.4 percent of youth from Curry County, and 11.6 percent of youth from Coos County, stated that they had not visited a dentist within the past twenty-four months.

During the course of celebrating its 50th Anniversary, the Oregon Community Foundation announced that it would allocate $1 million to each major region of Oregon, and that the leadership of each region could independently determine how to best invest those funds. While other regions chose to invest their allocations in high school retention, economic development, or addressing the root causes of poverty, the Coos and Curry County leadership group, after careful study, decided to invest its allocation in pediatric dental services. The resultant *Ready to Smile* program provides oral health screening and dental varnish services for all children in Grades 1, 2, 6 and 7, as well as restorative dentistry and treatment for children in Grades K to 7. The project has since been enjoined by the Curry Health Foundation, the Ford Family Foundation, the Sprague Family Foundation, and multiple Rotary Clubs.

## V. Medicaid Statistics and Health Disparities

**Medicaid Enrollees:** As of January 15, 2012, there were a total of 12,597 Oregon Health Plan, Medicaid, and CHIP enrollees in Coos County. Of these: 10,847 were participating in the managed care plan operated by DOCS; 105 were participating in alternate managed care plans; and 1,640 were on "open cards" or fee-for-service arrangements. As of January 15, 2012, there were a total of 3,336 Oregon Health Plan, Medicaid, and CHIP enrollees in Curry County. Of these: 1,872 were participating in the managed care plan operated by Mid-Rogue Independent Practice Association; 768 were participating in the managed care plan operated by DOCS; 7 were participating in alternate managed care plans; and 686 were on "open medical cards" or fee-for-service arrangements [DMAP].

As of January 15, 2012, 12,129 persons in Coos County, and 2,670 persons in Curry County, were enrolled with Advantage dental care organization; 450 persons in Coos County and 661 persons in Curry County were on "open dental cards" or fee-for-service arrangements.

As of January 15, 2012, 11,660 persons in Coos County, and 3,110 persons in Curry County, were enrolled with Jefferson Behavioral Health, while 891 persons in Coos County and 216 persons in Curry County, were on a fee-for-service basis for mental health care needs.

**Dually Eligible Medicaid and Medicare:** As of January 15, 2012, 2,274 persons in Coos County, and 587 persons in Curry County, were dually enrolled in Medicaid and Medicare (blind, disabled, and general assistance adults).

**Physical Health:** On May 26, 2011, the Oregon Health Authority published comparative disease rates among its various managed care organization and fully-capitated health plans. An analysis of this data confirms that the Medicaid population served by DOCS suffers from higher rates of overall chronic disease conditions than Oregon's statewide rate. In specific, the state rate for any type of chronic disease state among Medicaid beneficiaries is 311.55 per 1,000, while the chronic disease rate for Medicaid patients served by DOCS is 438.58. For some disease states (e.g., chemical dependency, post-traumatic stress disorder, borderline personality disorder, and hepatitis-c), the rates evident among Coos and Curry County's Medicaid population is greater than that of Medicaid beneficiaries enrolled in the state's high risk pool. These data are illustrated in Table 6.

**Table 6**
**Rates per 1,000 Patients for Oregon Health Plan Members with Chronic Disease Conditions**

| Diagnostic Category | Rate for DOCS' Members | Rate for State's High-Risk Pool | Statewide Rate |
|---|---|---|---|
| Chemical Dependency | 15.32 | 14.69 | 20.86 |
| Depression | 21.09 | 26.88 | 18.51 |
| Schizophrenia | 15.15 | 35.95 | 15.36 |
| Attention Deficit Disorder | 39.25 | 39.39 | 25.89 |
| Post-Traumatic Stress Disorder | 34.86 | 29.38 | 23.01 |
| Borderline Personality Disorder | 11.71 | 3.75 | 1.82 |
| Dementia | 8.26 | 34.39 | 8.84 |
| Alzheimers | 2.15 | 13.13 | 2.72 |
| Autism | 7.83 | 17.19 | 6.82 |
| Bipolar Illness | 19.02 | 25.32 | 16.35 |
| Diabetes | 75.75 | 111.91 | 48.92 |
| Congestive Heart Failure | 14.55 | 35.95 | 11.34 |
| Chronic Ischemic Heart Disease | 17.90 | 31.88 | 12.05 |
| Asthma | 69.47 | 78.46 | 50.72 |
| Emphysema | 6.46 | 10.94 | 2.75 |
| Chronic Bronchitis | 44.25 | 64.08 | 20.87 |
| Hepatitis C | 15.58 | 8.13 | 9.26 |
| **Rate per 1,000 Overall on Plan** | **438.58** | **617.07** | **311.55** |

**Mental Health:** During 2009/2010, Coos County Mental Health Department provided 40,000 billable services on behalf of 2,448 unduplicated Medicaid patients. Of these, 1,504 were adults and 944 were children. The most frequent diagnostic categories, in descending order, were: post-traumatic stress disorder; schizoaffective disorder; adjustment disorder with mixed disturbance of emotions and conduct (pediatric); attention deficit hyperactivity disorder (pediatric); anxiety disorder; schizophrenia; and, depressive disorder.

Coos County Mental Health Department began, as early as 2004, to develop hospital diversion programs resulting in the development of a six-bed acute psychiatric respite facility. Between 2004 and 2010, hospital bed days used at Bay Area Hospital were reduced by 563, from 904 in 2004, to 341 in 2010.

The public mental health system of care in Oregon is characterized by *managed mental health care* and the regional provider of these services for Medicaid beneficiaries is Jefferson Behavioral Health (JBH). This organization has produced some of the poorest mental health trend data in Oregon. For example, 7 percent of JBH's beneficiaries actually accessed mental health services, compared to a statewide average of 8.5 percent among all mental health managed care organizations. Further, of nine mental health managed care organizations, JBH's patients ranked second in the state with respect to the number of psychiatric hospital admissions (at 2.58 per 1,000). When JBH's patients were hospitalized, they received far less active treatment: the average length of stay for JBH patients was 5.4 days per admission, compared to a statewide average of 8.1 days; and 25 percent of all JBH patients were re-admitted within 180 days of discharge [Oregon MHO Utilization Quarterly Reports]. [DMAP discontinued publicly posting MHO Utilization Quarterly Reports in 2008.]

