EOCCO

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

Applicant Name: Eastern Oregon Coordinated Care Organization (EOCCO)

Form of Legal Entity (business corporation, etc.) Limited Liability Company (LLC)

State of domicile: Oregon

Primary Contact Person: Sean Jessup Title: Manager

Address: 601 SW 2nd Ave

City, State, Zip: Portland, OR 97204

Telephone: 503-228-6554 Fax: 503-243-3949

E-mail Address: jessups@odscompanies.com

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

Name: Robin J Richardson Title: Senior Vice President

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

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

Signature: _____ Title: Senior Vice President Date: June 11, 2012
(Authorized to Bind Applicant)

Applicant Name: Eastern Oregon Coordinated Care Organization (EOCCO)

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

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

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

Attestations for Appendix A – CCO Criteria

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

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
• Health information technology and medical records • Privacy officer • Compliance officer				
Attestation A-2. Applicant will participate in the learning collaboratives required by ORS 442.210.	X			
Attestation A-3. Applicant will collect, maintain and analyze race, ethnicity, and primary language data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities.	X			

Attestations for Appendix B – Provider Participation and Operations Questionnaire

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

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation B-4. Applicant will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested service area.	X			
Attestation B-5. Applicant will have all provider contracts or agreements available upon request.	X			
Attestation B-6. As Applicant implements, acquires, or upgrades health information technology (HIT) systems, where available, the HIT systems and products will meet standards and implementation specifications adopted under section 3004 of the Public Health Services Act as added by section 13101 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5.	X			
Attestation B-7. Applicant's contracts for administrative and management services will contain the OHA required contract provisions.	X			
Attestation B-8. Applicant will establish, maintain, and monitor the performance of a comprehensive network of providers to assure sufficient access to Medicaid Covered Services as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO. Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.	X			
Attestation B-9. Applicant will have executed written agreements with providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines.	X			
Attestation B-10. Applicant, through its contracted or deemed Participating Provider network, along with other specialists outside the network, community resources or social services within the CCO's service area, will provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through: • Prompt, convenient, and appropriate access to Covered Services by enrollees 24 hours a day, 7 days a week; • The coordination of the individual care needs of enrollees in accordance	X			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
with policies and procedures as established by the Applicant; • Enrollee involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care; • Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and • Addressing diverse patient populations in a culturally competent manner.				
Attestation B-11. Applicant will establish policies, procedures, and standards that: • Assure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO, • Ensure access to medically necessary care and the development of medically necessary individualized care plans for enrollees; • Promptly and efficiently coordinate and facilitate access to clinical information by all providers involved in delivering the individualized care plan of the enrollee; • Communicate and enforce compliance by providers with medical necessity determinations; and • Do not discriminate against Medicaid enrollees, including providing services to individuals with disabilities in the most integrated setting appropriate to the needs of those individuals.	X			
Attestation B-12. Applicant will have verified that contracted providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified providers in the future.	X			
Attestation B-13. Applicant will provide all services covered by Medicaid and comply with OHA coverage determinations.	X			
Attestation B-14. Applicant, Applicant staff and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities), and subcontractor staff will be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services	X			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Office of the Inspector General or by the General Services Administration. Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities).				
Attestation B-15. Neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation if applicable) or its subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services.	X			

Medicaid Assurances for Appendix B – Provider Participation and Operations Questionnaire

Assurance B-1. Emergency and Urgent Care Services. Applicant will have written policies and procedures and monitoring systems that provide for emergency and urgent services for all Members on a 24-hour, 7-days-a-week basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. (See 42 CFR 438.114 and OAR 410-141-3140]	X			
Assurance B-2. Continuity of Care. Applicant will have written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorizations to other providers. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3160]	X			
Assurance B-3. Applicant will have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance	X			

Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant's primary care and referral providers. Applicants will communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance. Applicants will document all monitoring and Corrective Action activities. Such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law. [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]				
Assurance B-4. Applicant will have an ongoing quality performance improvement program for the services it furnishes to its Members. The program will include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction. The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.200 and 438.240; OAR 410-141-0200]	X			
Assurance B-5. Applicant will make Coordinated Care Services accessible to enrolled Members. The Applicant will not discriminate between Members and non-Members as it relates to benefits to which they are both entitled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220]	X			
Assurance B-6. Applicant will have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with	X			

Exhibit I of the Appendix G "Core Contract". The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.228, 438.400 – 438.424; and OAR 410-141-3260 to 410-141-3266]				
Assurance B-7. Applicant will develop and distribute informational materials to potential Members that meet the language and alternative format requirements of potential Members. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.10; OAR 410-141-3280]	X			
Assurance B-8. Applicant will have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant, Member handbook, health education, availability of intensive care coordination for Members who are aged, blind and/or disabled and appropriate use of emergency facilities and urgent care. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.10; and OAR 410-141-3300]	X			
Assurance B-9. Applicant will have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Attachment 4, Core Contract. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]	X			
Assurance B-10. Applicants will provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3405]	X			
Assurance B-11. Applicant will maintain an efficient and accurate billing	X			

and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant and its providers will not hold Members responsible for the Applicants or providers debt if the entity becomes insolvent. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 447.46 and OAR 410-141-0420]				
Assurance B-12. Applicant will participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards. Applicant has executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]	X			
Assurance B-13. Applicant will maintain an efficient and accurate system for capturing encounter data, timely reporting the encounter data to OHA, and validating that encounter data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242; and the Contract]	X			

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

Informational Representations for Appendix B – Provider Participation and Operations Questionnaire

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-1. Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract.	X			During the initial launch of the EOCCO both ODS and GOBHI will continue to provide administrative functions as they did operating independently as an MCO. For each representation we have called out which functions are delegated by each entity.
Representation B-2. Applicant has an administrative or management contract with a delegated entity to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program.		X		GOBHI: Staffing needs will be handled internally by GOBHI. ODS: All staffing needs with be handled internally by ODS.
Representation B-3. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the systems or information technology to operate the CCO program for Applicant.	X			GOBHI: GOBHI will be collaborating with Gorge Health Connect to develop HIE capabilities for the region, and upgrading its internal IT capabilities. ODS: All systems and information technology will be handled internally by ODS.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-4. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the claims administration, processing and/or adjudication functions.	X			GOBHI: GOBHI has a contract in place with Phtech to perform these functions. ODS: All claims processing is handled in house by ODS. To complement our claims processing capabilities we use the following vendors: 1. ODS utilizes Scan One to scan and index paper Medical Claims. Paper claims are scanned and index and transmitted in an electronic format and downloaded into ODS' claims processing system. 2. TC3 provides 3 important services to ODS. Provider Integrity review, enhanced Clinical Editing and Bill negotiation services

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-5. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Enrollment, Disenrollment and membership functions.		X		GOBHI: No, all enrollment and membership functions will be handled internally. ODS: No, all enrollment and membership functions will be handled internally.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-6. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the credentialing functions.	X			GOBHI: The credentialing functions are performed internally by GOBHI and its contracted mental health providers ODS: Our credentialing program includes policies and procedures to delegate the provider credentialing function to qualified independent practice associations and medical groups. A credentialing delegation agreement stipulates the responsibilities of our health plan and the credentialing delegate. Of the 14 credentialing delegations we have, the following processes credentialing of ODS OHP providers: PrimeCare, Idaho Physicians Network, MidRogue IPA, and Managed Healthcare Northwest.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-7. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the utilization operations management.	X			GOBHI: The utilization review functions are performed internally by GOBHI and its contracted mental health providers. ODS: The majority of utilization management is done by in-house ODS staff. The following utilization management services have been outsourced by ODS: 1. AllMed Healthcare Management is a URAC accredited External Review Organization. The medical consultants of AllMed provide medical review services for same specialty review and appeals. 2. ODS has contracted with AIM to conduct pre-authorization review of high-cost imaging services.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-8. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Quality Improvement operations.		X		GOBHI: The Quality Improvement functions will be performed internally by GOBHI and its contracted health providers. ODS: All Quality Improvement operations are performed in house.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-9. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of its call center operations.	X			GOBHI: Call center functions will be coordinated with ODS. ODS: The majority of call center operations is done by in-house ODS staff. We use vendors for the following call center functions. 1. Through a business agreement with Language Line Services, ODS is able to provide multilingual customer service. This service offers 140 different languages and is available during regular customer service hours. 2. MedImpact provides pharmacy customer service beyond ODS' standard call center hours for urgent pharmacy needs.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-10. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the financial services.		X		GOBHI: All financial services are performed in house. ODS: All financial services are performed in house.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-11. Applicant will have an administrative or management contract with a delegated entity to delegate all or a portion of other services that are not listed.	X			1. ODS subcontracts with MedImpact for back end PBM services. MedImpact provides the point of service claims processing system, network management, rebate management and the eprescribing – MedPrescriptions platform. 2. **SunRx, Inc.** - Through our relationship with MedImpact, ODS contracts with SunRx to provide 340B claims administration and contract pharmacy services. 3. Walgreens – ODS currently contracts direct with Walgreens for specialty pharmacy services.

(Applicant Authorized Officer)

Signature: _____ Title: Senior Vice President Date: April 30, 2012

EOCCO

ATTACHMENT 7 –APPLICATION CHECKLISTS

The checklist presented in this Attachment 7 is provided to assist Applicants in ensuring that Applicant submits a complete Technical Application and Financial Application that will satisfy the pass/fail requirements for an Application submission in accordance with RFA section 6.1.2.

1. Technical Application, Mandatory Submission Materials

✓ **a.** Application Cover Sheet (Attachment 1)

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

✓ **c.** This Technical Application Checklist

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

✓ **e.** Résumés for Key Leadership Personnel.

✓ **f.** Organizational Chart.

✓ **g.** Services Area Request (Appendix B).

h. Questionnaires

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

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

✓ **(3)** Accountability Questionnaire (Appendix C)

✓ • Services Area Table.

✓ • Publicly Funded Health Care and Service Programs Table

✓ **(4)** Medicare/Medicaid Alignment Demonstration Questionnaire (Appendix D).[1]

2. Technical Application, Optional Submission Materials

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

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

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

[1] For the 1st Application date, Appendix D responses are not due until May 14, 2012.

ATTACHMENT 7 –APPLICATION CHECKLISTS

The checklist presented in this Attachment 7 is provided to assist Applicants in ensuring that Applicant submits a complete Technical Application and Financial Application that will satisfy the pass/fail requirements for an Application submission in accordance with RFA section 6.1.2.

	3.	**Financial Application, Mandatory Submission Materials**
		APPENDIX E
✓	**a.**	Certified copy of the Applicant's articles of incorporation.
✓	**b.**	Listing of ownership or sponsorship.
✓	**c.**	Chart or listing presenting the identities of and interrelationships between the parent, the Applicant.
☐	**d.**	Current financial statements.
✓	**e.**	Contractual verification of all owners of entity.
☐	**f.**	Guarantee documents.
✓	**g.**	Developmental budget.
	h.	Operational budget.
✓	**i.**	Monthly staffing plan.
✓	**j.**	Pro Forma Projections for the First Five Years.
☐	**k.**	Quarterly developmental budget.
☐	**l.**	Quarterly operational expenses.
☐	**m.**	Reinsurance policy.
		APPENDIX F
✓	**a.**	Base Cost Template

Eastern Oregon CCO Letters of Support
GOBHI/ODS

Letter From:	Community of Origin
Advantage Dental	Redmond
Assoc. of Oregon Community Mental Health Programs	Salem
Asher Community Mental Health	Fossil
Baker County Board of Commissioners	Baker City
Center for Human Development, Inc.	La Grande
City of Pendleton Police Department	Pendleton
Community Counseling Solutions	Heppner
Gilliam County Court	Condon
Grande Ronde Child Center	La Grande
Grant County Court	Canyon City
Hilltop House	Pendleton
Intermountain Education Service District	Pendleton
Intermountain Hospital	Boise, Idaho
Jefferson Behavioral Health	Grants Pass
Lake County Board of Commissioners	Lakeview
Lakeview Heights Secure Res. Treatment	Lakeview
Lifeways, Inc.	Ontario
Lines for Life	Portland
Malheur County Court	Vale
Mtn. Valley Mental Health Programs	Baker City
Northeast Oregon Network (NEON)	La Grande
New Day Enterprises	La Grande
OHCA	Portland
Oregon Health Network	Lake Oswego
Oregon School-Based Health Care Network	Portland
Oregon State Hospital	Portland
Pioneer Guest Home, Inc.	Enterprise
Symmetry Care	Burns
Umatilla County Board of Commissioners	Pendleton
Umatilla County Community Corrections	Pendleton
Umatilla-Morrow Head Start, Inc.	Hermiston
Union County Board of Commissioners	La Grande
Wallowa River House	Wallowa
Wallowa Valley Center for Wellness	Enterprise
Winding Waters Clinic	Enterprise

Advantage Dental Services, LLC
The Advantage Community

April 24, 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 Eastern Oregon CCO's 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 Eastern Oregon CCO's 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 Eastern Oregon CCO. 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 Eastern Oregon CCO in the formation of the CCOs and coordinating care for its community members.

Sincerely,

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

ASSOCIATION OF OREGON COMMUNITY MENTAL HEALTH PROGRAMS

Addictions • Mental Health • Developmental Disabilities

Cherryl Ramirez, Executive Director, cramirez@aocweb.org
Jessica van Diepen, Data & Communications, jvandiepen@aocweb.org
Diana L. Bronson, Executive Assistant, dbronson@aocweb.org
Andrew J. Smith, Legislative Liaison, asmith@aocweb.org
Sarah Jane Owens, Develop. Disabilities Spec., sjowens@aocweb.org

D. Greg Schneider, President
Lifeways, Inc.
Malheur and Umatilla

Rod Calkins, 1st Vice President
Marion County Health Department

Roland Migchielsen, 2nd Vice President
Columbia Community Mental Health

Kimberly Lindsay, Treasurer
Community Counseling Solutions
Grant, Morrow, Wheeler & Gilliam

Baker County
Mountain Valley Mental Health Programs, Inc.
Benton County Mental Health
Clackamas County Health, Housing & Human Services
Clatsop Behavioral Healthcare
Confederated Tribes Community Counseling Center of Warm Springs
Coos County Mental Health
Crook County Mental Health
Lutheran Community Services
Curry County Human Services
Deschutes County Mental Health Department
Douglas County Health and Social Services
Harney Behavioral Health
Jackson County Health and Human Services
Jefferson County
BestCare Treatment Services
Josephine County
Options for Southern Oregon, Inc.
Klamath County Mental Health
Lake County Mental Health
Lane County Health and Human Services
Lincoln County Health and Human Services
Linn County Health Department
Malheur County
Lifeways, Inc.
Mid Columbia Center for Living
Sherman, Hood River & Wasco
Multnomah Health and Addiction Services
Polk County Mental Health
Tillamook Family Counseling Center
Umatilla County
Addictions Program
Union County
Center for Human Development, Inc.
Wallowa Valley Center for Wellness
Washington County Behavioral Health & Developmental Disabilities Division
Yamhill County Health and Human Services

June 11, 2012

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Letter of Support
Eastern Oregon Coordinated Care Organization (EOCCO)

Dear Members of the CCO Review Team:

AOCMHP is pleased to provide this letter of support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. (ODS) in their collaboration to form the Eastern Oregon Coordinated Care Organization (EOCCO), covering twelve counties (Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler).

GOBHI and ODS have proven records of success based on their basic models of localized behavioral and physical health care delivery that stress prevention, early intervention, and support services to improve overall health and reduce cost. Over the last decade, AOCMHP has witnessed first hand the excellence of GOBHI in serving the needs of rural Oregonians.