**Behavioral Health:** During the immediately preceding twelve-month period, ADAPT, the chemical dependency treatment provider in Coos County, provided behavioral health services to 337 unduplicated medical users who were insured pursuant to the Oregon Health Plan.

## VI. Modifiable Risk Factors and Issues of Prevention: Considerations for the *Community Health Improvement Plan*

**Substance Use:** While 2 in every 10 adults in Coos and Curry Counties continue the use of tobacco products, at least 1.5 of every 10 Medicaid beneficiaries in Coos and Curry Counties seeks assistance for illicit substance use. It is estimated that for every adult who seeks substance abuse treatment, there is at least one additional adult who does not. While tobacco use is highly detected in all health care settings, illicit substance use is among the most frequently under-detected conditions in primary care practices. The literature relevant to the causal effects of tobacco use on a multiplicity of negative health conditions and outcomes is substantial and convincing. While literally thousands of journal articles have investigated drug abusers' lack of compliance with psychiatric or chemical dependency treatment regimes, very little clinical research has investigated drug abusers' lack of adherence to medical treatment regimes [Carroll, 2009]. A retrospective study of all patients discharged against medical advice (AMA) from a university general hospital over a one-year period found that drug addiction was the diagnosis most strongly associated with AMA discharges. In another retrospective study of patients with known cardiac conditions who failed to comply with recommended treatment protocols, there was a high correlation with alcohol abuse, but only a lesser correlation with drug abuse.

Poorly controlled hypertension has been identified as a major health problem, particularly among minority populations, the poor, and those with lower educational attainment levels. In a 1992 study [Misra, et al.] of patients with severe uncontrolled hypertension who presented in emergency rooms, uncontrolled hypertension was more common among patients with no primary care provider and among those who reported drug use (marijuana, cocaine, heroin, and other drugs). In yet another study, 109 patients with chronic, nonmalignant pain were asked about their current medication intake during the 24 hours prior to a routine examination and were told a urine test would be done to verify their statements about current drug intake. Polymedication (defined as daily consumption of three or more medications) was seen in 38 percent of patients. Only 68 percent of self-reports of current

medication were found to be congruent with urine toxicology screens. Among all patients in the study, 21 percent concealed drug consumption from their physician. Of the drugs concealed, 54 percent fell within the categories of benzodiazepenes, hypnotics, or antidepressants. The consumption of analgesics was also frequently denied falsely [Berndt].

In a general review of psychosocial factors associated with chronic pain, it was found that substance abuse may arise in conjunction with the pain problem (e.g., opiates, benzodiazepenes) or precede it (e.g., alcohol, marijuana, cocaine). In either form, substance abuse impedes rehabilitation and must be addressed aggressively. Abuse can manifest itself as signs of medication dependence, including escalating doses and maneuvering the health care system to acquire additional drugs.

In New York state, alcohol and drug abuse screening, referral, and treatment are a Medicaid eligibility requirement for single individuals and childless couples who are age 21 and over, not pregnant or certified blind/disabled and for federally non-participating parents (i.e., fathers of unborn and stepparents with no other children of their own in the household). Drug and alcohol screening requirements do not apply to persons eligible for Family Health Plus or for Family Planning benefits, and therefore applies primarily to individuals who are eligible for Temporary Assistance to Needy Families (TANF). Because of rising costs in Illinois' public aid and Medicaid programs, policymakers have introduced legislation that would require participants in these programs to randomly undergo drug testing before qualifying for benefits. Florida, Indiana, Massachusetts, Minnesota, New Jersey, Virginia, and Wisconsin all have random drug testing programs to reduce the costs of Medicaid programs. In these states, applicants for TANF or Medicaid must pass a urine test for substance abuse before qualifying for benefits. Applicants are not barred from eligibility unless they fail a re-test to rule out false positive results from the first test. Persons who have a positive re-test are required to complete a substance abuse treatment program within sixty days. Failure to complete a treatment plan and subsequent substance abuse test are barred from receiving benefits for one year. The Medicaid provisions apply only to non-pregnant adults to ensure that minor children and unborn neonates still receive health care coverage. Persons living in nursing homes are exempt from the testing requirements. The American Civil Liberties Union is currently protesting random drug testing in Florida, Illinois, and some other states.

**Childhood Obesity:** Childhood overweight and obesity have reached epidemic proportions and are major public health problems within the United States and some foreign countries (Institute of Medicine, 2011). Between 1970 and 2010, the prevalence of overweight almost tripled among U.S. preschoolers, and quadrupled among children aged six to eleven years (Ogden, et al, 2010). In 2010, 17.1 percent of children aged two-to-eighteen years were at or above the 95$^{th}$ percentile of Body Mass Index (BMI), compared to 6 percent in 1970. In Coos and Curry Counties, 10.8 percent of all eighth-grade students, and 10.9 percent of all eleventh-grade students are at or above the 95$^{th}$ percentile of BMI.

Obesity during childhood has been associated with numerous adverse effects, including a variety of health complications such as hypertension, dyslipidemia, left ventricular hypertrophy, atherosclerosis, metabolic syndrome, type 2 diabetes, sleep disorders, and non-alcoholic fatty liver disease, as well as psychological effects such as stigmatization, discrimination, depression, and emotional trauma (Daniels, et al, 2012; Din-Dzietham, et al, 2007; Lorch & Sharkey, 2007). Obesity in childhood also substantially increases the risk of being an obese adult (Whitaker, et al, 2007).

The development of obesity in childhood involves interactions among multiple factors that may shape daily diet and physical activity behaviors and increase obesity and cardiovascular disease risk. These factors are personal (e.g., beliefs; attitudes; cultural experiences; taste preferences; dietary composition), environmental (e.g., homes; schools; communities; food availability and cost; built environment, i.e., proximity to a *food desert*), societal (e.g., cultural norms; advertising and food marketing; social networks; technological developments; economics; public policy), and health-care related (e.g., provider counseling and treatment; reimbursement), as well as physiological (e.g., intrauterine and early life programming; appetite and satiety mechanisms and regulation; adipose tissue metabolism; genetic predisposition) (Schonfeld-Warden, 2007).

In light of the recognition of childhood obesity as a major public health problem with multiple etiological factors and co-morbidities, numerous health organizations and foundations (e.g., Institutes of Medicine; American Academy of Pediatrics; American Medical Association; American Heart Association; Robert Wood Johnson Foundation; National Institutes of Health) have called for cutting-edge research on both prevention and treatment. Prevention research, in contrast to treatment research, focuses on entire populations or a sub-population of children to decrease the numbers who become overweight or obese and to reduce additional weight gains in those who may already be overweight. A review of recent pediatric obesity research (Katz, et al, 2005; Summerbell, et al, 2009; Flynn et al, 2007; Bluford, et al, 2007; Stice, et al, 2006; Doak, et al, 2007) noted many limitations in research design and outcomes. For example, a Cochran review (Summerbell, 2009) of 22 randomized controlled trials concluded that there was insufficient evidence from the trials to prove any one program or approach can prevent obesity in children or adolescents. Twelve of the 22 studies were short-term (<12 months), or which 8 focused on combined diet and physical activity and found no intervention effects on BMI. The other 4 studies focused on single interventions (e.g., television reduction time), but only two found significantly lower BMI in the intervention group compared to the control group (Robinson, 1999; Flores, 1995). [These two studies involved dancing for health, and reducing television time.] Of the 10 longer-term studies (>12 months), only two reported significantly lower BMI in the intervention compared to the control group (Gortmaker, et al, 1999; Mueller, et al, 2001). [These two studies involved a school-based intervention, and the international Kiel Obesity Prevention Study.] Other reviews (Flynn, et al, 2007; Bluford, et al, 2007) reported a paucity of studies that addressed obesity prevention in certain sub-groups of children (e.g., pre-schoolers; minorities; males; immigrants).

Theoretical models and conceptual frameworks that have been used in childhood obesity prevention research include the Transtheoretical Model (Prochaska, et al, 1997), Health Belief Model (Becker, 1974); Social Cognitive Theory (Bandura, 1986; Rosentock, et al, 1983); and Socio-Ecological Models (Glanz, et al, 2002). In most cases, these models and theories have provided the bases for studies that intervene on a select number of modifiable variables. However, theoretical models have accounted for less than 50 percent of the variance resulting from behavior change interventions (Resincow, et al, 2006). It is noted that behavior change is highly variable, sensitive to individual conditions, non-linear, and involves multiple interactions with, and influences from, the social and physical environments (Baranowski, 2006).

The environments of children include the home, child-care settings, school, community, recreational facilities, community, and transportation infrastructure. Studies on environmental correlates of children's eating and physical activity behaviors are mostly cross-sectional and thus cannot provide causal inferences between the environment and behavior or BMI.

A review of 147 multi-level intervention studies by Flynn, et al, (2007) concluded that there have been a paucity of studies testing population-based and multi-level intervention approaches and that the studies that did exist regarding modifying nutrition and physical activity lacked adequate methodological rigor. Very few studies conducted interventions in community or home settings or both, involved stakeholders in program implementation and evaluation, or intervened on pre-school children, immigrant populations, and males. Few interventions focused on environmental change. In a review of 38 school-based studies by the Centers for Disease Control and Prevention (Katz, 2006), only ten studies were judged to have adequate methodology to be considered. Many of those studies showed some behavioral and/or weight changes in the hypothesized direction favoring the intervention group; however, the interventions and measures used were so varied that the CDC could not determine which approaches to school-based interventions were effective, and thus did not develop specific recommendations based on these studies. Other reviews conducted by the CDC found a lack of evidence that identified intervention components, duration, intensity, and settings most effective for childhood obesity prevention.

From their review of literature, both the Centers for Disease Control and the National Heart, Lung, and Blood Institute (a division of the National Institutes of Health) concluded that the existing body of research provides no definitive answers concerning the optimal intervention approaches or settings for obesity prevention in children. There is a substantial gap between the call for multi-level interventions by such groups as the Institute of Medicine and evidence to guide what are believed to be the most promising interventions. The Centers for Disease Control and NHLBI recommend more research that includes multi-level and multi-component interventions, recognizing the additional challenges presented by such studies. In particular, the role of parents and other family members, as well as parental lifestyle factors and their effects on child body weight, deserve more study. There is early, but strong, research that suggests that breast feeding until at least six months of age may reduce childhood obesity.

**Adult Obesity:** Research conducted by the National Task Force on the Prevention and Treatment of Obesity finds that 60 percent of all low-income adults in the United States are overweight or obese, and that obese persons are more likely to be ill than those who are not. Nonetheless, many obese patients may work overtime to escape involvement in the health care system because of concerns about disparagement by physicians and health care staff, or fears of being weighed. Weight stigma is on the rise in America, according to the Rudd Center for Food Policy and Obesity at Yale University, and, ironically, nowhere is it more deeply rooted than among health care providers. Multiple studies have found that physicians, medical students, registered nurses, dieticians, and other health care professionals routinely stereotype their heavy patients. In landmark research from the University of Pennsylvania (2003), more than half of the 620 primary care physicians surveyed characterized their obese patients as "awkward," "unattractive," "ugly," and "noncompliant." More than one-third of the physicians regarded their obese patients as "weak-willed," "sloppy," and "lazy."

Women bear the brunt of these characterizations – even when they are not obese. Physicians' weight prejudices start when a female patient is as little as thirteen pounds overweight. For men, the bias did not kick in until they were approximately thirty-five pounds overweight. This bias can have a dramatic effect on women's health, resulting in incorrect assessment. Many female patients reported to researchers that, regardless of their symptoms, their physician attributed the symptom to being overweight, and it is for this reason that obese women will typically avoid seeking health care services until such time as their symptoms are too advanced to delay care any longer.