The goal of the EOCCO is to be local enough to be relevant and large enough to be financially sustainable. EOCCO will work within each of the communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

AOCMHP is the unified statewide voice of local governments that are accountable for the well being of people with mental illness, addictions and developmental disabilities. We are confident that the partnership between GOBHI and ODS will foster one of the most innovative and effective CCOs in the state and urge you to support EOCCO's certification as a CCO.

Sincerely,

Cherryl L. Ramirez

Cherryl Ramirez, MPA, MPH
Executive Director

RECEIVED APR 27 2012

Asher Community Health Center
Asher Clinic: P.O Box 307, Fossil OR 97830
Spray Clinic: 106 2nd St., Spray OR 97874
Mitchell School-Based Health Center: 340 SE High St., Mitchell, OR 97750
Telephone: (541) 763-2725 • Fax: (541) 763-2850 • TTY: 1 (800) 735-2900

April 25, 2012
Kevin Campbell, Executive Director
Greater Oregon Behavioral Health, Inc.
309 E. 2nd Street
The Dalles, OR 97058

Dear Mr. Campbell,
It was a pleasure meeting with you Monday April 23rd to discuss GOBHI's plans to form a CCO that would include Wheeler County. To ensure that I have accurate information to present to my Board on May 18 I want to recap my understanding of our discussion.

1. GOBHI assures us that existing referral patterns of Wheeler County patients to hospitals and specialists will have contractual arrangements in place by August 1, 2012 to continue. This will allow Asher Community Health Center to continue to refer to the regional specialists, mostly in Central Oregon, with which we have a long standing relationship and which are closer proximity to our patients. It also allows the most proximal access to regional hospitals from each of Wheeler County's three communities.
2. We are in agreement that assertive outreach, patient education, and support are the keys to optimizing health and reducing more intensive and costly medical intervention. This will require in-County rather than out-of-County outreach workers. Their care coordination needs to include schools and social service agencies as well as medical care coordination.
3. In order for Asher Community Health Center to adequately fund such an outreach position(s) GOBHI is offering a capitated rate of $50 per member per month for a two year period. Continuation of this rate after two years is dependent upon reduction in use of intensive medical services, primarily hospitalization, to regional norms.

Sincerely,

James I. Carlson, Administrator
Asher Community Health Center
Cc: County Judge Jeanne Burch, Commissioner Patrick Perry, Marj Sharp

April 30, 2012

Fred Warner Jr.
Commission Chair
fwarner@bakercounty.org

Tim L. Kerns
Commissioner
tkerns@bakercounty.org

Carl E. Stiff, M.D.
Commissioner
cstiff@bakercounty.org

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

RE: Letter of Support for Eastern Oregon Coordinated Care Organization (EOCCO)

Dear Ms. Hurst,

Baker County supports the efforts of Greater Oregon Behavior Health, Inc (GOBHI) and ODS Community Health, Inc. in the development of a Coordinated Care Organization that will serve 12 counties across Eastern Oregon. We believe this partnership should be explored for the rural counties of Eastern Oregon.

Sincerely,

Fred Warner, Jr., Chairman
Baker County Board of Commissioners

cc: Dr. Bruce Goldberg, Oregon Health Authority
Tammy Dennee, GOBHI

CHD Center for Human Development, Inc.
2301 Cove Avenue La Grande, OR 97850 (541) 962-8800 Fax (541) 963-5272 TTY Dial 711

April 24, 2012

Dr. Bruce Goldberg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

Dear Dr. Goldberg:

The Union County Center for Human Development, Inc. is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) in collaboration with Oregon Dental Services to improve the health of the citizens of rural Oregon – in particular, it's their application to become a Coordinated Care Organization (CCO). GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

The Center for Human Development, Inc. represents the citizens of Union County. Our mission is "working for healthy communities". GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Dwight W. Dill
Mental Health Director

CITY OF PENDLETON

Office of Chief of Police
622 Airport Road
Pendleton, OR 97801
Phone (541) 276-4411
Fax (541) 276-9108
Dispatch (541) 966-3650
www.ppd.pendletonpolice.or.us

Oregon Healthy Authority
500 Summer Street, NE E-20
Salem, Oregon 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

The Pendleton Police Department is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) to improve the health of the citizens of rural Oregon – in particular, its application to become a Coordinated Care Organization (CCO) for 19 counties across the state. GOBHI has a demonstrated record of accomplishment with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings through reinvesting in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, comprehensive and more appropriate full-service health care model that better serves the needs of rural Oregon– the Greater Oregon Better Health Initiative.

The Pendleton Police Department provides law enforcement services to the City of Pendleton in Umatilla County. The Pendleton Police Department's mission is to enhance the safety, security and quality of life for all citizens, visitors and special guests of the City of Pendleton. GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Respectfully,

Stuart A. Roberts
Chief of Police

Community Counseling Solutions

120 So. Main Street
P.O. Box 469
Heppner, Oregon 97836
(541) 676-9161 Fax: (541) 676-5662

Kimberly Lindsay
Executive Director

June 8, 2012

Serving Morrow, Wheeler, Gilliam and Grant Counties

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of Eastern Oregon Coordinated Care Organization (EOCCO) Application

Community Counseling Solutions is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members – in particular, its application to become a Coordinated Care Organization (CCO) for 12 Eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

Community Counseling Solutions provides services in Morrow, Wheeler, Gilliam and Grant Counties. Its mission is to "provide dynamic, progressive and diverse supports to improve the wellbeing of our communities". The Eastern Oregon Coordinated Care Organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Kimberly Lindsay
Executive Director
Community Counseling Solutions

County Court
221 S. Oregon St. PO Box 427 Condon, OR 97823
Judge: 541.384.6351 Admin: 541.384.3303 Fax: 541.384.3304

June 6, 2013

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of Eastern Oregon Coordinated Care Organization (EOCCO) Application

Gilliam County Court is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members – in particular, its application to become a Coordinated Care Organization (CCO) for 12 Eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

The Gilliam County Court represents the citizens of Gilliam County. Our mission is to provide essential public services, both legally required and locally desired, that protect and enhance the quality of life in an efficient, effective and respectful manner. The Eastern Oregon Coordinated Care Organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Pat Shaw

Pat Shaw
Gilliam County Judge

Judge Pat Shaw
pat.shaw@co.gilliam.or.us

Commissioner Michael Weimar
mike.weimar@co.gilliam.or.us

Commissioner Dennis Gronquist
dennis.gronquist@co.gilliam.or.us

902 D Avenue
La Grande, Oregon 97850
Phone: 541 963-8666
Fax: 541 663-8006
e-mail: jsgrcc@eoni.com

April 26, 2012

Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

The Grande Ronde Child Center (GRCC) is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) to improve the health of the citizens of rural Oregon-in particular, its application to become a Coordinated Care Organization (CCO) for 19 counties across the state. GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model—the Greater Oregon Better Health Initiative.

The Grande Ronde Child Center is a private non-profit corporation which provides psychiatric day treatment and therapeutic foster care services to children within GOBHI's region. Its mission is to encourage the emotional health and social well-being of children and families of our community and the region. GRCC strives to provide therapeutic activities in concert with other community agencies as a part of a coordinated continuum of health, social, and educational services. GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Jim Sheehy, LCSW
Executive Director

Grande Ronde Child Center, Inc. Board of Directors
President: Nod Palmer Vice President: Pat Kennedy Sec. /Treas.: Virginia Bertels
Dwight Dill, Misty Free, Mat Miles
Boyd Rasmussen, Juanita Welssenfluh

County Court of Grant County
Judge Mark R. Webb
Commissioner Scott W. Myers
Commissioner Boyd Britton

April 30, 2012

Dr. Bruce Goldberg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

The Grant County Court is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) in collaboration with ODS, to improve the health of the citizens of rural Oregon – in particular, it's their application to become a Coordinated Care Organization (CCO). GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings.

GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable. We believe it is well position to move from managed care to a coordinated, full service care model -- the Greater Oregon Better Health Initiative.

Sincerely,

Mark R. Webb
County Judge

Scott W. Myers
County Commissioner

Boyd Britton
County Commissioner

201 S. Humbolt St, Ste 280 Canyon City OR 97820 Phone 541-575-0059 Fax 541-575-0065

Dr. Bruce Goldberg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

The Hilltop House is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) in collaboration with Lifeways Inc.to improve the health of the citizens of rural Oregon – in particular, it's their application to become a Coordinated Care Organization (CCO). GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

The Hilltop House represents Lifeways Inc.. Its mission is to provide individualized services for our residents that promote mental clarity and emotional well-being, enhance the ability to accomplish meaningful personal goals and prepare our residents for community reintegration. We are committed to providing these services in a safe , friendly, and welcoming environment, We respect the dignity, autonomy, and individual and cultural differences of our residents. GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Sandra Peery

InterMountain
EDUCATION SERVICE DISTRICT

2001 SW Nye Avenue
Pendleton, Oregon 97801
main 541.276.6616
fax 541.276.4252
www.imesd.k12.or.us

June 6, 2012

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of Eastern Oregon Coordinated Care Organization (EOCCO) Application

The InterMountain Education Service District is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members – in particular, its application to become a Coordinated Care Organization (CCO) for 12 eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant, and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

The InterMountain Education Service District represents 19 school districts in a four county service area. Its mission is to assist school districts in improving student performance; enable school districts to operate more efficiently and economically; and provide leadership in helping Baker, Union, Umatilla and Morrow counties address demographic changes and the impact those changes will have on the needs of their schools and communities.

The Eastern Oregon Coordinated Care Organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Mark Mulvihill, Ed.D
Superintendent

INTERMOUNTAIN
HOSPITAL

Kevin Campbell
Chief Executive Officer
Greater Oregon Behavioral Health, Inc.
309 E. 2nd Street
The Dalles, OR 97058

Dear Kevin:

Intermountain Hospital has appreciated the relationship our two organizations have shared over the years. We have appreciated the ability to provide inpatient psychiatric hospitalization for Greater Oregon Behavioral Health, Inc. (GOBHI) clients from eastern Oregon, particularly as treating these clients at Intermountain Hospital is closer to their homes than many of the other alternatives.

As I have been apprised of GOBHI's efforts to become a Coordinated Care Organization for many of the rural counties in Oregon, I am pleased to offer my enthusiastic support for this endeavor. I look forward to continued collaboration with GOBHI in the future.

Please feel free to contact me if I can provide further information or assistance. I can be reached at 208-377-8400.

Sincerely,

Brent J. Bryson
CEO

JEFFERSON
BEHAVIORAL
HEALTH

Managed Mental Health Care Organization for Coos, Curry, Jackson, Josephine and Klamath Counties
550 NE E Street, Grants Pass, Oregon 97526 • Phone: 541-955-9565 • Fax: 541-955-8290 • www.jbh.org

June 6, 2012

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: **Support of Eastern Oregon Coordinated Care Organization (EOCCO) Application**

As the Executive Director of Jefferson Behavioral Health, I am pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members – in particular, its application to become a Coordinated Care Organization (CCO) for 12 Eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

Jefferson Behavioral Health represents five counties in Southern Oregon. While our territory is not included in the 12 Eastern Oregon counties potentially served by EOCCO), we recognize the organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Bob Nikkel, MSW, Executive Director
Jefferson Behavioral Health

Lake County Board of Commissioners
513 Center Street
Lakeview, Oregon 97630
(541) 947-6003
Fax: (541) 947-5775

Bradley J. Winters, Chairman
Ken Kestner, Vice-Chairman
Dan Shoun, Commissioner

April 25, 2012

Dr. Bruce Goldberg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

Dear Dr. Goldberg:

The Lake County Board of Commissioners is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) in collaboration with Oregon Dental Service to improve the health of the citizens of rural Oregon – in particular, it's their application to become a Coordinated Care Organization (CCO).

GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

The Lake County Board of Commissioners represents Lake County. Our mission is to protect and promote the best interest of our citizens. GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Bradley J. Winters Ken Kestner Dan Shoun

June 7th, 2012

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of Eastern Oregon Coordinated Care Organization (EOCCO) Application

Lakeview Heights Secure Residential Treatment Facility is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members – in particular, its application to become a Coordinated Care Organization (CCO) for 12 Eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

Lakeview Heights Secure Residential Treatment Facility represents Morrow County. Its mission is providing dynamic, progressive and diverse supports to improve the well being of our communities. The Eastern Oregon Coordinated Care Organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Matt Bergstrom
Facility Administrator Lakeview Heights

LIFEWAYS
HELPING PEOPLE

702 SUNSET DRIVE ONTARIO, OR 97914

June 7, 2012

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of Eastern Oregon Coordinated Care Organization (EOCCO) Application

Lifeways, Inc. is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members – in particular, its application to become a Coordinated Care Organization (CCO) for 12 Eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

Lifeways offers a comprehensive array of behavioral health services. In Malheur County, services include help with issues related to mental and emotional health, developmental disabilities, substance use and problem gambling. In Umatilla County, services are limited to help with mental and emotional problems. The mission of Lifeways Behavioral Health Services is to provide individualized services for our clients and community that promote mental clarity and emotional wellbeing, strengthen positive relationships, and enhance the ability to accomplish meaningful personal goals. We are committed to providing these services in a safe, friendly, and welcoming environment. We respect the dignity, autonomy, and individual and cultural differences of our clients.

The Eastern Oregon Coordinated Care Organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

D. Greg Schneider, M.S.
Executive Director

OREGON PARTNERSHIP
lines for life
Preventing Substance Abuse & Suicide

April 26, 2012

Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

Oregon Partnership/Lines for Life is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) to improve the health of the citizens of rural Oregon – in particular, its application to become a Coordinated Care Organization (CCO) for 19 counties across the state. GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

Lines for Life represents thousands or Oregonians who call us each year for crisis intervention and referrals on a variety of issues. Its mission is to prevent substance abuse and suicide. GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Judy Cushing
CEO

MALHEUR COUNTY

COUNTY COURT

251 B Street West, #5 ▪ Vale, Oregon 97918 ▪ (541) 473-5124 ▪ Fax (541) 473-5576

June 6, 2012

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem OR 97301-1097

RE: Support of Eastern Oregon Coordinated Care Organization (EOCCO) Application

The Malheur County Court is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members – in particular, its application to become a Coordinated Care Organization (CCO) for 12 Eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

The Eastern Oregon Coordinated Care Organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Dan P. Joyce

Dan P. Joyce
Malheur County Court Judge

Mountain Valley Mental Health Programs, Inc.
P.O. Box 649 · 2200 Fourth Street · Baker City Oregon 97814
Phone 541-523-3646 · Fax 541-523-7602

(6/4/12)

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

The Mountain Valley Mental Health Programs, Inc is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members – in particular, its application to become a Coordinated Care Organization (CCO) for 12 Eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

The Mountain Valley Mental Health Programs, Inc represents Baker County Mental Health and Developmental Disability Programs. Our mission is to provide individualized services for our clients and community that promote mental and emotional wellbeing, strengthen positive relationships, and enhance their ability to accomplish meaningful personal goals. We are committed to providing these services in a safe, friendly, and welcoming environment. We respect the dignity, autonomy, and individual and cultural differences of our clients The Eastern Oregon Coordinated Care Organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Jennifer Yturriondobeitia

Jennifer Yturriondobeitia, MSW
Executive Director,
Mountain Valley Mental Health Programs, Inc.

Focusing Together on Health

1802 4th Street Ste.A, La Grande, OR. 97850 - Office: (541) 624-5101 Fax: (541)624-5105
Website: www.neonoregon.org – Email: info@neonoregon.org

4/25/2012

Dr. Bruce Goldberg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

Dear Dr. Goldberg,

As a community health collaborative, our mission is to increase access to and quality of integrated healthcare for all residents in Union, Baker and Wallowa Counties. Since we are a collaborative, we accomplish this mission by assessing community health system gaps, facilitating community developed solutions and advocating for health policy change. We have been actively involved in the Health Care Transformation policy making process in Oregon, and are excited to see some of those long awaited changes beginning to take place. We are both ready and pleased to partner with all organizations working with our local communities to improve health.