Simple accommodations, such as providing large-sized examination gowns and armless chairs, as well as weighing patients in private areas or initially foregoing the taking of weight measures, may make the medical setting more accessible and comfortable for obese patients. Some communities have found early success in recruiting obese women into care by offering special *weight-friendly* clinics. Although physical examination may be more difficult in obese patients, their disproportionate risk for some illnesses that are amenable to early detection and intervention increases the priority for preventive evaluations. The health care system can encourage improvement in healthy behaviors, regardless of the patient's desire for, or success with, weight loss treatment. Restriction of calories and increased physical activity are central to most strategies for weight reduction. Strong evidence shows that physical activity results in modest weight loss and increased cardiovascular fitness independent of weight loss. Cognitive behavioral interventions, coupled with motivational interviewing by the provider, enhance weight loss. Lifestyle strategies that combine a controlled energy diet, increased physical activity, and behavioral interventions, provide the most successful treatment for weight loss and maintenance of that weight loss.

At the prevention level, there is a strong body of emerging evidence that "collective impact" models may be effective in reducing obesity throughout a community population. Such strategies require the convening of a full spectrum of community stakeholders, much as was evident in the successful *Southern Oregon Meth Project*. Examples of this approach include: Kansas City's *Weighing In* program; Massachusetts' *Healthy Choices* program; Blue Cross' *Walking Works* program (when expanded beyond the school level); and North Carolina's *Fit Together* program.

**Pediatric Mental Health:** The Substance Abuse and Mental Health Services Administration (SAMHSA) is the primary sponsor of the *National Registry of Evidence-Based Practices and Programs* (NREPP at http://nrepp.samhsa.gov), with a particular emphasis on the evidence-base as it relates to all aspects of mental health and substance abuse prevention, early intervention, and treatment (dichotomized into residential, in-patient, intensive day treatment, out-patient). NREPP is an on-line database that may be searched by age, ethnicity, rural/urban, and other relevant factors (e.g., specific drugs of choice, criminal justice populations, school- or community-based). When consulted for mental health prevention or early intervention evidence-based practices and programs for a population aged 0 to 5, three results emerged – all of which are parenting programs: (1) *Incredible Years* is a positive and nurturing parenting education that may have particular value with parents who are harsh or negative, or for parents who are parenting children with early signs of problematic behavior or lack of social competencies. The program may be provided in home, school, and community settings. (2) *Systematic Training for Effective Parenting (STEP)* is a parenting education program that specifically focuses on problematic child behavior, general family functioning, parenting stress, and parent-child interaction, and may be of particular value to parents who are at risk for physical abuse of the child. The program may be offered in school and other community settings. (3) *Triple P – Positive Parenting Program* is specifically designed to work with negative and disruptive child behaviors and corresponding negative parenting practices, by promoting positive parenting practices as a protective factor for later child behavior problems. The program is typically only offered in "other community settings," i.e., public health and primary health care settings. For families in which children are displaying more advanced and/or confirmed signs of mental illness, parent-child interactive therapies are recommended.

**Adult Mental Health:** In Coos and Curry Counties, 5 out of every 10 adult Medicaid beneficiaries carry a formal psychiatric diagnosis, and one out of every three (non-dually eligible) adults seek mental health

intervention each year – rates that are significantly elevated above a normal population distribution in which 1 out of every 20 adults is anticipated to annually seek mental health assistance. Research has shown that underlying mental health and substance use disorder problems account for up to 70 percent of all primary care visits.

The Four Quadrant Model advocates for the clinical integration of mental and behavioral health care services with primary health care services. In federal fiscal year 2012, the Bureau of Primary Health Care will seek ten demonstration projects in which federally qualified health centers co-locate the full range of mental and behavioral health services on-site, while the Substance Abuse and Mental Health Services Administration will seek ten demonstration projects in which primary health care services are co-located at, and fully integrated with, community mental health treatment programs. While it is the goal of the patient-centered primary care medical home model to offer integrated behavioral and mental health care services within the primary care medical home setting, most authorities agree that when it comes to serious and persistent mental illness, the primary care medical home will make referrals to mental health specialists, just as it does for every other medical specialty need – resulting in care that may be more collaborative and coordinated, than integrated.

To grapple with these issues, the prestigious Robert Wood Johnson Foundation (2007) initiated its hallmark study, *Integrating Publicly Funded Physical and Behavioral Health Services* that sought to evaluate sixteen different program models that featured varying methods and levels of integrated services across multiple geographies for which rigorous outcome and evaluation results were available. The project identified integration initiatives being carried out across a range of stakeholders, from efforts by individual providers, to community-based initiatives, to efforts undertaken by managed care plans or sponsoring public agencies. Common elements among the programs included a shared conceptual framework, use of common communication tools, case management, and universal screening. In the final analysis, co-location, patient engagement, and integrated funding were identified as critical factors in producing desired outcomes. Given the significant number of local Medicaid patients who are involved in the mental health system, and who have found a comfort level within that system, a strong argument can be made for integrating primary health care services at the community mental health program where patients are already engaged, rather than integrating mental health services at a multiplicity of primary health care settings, particularly for those individuals who are diagnosed with serious, chronic, and persistent mental illnesses. Patient-centered primary care medical homes can and should be held accountable for fully integrating mental health services at the assessment (or screening) and early intervention levels, and for less acute or chronic mental illnesses that are amenable to brief, problem-focused treatment.

**Oral Health:** With the advent of dental sealants and fluoride varnishes, safe and effective means exist to prevent dental decay and caries among pre-school and school-aged children. One report has shown that sealant application resulted in a 60 percent decrease in tooth decay on molars. In some cases, sealants can even stop tooth decay that has already started (CDC, 2007). In a study conducted in neighboring Jackson County, after an eight-year period of administering dental sealants and varnishes to school-aged children, it was found that, among those children who still suffered significant and multiple dental caries, 95 percent had been continuously dentally insured under the Medicaid program since the time of birth, suggesting that access to dental health insurance is <u>not</u> as significant of a contributing factor to good oral health as is parental diligence and responsibility. It is for this reason that the U.S.

Task Force on Community Preventive Services strongly urges school-based or school-linked sealant programs. In addition, researchers affiliated with the Centers for Disease Control evaluated multiple strategies and found that delivering sealants to all children attending low-income schools was a cost-effective strategy for reducing dental disparities.

**Patient Engagement:** The single greatest variable that confounds the delivery of quality health care services in Coos and Curry Counties, while occluding improved health outcomes and contributing to the escalation of health care costs, is that of patient engagement. It is estimated that 3 in every 10 adult Medicaid beneficiaries is engaged in the use of illicit substances, and fully one-half of these individuals do not want to engage in substance abuse treatment, and therefore actively seek to conceal chemical dependency addiction from their primary care providers. Obese adults, and particularly obese female adults, work overtime to avoid engaging the health care system, but when their medical symptoms are no longer tolerable, they enter the health care system with chronic conditions that could have been prevented, or expensive emergent needs. Five out of every ten adult Medicaid beneficiaries in Coos and Curry Counties have been diagnosed with significant mental illness, and the very nature of the mental illness is such that it either interferes with, or precludes, patients' pro-active engagement in the health care system. Mental illness can render a patient avoidant of health care services, incapable of complying with prescribed medical protocols, unable to anticipate consequences of poor health decisions, or unable to forestall gratification or sufficiently bind anxiety, all of which can result in poor health outcomes, increased needs for health care services, and overutilization of inappropriate emergency department services. Children being raised under circumstances in which a mental illness is present among one or both parents are significantly more likely to evidence pediatric behavioral disturbances and to become mental health patients and second-, third-, or fourth-generation Medicaid beneficiaries as adults. Even among children who have been continuously dentally insured since birth, high rates of dental caries arise as the result of unengaged parents who do not understand the consequences of neglected oral care.

The majority of research that has been conducted on patient engagement describes such engagement in terms of patient satisfaction. However, *satisfaction* is a term bestowed upon patients' feelings toward adequate health care. But a *satisfied* patient is not necessarily an *engaged* patient. The Gallup Research Organization, through its polling process, has determined that truly engaged patients are *emotionally attached* to the provider and the provider's brands or services. Patient engagement is the key to self-management and better medical outcomes and some researchers suggest that "patients are the most under-utilized resource in health care service delivery today." Yet, when one examines the available research on the topic of patient engagement, most such research describes what the provider must do to cultivate engagement, and not what the patient must do to capitalize upon the provider's efforts at engagement. The onus for patient engagement falls with the provider and the health care service delivery system under tremendously difficult and challenging environments in which an estimated one-third of all adult beneficiaries are disengaged and characterized by circumstances in which disengagement occurs by choice or very real psychiatric delimitations.

## VII. Issues Impacting Health Equity

**Health Equity:** The Centers for Disease Control states that *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 inequities are reflected in differences in: length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment. The overarching goal of the CDC is to achieve health equity by eliminating health disparities. The social determinants of health include poverty, unemployment, low educational attainment, rural geographies, and cultural or ethnic barriers.

**Chronic Disease and Poverty:** Chronic disease and poverty are interconnected in a vicious cycle. Chronic diseases result in lost time at work and thus create and contribute to poverty, drawing individuals and families into a downward spiral of worsening disease and poverty. Persons living in poverty are more vulnerable to chronic disease, including greater exposure to inherited and other risk factors and decreased access to health services. In short, the chronic disease burden is concentrated among the poor. In Coos and Curry Counties, the burden of chronic disease is now visiting the third and fourth generation of those who have lived in chronic poverty. Of those who are diagnosed with chronic disease states, the overwhelming majority are characterized by mental and emotional illnesses, and these very illnesses can create barriers to care and resultant inequities.

**Cultural and Linguistic Barriers:** Although small in number, fully one-third of the community's Hispanic persons are not native English speakers, and thus will have limited English proficiency. For these individuals, complex health care systems will be difficult to navigate, thereby resulting in barriers to care and resultant inequities. For a greater number of Coos and Curry County residents, multigenerational poverty has produced a culture of poverty that is more inextricably linked with health inequities than those experienced by minority cultures. Over time, if not already present, health care professionals may also observe the emergence of a culture of obesity with its resultant isolation and health inequities. Early research is confirming that those who are obese experience less degrees of acceptance within the health care system, resulting in access barriers.

**Low Educational Attainment and Literacy Skills:** One out of every four adults aged 30 to 50 in Coos and Curry Counties has failed to attain a high school education. These individuals may experience difficulty in reading printed patient or consumer information, following printed health care instructions, or understanding the detail sheets that accompany prescription medications. While many who are capable of solid reading and comprehension skills will often find health literacy to be challenging, the task will be much more difficult and off-putting for those with low educational attainment.

**Geographic Barriers:** For low-income persons who live in Powers (Coos County) or Agness (Curry County), the nearest source of primary health care services will be at least 45 miles in a single direction. With no developed public transportation system, these individuals will be reliant on privately-owned vehicles or the good will of friends and neighbors to transport them to health services. Of interest, 12 percent of all households in Coos and Curry Counties do not own a motor vehicle.

**Public Policy:** Medicaid is, and has always been, a form of health insurance, the purpose of which is to provide *medically necessary* care. The root causes of health inequity are often, but not always, bound in

complex socioeconomic conditions, the resolution of which do not fall within the parameters of *medically necessary* care or the delimitations of the federal and state Medicaid program. While it is incumbent on health care providers and planners to be cognizant of the confounding socioeconomic landscape that gives rise to the potential for health inequities, it must be understood that publicly sponsored health insurance is just that – health insurance -- and not a general funding vehicle for social change initiatives or addressing the root causes of poverty. Health providers and planners can best address health inequities by addressing health disparities, consistent with the Centers for Disease Control's definition.