The Northeast Oregon Network represents all residents and communities in our three counties, as well as speaks and advocates for rural health in Oregon overall. GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is in line with NEON's mission, and represents a desirable goal for Eastern Oregon. We are looking forward to partnering with them in their efforts to improve rural health.

Sincerely,

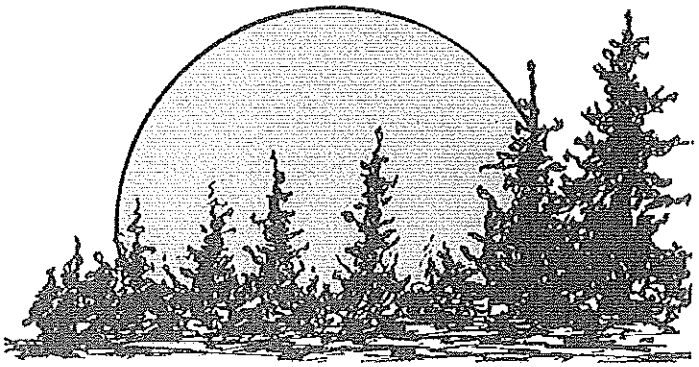
Lisa Ladendorff

Lisa Ladendorff, LCSW
Northeast Oregon Network, Executive Director

NEW DAY ENTERPRISES, INC.

1502 Washington Avenue
P. O. Box 3296
La Grande, Oregon 97850
(541) 963-2348
FAX 962-7230

Residential Programs
(541) 963-9081
Vocational Programs
(541) 963-5077



April 16, 2012

Oregon Health Authority
500 Summer Street, NE-E 20
Salem, OR 97301-1097

Re: Support of GOBHI Coordinated Care Organization Application

New Day Enterprises is pleased to offer this Letter of Support for GOBHI (Greater Oregon Behavioral Health Incorporated) in its application to become a Coordinated Care Organization for 19 counties across Oregon. We are fully supportive of GOBHI's efforts to improve all health aspects of people in rural Oregon.

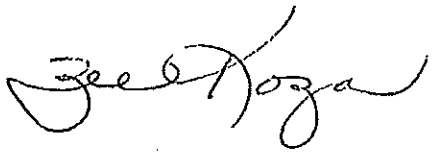
Our organization has an excellent relationship with GOBHI in their services with managed behavioral health care. GOBHI has a working model that is experienced and successful with its current system and has proven their ability to improve health issues and reduce costs. They have demonstrated their system to be creative and responsive to individual needs while serving the greater good. Significant cost savings have been realized by utilizing local models. GOBHI has a reputation for providing excellent services to a high need population.

New Day Enterprises represents adults with developmental disabilities. Our mission is to serve individuals in Union county with employment and residential services.

I am confident that the GOBHI network is well positioned to move toward a coordinated, full service health care model that incorporates physical, mental and dental health care services. Their commitment to serve rural communities by incorporating collaboration with a variety of partners to develop and maintain quality services is admirable. They are a "can-do" organization that has already proven their ability to network and have already established excellent working relationships with many service providers. Their success has been widely recognized and broadly supported in Eastern Oregon.

I am pleased to endorse and fully support GOHBI's application to be a Coordinated Care Organization.

Sincerely,



Zee Koza
New Day Enterprises, Inc.

OHCA
OREGON HEALTH
CARE ASSOCIATION

11740 SW 68th Parkway, Ste. 250
Portland, Oregon 97223
Office: 503.726.5260
Fax: 503.726.5259
www.ohca.com

Oregon's Voice for Long Term Care & Senior Housing

April 5, 2012

Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301-1097

The Oregon Health Care Association is pleased to provide this letter of support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) to improve the health of the citizens of rural Oregon – in particular, its spplication to become a Coordinated Care Organization (CCO) for 19 counties across the state. GOBHI has a demonstrated track record of success with its basic model of localized behavioral healthcare delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

The Oregon Health Care Association represents more than 620 nursing homes, assisted living, residential care, senior housing facilities, and in-home care agencies across the state. Its mission is to promote high quality long term care services, effective advocacy, and professional development opportunities, is designed to enhance health care, housing, and supportive social services provided by our members.

I respect GOBHI's commitment to serving rural communities, and the Association has begun a dialog with GOBHI about incorporating innovative and effective collaborations between the CCO and long-term care providers. Should it become a CCO as planned, the Association will work with GOBHI to support health care efforts in the 19 counties it serves by assisting existing long-term care providers as they transition into a new delivery system model and by providing other services as needed.

If you have any questions, please don't hesitate to contact me.

Sincerely,

James A. Carlson, President & CEO
Oregon Health Care Association

OREGON HEALTH NETWORK

Two Centerpointe Drive, Ste 570
Lake Oswego OR 97034
503.697.7394

April 30, 2012

Kevin Campbell, CEO
GOBHI
312 E. 3rd Street
The Dalles, OR 97058

Re: Letter of Support in Recognition of GOBHI's CCO Consortium Applications

Kevin,

Please consider this letter as one of full support and endorsement of GOBHI's consortium agreements as outlined below, to be named as Coordinated Care Organizations per the State of Oregon's recent request for applications. OHN recognizes and supports the following GOBHI partnerships:

- GOBHI and Care Oregon, jointly forming Columbia Pacific CCO in Wasco, Hood River, Columbia, Clatsop, Tillamook Counties and the Reedsport Area of Douglas County'
- GOBHI and Oregon Dental Service forming the Eastern Oregon CCO for 12 Counties of Eastern Oregon;
- GOBHI and partners forming Umpqua Health Alliance in Reedsport Area;
- GOBHI individually applying to become the CCO in Klamath County.

The mission of the coordinated care program is in line with both OHN's and GOBHI's overall mission to insure that all Oregonians have access to healthcare regardless of location. With OHN's current work to date of deploying subsidized broadband through all of Oregon with a focus on rural Oregon, we have laid the infrastructure groundwork that is key and primary for electronic health records, video conferencing and healthcare administration to be utilized. This pre-work will allow for GOBHI and partners to quickly move to installing solutions that maximize the coordination of patient care.

We look forward to continued support of GOBHI and the mutually supported goals surrounding healthcare delivery and access.

If you have any questions, please feel free to contact me.

Thank you.

Kim Klupenger
Chief Operations Officer
Oregon Health Network
503.781.7929

April 12, 2012

Oregon Health Authority

The Oregon School-Based Health Care Network (Network) is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) to improve the health of the citizens of rural Oregon – in particular, its Application to become a Coordinated Care Organization (CCO) for 19 counties across the state. GOBHI has a demonstrated track record of success with its basic model of localized behavioral healthcare delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well position to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

The Network represents more than 63 school-based health centers (SBHCs) across the state. Our mission is to promote the health and academic success of children and youth. We appreciate GOBHI's dedication to serving rural communities and their recognition of the reciprocal relationship between health and educational outcomes. The Network has begun a dialogue with GOHBI about the importance of involving SBHCs and schools in their CCO to provide cost-effective services that will reach all kids – especially those with health disparities. Should it become a CCO as planned, the Network will work with GOHBI to support health care efforts in the 19 counties it serves by assisting SHBCs as they transition into a new delivery system model and by providing other services as needed.

Sincerely,

Paula Hester

Paula Hester
Executive Director, Oregon School-Based Health Care Network

April 24, 2012

Dr. Bruce Goldberg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

Oregon State Hospital is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) in collaboration with Addictions and Mental Health to improve the health of the citizens of rural Oregon – in particular, it's their application to become a Coordinated Care Organization (CCO). GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Nancy Griffith,
Oregon State Hospital
Program Director, Adult Treatment Services

Pioneer Guest Home, Inc.
101 E. Main St.
P.O. Box 326
Enterprise, OR 97828
June 8, 2012

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of Eastern Oregon Coordinated Care Organization (EOCCO) Application

The Pioneer Guest Home, Inc. is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members – in particular, its application to become a Coordinated Care Organization (CCO) for 12 Eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

The Pioneer Guest Home serves 16 residential consumers. Licensed by Oregon Department of Human Services, the Pioneer Guest Homes mission is to provide residential care services and life skills training to serious & persistent mentally ill persons within the local community of Enterprise, OR. The Eastern Oregon Coordinated Care Organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Randall P. Roddey
Licensed Administrator

cc: Wallowa Valley Center For Wellness

SYMMETRY CARE

348 West Adams • Burns, Oregon 97720 • 541-573-8376 • Fax 541-573-8378

April 23, 2012

Dr. Bruce Goldburg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: **Support of GOBHI Coordinated Care Organization (CCO) Application**

Symmetry Care is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) to improve the health of the citizens of rural Oregon – in particular, its application to become a Coordinated Care Organization (CCO) for 19 counties across the state. GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

Symmetry Care is the Community Mental Health Program for Harney County. Its mission is to provide outstanding behavioral health services. GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Chris Siegner

Chris Siegner, LCSW,
Director Symmetry Care

Umatilla County

Board of County Commissioners

Commissioners

Bill Hansell
541-278-6201

Larry Givens
541-278-6203

Dennis Doherty
541-278-6202

Executive Assistant
Connie Caplinger
541-278-6203

Executive Secretary
Laura Headley
541-278-6204

County Counsel
Douglas Olsen
541-278-6208

Budget Officer
Bob Heffner
541-278-6209

April 30, 2012

Oregon Health Authority
500 Summer St, NE- E-20
Salem. OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

The Umatilla County Coordinated Stakeholders is pleased to provide this Letter of support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) in a partnership entity to improve the health of the citizens of rural Oregon – in particular, its application to become a Coordinated Care Organization (CCO) in partnership with another medically centered entity for 19 counties across the state. GOBHI as a mental health managed care organization has had success with localized behavioral health care delivery. Stressing prevention, early intervention, and support services improves health status and helps to reduce costs. GOBHI as a managed mental health care organization has committed to flexible funding models making it possible to create cost savings that can be reinvested in a variety of local service offerings. GOBHI is positioned to move from managed behavioral health to operating in a coordinated full –service care model.

Umatilla Dept. of Health and Human Services, Umatilla County Public Health, Umatilla County Human Services, Umatilla County Community Corrections, InterMountain ESD, Lifeways- Umatilla, DHS- District 12, Eastern Oregon Alcoholism Foundation, Center for Women and the Family, represent the Umatilla County coordinated care partners who would like to be part of the development of the coordinated system.

Sincerely

Connie Caplinger /fff by direction

Connie Caplinger, Dir. Dept. of UC Health and Human Services
Genni Lehnert-Beers RN MSN, Administrator, UC Public Health
Carolyn Mason, MS, Administrator, UC Human Services
Mark Royal, Director, UC Community Corrections
Mark Mulvihill, EdD. Supt., InterMountain ESD
Mike Gregory, Clinical Operations Manager, MA LPC, Lifeways – Umatilla
Linda Olson, MSW, Manager, DHS – District 12
Sonja Hart, Executive Director, Eastern Oregon Alcoholism Foundation
Cesareo Texidor, PA-C, MPH, CEO, Center for Women and the Family

Umatilla County Community Corrections

4705 N.W. Pioneer Place Pendleton, OR 97801 Phone 541-276-7824

June 6, 2012

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of Eastern Oregon Coordinated Care Organization (EOCCO) Application

The Umatilla County Community Corrections Department is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members – in particular, its application to become a Coordinated Care Organization (CCO) for 12 Eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

The Umatilla County Community Corrections Department represents Umatilla County, Oregon. Its mission is to enhance public safety and increase positive offender behavior utilizing evidence based practices, community partnerships, community presence, and agency professionalism. The Eastern Oregon Coordinated Care Organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Mark A. Royal, Director
((541) 276-7824 ext. 229

Umatilla-Morrow Head Start, Inc.
110 N.E. 4th Street
Hermiston, OR 97838
(541) 564-6878 · Fax (541) 564-6879
1-800-559-5878

A HEAD START, EARLY HEAD START AND OREGON PRE-KINDERGARTEN PROGRAM SERVING...
Umatilla
Morrow
Grant
Wallowa
Sherman
Wheeler
And Gilliam
Counties

A WIC PROGRAM SERVING...
Umatilla,
Morrow, and Wheeler
Counties

A CHILD CARE RESOURCE REFERRAL PROGRAM SERVING...
Umatilla
and
Morrow
Counties

A FAMILY SUPPORT & CONNECTIONS PROGRAM SERVING
Umatilla
and
Morrow
Counties

CASA PROGRAM

HEALTHY START/HEALTHY FAMILIES PROGRAM

A CAR SEAT LOAN PROGRAM

June 6, 2012

CCO Review Team
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: **Support of Eastern Oregon Coordinated Care Organization (EOCCO) Application**

Umatilla-Morrow Head Start, Inc. is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health Inc. in their collaboration to form the EOCCO to better meet the needs of Oregon Health Plan Members in Umatilla and Morrow counties - particular, its application to become a Coordinated Care Organization (CCO) for 12 Eastern Oregon counties. These partners have a demonstrated track record of success with their basic model of localized behavioral and physical health care delivery that stresses prevention, early intervention, and support services to improve overall health status and reduce cost.

The goal of the Eastern Oregon CCO is to be local enough to be relevant and large enough to be financially sustainable. The EOCCO will work within each of the twelve communities to bring new models of care that are patient-centered and team-focused, governed by a partnership among local health care providers and community members.

Umatilla-Morrow Head Start, Inc. represents low income children and families through its Head Start, Early Head Start, WIC, Healthy Start, Family Support & Connections, Child Care Resource & Referral and CASA programs. Its mission is to build Stronger Families, Better Communities for Brighter Futures. The Eastern Oregon Coordinated Care Organization's commitment to serve rural communities by incorporating an innovative and effective collaboration bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Cathy Wamsley

Cathy Wamsley
Executive Director
Umatilla-Morrow Head Start

UNION COUNTY
BOARD OF COMMISSIONERS

STEVE McCLURE, Commissioner
MARK D. DAVIDSON, Commissioner
WILLIAM D. ROSHOLT, Commissioner

1106 "K" AVENUE LA GRANDE, OR 97850 PHONE (541) 963-1001 FAX (541) 963-1079 TTY 1-800-735-1232

April 24, 2012

Dr. Bruce Goldberg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

Dear Dr. Goldberg:

The Union County Board of Commissioners is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) in collaboration with Oregon Dental services to improve the health of the citizens of rural Oregon – in particular, their application to become a Coordinated Care Organization (CCO). GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

The Union County Board of Commissioners represents the citizens of Union County and works to promote economic, physical and mental health of the citizens of Union County. GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

William Rosholt
Chair

Steve McClure
Commissioner

Mark Davidson
Commissioner

Wallowa River House
601 Whiskey Creek Road
Wallowa, OR 97885
(541) 886-3142

Dr. Bruce Goldberg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

The Wallowa River House is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) in efforts to improve the health of the citizens of rural Oregon – in particular, it's their application to become a Coordinated Care Organization (CCO). GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

The Wallowa River House, under the umbrella of Wallowa Valley Center for Wellness, is a non-profit program that serves as the community mental health program for Wallowa County. Wallowa River House provides both psychiatric and medical care of people with severe and persistent mental illness who are also medically fragile. It is the only provider of these specific services in the county, and one of only two in the state of Oregon. WVCW is currently working on developing an integrated program with the local primary care providers and is having clinicians cross-trained to be Behavioral Health Specialists using the University of Massachusetts model. Our mission is to bring health, well-being, dignity and hope to individuals and families in Wallowa County by providing accessible, compassionate, and quality care.

WE believe GOBHI's commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Chantay D. Jett, M.A.
Administrator

Wallowa Valley Center for Wellness

"Supporting Community Wellness"

Dr. Bruce Goldberg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

The Wallowa Valley Center for Wellness, is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI to improve the health of the citizens of rural Oregon – in particular, their application to become a Coordinated Care Organization (CCO). GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings. GOBHI is well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative.

Wallowa Valley Center for Wellness is a non-profit program that serves as the community mental health program for Wallowa County. It provides mental health care, drug and addiction services, and the services for people with developmental disabilities. It is the only provider of these services in the county. The Center is currently working on developing an integrated program with the local primary care providers and is having clinicians trained to be Behavioral Health Specialists using the University of Massachusetts model (Sandy Blount). Our mission is to bring health, well-being, dignity and hope to individuals and families in Wallowa County, by providing accessible, compassionate, and quality

We believe GOBHI, with its commitment to serve rural communities by incorporating innovative and effective collaborations bridging physical, mental and dental health is the best choice for our county, and that its approach is both commendable and achievable.

Sincerely,

Stephen Kliewer, MS, DMin. LPC
Executive Director

Winding Waters Clinic P.C. Physicians & Surgeons

Improving the Health of Our Community

Dr. Bruce Goldberg
Oregon Health Authority
500 Summer Street, NE – E-20
Salem, OR 97301-1097

RE: Support of GOBHI Coordinated Care Organization (CCO) Application

Winding Waters Clinic is a Rural Health Clinic and a recognized Tier 3 Patient Centered Primary Care Home and serves as the safety net clinic for primary care in Wallowa County. Winding Waters Clinic's mission is to provide excellent, comprehensive, compassionate health care to the families and visitors of Wallowa County in order to improve the health of the whole community. Winding Waters Clinic is pleased to provide this Letter of Support for the efforts of Greater Oregon Behavioral Health, Inc. (GOBHI) in their application to become a Coordinated Care Organization (CCO).

GOBHI has a demonstrated track record of success with its basic model of localized behavioral health care delivery that stresses prevention, early intervention, and support services to improve health status and reduce cost. GOBHI's commitment to flexible, innovative funding models has made it possible to create significant cost savings that have been reinvested in a variety of local service offerings – we have seen the beneficial effects of this in our community. GOBHI seems well positioned to move from managed behavioral health to a coordinated, full-service health care model – the Greater Oregon Better Health Initiative. We at Winding Waters Clinic feel GOBHI's commitment to serve rural communities by effecting innovative and effective collaborations bridging physical, mental and dental health is both commendable and achievable.

Sincerely,

Elizabeth Powers, MD
Owner
Winding Waters Clinic
Enterprise, OR 97828

Saint Alphonsus Medical Center

BAKER CITY

March 30, 2012

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

RE: Non-binding Letter of Endorsement for ODS Non-binding LOI for Eastern Oregon CCO

Dear Tammy L Hurst, Contract Specialist;

We, the CEO's of Eastern Oregon rural "A" hospitals understand that Oregon Health Transformation has become law and recognize that the creation of Coordinated Care Organization (CCOs) are part of the transformation process. In addition, we acknowledge that the creation of at least one CCO to serve eastern Oregon is necessary.

However, we do have trepidation and concern about unintended consequences that could result due to the aggressive timeline identified for the CCO development. We do acknowledge that ODS has taken the lead in the development of the non-binding Letter of Intent (LOI) for an eastern Oregon CCO.

Although many details are left to be determined, our signatures below endorse the concept of a partnership between the identified hospitals, ODS and Greater Oregon Behavioral Health, Inc. (GOBHI) and we are willing to pursue the eastern Oregon CCO concept further. This exploration likely will involve the creation of a new partnership governance entity.

Our intent is to continually update the Oregon Health Authority (OHA) on our progress.

Sincerely,

Ray Gibbons,
Saint Alphonsus Medical Center-Baker City

Rick Palagi
Saint Alphonsus Medical Center-Ontario

Supports this Letter through
electronic notification

Michael Blauer
Pioneer Memorial Hospital

Bob Houser
Blue Mountain Hospital

3325 Pocahontas Road
Baker City, Oregon 97814
Phone: 541-523-6461 | Fax: 541-523-8151
www.stelizabethhealth.com

GREATER OREGON BEHAVIORAL HEALTH, INC

KEVIN M. CAMPBELL, CEO

Professional Experience

Greater Oregon Behavioral Health, Inc., Chief Executive Officer, 2001-Present
GOBHI is a member-owned Benefits Management Company (501 C 4) dedicated to assuring high quality services delivered through rural community behavioral health programs. The Counties of GOBHI constitute approximately 70% of Oregon's land mass and 14.5% of its population. GOBHI is the only Mental Health Organization in Oregon that is also a Licensed Child Placing Agency and operates more than 25 therapeutic foster homes throughout rural Oregon. In 2011, Kevin was appointed to the Board of directors of the National Council for Community Behavioral Healthcare

Campbell Crossing Ranch, Kimberly, OR, Owner, 2007-Present
CCR is a fourth generation, family owned, Angus Cattle Ranch in the John Day River Valley which is operated by Kevin's Son Brian

Eastern Oregon Human Services Consortium, Coordinator, 1995-2001
EOHSC Provides Regional Mental Health and Developmental Disability Services across 13 Rural Counties in Eastern Oregon

Grant County OR, County Judge, 1989-1995
The County Judge in Grant County has three major functions; Probate Judge, Chair of the Board of County Commissioners, and County Administrator. Kevin also served as President of the Association of Oregon Counties in 1991-92

Howard Mercantile, Kimberly, OR, Owner, 1984 - 1989

Campbell Livestock Inc., Rancher, Kimberly, OR, 1980 - 1984

G & H Aircraft, El Monte, CA, Ground Operations Manager, 1978 - 1980

General Electric Credit Corporation, Area Credit and Collections Manager,
Portland, OR, Ventura, CA, and San Diego, CA 1975 - 1978

FMC CORPORATION, Portland, OR, Journeyman Boilermaker, 1974-1975

Education

University of Portland, Portland, OR, B.S. Business Administration, 1973
Monument High School, Monument, OR, 1969

TODD JACOBSON, L.C.S.W.

Operations Manager

PROFESSIONAL EXPERIENCE

Operations Manager, Greater Oregon Behavioral Health, Inc., June 2010 – present

Primary Responsibilities:

- Staffing: hiring, dismissal, and correction.
- Public relations: receiving and presenting information conducive to the enhancement of GOBHI operations.
- Departmental structure: design, efficiency and collaboration of effort.
- Quality assurance/improvement: clinical design, operations, and resource development; internally and with external contracted providers.
- Contract monitoring: contractor site and compliance reviews.
- External plans of improvement: developed with contracted providers.
- Grievances/appeals/complaints: facilitation, tracking, and resolution of GOBHI member and external provider concerns.
- Facilities: ensure ergonomic, safe, and comfortable working environment.

Clinical Services Manager, Alcohol and Other Drugs, Intellectual and Developmental Disabilities Program, Eastern Oregon Regional Developmental Disabilities Crisis Program, and Enhanced Care Services, Mid-Columbia Center for Living, The Dalles, OR, May 2007 to June 2010

Primary Responsibilities:

- Management of Criminal Justice Service Division Byrne Grant: Development of a Family Dependency Treatment/Drug Court in Hood River and Wasco Counties.
- Planning and Management Advisory Committee: Representative for Association of Oregon Counties to Oregon State Medicaid Block Grant program.
- Local Planning and Safety Coordinating Council: Representative for Mid-Columbia Center for Living in Sherman County.
- Agency Budget planning and oversight: In collaboration with Executive Director.
- Oversight of Agency compliance with applicable Oregon Administrative Rules for Alcohol and Other Drug, Developmental Disabilities, and Enhanced Care Services programs and ensuring policies/procedures accurately reflect requirements.
- Process Improvement coordination: Utilizing NIATx principles to guide agency towards best practices in a progressive and effective fashion manner
- Supervision of four Program Supervisors. Ensuring all service areas are collaborating with customers, partners, employees, and purchasers.

Interim Assistant Director, Mid-Columbia Center for Living, The Dalles, OR, July 2005 to May 2007

Primary Responsibilities:

- Oversight of all clinical operations
- Grants management.
- Planning and Management Advisory Committee: Representative for Association of Oregon Counties to Oregon State Medicaid Block Grant Program.
- Local Planning and Safety Coordinating Council: Representative for Mid-Columbia Center for Living in Sherman County.
- Agency budget planning and oversight: In collaboration with Executive Director and program managers.
- Oversight of agency compliance with applicable Oregon Administrative Rules and that policies/procedures accurately reflect requirements.
- Process Improvement coordination: Utilizing NIATx principles to guide agency towards best practices in a progressive and effective fashion.
- Supervision of three service area program managers, one program supervisor, and nine alcohol and drug counselors.
- Ensuring all service areas are collaborating with customers, partners, employees, and purchasers.

Program Manager, Intellectual and Developmental Disabilities Service Coordination, Eastern Oregon Regional Developmental Disabilities Crisis Program, Consumer Run Drop-in Center, and Enhanced Care Services, Mid-Columbia Center for Living, The Dalles, OR, September 1997 to June 2005

Primary responsibilities include:

- Quality assurance and improvement.
- Annual budget oversight and development.
- Service coordination with partner agencies.
- Consensus building and supervision.
- Contract development and monitoring.
- Program design and upgrades.
- Program and subcontractor compliance with all applicable laws and statutes.
- Development and updating of policies and procedures.
- Community and program negotiations.

Community Rehabilitation Coordinator, Psychosocial Rehabilitation Program, Consumer Run Drop-In Center, and Assertive Community Treatment Case Management Program, Mid-Columbia Center for Living, The Dalles, OR, September 1995 to September 1997

Primary responsibilities include:

- Designed and implemented community support services.

- Quality assurance and improvement.
- Ensuring consumer participation in all aspects of the program.
- Service delivery and coordination with partner agencies.
- Supervision and consultation to the consumer drop-in center.
- Supervision of Assertive Community Treatment Case Management Program.
- Budget development and monitoring.
- Employment services.
- Individual therapy.

Program Manager, Adult Day Treatment, Fountain House Program, Adult Day Treatment, and Case Management, , Central Washington Comprehensive Mental Health, Yakima, WA, July 1992 to September 1995

Primary responsibilities include:

- Supervision of Adult Day Treatment and Fountain House.
- Program design and implementation.
- Team development.
- Fiscal management.
- Group and individual therapy.
- Quality assurance within team.
- Oversight of an Adult Basic Education program.
- Case management.

Case Manager, Sunrise Club, Central Washington Comprehensive Mental Health, Yakima, WA, June 1990 to July 1992.

Primary responsibilities include:

- Case management.
- Facilitation of a work ordered day in the Fountain House program.
- Employment services.
- Medication management.
- Money management.
- Service coordination with other departments

EDUCATION

- Eastern Washington University: June 1993
  Master of Social Work

- Central Washington University: June 1987
  Bachelor of Arts, Psychology

LICENSE AND CERTIFICATION

- State of Oregon Licensed Clinical Social Worker

ADDITIONAL EXPERIENCE

- Winter term 2001, 2002, and 2004: Instructor of 3 credit course, "Crisis Intervention" at Columbia Gorge Community College in The Dalles, Oregon. The class is a required course for student Paramedics and emergency medical technicians.
- Residential Manager for 30 bed congregate care facility in Everett, Washington, 1988 to 1990.

DAVID S. BAKER

Interim Chief Financial Officer

PROFESSIONAL EXPERIENCE

Financial Analysis, Planning, Evaluation for Human Services Organizations, Portland, OR, January 1, 2008-Present

- Coordinated Care Organization, Fully Capitated Health Plan analysis, mental health services analysis, financial and risk analysis. Greater Oregon Behavioral Health (GOBHI)
- Financial system setup and monitoring; financial analysis. Bridgeway Recovery Services
- Financial accounting system review, budget development. Mental Health America of Oregon
- Financial Analyses for various DD program agencies. Oregon Technical Assistance Corp.
- Fiscal Compliance Reviews. Oregon Association of Hospitals & Health Systems; Public Health Division
- Design process and perform fiscal compliance monitoring reviews for grant awardee sub-recipients of Federal HRSA Emergency Preparedness funds in the State of Oregon.

Financial Services Manager, Department of Human Services Finance (currently for State of Oregon Public Health Division), July 1, 2001-Dec 31, 2007, Portland/Salem, Oregon

- Prior supervision of DHS Accounting for Senior and Disabled Services, Director's Office, and current supervision for DHS Financial Services of Oregon Public Health Division in Portland
- Provision of oversight for accounting and financial operations, including cash management, bill paying, recording and reporting expenditures, and federal grant financial reports
- Responsibility for directing and managing the overall accounting tasks, internal controls, audit preparation and support, and support of financial issues related program offices
- Management and leadership of an accounting unit including developing and implementing short and long range goals and plans relating to customer services, team building, strategic planning, communication, process improvement, and daily workflow
- Work with state, federal and internal auditors in their reviews of the Public Health Division's federal grants financial systems, operating procedures, etc. Confer, advise and assist DHS management in the evaluation of the financial systems which includes problem resolution, policy recommendations
- Management and supervision of the financial compliance review activities of sub-recipients of federal grant funds. (Retired from State service)

Policy & Budget Analyst, & Budget Administrator, **DHS Fiscal Policy & Analysis**

- Supervision, planning, development and monitoring of the execution of a biennial budget of $2.5billion
- Maintenance of internal controls over execution of the budget by updating revenue and expense projections
- Monitoring compliance with federal and other bidding source requirements, and preparation of budget rebalancing plans as needed

- Conducting special exception studies that analyze budget areas where problems and opportunities are evident
- Provision of reports to administration with background information, issue description, analysis conclusions and recommendations regarding program expenditures and revenue grant sources. Estimate the fiscal impact of proposed legislation
- Maintenance effective communication links to county and community service providers

Associate Director (then Interim Director), Oregon Technical Assistance Corp., May 1998-June 2001
Salem, Oregon

- Supervision of project, fiscal and operations staff for special program projects, accounting, financial and budget operations
- Evaluation of projects by developing procedures, including data maintenance to meet contract requirements
- Development of program budget, operations and evaluation procedures in the implementation of initiatives
- Provision of technical assistance to community DD nonprofit providers that include financial projections and budget preparation, program financial feasibility, financial/accounting system analysis and accounting system reorganization assistance
- Development and operations of **Resource Connections of Oregon**, a DD client fiscal intermediary organization

Chief Financial Officer, Garlington Center for Behavioral HealthCare , Portland, OR, May 1997 - May 1998

- Supervision of fiscal services staff for all accounting, billing and budget functions and related reporting requirements
- Financial evaluation of programs
- Direction of activities relating to program strategic planning for short and long-range goals and objectives
- Development of program financial rules and policies for transition to a managed care environment
- Development and management of different managed care program evaluation budget models
- Review, interpretation and identification of identify financial risk and evaluate capitated managed care contracts
- Development of administrative and program operating procedures
- Presentation and interpretation of financial data, managed care financial impacts to community regulatory entities and community volunteer professionals
- Development and maintenance of automated systems, procedures and controls
- Coordination of interim and annual audit activities
- Representation of management in union labor negotiations

Program Analyst, DHR Director's Office, Salem, OR, June 1990-May 1997

- Responsibility for analyzing, reviewing, and monitoring the fiscal and program policies of DHR Divisions and Program Offices