## VIII. Community Participation

Provisional data sets and findings from this Community Health Needs Assessment Study were shared with a focus group of thirteen (13) low-income, medically uninsured, Medicaid beneficiaries, and Medicare enrollees, drawn largely from the more sparsely populated area of Coos and Curry Counties (Coquille, Bandon, Langlois, and Port Orford) in December, 2011. There was general consensus that the data sets and findings were accurate and reflected the experiences of focus group members. Additional concerns, not reflected in this Study, included:

- The need for affordable dental care services beyond the boundaries of the population centers in Gold Beach, Coos Bay, and North Bend (expressed four times);
- The need for more proximally located physical therapy, medical specialty, diagnostic imaging, and medical laboratory services (expressed six times);
- The need for more wellness and preventive education and services (expressed a single time); and,
- The need for same-day, walk-in, or urgent care appointing (expressed two times).

Provisional data sets and findings from this Community Health Needs Assessment Study were shared with a focus group of six advocates for low-income persons, drawn largely from the more sparsely populated areas of Coos and Curry Counties (Coquille, Bandon, Myrtle Point, Langlois, Port Orford) in December, 2011. There was general consensus that the data sets and findings were accurate and reflected the experiences of focus group members. Additional concerns, not reflected in this Study, included:

- The need for same-day, walk-in, unscheduled, or urgent care appointing, because *it is tough for the people we work with to make an appointment that is multiple days hence and stick with that schedule to be seen* (expressed four times); and,
- The need for more proximally located affordable dental services (expressed two times).

# Western Oregon Advanced Health 2012
# Draft Policies for Patient Rights, Responsibilities, Choice, Priorities, and Engagement



| Policy Title | Patient Rights, Responsibilities, Choice, Priorities, and Engagement |
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| **Policy Description** | Western Oregon Advanced Health advances written policies regarding Patient Rights, Patient Responsibilities, Patient Choice, Prioritized Patients, and Patient Engagement, in the interests of clarity of, and transparency in, all transactions that involve consumers, providers, and the CCO's community partners. The policies set forth in this document are incumbent upon all providers affiliated with the CCO and other entities that may contract with the CCO for the provision of patient services. |
| **Position Statement** | It is the humane, moral, ethical, and legal privilege and obligation of Western Oregon Advanced Health to respect its consumers' rights and choices, and to establish prioritized groups of consumers, based on medical need and individualized circumstances, for whom an extended menu of enabling assistance services will be accorded. Reciprocally, consumers and their family members are recognized as the most important members of the integrated health care team, and as team members, inherit certain responsibilities, including the obligation to pro-actively, prescriptively, and preventively engage the health care system.<br><br>The CCO ascribes to a philosophy of patient-centered care, delivered within the context of an integrated medical home, meaning that the CCO fully integrates primary, medical, oral, behavioral, mental, and emotional care within its practice model. Health care services offered by the CCO are holistic and personalized to meet the unique needs of each individual. In providing patient-centered care, the CCO is sensitive to patients' unique needs, cultural relevancy, and the involvement of family members to the extent that patients' desire to have family members, or other representatives, involved in their care. Because the CCO practices fully integrated care, consumers will not be separately identified as "physical health patients," or "dental patients," or "mental health patients." Therefore the policies and procedures governing patient rights and responsibilities will be identical for <u>all</u> patients.<br><br>The CCO expects its personnel, providers, and contractors to treat all persons with dignity and respect, and anticipates that this relationship will be reciprocal.<br><br>Notwithstanding the foregoing, the Coordinated Care Organization accepts that some consumers will choose not to exercise their responsibilities, or will choose not to engage the health care system, or will choose to engage that system only episodically. This is their right and prerogative. |

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| **Patient Rights Policy** | Patients of the Coordinated Care Organization have the right to:<br>• Be treated with respect, consideration, and without judgment; and be treated no differently than other people seeking health care benefits to which they are entitled;<br>• Refer oneself to mental health, addiction treatment, or family planning services without the need for a referral from a PCP or prior authorization;<br>• Be actively engaged in their health care, including: providing informed written consent prior to the start of treatment; participating in decision-making; being informed about treatment options; assisting in the development of individualized services and support (or treatment) plans; and serving as the final voice on any matter that presents an ethical dilemma;<br>• Be given quality care and service that respects individual values and beliefs;<br>• Receive courteous and fully professional treatment;<br>• Have privacy, confidentiality, and dignity respected;<br>• Be provided care and service in safe, secure, inviting, and sanitary environments;<br>• After initial assignment to a geographically proximal PCP, alter that assignment to the extent that the CCO's equitable impanelment provisions permit;<br>• Receive explanations for all recommended health care services, including expected outcomes and possible risks;<br>• Know the name, title, and qualifications of the providers and team members who provide care;<br>• Be able to express concerns about care and receive answers in timely and respectful manners;<br>• Have medical records and personal health information treated confidentially, with information sharing occurring only when written informed consent has been granted or when otherwise required by law;<br>• Be informed with respect to billing practices, charges for services, agreements with outside providers, and available financial assistance for medical treatment;<br>• Have a custodial parent, guardian, or representative assist with understanding any information that is presented by a member of the integrated provider team;<br>• Inspect medical records with the provision of reasonable advance notice;<br>• Refuse to participate in experimentation or research;<br>• Receive medication, specific to individually diagnosed clinical needs;<br>• Receive prior notice of service conclusion, termination, or transfer, unless the circumstances necessitating these pose a threat to health and safety;<br>• Receive assistance in navigating the health care system;<br>• Choose from among available mental, emotional, and behavioral health services and supports, those that re the least restrictive to individual liberty, the least intrusive, and that provide for the greatest degree of independence;<br>• Be free from abuse or neglect, and to report any incident of abuse or neglect without fear of retaliation;<br>• Have religious freedom;<br>• Be free from seclusion and restraint;<br>• Have family members involved in, or excluded from, service delivery and planning;<br>• Make a declaration for mental health treatment, when legally an adult;<br>• File grievances, including appealing decisions that result from the grievance; and,<br>• Exercise all and each of these rights without any form of reprisal, threat, or punishment. |