- Development and maintenance of up-to-date information of current and future policy, program, service delivery, federal funding and fiscal issues
- Responsibility for guiding and coordinating DHR staff in the implementation of activities, which are DHR-wide or cross Division authorities
- Evaluation of program effectiveness and efficiency through program analysis and comparison, and identification of long-term alternative solutions to problems
- Development of policy papers and recommendations and coordinate Legislative concepts that cross organizational lines
- Provision of assistance to Divisions regarding Legislative concepts and fiscal impact data

Budget, Grants, and Contracts Coordinator, Oregon DD Council (MHDDSD), 1995-96

- Preparation, review and coordination of Requests for Proposal and related contracts
- Direction of the contract process with, and provide performance assistance to grantees
- Monitoring contract performance and compliance
- Development, preparation and monitoring of the execution of the DD Council's state biennial budget and the Council's federal grant budget
- Preparation of financial data for the annual grant progress reports

Budget Manager-Fiscal Coordinator, MHDDSD - 1991-95

- Planning and monitoring the execution of a biennial budget of over $400,000,000
- Monitoring compliance with federal and other bidding source requirements, and preparation of budget rebalancing plans as needed
- Conducting special exception studies that analyze budget areas where problems and opportunities were evident
- Provision of reports to administration with background information, issue description, analysis conclusions and recommendations
- Estimation of the fiscal impact of proposed legislation
- Maintenance of effective communication links to county and community service providers
- Supervision of contract staff to prepare and monitor contracts through which the Division obligated $200,000,000+ in community funds
-

Rate Restructuring Coordinator, MHDDSD - 1990-91

- Coordination of the development of a new rate system model for DD community-based programs
- Coordination of activities of, and provided project direction for various rate restructuring advisory committees
- Researching rate models in development and in use by other states
- Development of surveys to accumulate community program expense data and client needs assessment data used to develop new rate models
- Preparation of detailed project report for legislative presentations

Administrator, Fiscal Services, Albertina Kerr Centers, Portland, Oregon, April 1980-Jan 1990

- Supervision of accounting staff to monitor and execute the recording, reporting, and analysis of monthly financial data
- Successful development and maintenance of computer systems, procedures and controls
- Direction of activities relating to program strategic planning, and participated in fund development activities
- Planned, prepared, and monitored the annual budget
- Preparation of grant financial reports
- Provision of advice to, and preparation of various financial analyses for, administration, program managers, board members, and county/state regulatory personnel informing of organizational and environmental trends, overall budget status, and financial stability
- Coordination of a special project on Privatization, Child Welfare League of America, Washington, DC, Loaned Executive Program, Summer, 1986

Assistant Controller, Metropolitan Hospitals (Now Legacy Health Systems), Portland, Oregon, May 1973-March 1980

- Supervision of accounting staff and coordinated financial recording and reporting functions of four Metro Area hospital facilities
- Coordination of management services organization (MSO) Accounting/Accounts Receivable and computer system consolidation procedures and controls for the four member hospitals
- Monitoring, analysis and reporting of Medicare/Medicaid cost reimbursement issues
- Interim Director of Patient Accounts Department, Emanuel Hospital, to reorganize the department
- Member of the operational consultant team for hospitals in Redmond, Seaside, Lincoln City, and Astoria

LAURENCE COLMAN, MD, MPH
Medical Director

PROFESSIONAL EMPLOYMENT AND ACTIVITIES

Candidate in Psychoanalytic Training, Oregon Psychoanalytic Institute, Portland, Oregon, 2009 – Present

Medical director, Greater Oregon Behavioral Health, Inc., The Dalles, Oregon, 2008 – Present

Hospital Active Staff, Acute Inpatient Child & Adolescent Unit, Emanuel Hospital, Legacy Health Network, Portland, Oregon, 2007 – 2011

Solo Outpatient Private Practice, Portland, Oregon, 2006 – Present

Consultant, Inpatient Child & Adolescent Sub-acute Services, Albertina Kerr Centers, Portland, Oregon, 2006 – Present

Assistant Clinical Professor of Psychiatry, Oregon Health & Science University, Portland, Oregon, 2006 – Present

EDUCATION AND BOARD CERTIFICATION

board Certified Diplomate in Psychiatry
American board of Psychiatry & Neurology
2006 - Present

Child & Adolescent Psychiatry Fellowship
Oregon Health & Science University
Portland, Oregon
July 2004 – June 2006

General Psychiatry Residency
Oregon Health & Science University
Portland, Oregon
July 2001 – June 2005

Doctor of Medicine
Columbia University
College of Physicians & Surgeons
New York City, New York
August 1997 – May 2001

Masters in Public Health
Columbia University
Mailman School of Public Health

New York City, New York
September 1997 – June 2001

Bachelors in Economics
University of California at Berkeley
With Honors and High Distinction
Berkeley, California
August 1988 – May 1992

PROFESSIONAL SOCIETY MEMBERSHIPS

Oregon Council of Child & Adolescent Psychiatry (OCCAP), 2006 – Present

Oregon Psychiatric Association (APA), 2006 – Present

Oregon Medical Association (OMA), 2009 – Present

American Psychiatric Association (APA), 2001 – Present

American Academy of Child & Adolescent Psychiatry (AACAP), 2005 – Present

American Psychoanalytic Association (APSA), 2009 – Present

REFERENCES

Ajit Jetmalani, MD. Director, Division of Child & Adolescent Psychiatry, Oregon Health & Sciences University

David Jeffery, MD. Northern Region medical director, Trillium Family Services

Nancy Winters, MD. Faculty, Oregon Psychoanalytic Institute, and former Training Director, Division of Child & Adolescent Psychiatry, Oregon Health & Sciences University

MORRIS M. VOLKOV

Interim Information Technology Manager

PROFESSIONAL EXPERIENCE

Interim Information Technology Manager, Greater Oregon Behavioral Health, Inc., 2012 – Present

Information Technology Manager, Marion County, Salem, OR. 1987-2012

- Long career in Information Technology with a focus on Public Safety and Criminal Justice applications
- Co-developed Criminal Justice applications now being used in major cities
- Conceived the idea and lead the development of a statewide criminal justice information system based on modern search engine technology
- Experience with managing people, budgets, and projects
- Experience managing and leading various special teams
- IT Service Management practitioner responsible for Service Management implementation
- Experience with I.T. Service Management tools
- Experience managing a Service Desk along with a number of technical support staff

IT Service Management, President, Presenter, Leader, Salem, OR 2007- 2012

- Experience preparing and giving presentations including national conventions (itSMF Fusion, 2009 and 2010)
- Experienced instructor and leader
- President Oregon Local Interest Group (LIG) of the IT Service Management Forum (itSMF)
- Long-time member and presenter for the Oregon Association of Government Information Technology Managers (OAGITM)

Software Services and Training Consultant, Digital Equipment Corporation (DEC), Portland, OR, 1984-1987

- Pre-Sales consultation
- Extensive training, consulting, and customer installation experience with government agencies, banks and manufacturing companies

Senior Sales Representative, Various Sales Positions, Salem, OR, 1980-1984

- Always a leader in computer sales

- Especially good at delivering customized solutions

EDUCATION

Granite Computer Institute, Programming Certification, Los Angeles, CA, 1969-1971

PROFESSIONAL CERTIFICATIONS

ITIL (Information Technology Infrastructure Library) V2 Foundation

ITIL V3 Foundation

ITIL Practitioner- IPRC Release and Control

ITIL Intermediate Service Operation

ITIL Intermediate Service Transition

ITIL Intermediate Service Design

ITIL Intermediate Service Strategy

ITIL Intermediate Continual Service Improvement

ITIL Managing Across the Lifecycle resulting in **ITIL Expert Status**

ISO 20000 Foundation

Computer Forensics Certification

Robert G. Gootee

President & CEO, The ODS Companies

Robert Gootee brings to work each day a broad range of business experience and a singular commitment to his community. As President and Chief Executive Officer of The ODS Companies, one of Portland's largest employers, Robert is widely recognized as a civic leader in business ethics, environmental standards and more sustainable corporate cultures.

Born and raised in Texas, Robert earned an undergraduate degree in forestry and a Masters of Business Administration from Texas A&M University before launching his career as a certified public accountant. He rose through financial management positions in the high-tech, environmental, healthcare and insurance industries before joining ODS as Vice President, Finance, in 1988. Since being appointed President and Chief Executive Officer in 1998, Robert has led the company through significant growth to annual revenues of well over $1 billion.

A passionate bicyclist, Robert is well-known in Portland and at ODS as a frequent commuter on two wheels. ODS's landmark downtown headquarters, ODS Tower, is well known for providing one of Portland's finest facilities for bicycling commuters. But Robert's environmental contributions extend far beyond bicycle commuting. Restoring native landscapes at their Eastern Oregon ranch, Robert and his wife, forester Roje Gootee, have planted more than 60,000 trees and both are long term members of The Nature Conservancy where Robert has served as Chairman of the Board of Trustees of the Oregon chapter.

Robert's community involvement includes ongoing service on the board of the Dental Foundation of Oregon, working to improve oral health for Oregon's children, and a recent stint as Chairman of the Board of Delta Dental Plans Association, America's largest dental benefits provider.

Founded in 1955, now serving more than 1 million members throughout the Northwest and Alaska, ODS is a multifaceted organization that provides medical, dental, vision and professional liability insurance products, along with an associated variety of business services. In addition to its signature downtown tower, ODS has offices in Milwaukie, Medford, Bend and La Grande, Ore., and in Bothell, Wash., and Anchorage, Alaska.

For more information, visit www.odscompanies.com.

DAVID W. EVANS, CPA

Senior Vice President & Chief Financial Officer | (503) 243-3952 | evansd@odscompanies.com

PROFESSIONAL EXPERIENCE

The ODS Companies

Senior Vice President & Chief Financial Officer **2011-current**

- Oversee Finance, Treasury, Legal, Information Services, Underwriting and Actuarial departments
- Manage cash flows to ensure maximized returns while meeting working capital needs
- Oversee compliance with external regulatory agencies – tax compliance, State insurance regulators and other government regulatory agencies
- Implement financial aspects of strategic plan focusing on long-term capital growth by maximizing return on equity while managing risk
- Evaluate and advise on the impact of strategies and initiatives

Corporate Controller **2001-2011**

- Oversee day to day accounting and finance activities
- Ensure timely and accurate reporting of financial statements
- Implement and enforce effective internal controls to safeguard corporate assets
- Develop and monitor annual forecast; including presentation to Board of Directors
- Ensure compliance with the Board approved asset allocation and investment portfolio
- Comply with local, state and federal government reporting requirements and tax filings

PricewaterhouseCoopers LLP

Audit Manager **1999-2001**

- Develop overall audit strategy and supervise implementation for SEC and mid to large sized privately held entities with a focus on insurance and real estate
- Review, examine and evaluate financial and internal controls for adequacy and effectiveness; present suggestions and guidance for improvements and implementations to client management and audit committees
- Evaluate compliance of financial statements with GAAP accounting, Statutory accounting, SEC and other external reporting requirements

DAVID W. EVANS, CPA

- Resolve technical accounting and auditing issues with client management
- Develop and deliver presentations to client management, board of directors, audit committees and prospective clients
- Responsible for scheduling staff and resolving conflicts
- Accountable for engagement economics, billing arrangements and subsequent collections
- Instruct technical courses, recruit, mentor and evaluate staff members

Audit Senior Associate **1997-1998**

- Planned, performed and supervised engagements
- Prepared quarterly and annual financial statements, including required SEC, statutory and regulatory communications
- Participated in initial public offering engagements and other various SEC filings
- Examined and evaluated financial and internal controls for adequacy and effectiveness
- Researched technical issues and implemented new accounting pronouncements and guidance

Audit/Tax Associate **1995-1996**

- Compiled, analyzed and verified supporting documentation for balance and income statement accounts
- Assisted in the preparation of financial statements and resolution of accounting and auditing issues
- Prepared individual tax returns

EDUCATION

Bachelor of Science, Concentration in Accounting - 1994
Oregon State University; Corvallis, Oregon

ORGANIZATION ACTIVITIES

American Institute of Certified Public Accountants

Oregon Society of Certified Public Accountants

OSCPA- Coaching Program

Leadership Portland Participant

Financial Executives International

DAVID W. EVANS, CPA

Advisory Board – Assistance League

Metro Natural Areas Program Oversight Committee

Metro- Oregon Zoo Bond Citizens Oversight Committee

William E Johnson, MD, MBA, FACS, FICS
601 SW Second Ave
Portland, OR 97204-3156
Tel: 503-412-4041 johnsow@odscompanies.com

Senior Vice President- The ODS Companies **June 1, 2011**

- Member of Senior Executive Team providing Strategic direction to ODS.
- Responsibilities include: Medical Management, ODS Quality Programs, Wellness, Corporate Web and Digital Strategy, ODS-Marketing/Branding, and ODS-Document Services.
- Provides medical expertise and support to ODS departments including. Analytics, pharmaceutical programs, actuarial and underwriting, professional services, claims, customer service, corporate compliance and sales & service.

American Cancer Society Impact Conference Steering Committee
Rules Advisory Committee for the State of Oregon for Health Information Exchange
Oregon Health Leadership Council
American Health Insurance Plan- HSA Leadership Council
American Health Insurance Plan- Chief Medical Officer Committee
eValue8 Health Plan Advisory Council
National Business Coalition on Health-National Health Leadership Council
Medical Director Advisory Panel- Johnson & Johnson, Ethicon Endo-Surgery

- Provide strategic counsel to scientific innovations throughout all stages of the product lifecycle with regard to technology assessment, payer coverage, and medical policy development.

Medical Director Advisory Board- Argenta TEC™

- A subsidiary of Argenta Advisors™, who provides strategic counsel to life sciences companies throughout all stages of the product lifecycle with regard to technology assessment, payer coverage, and medical policy development.

Vice President, Healthcare Services, Chief Medical Officer and Director Corporate Web & Digital Strategy -The ODS Companies **2009- 2011**

Medical Director - The ODS Companies **2008-2009**

President and CEO -Surgical Associates **2003-2008**

Accounts Receivable Supervisor-Surgical Associates **2001-2008**

Surgeon-Surgical Associates **1999-2008**
General /Thoracic and Vascular Surgeon

Surgeon- HealthFirst **1996-1999**

General/ Thoracic and Vascular Surgeon

EDUCATION

Undergraduate

Harvard University, Cambridge,	1983
Biology - University of Southern California, Los Angeles,	1984

Medical School

MD - University of Southern California, Los Angeles,	1989

Graduate School

MBA- University of Tennessee	2009

Internship

General Surgery - Los Angeles County + USC Hospital,	June 1989- July 1990,

Residency

General Surgery - Los Angeles County + USC Hospital	July 1990-July 1994

Fellowships

Esophageal Research USC Department of Surgery Foregut Division	July 1994-April 1995
Assistant Unit Chief, Division of Foregut & Thoracic Surgery Los Angeles County + USC Hospital	April 1995-June 1995
Cardiovascular Fellow Beth Israel Hospital, Harvard Medical School	July 1995-1996

HONORS & AWARDS

- ***Phi Kappa Phi Honor Society***, University of Tennessee MBA 2009
- ***International Honour Society***, University of Tennessee MBA 2009
- ***American College of Physician Executives***
  - Academic Achievement in Medical Management 2008 ACPE
- Affiliate Professor of Surgery, OHSU 2009-P
- Clinical Associate Professor of Surgery, OHSU 2003-2009
- American Registry of Outstanding Professionals 2004
- Clinical Faculty Teaching Award, Oregon Health Sciences University, 2003
- Golden Scalpel Resident Teaching Award, St. Vincent's Hospital, 2003
- Outstanding Clinical Instructor, In Surgical Education, Good Samaritan Hospital, 2000-2001
- Outstanding Chief Resident Teaching Award, 1994.
- Outstanding Church and Community Service, 1994.
- Student National Medical Association, Clinical Excellence, 1993.
- Dean Scholar USC, 1982-1983.

QUALIFICATIONS

Academic Appointments Affiliate Professor of Surgery OHSU 2009
Visiting Faculty University of Tennessee School of Business

Licensure	Oregon, 1996 (2004), Active Administrative Massachusetts, 1995 (81683), Inactive California, 1990 (G07004), Active Unrestricted
Certification	Fellow International College of Surgeons (FICS) Fellow American College of Surgeons (FACS) Board Certified American Board of Surgery, 1998-2007 Diplomat American Board of Surgery, 1998. Diplomat National Board of Medical Examiners, 1990.

Society Memberships

- AcademyHealth
- Healthcare Information and Management Systems Society
- Pacific Coast Surgical Association
- American College of Physician Executives
- American College of Medical Practice Executives
- Society of Black Academic Surgeons
- Providence Thoracic Surgery Program
- MGMA
- The North Pacific Surgical Association
- Portland Surgical Society
- Oregon Medical Association
- American Medical Political Action Committee (AMPAC)
- Society of Graduate Surgeons USC
- National Medical Association
- California Medical Association

Current Work Groups

- Oregon Healthcare Leadership Council Evidence Based Best Practice
- Oregon Healthcare Leadership Council- Medical Home
- Oregon Healthcare Leadership Council- Administrative Simplification
- Oregon Hospital Association "Never Events" Task Force
- Legislative Committee- Salem Oregon Rep Providers and The ODS Companies
- OMA Finance Committee

Business Proposals

- Breast Cancer Practice Expansion
- Pacific Summit Healthcare – Lean Emergency Department
- Cascade Acute Surgical Services (CASS)
- Surgical Associates Transfer Service (SATS)

Practice Management & Business Plan Software Program- Designed for small to medium size subspecialty practices.

BUSINESS OWNERSHIP

- TOBB Enterprises LLC- Publishing
- TOBB Properties LLP- Property Management

- Synergistic Investment Solutions LLC- Financial Management
- 3 Copyrights

PRESENTATIONS

- **Ethicon Endo-Surgery Inc. Thoracic Advisory Board-** HealthCare Finance & Credentialing
- **Point b Problem Solver Series-Speaker Panel** –Innovation in Health Care
- **Keynote Speaker- Oregon Coalition of Health Care Purchasers** -Supply Chain Management; Maximizing Your Benefit Dollars & Employee Productivity With Minimally Invasive Procedures.
- **Health Insurance CEO Roundtable-** Healthcare Reform
- **Keynote Speaker-OHAU State Convention-** The Health Care Environment

PUBLICATIONS

Books:

Children's Book "The Whales Are Calling" by Dick Wisshack
Editor William E Johnson, M.D. 2009: ISBN

Children's Book "Mommy Found A Lump" by Nathalie Johnson, M.D. Editor William E Johnson, M.D. 2008: ISBN 978-09814-7980-4, ISBN 978-0-9814-7981-1

"Understanding Breast Cancer for the Young Adult" by Nathalie Johnson, MD & Margie Glissmeyer PAC. Editor William E. Johnson, M.D. 2009

Children's Book "Just a Heartbeat Away" by Jacques Rene Marion and Dick Wisshack- Editor William E. Johnson 2011

"Crossing Paths: The Importance of Education to Improve Viability in Underserved Communities" Co-authors Algie Gatewood PhD, William E Johnson, MD, MBA in progress

Peer-Reviewed Professional Journal Articles:

William Johnson, MD MBA : **Improving Outcomes and Reducing Costs with Minimally Invasive Procedures.** Journal of Managed Care Medicine. Vol.15, No.1, 2012.

Integrating the Patient Activation Measure Into Health Coaching to Improve Patient Engagement. NCQA Quality Profiles. Pg 75-80. 2011.

Eugene Y. Chang, MD[2], Paul B. Dorsey, MS[1], Joseph Frankhouse, MD[1], □Deb Walts, MSN[1], William Johnson, MD[1], George Anadiotis, DO[1], □Nathalie Johnson, MD: **Combination of microsatellite instability and lymphocytic infiltrate as a prognostic indicator in colon cancer.** Archives of Surgery

2008 (in press)

Eugene Chang, M.D., William Johnson, M.D., Christopher Komanapalli, M.D., Deb Walts, M.S.N., Diana Mahin, C.T.R., Nathalie Johnson, M.D. **The Evaluation and Treatment Implications of Pulmonary Nodules in Patients with a Recent History of Breast Cancer.** American Journal of Surgery 2006

Eugene Y. Chang, MD, Joseph Frankhouse, MD, Paul B. Dorsey, MS, DebWalts, MSN, William Johnson, MD, Louis Homer, MD, Nathalie Johnson, MD. **Microsatellite Instability An Independent Predictor of Outcome In Colorectal Cancer.** American Journal of Surgery 2006

Chang E, Johnson NM, Webber B, Johnson WE, Booth J, Gannet, D, Zegzula D: **Bilateral Reduction Mammoplasty In Combination With Lumpectomy For Treatment of Breast Cancer In Patients With Large Breasts.** American Journal of Surgery 2004

Crookes PF, Ritter MP, Johnson WE, Bremner CG, Peters JH, DeMeester TR: **Static and Dynamic Function of the Lower Esophageal Sphincter Before and After Laparoscopic Nissan Fundoplication.** Journal of Gastrointestinal Surgery 1:499-504, 1997.

Johnson WE, Hagen JA, DeMeester TR, Kauer WKH, Ritter MP, Peters JH, Bremner CG: **Outcome Of Respiratory Symptoms After Antireflux Surgery On Patients With Gastroesophageal Reflux Disease.** Arch Surg 131: 489, 1996.

Tsai P, Peters J, Johnson W, Cohen R, Starnes V. **Laparoscopic Fundoplication One Month Prior To Lung Transplantation.** Surgical Endoscopy. 10(6):668-70, 1996 Jun.

DeMeester TR, Johnson WE. **Outcomes Of Respiratory Symptoms After Surgical Treatment Of Swallowing Disorders.** Sem Resp Crit Care 16(6): 514-519, 1995.

Published Abstracts:

Kauer WKH, Ireland AP, Peters JH, Johnson WE, Bremner CG, DeMeester TR: **Evaluation of Duodenogastric Reflux in Patients with Gastric Symptoms Utilizing a Fiberoptic Sensor for Bilirubin.** Gastroenterology 108(4):A1225, 1995.

Abstracts Submitted:

Eugene Chang, M.D., William Johnson, M.D., Christopher Komanapalli, M.D., Deb Walts, M.S.N., Diana Mahin, C.T.R., Nathalie Johnson, M.D. **The Evaluation and Treatment Implications of Pulmonary Nodules in Patients with a Recent History of Breast Cancer.** 2005

Eugene Y. Chang, MD, Joseph Frankhouse, MD, Paul B. Dorsey, MS, DebWalts, MSN, William Johnson,MD, Louis Homer, MD, Nathalie Johnson, MD. **Microsatellite Instability An Independent Predictor of Outcome In Colorectal Cancer.** 2005

Chang E, Johnson WE, Johnson NM: **Lymphatic Mapping and Sentinel Node Identification After Previous Nodal Dissection.** 2003

Johnson NM, Johnson WE, Peck JJ: **Gastrointestinal Stromal Tumors (GIST) Clinical Decision Making.** 1998

Johnson WE, Eidemiller LA, Johnson NM, Irish EC, Frankhouse JE, Peck JJ: **Multimodality Therapy Can Offer Improved Clinical Outcomes in Esophageal Cancer Patients.** 1999

Other Publications:

Legacy Cancer Annual Report 2001. **Lung Cancer: To Screen or Not to Screen.**

Oncology Matters April 2005. **Esophageal Cancer Treatment options.**

SUE HANSEN

Vice President and Chief Information Officer | 503.265.5705 | hansens@odscompanies.com

CREDENTIALS

Executive level professional with 33 years experience in all aspects of Health insurance industry and technology

CORE COMPETENCIES

- Strategic Focus
- Business Implementation
- Technology solutions
- Project Management
- Creativity
- Energetic and motivational

PROFESSIONAL EXPERIENCE

Vice President and Chief Information Office, ODS, 2008 - present

- Consolidation and implementation of core administrative system including online services
  - Completion of the implementation of the Facets Extended Enterprise system
- Transformation of ODS Information Service division
  - Mainframe transformation to client-server based infrastructure technology

Primary duties

- ODS strategic technology development and implementation
- Accountable for all technology solutions
- Accountable for all ODS corporate initiatives and project implementations
- Accountable for large portion of the ODS administrative budget – both capital and operating

Director Information Services, ODS, 2004- 2008

- Implementation of integrated core administrative system
  - Successful selection and implementation of the Facets Extended Enterprise system including business process re-engineer

Primary duties

SUE HANSEN

- Accountable for planning, development and implementation of the Facets Extended Enterprise system for ODS
- Led 150 IS professionals focused on the implementation activities

Director and Vice President System Consolidation, The Regence Group, 1998-2003

- Led 350 IT professional team across four states in multi-year systems and business consolidation initiative
    - Successful implementation of Facets Extended Enterprise system

Primary duties

- Led large IT professional team
- Accountable to system implementation including business process re-engineering

Assistant Vice President, The Regence Group, 1996-1998

- Managed Large Account implementations
    - Successful implementation of all aspects of large national accounts
- Project management
    - Successful implementation of several projects both business and technical

Primary duties

- Directed and led a team of 85 technical professionals
- Accountable for large account implementations
- Account for successful project management and implementations

Manager, BlueCross and BlueShield of Oregon, 1987-1996

- Managed corporate project initiatives
    - Successful implementation of projects including various systems including membership/billing, and managed care claims processing systems.
- Managed membership accounting operational department
    - Successful operational department exceeding customer needs and ensuring accurate eligibility, premium billing and reconciliation

Primary duties

- Managed 45 IT professionals both technical and business systems analysts
- Project Manager
- Managed operational membership accounting department

SUE HANSEN

EDUCATION

Successful completion of various courses in business management, project management, and systems analysis and design throughout the course of my 33 year career in the health insurance industry.

ROBIN JAY RICHARDSON

Senior Vice President, Pharmaceutical Programs | (503) 243-4491 | richarr@odscompanies.com

PROFESSIONAL EXPERIENCE

The ODS Companies, Portland, OR

Senior Vice President, 2/10-Current

Vice President, Medical Services, 11/04-2/10

Director, Medical Professional Relations, 2000-2004

Director, Pharmaceutical Programs, 1998-2004

American Managed Care Consultants Inc., Alexandria, Virginia

President, 1997-98

National Home Infusion Association, Alexandria, Virginia

Executive Director, 1991-97

National Association of Community Pharmacists, Alexandria, Virginia

Vice President Home Health Care and Institutional Services, 1991-97

Pharmacists' Service Group, Salem, Oregon

Managing Director, 1984-91

Payless Pharmacy, McMinnville, Oregon

Pharmacist, 1984-86

ROBIN JAY RICHARDSON

South Salem Pharmacy, Salem, Oregon

Pharmacy Extern, 1984

Student American Pharmaceutical Association

National Vice President, 1983-84

Good Samaritan Hospital Pharmacy. Corvallis, Oregon

Pharmacy Intern, 1983-84

Holiday Park Hospital Pharmacy, Portland, Oregon

Pharmacy Intern, 1981-83

EDUCATION

B.A., Pharmacy - 1984

Oregon State University; Corvallis, Oregon

General Science Major - 1977-81

University of Oregon; Eugene, Oregon

PAPERS PRESENTED

Total Parenteral Nutrition Monitoring, R.J. Richardson, College of Pharmacy, Oregon State University. Presented to the Oregon Society of Hospital Pharmacists, Southern Chapter Meeting, Ashland, Oregon, June 1984.

ROBIN JAY RICHARDSON

System Documentation as a Marketing and Managing Tool for Pharmacy PPO's. R.J. Richardson, Pharmacists' Service Group, Oregon State Pharmacists Association, Salem, Oregon; L.R. Strandberg and D.J. Stennett, College of Pharmacy, Oregon State University, Corvallis, Oregon. Presented at the American Pharmaceutical Association Annual Meeting, Economic, Social and Administrative Science Section APS Contributed Papers, March 17, 1986, San Francisco, California.

The Economic Impact of a Pharmacy PPO. L.R. Strandberg, College of Pharmacy, Oregon State University, Corvallis, Oregon; R.J. Richardson, Pharmacists' Service Group, Oregon State Pharmacists Association, Salem, Oregon; D.J. Stennett, Oregon State University. Presented at the American Pharmaceutical Association Annual Meeting, Economic Social and Administrative Science Section APS Contributed Papers, March 17, 1986, San Francisco, California.

Drug Utilization Review: A Benefit of Pharmacy PPO's. D.J. Stennett, College of Pharmacy, Oregon State University, Corvallis, Oregon; R.J. Richardson, Pharmacists' Service Group, Oregon State Pharmacists Association, Salem, Oregon; L. R. Strandberg, College of Pharmacy, Oregon State University. Presented at the American Pharmaceutical Association Annual Meeting, Economic, Social and Administrative Science Section APS Contributed Papers, March 17, 1986, San Francisco, California.

PUBLISHED PAPERS

American Pharmacy: **Third Party Contracting and Buying Groups Across the United States.** R.J. Richardson, L.R. Strandberg and Mike Fenerin, Pharmacists' Service Group, Oregon State Pharmacists Association; College of Pharmacy, Oregon State University; Bergen Brunswig Drug Company. PP 42-44: Volume NS26; July 1986.

Journal of Pharmaceutical Marketing and Management: **Oregon's Pharmacists' Service Group: The First Year's Experience.** R.J. Richardson, L.R. Strandberg and D.J. Stennett, Pharmacists' Service Group, Oregon State Pharmacists Association; College of Pharmacy, Oregon State University; College of Pharmacy, Oregon State University. PP 105-114: Volume 1, No. 24: Summer 1987.

ROBIN JAY RICHARDSON

Drug Benefit Trends: The Health Care Rationing Movement: Some Implications for Pharmacy. L.R. Strandberg, R.J. Richardson, C.F. Gress, College of Pharmacy, Oregon State University; Pharmacists' Service Group, Oregon State Pharmacists Association; Oregon State Pharmacists Association. PP 6-9: Volume 3, No.1: January/February 1991.

PRESENTATIONS

Contracting and Buying Groups: Different Points of View. Sacramento, California, November 1985.

Group Buying and Pharmacy PPO's: Different Points of View. San Francisco, California, February 1986.

Alternative Practice Environments. American Pharmaceutical Association's 185th Annual Meeting, San Francisco, California, March 1986.

Claims Processing for Pharmacy PPO's. National Association of Retail Druggists PSAO Symposium, Kansas City, Missouri, May 1986.

The Oregon PSG Program. The Oregon State Pharmacists Association's 95th Annual Meeting, Gleneden Beach, Oregon, June 1986.

PPO Workshop. Presented to various regional meetings of state pharmaceutical associations, 1985-86.

Starting a PSAO. The New Mexico Pharmaceutical Association, Albuquerque, New Mexico, November 23, 1986.

PSAO's and Buying Groups. Oregon State University College of Pharmacy, Corvallis, Oregon, February 9, 1987.

Starting a PSAO. South Dakota Pharmaceutical Association's Mid-Winter Seminars, Rapid City South Dakota, February 28, 1987; Sioux Falls , South Dakota, March 1, 1987.

ROBIN JAY RICHARDSON

Marketing a Pharmacy PPO to Tomorrow's Health Care Purchasers and Users. American Pharmaceutical Association Annual Meeting, Chicago, Illinois, April 1, 1987.