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| **Patient Responsibility Policy** | Patients of the Coordinated Care Organization have the responsibility to:<br>• Provide complete and accurate information regarding health history, current medical status, medications taken, and changes in symptoms or medical conditions;<br>• Establish an ongoing relationship with the chosen primary care provider;<br>• Participate in decision-making about health care needs and services, and make informed decisions about treatment procedures before they are performed;<br>• Follow any treatment plan for which agreement has been expressed to the provider;<br>• Inform providers if treatment plans are not clearly understood, if it is not known what is expected, or if it is believed that follow-through will be unlikely or impossible;<br>• Treat health care professionals, staff, and other patients, and the providers' facilities, equipment, and property, in a considerate and respectful manner;<br>• Make and keep appointments, or provide at least twenty-four hours advance notice when appointments must be cancelled;<br>• Be on time for scheduled appointments;<br>• Refrain from inappropriate use of hospital emergency department services for those matters that can be addressed by the primary care provider during regular office hours;<br>• Call medical needs to the attention of the primary care provider sufficiently early in the day in an effort to avoid the after-hours use of the hospital emergency department;<br>• Keep the CCO up-to-date on current telephone number and address information;<br>• Present insurance cards when seen for services;<br>• Fulfill financial obligations for health care services provided;<br>• Safeguard prescription medications, keeping them safe and secure from use by any and all other persons;<br>• Take prescription medications exactly as prescribed – at the right time and in the right dose;<br>• Promptly report any negative side effects from prescribed medications or treatments;<br>• Notify the office well in advance of a prescription's expiration if there is reason or need for the prescription to be continued;<br>• Ask questions; and,<br>• Make recommendations, suggestions for improvement, or express concerns or complaints, either formally through the established grievance process or the Community Advisory Council, or informally to a member of the integrated care team. |

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| **Patient Choice Policy** | When selecting a primary care provider, provider team, and/or medical home, patients will be given a choice from among those providers that are participating in the CCO and that are open for the acceptance of new patients. Patients may expect to chose providers that are in relative proximity to patients' home communities.<br><br>During the transition period, from a Managed Care Organization (MCO) to a Coordinated Care Organization, for the purposes of assuring continuity of care, patients will be assigned to the primary care provider who served them under the MCO arrangement.<br><br>Patients may change their choice of primary care providers, provider teams, and/or medical homes one time per twelve-month period. Patients who wish to make a second or subsequent change in primary care providers within a twelve-month period of time must petition the CCO for an exception to this policy.<br><br>Providers, when making treatment recommendations, shall present balanced information about expected outcomes and risks, and shall respect the right of patients to chose not to undergo treatment, or to chose an optional treatment. [Not all optional treatments will be included on the CCO's list of covered and included benefits.]<br><br>Providers, when making referrals for medical specialty services, mental or behavioral health treatment services, oral health services, diagnostic medical tests, home health or hospice care, in-patient care, or other health-related services that are included within the global payment structure, shall equitably consider patient choice, patient preference, patient needs, continuity-of-care, efficacy, and cost.<br><br>Providers, when making referrals for minority populations, English Language Learners (ELL), or persons with cognitive impairments or educational limitations, shall, in addition to the requirements of the preceding sentence, give equitable consideration to providers and systems that may best meet the cultural or communication needs of referred patients.<br><br>Providers, when ordering prescription medications, and under those circumstances where there is a choice among multiple potentially beneficial medications, will advise patients of the choices and options available, along with both medical efficacy and cost implications. [Not all prescription medications will be included in the CCO's global budget formulary.]<br><br>Within eighteen months of the adoption of this policy, the CCO shall develop an incentive for those providers who demonstrate high rates of patient retention. |

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| **Policy Governing Priority Patients and Services** | The Coordinated Care Organization shall develop responsive systems of services, in descending order, for priority patients who are:<br><br>• In emergent or acute distress;<br>• At high risk for hospitalization or institutionalization;<br>• Characterized by frequent and inappropriate utilization of hospital emergency department resources;<br>• Diagnosed with complex multi-system disorders, or multiple chronic disease states (including mental and emotional disorders);<br>• Diagnosed with a single chronic disease state (including mental and emotional disorders);<br>• Pregnant, parenting a child under the age of twenty-four months, or under the age of eighteen;<br>• Unable to comply with recommended medical protocols;<br>• Chemically addicted, or engaging in drug-seeking behavior;<br>• Characterized by limited cognitive capacity or limited educational attainment;<br>• Characterized by minority cultural status or limited English proficiency;<br>• Characterized by other barriers to care; and/or,<br>• Characterized by health inequities or health disparities; and/or,<br>• Unwilling to comply with recommended medical protocols. |
| **Patient Engagement Policy** | Based on patient-centered primary care medical home models, and principles articulated by the Agency for Healthcare Research and Quality, the framework for conceptualizing patient engagement in medical home design and functioning exists in three contexts:<br><br>• Care for the individual patient;<br>• Practice improvement; and<br>• Policy design and implementation.<br><br>Within each context, there are multiple opportunities for involving patients. These levels of engagement should build on one another. Thus, efforts to engage patients and families in their own care develops a pool of informed and activated patients who can serve as effective participants in practice design. With new knowledge of practice functioning and exposure to the concerns of multiple patients, some of these individuals (e.g., peer wellness specialists) can play an effective role in representing peers in policy development or inform others who represent them (e.g., personal health navigators). Likewise, practices that seek patient participation in quality improvement may respond more effectively to patient and family needs, and policy can promote practice transformation that supports patient engagement in their own care. |