PSAO Marketing. The National Association of Retail Druggists Second Annual PSAO Conference, New Orleans, Louisiana, April 30, 1987.

Starting a PSAO. Idaho State Pharmaceutical Association's Annual Meeting, McCall Idaho, June, 6. 1987.

Economics and Politics of Drug Purchasing Programs: University of Southern California's 30th Anniversary Post Graduate Refresher Course, Honolulu, Hawaii, August 25, 1987.

PSAO's a National and State Perspective: University of Southern California's 30th Anniversary Post Graduate Refresher Course, Maui, Hawaii, August 25, 1987.

The Impact on Pharmacy of a Managed Health Environment, Searle Symposium. The National Association of Retail Druggists' Annual Meeting, Las Vegas, Nevada, October 18, 1987.

The Future of Community Pharmacy and Pharmacy Administrative Organizations. The American Pharmaceutical Association's Mid-Year Regional Meetings, Baltimore, Maryland, October 31, 1987, and St. Louis Missouri, November 7, 1987.

Where is "Managed Care" Taking the U.S. Health Care System? Minnesota State Pharmaceutical Association's 16th Annual Mid-Winter C.E. Conference, St. Louis Park, Minnesota, January 17, 1988.

Coping with Managed Care Systems. North Dakota State University's 29th Annual Mid-Winter Pharmacy Institute, Bismarck, North Dakota, January 24, 1988.

The Role of PSAO's in Tomorrow's Managed Care System. The American Pharmaceutical Association's Annual Meeting, Atlanta, Georgia, March 14, 1988.

ROBIN JAY RICHARDSON

Coping with Managed Care Systems. Oregon State Pharmacists Association's 2nd Annual Mid-Winter Seminar, Bend, Oregon, March 19 & 20, 1998.

Coping with Managed Care Systems. Oregon State Pharmacists Association's 99th Annual Convention, Ashland, Oregon, June 21, 1988.

Issues Surrounding Brand Versus Generic Use in Managed Care Systems. Oregon State University's Twelfth Annual Contemporary Pharmacy Practice Seminar, Corvallis, Oregon, September 17, 1988.

How to Evaluate Third Party Programs. National Association of Chin Drug Stores HMO/Third Party Contracting Seminar, Chicago, Illinois, March 29, 1989.

Evaluating Managed Care Contracts. A Workshop and Presentation: American Pharmaceutical Association's 136th Annual Meeting, Anaheim, California, April 10, 1989.

How the Medicare Catastrophic Legislation will Affect Pharmacy: Oregon State Pharmacists Association's 100th Annual Convention, Portland, Oregon, June 27, 1989.

The Health Care Crisis of the 1990's: What's Ahead for Pharmacy: Lederle Symposium, Portland, Oregon, March 25, 1990.

Evaluating Managed Care Contracts in Order to Sell Pharmacy's Story, NARD's RxExpo, Reno Nevada, May 22, 1991.

Evaluating Third Party Contacts: University of Utah College of Pharmacy's Seminar, :Planning for Success in the 90's", Salt Lake City, Utah, June 1, 1991.

Evaluating Third Party Contracts: Washington State Pharmacists Association's Women's Health and Pharmacy Management Seminar" Seattle, Washington, September 22, 1991.

Opportunities in Home Health Care: Auburn University School of Pharmacy's "Career Day for Pharmacy Students", Auburn, Alabama, January 22, 1992.

ROBIN JAY RICHARDSON

Health Care Reform: NARD's Town Hall Forum on Health Care Reform", Dallas Texas, March 28, 1992, Portland, Oregon, April 4, 1992, Los Angeles, California, April 5, 1992.

The Changing Face of Pharmacy: Owens-Brockway Prescription Product's 1992 Business Conference, Arlington, Virginia, June 16, 1992.

A Home Infusion Update: HITFOA's 1992 Mid-Year Conference, Washington D.C., June 19, 1992.

Developing a Home Health Care and Home Infusion Program: Oregon State Pharmacists Association's 103rd Annual Convention, Ashland, Oregon June 20, 1992.

DME/Home Health Care Update: Alabama Pharmaceutical Association's 111th Annual Convention, Sandestin, Florida, June 28, 1992.

The Role of Pharmacists in Comprehensive Drug Therapy Management-Panel Member: Florida Pharmacy Associations' 102nd Annual Meeting, Boca Raton, Florida, July 16, 1992.

A Home Infusion Market Overview: West Texas Pharmaceutical Association's Fifteenth Annual Continuing Education program, Lubbock, Texas, September 13, 1992.

Protecting the Health of Your Pharmacy Practice-Government Imposed Challenges: American College of Apothecaries' 1992 Annual Conference, Scottsdale, Arizona, September 19, 1992.

A Home Infusion Industry Update: Option Care's 9th Annual Meeting, Tucson, Arizona, October 1, 1992.

Professional and Regulatory Issues Concerning Home Health Care and the Evolving Challenges: Massachusetts Pharmacists Association's "Home Care: Professional and Regulatory Issues for Pharmacists", Westborough, Massachusetts, November 18, 1992.

ROBIN JAY RICHARDSON

Home Care Opportunities for Community Pharmacy: NARD's Multiple Locations Conference, Acapulco, Mexico, January 20, 1993.

A Home Infusion Industry Update: Option Care's 10th Annual Meeting, Kona, Hawaii, October 8, 1993.

The Home Infusion Industry: HME Dealer Conference, New Orleans, Louisiana, March 25, 1994.

Community Pharmacy's Perspective on Pharmacy Technicians: The Second Annual John Saunders Memorial Lecture, Northeastern University, Weston Massachusetts, May 25, 1994.

Community Pharmacy Today, New Opportunities, New Challenges, Indo-American Pharmaceutical Association Annual Meeting, New York, New York, June 20, 1994

A Home Infusion Industry Update: Option Care' 11th Annual Meeting, Lincolnshire, Illinois, October 14, 1994.

A Home Infusion Industry Update: Vital Care Annual Meeting, Sandestin, Florida, March 25, 1995.

Legislative and Regulatory Challenges Facing the Home Infusion Industry: Missouri Home Infusion Association, Lake of the Ozarks, Missouri, June 16, 1995.

A Home Infusion Industry Update: Option Care's 13th Annual Meeting, Phoenix, Arizona, September 28, 1995

A Home infusion Industry Update: Option Care's 12th Annual Meeting, Orlando, Florida, September 29, 1996

What to Look for in a Pharmacy Benefit Management Company, Southwest Washington Association of Health Underwriters Forum, Tacoma, Washington, November 12, 1996.

ROBIN JAY RICHARDSON

The Evolution and Role of PBM's: Who Controls the Prescription Dollar?, Immunex Corporation, Seattle, Washington, May 29, 1997.

Managing Pharmacy Benefits in a Challenging and Changing Environment, Associated Oregon Industries, Salem Oregon, October 16, 1999.

Health Care Policy Issues Surrounding the Management of Obesity, Panel Member, Foundation for Medical Excellence, Portland, Oregon, June 2, 2000.

What is Managed Care? An Insurance Industry Perspective, GlaxoSmithKline Regional Meeting, Portland, Oregon February 1, 2002.

Pharmacy Benefit Trends, Oregon Education Association, Salem, Oregon, March 9, 2002.

Prescription Benefits, The Past, Present and Future, Oregon Education Association, Portland, Oregon, November 15, 2003.

Where are the Pharmacists? Oregon State University College of Pharmacy Intercampus Student Meeting, Portland, Oregon, January 30, 2004.

Prescription Benefits: The Past, Present and Future. Klamath-Lake Association of Insurance and Financial Advisors, Klamath Falls, Oregon, February 11, 2004.

Provider Contracting. Portland Association of Health Underwriters 2004 Spring Forum, Portland, Oregon, April 14, 2004.

Partners in Prevention, Diabetes Management, The Payor's Perspective. American Diabetes Association's Community Assembly and Annual Meeting, San Diego, California, June 9, 2005.

Insurance Coverage of the Management and Treatment of Obesity. The Foundation for Medical Excellence, Portland, Oregon, June 24, 2005.

ROBIN JAY RICHARDSON

Pharmacy and Medicare, The Times, They are Changing. Delta Dental Summer CEO Retreat, Bend, Oregon, August 17, 2005.

The Status of Healthcare Costs and Coverage in Today's Marketplace. Oregon Dental Association's House of Delegates, Skamania, Washington, September 7, 2007.

Health versus HealthCare: What and How Should We Purchase, Oregon Health Forum Breakfast Forum Panel, Portland, Oregon, February 24, 2009.

PUBLISHED ARTICLES

The Pharmacy Student, The Whys of Student APhA, R.J. Richardson. Volume 13, Number 3, Autumn 1983, pp.3-4.

Oregon Pharmacist: What is a PPO? R.J. Richardson. Volume 34, Issue 4, April 1986, p. 15.

Oregon Pharmacist: PSG Founding Philosophies. R.J Richardson. Volume 34, Issue 5, May 1986, p.10.

Oregon Pharmacist: The Beginning. R.J. Richardson. Volume 34, Issue 6, June 1986, p.9.

Oregon Pharmacist: Usual and Customary: Myth or Reality? R.J. Richardson. Volume 34, Issue 7, July 1986, p.8.

Oregon Pharmacist: Generic Dispensing: Is it worth It? R.J. Richardson. Volume 34, Issue 9, September 1986, p.10.

Oregon Pharmacist: Maintenance Medications. R.J. Richardson. Volume 34, Issue 10, October, 1986, p.9.

Oregon Pharmacist: The Starter Supply Concept: An Event Where There are No Losers. R.J. Richardson. Volume 34, Issue 11, November 1986, p.7.

Oregon Pharmacist: Claims Processing for Prescription Drug Programs: An Overview. R.J. Richardson. Volume 35, Issue 2, February 1987, p.7.

Oregon Pharmacist: Marketing a PSAO Program to New Heights: Stage 1. R.J. Richardson. Volume 35, Issue 4, April 1987, p.7; Stage 2, Volume 35 Issue 5, May 1987, p.7; Stage 3, Volume 35, Issue 6, June 1987, pp.5-6.

Oregon Pharmacist: The PSG Engine: The Claims Processing System. R.J. Richardson. Volume 35, Issue 8, August 1987, p.7.

ROBIN JAY RICHARDSON

Oregon Pharmacist: Patient Education by Pharmacists, The PSAO Marketing Tool. R.J. Richardson. Volume 36, Issue 3, March 1988, p.9; Part 2, Volume 36, Issue 4, April 1988, p.9; Part 3, Volume 36, Issue 5, May 1988, P.9.

Oregon Pharmacist: Maintenance Medication Programs: The Third Party Feature of the 1990's, Part I. R.J. Richardson. Volume 36, Issue 8, August 1988, p.8; Part 2, Volume 36, Issue 9, September 1988, p.8; Part 3, Volume 36, Issue 10, October 1988, p.8.

Oregon Pharmacist: Issues Surrounding Brand Versus Generic Usage in Health Benefits Programs. R.J. Richardson, Volume 37, Issue 1, January 1989, p.9; Part 2, Volume 37, Issue2, February 1989, pp.7,18; Part 3, Volume 37, Issue3, March 1989, p.7.

Oregon Pharmacist: The Medicare Catastrophic Coverage Act; A Review and Discussion. R.J. Richardson. Volume 37, Issue 4, April 1989, p.7; Part 2, Volume 37, Issue 5, May 1989, p.7; Part 3, Volume 37, Issue 6, June 1989, p.7; Part 4, Volume 37, Issue 7, July 1989, p.9; Part 5, Volume 37, Issue 8, August 1989, pp. 9,11; Part 6, Volume 37, Issue 9, September 1989, p.9; Part 7, Volume 37, Issue 10, October 1989, p9.

Oregon Pharmacist: Confusion. R.J. Richardson. Volume 37, Issue 11, November 1989, p.9.

Oregon Pharmacist: The Medicare Catastrophic Coverage Act: A Eulogy. R.J. Richardson. Volume 37, Issue 12, December 1989, p.9.

Partners In Health: From the Pharmacists Counter; Are you at Risk for Mismedication? R.J. Richardson. Volume 1, Number 3, Fall 1989, p.4.

Partners In Health: Form the Pharmacist's Counter; What's involved in Mismedication? R.J. Richardson. Volume 1, Number 4, Winter 1989, p.2.

Oregon Pharmacist: Pharmacy Services: Fact or Fiction? R.J. Richardson. Volume 38, Issue 4, April 1990, p.7.

Partners In Health: From the Pharmacist's Counter; Part 2, Are you at Risk for Mismedication? R.J. Richardson. Volume 2, Number 1, Spring 1990, p.4.

Oregon Pharmacist: The Health Care Crisis of the 1990's: What's Ahead for Pharmacy?. R.J. Richardson. Volume 38, Issue 5, May 1990, p.7; Part 2, Volume 38, Issue 6, June 1990, p.9; Part 3, Volume 38, Issue 7, July 1990, pp7,8; Part 4, Volume 38, Issue 9, September 1990, pp.9,11; Part 5, Volume 38, Issue 10, October 1990, p.7; Part 6, Volume 38, Issue 11, November 1990, pp.7,8; Part 7, Volume 38, Issue 12, December, 1990, pp.7,15; Part 8, Volume 39, Issue 1, January 1991, p.7; Conclusion, Volume 39, Issue 2, February 1991, pp.7,20.

ROBIN JAY RICHARDSON

Partners In Health: From the Pharmacist's Counter: What Should You Expect from Your Pharmacist? R.J. Richardson. Volume 2, Number 2, Summer 1990, p.4.

Partners In Health: From the Pharmacist's Counter: Using Aspirin to Prevent a Heart Attack-Should You? R.J. Richardson. Volume 2, Number 4, Winter, 1991, pp.5,6.

Infusion: NHIA Raises Concerns on Proposed Medicare Policies for Home Parenteral Nutrition. R.J. Richardson. Volume 1, Issue 11, 1995, pp28-36.

Infusion: The Infusion Industry: Emerging Business Benchmarks. R.J. Richardson. Volume 3, Issue 4, 1997, pp. 28-35

VOLUNTEER BOARDS AND COMMITTEES

American Diabetes Association-National Board of Directors, 2008- current

American Diabetes Association-National Strategic Planning Committee, 2010-current

American Diabetes Association-Portland Area Leadership Council Chair; 2007- current

American Diabetes Association-National Income Development Committee; 2008-2010

American Diabetes Association-Portland Area Auction Committee; 2000 - 2008

American Diabetes Association Annual Meeting-Oregon Delegate; 2001- 2005

American Diabetes Association National Marketing and Communications Committee; 2004-2006

Foundation for Medical Excellence: Member, Board of Directors; 2004 - current

Foundation for Medical Excellence: Chairman; 2006 - 2008

Foundation for Medical Excellence: Secretary/Treasurer; 2005 - 2006

Oregon Dental Foundation: Golf Tournament Co-Chair; 2006

Oregon Diabetes Coalition Steering Committee; 2003- 2005

Oregon State University College of Pharmacy: Advisory Council Member; 2000 - current

Oregon State University College of Pharmacy: Dean Search Committee Member; 2009-current

Oregon State University College of Pharmacy: Advisory Council President; 2003- 2006

ROBIN JAY RICHARDSON

University of Pennsylvania-The Wharton School, Executive Management Program for Pharmacy Leaders-Advisory Board Member; 2003 - 2005

PREVIOUS BOARDS AND COMMITTEES

American Pharmacy: Reviewer Panel; 1989-91.

American Pharmaceutical Association: APPM's Administrative Practice Section Advisory Committee for Industry/HMO's; 1989-91.

Drug Benefit Trends; Editorial Advisory Board; 1989-91.