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| **Patient Engagement Policy,** Continued | **Patients engage in their own care:** (1) through communication and information-sharing (i.e., learning about how the practice works; discussing roles with the patient care team; getting help from the team with organizing and coordinating care; (2) by engaging in self-care (i.e., working with their care team to set self-care goals; getting help with managing chronic illness; participating in activities to reduce health risks; participating in peer support groups); (3) by participating in decision-making (i.e., using evidence-based decision aids; discussing risks and benefits of different options; deciding jointly with the health care provider on treatment strategies); and, (4) by becoming health-safety-conscious (i.e., reviewing medical information and treatment results with the clinician or practice team; sharing information about medications and treatments received in other settings; reporting on adverse events and potential safety problems).<br><br>**Patients engage in practice improvement** by: participating in quality improvement activities; participating in Community Advisory Councils; providing feedback through surveys; assisting in the development of patient orientation and education materials; participating in focus groups; and doing "walk-throughs" with staff to provide a patient perspective of practice workflow.<br><br>**Patients engage in policy** when they: serve on policy and quality improvement committees; gather input from other consumers; participate in the design of the medical home or other demonstration projects; or participate in training for practice teams.<br><br>**In planning for patient engagement, the CCO will:**<br>• Test, and then implement, effective methods for communicating with patients;<br>• Require all providers to complete motivational interviewing training;<br>• Require all providers and their employees to complete HRSA's cultural competency and health literacy training;<br>• Adapt to different populations;<br>• Work consistently with patients to obtain a "shared understanding" of roles and responsibilities,<br>• Advance Information Technology tools that support information-sharing between providers and patients;<br>• Support patients in developing and following self-care guidelines about diet, exercise, medication adherence, and symptom recognition;<br>• Support patients in their engagement of health risk reduction;<br>• Assist patients in acquiring skills for self-care;<br>• Support patients who want to play an active role in medical decision-making;<br>• Encourage patients to participate in practice improvement, quality assurance, and policy initiatives; and,<br>• Deploy community health workers, peer wellness specialists, and personal health navigators to assist in the attainment of these ends. |

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| **Patient Rights, Responsibilities, Choice, Priorities, and Engagement -- Implementation Schedule** | 1. Review draft of broad policies with CCO Planning Committee ..... 03-01-12<br>2. Board adopts provisional policy statements ..... 04-29-12<br>4. Procedures, to support Policy Statements, are drafted ..... 08-01-12<br>5. Governing board approves implementation procedures ..... 09-15-12<br>6. Patient orientation and educational materials are developed .... 10-15-12<br>7. Provider handbook, emphasizing methods of patient engagement, is developed ..... 11-15-12 |
| **Recitals** | **From HB 3650**<br>Section 1: *Services are person-centered, and provide choice, independence and dignity reflected in individual plans and provide assistance in accessing care and services.*<br>Section 4: *Each member of the CCO receives integrated person-centered care designed to provide choice ... Each member has a consistent and stable relationship with a care team ... Each CCO complies with safeguards for members ... Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves (engages) these members in accessing and managing appropriate preventive, health, remedial and supportive care services ... Members have a choice of providers with the CCO's network.*<br>Section 7: *Members must be encouraged to be an active partner and not a passive recipient of care. Members shall be encouraged within all aspects of the integrated and coordinated care delivery system to use wellness and prevention resources.*<br>Section 8: *Members and their providers and CCOs have the right to appeal decisions about care and services through the Oregon Health Authority. The Health Authority shall monitor and enforce consumer rights. Each member must be encouraged to be an active partner ... be educated about the coordinated care approach ... have access to advocates ... be encouraged to use wellness and prevention ... be encouraged to work with the member's care team*<br>Section 12: Governs members right to confidentiality and privacy<br><br>**From SB 1580-9:**<br>Section 20: *In selecting one or more CCOs to serve a geographic area, the Oregon Health Authority shall, for members and potential members, optimize access to care and choice of providers ...*<br><br>Each recital referenced herein is made a part of this Policy Statement. |

These preliminary policies and procedures were submitted to Western Oregon Advanced Health's governing board and adopted by majority vote at the regularly scheduled meeting convened on __(date)__. The governing board has elected to next review these policies either two years hence, or on the date of (date), whichever shall first occur.

President of the Board

Secretary of the Board

Exhibit I

# SCANNED ORIGINAL SIGNATURES

5. Applicant has followed the instructions provided and has identified any deviations from specifications within its Response. Applicant confirms that any instructions or specifications that it felt were unclear have been questioned in advance of this Application.

6. Applicant acknowledges receipt of all addenda issued under this RFA, as listed on OHA's web portal.

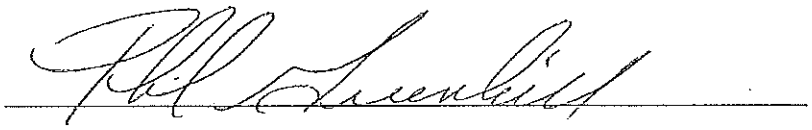
7. If awarded a Contract, Applicant will be required to complete, and will be bound by, a Contract described in this RFA. Applicant agrees to the Core Contract terms and conditions in Appendix G, except to the extent Applicant has timely requested a change or clarification or filed a protest in accordance with this RFA.

8. If awarded a Contract, Applicant will meet the highest standards prevalent among Medicaid health plans in Oregon.

9. Applicant and its Affiliates complied with the Code of Conduct in Section 7.15 of the RFA in connection with the RFA.

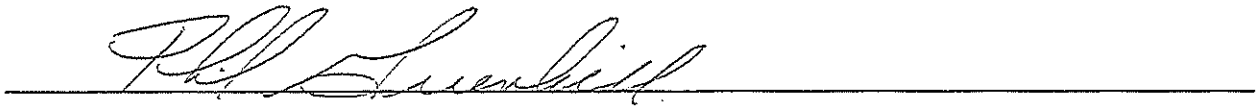
10. Applicant accepts the terms and conditions for OHA's web portal, as posted on the web portal.

11. Applicant will negotiate in good faith regarding the statement of work for the Contract.

| | | |
|---|---|---|
| **Signature** | : |  |
| **Name Printed** | : | Phil Greenhill |
| **Title** | : | Chief Executive Officer and Authorized Official |
| **Date** | : | 28 April 2012 |

## Informational Representations for Appendix B, Continued

| Informational Representation | Yes | No | Qualified Yes | Explanation if *No* or *Qualified* |
|---|---|---|---|---|
| **B-11.** Applicant will have an administrative or management contract with a delegated entity to delegate all or a portion of other services that are not listed. | | | Yes | Western Oregon Advanced Health may enter into a limited contractual agreement with Southwest Oregon Independent Practice Association for the provision of other services that are not listed. |

**Signature** : 

**Name Printed** : Phil Greenhill

**Title** : Chief Executive Officer and Authorized Official

**Date** : 28 April 2012