Foundation for Medical Excellence: Board Member, N.W. Center for Physician and Patient Communication; 2000, 2001, 2002, 2003

Joint Commission of Pharmacy Practicitioners: Compounding Committee; 1992.

National Association of Retail Druggists: Steering Committee on Third Party Payment Programs; 1991.

Oregon Medical Assistance Programs: Medical Budget Forecast Committee; 1989-91.

Oregon Medical Assistance Programs: Senate Bill 27 Actuary Advisory Committee; 1989-91.

Oregon Medical Assistance Programs (OMAP); Pharmacy Advisory Task Force; 1985-91.

Oregon Medical Assistance Programs: Pharmacy Advisory Task Force Maximum Allowable Cost Subcommittee; 1987-91

Oregon Medical Assistance Programs: Pharmacy Advisory Task Force Dispensing Fee Subcommittee; 1989-90.

Oregon State Pharmacists Association Convention Committee; 1987-91.

RxNet: Board of Directors; 1990.

RxNet Affiliated PSAO Advisory Committee; 1987-90.

HONORS / AWARDS

Oregon State University Alumni Fellow, 2008

ROBIN JAY RICHARDSON

The ODS Companies Community Service Award Recipient, 2003

Parke-Davis Distinguished Lecturer, Ferris State University, 1994

"Pharmacist of the Year," Portland Retail Druggists Association, 1990

Marion Laboratories "Distinguished Young Pharmacist", State of Oregon, 1989

Named as an "Outstanding Young Man of America", 1987

CONFERENCES / EDUCATIONAL PROGRAMS ATTENDED

- Health Care Leadership for the 21st Century: The Foundation for Medical Excellence in collaboration with the University of Southern California Marshall School of Business, May 19-21, September 29-October 1, 2004, Portland, Oregon
- Executive Management Program for Pharmacy Leaders: Leonard Davis Institute of Health Economics, The Wharton School, University of Pennsylvania, September, 2002, Philadelphia, Pennsylvania
- Health Economics in Managed Care: Department of Health Care Policy, Harvard Medical School, September 13-14, 2001, Cambridge Massachusetts

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PERSONAL VOLUNTEER ACTIVITIES

American Diabetes Association

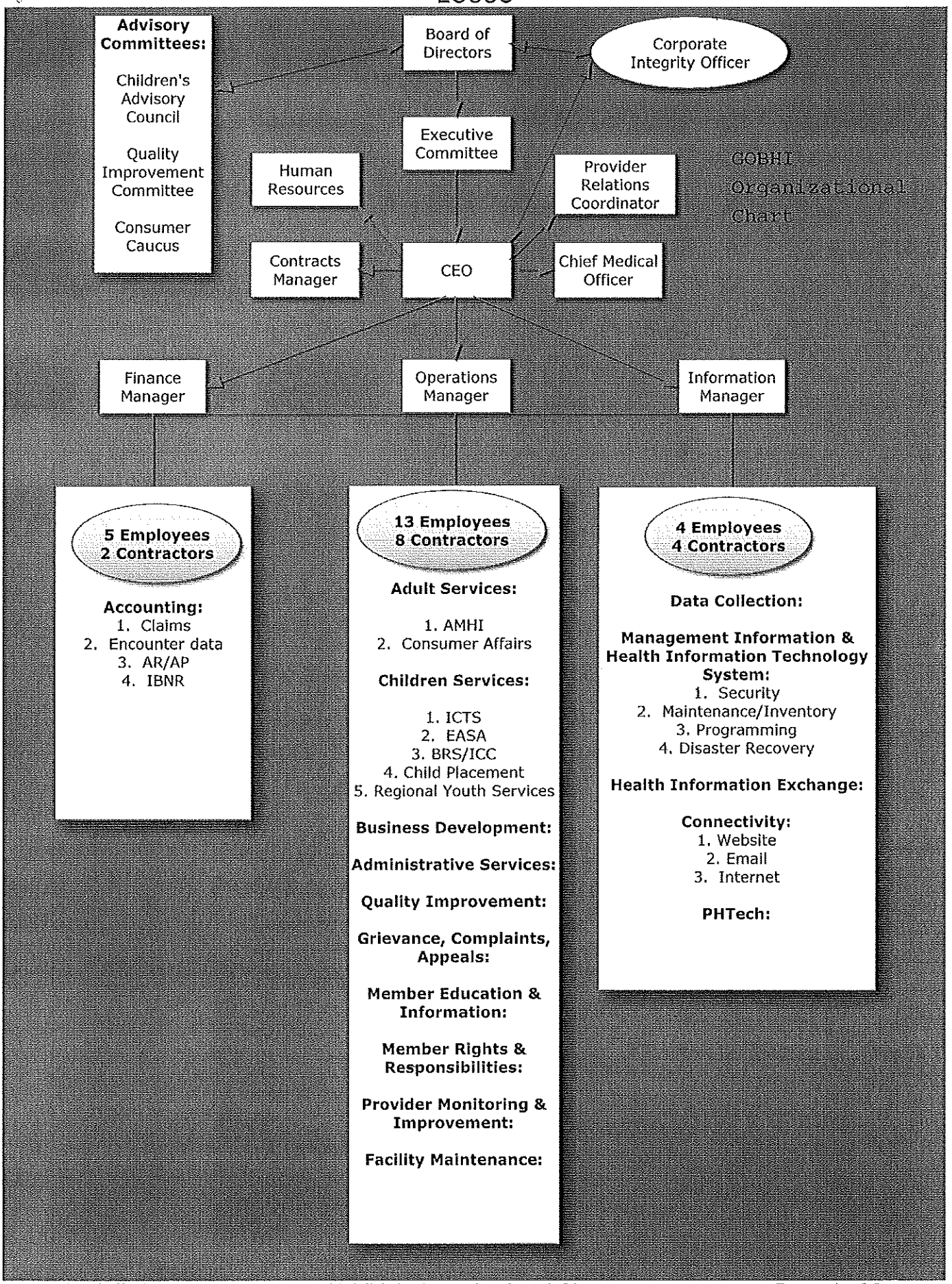
SMART Reading Program

MEMBERSHIPS

American Diabetes Association

Oregon State University Alumni Association

EOCCO


Advisory Committees:
Children's Advisory Council
Quality Improvement Committee
Consumer Caucus
Board of Directors
Corporate Integrity Officer
Executive Committee
Human Resources
Provider Relations Coordinator
COBHI Organizational Chart
Contracts Manager
CEO
Chief Medical Officer
Finance Manager
Operations Manager
Information Manager
5 Employees
2 Contractors
Accounting:
1. Claims
2. Encounter data
3. AR/AP
4. IBNR
13 Employees
8 Contractors
Adult Services:
1. AMHI
2. Consumer Affairs
Children Services:
1. ICTS
2. EASA
3. BRS/ICC
4. Child Placement
5. Regional Youth Services
Business Development:
Administrative Services:
Quality Improvement:
Grievance, Complaints, Appeals:
Member Education & Information:
Member Rights & Responsibilities:
Provider Monitoring & Improvement:
Facility Maintenance:
4 Employees
4 Contractors
Data Collection:
Management Information & Health Information Technology System:
1. Security
2. Maintenance/Inventory
3. Programming
4. Disaster Recovery
Health Information Exchange:
Connectivity:
1. Website
2. Email
3. Internet
PHTech:

President & Chief Executive Officer, ODS Health
Robert Gootee

Senior Vice President
Robin Richardson

- VP Client Strategies
  Chandra Wahrgren
  - Thad Mick
  - Erin Thompson
- VP Human Resources
  Mary Lou True
  - Facilities/ Purchasing
    David Shaffer
- Medicaid & Medicare Services
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- Dental Professional Relations and Billing and Eligibility
  Doreen Crail
  - Colleen Martin
- Marketing & Informatics
  Rachel Picado
- ODS College of Dental Sciences
  Dr. Ed Stuedli
- VP DBC/DBIC, DMC, NORDIC
  Chris Verbiest
  - Diane Abbondola
  - Teresa Johnson
  - Melissa Moore
- DMC
  Fred Bruderlin
  Bill Hockett
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  Scott Loftin
  - Chelyn Briand
  - Robin Hilleary
- VP Client Strategies
  Chandra Wahrgren
  - Theresa Barney
  - Alice Cobb
- Statewide Government Programs
  Gordon Hoberg
- Medical & Dental Claims
  Margaret Thornburg
  - Janie Blackman
  - Eric Nielsen
  - Karen Nolon
  - Jody Salisbury
  - Coy Sexton
  - Julie Williamson
  - Customer Service
    Janell McCartin
    - Nancy Avery
- BenefitHelp Solutions
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  - Toni Olin
  - Michelle Taylor, M.D.
- VP Marketing
  Jonathan Nicholas
  - Document Services
    Jerry Connolly
- Health Business Strategy
  Ursula Luckert

Senior Vice President / CFO
Dave Evans

- VP Actuarial/ Underwriting
  Kraig Anderson
  - Jim Light
  - Rebecca Owen
- Accounting
  Brian English
  - Jeff Schorr
  - Meagan Dahlgren
- VP & CIO
  Sue Hansen
  - Jeanette Williams
  - Information Services
    David Luther
    - Terry Allan
    - Marc Cortes
    - Craig Moore
- VP Legal & Regulatory Affairs
  Tom Bikales
  - Deanna Laidler
  - Brian Landon
  - Mark Turner
  - Privacy HIPAA/EDI
    Pat Van Dyke

Vice President Strategic Planning and Medical Professional Relations
James Foley

- Medical Professional Relations
- Strategic Planning & Medical Professional Relations
  Shikha Gupta

Vice President, Marketing
Jonathan Nicholas

- Marketing
  Katie Paullin

Vice President, Financial Services
Mike Paul

■ Subsidiary companies

BAKER	GILLIAM	GRANT	HARNEY	LAKE	MALHEUR	MORROW	SHERMAN	UMATILLA	UNION	WALLOWA	WHEELER
97814	97812	97845	97710	97620	97901	97818	97029	97801	97824	97828	97750
97819	97823	97848	97720	97630	97902	97836	97033	97810	97827	97842	97830
97833	97830	97856	97721	97635	97903	97839	97039	97813	97841	97846	97874
97834		97864	97722	97636	97906	97843	97050	97826	97850	97857	
97837		97865	97732	97637	97908	97844	97065	97835	97867	97885	
97840		97869	97736	97638	97909			97838	97876		
97870		97873	97738	97640	97910			97859	97883		
97877			97758	97641	97911			97862			
97884			97904	97735	97913			97868			
97905					97914			97875			
97907					97917			97880			
					97918			97882			
					97920			97886			

EOCCO

APPENDIX A – CCO Criteria Questionnaire

A.I. Background Information about the Applicant

a. EOCCO is a Limited Liability Corporation under Oregon law, and is domiciled within the State of Oregon. EOCCO is initially comprised of two entities, ODS Community Health, Inc. ("ODS") and Greater Oregon Behavioral Health, Inc. ("GOBHI"). ODS is a domestic business corporation domiciled in Portland, Oregon. GOBHI is a domestic nonprofit corporation domiciled in The Dalles, Oregon. Both GOBHI and ODS are funding EOCCO as equal 50/50 partners.

b. Our known affiliates include Greater Oregon Behavioral Health, Inc. (GOBHI) and ODS Community Health, Inc. (ODS). Additional affiliates may include but are not limited to community hospitals and hospital districts, physician organizations, dental care organizations and county governments within the proposed service area.

c. EOCCO intends to begin serving Medicaid populations by September 1, 2012.

d. No, we are not invoking alternative dispute resolution with respect to any provider at this time.

e. No, we do not request to negotiate terms and conditions in the Core Contract at this time.

f. Please see the document titled: Service Area by Zip Code.xls

g. The corporate and administrative offices for the known affiliates are listed below.

Greater Oregon Behavioral Health, Inc.
309 E. 2nd Street
The Dalles, OR 97058

ODS Community Health, Inc.
601 SW 2nd Ave.
Portland, OR 97204

ODS Community Health, Inc.
909 Adams Avenue
La Grande, OR 97850

h. The counties included in the proposed service areas are listed in the chart below: Please note that EOCCO has received condition approval for four of the 12 counties listed below. The counties in which we seek approval in this application are noted in red.

Eastern Oregon CCO

Baker	Morrow
Gilliam	Sherman
Grant	Umatilla
Harney	Union
Lake	Wallowa
Malheur	Wheeler

EOCCO's affiliate GOBHI:
Representatives of county health departments and public health agencies have attended meetings with GOBHI regarding CCO's and participated in discussions regarding the importance of public health services to the success of health reform in Oregon. They have been assured that they will be represented on the local governing bodies and in addition, that they will be supported by contracts with EOCCO to insure access to public health care and services through contracts with GOBHI, as required by ORS 414.153.

EOCCO's affiliate ODS:
ODS has an agreement with the county health department in each of our current Fully Capitated Health Plan (FCHP) service areas. The agreements allow members to seek medical services as required by ORS 414.153. We are in the process of obtaining agreements with the county health departments in the expansion service areas.

i. The newly forming legal entity did not have a contract as a managed care organization as of October 1, 2011. The known affiliates did have contracts in place as of October 1, 2011. GOBHI has an MCO contract with the Oregon Health Authority (OHA) as a Mental Health Organization (MHO). GOBHI has offered an MHO since 1995.ODS Community Health, Inc. has MCO contracts with the Oregon Health Authority (OHA) to offer a Fully Capitated Health Plan (FCHP) and a Dental Care Organization (DCO). ODS has offered an FCHP since 2006. Prior to 2006, ODS served as a Third Party Administrator (TPA) for the largest FCHP in Oregon and has previous experience operating as a TPA for MHO's. ODS has offered a DCO since the inception of the Oregon Health Plan in 1994.

j. EOCCO affiliates GOBHI and ODS have developed a new legal entity called Eastern Oregon Community Care Organization (EOCCO). GOBHI and ODS are the known affiliates at this time and both organizations are funding EOCCO as equally 50/50 partners. Additional affiliates may include but are not limited to community hospitals and hospital districts, physician organizations, dental care organizations and county governments within the proposed service area.

k. Yes, GOBHI has a current MHO contract with OHA. ODS Community Health, Inc. has a current contract as an FCHP and as a DCO. We do not plan to integrate DCO's for the initial roll out.

l. EOCCO's affiliate GOBHI is currently contracted in each of the 12 proposed service areas.

EOCCO's affiliate ODS is proposing to increase the number of contracted service areas we have in place today with the OHA. The chart below shows our current service areas and the additional service areas we are proposing to serve. ODS has recently agreed to purchase the current FCHP line of business from CareOregon in Morrow and Umatilla counties. The transaction to complete this transfer is currently in process. The lives in Morrow and Umatilla counties will represent an additional 1,200 ODS FCHP lives that will become part of EOCCO.

EOCCO

Eastern Oregon CCO

Current MCO Service Areas	Additional Service Areas
Baker	Gilliam
Malheur	Grant
Union	Harney
Wallowa	Lake
Morrow **(pending OHA approval)**	Sherman
Umatilla **(pending OHA approval)**	Wheeler

m. EOCCO's affiliate ODS works closely with the OHA in many areas. We are an FCHP in eight counties (with two additional counties pending. See (l) above for additional information), serving 13,000 medical lives, and a DCO in 22 counties, serving 67,000 dental lives. We are the insurer for more than 109,000 medical and dental members through the Oregon Educators Benefit Board (OEBB), and the TPA for more than 98,000 dental members through the Public Employees Benefit Board (PEBB). ODS is the administrator of the Oregon Prescription Drug Program (OPDP). In 2007, we were also chosen to be the pharmacy benefits administrator for the Northwest Prescription Drug Consortium, currently serving more than 802,000 Consortium members and 404,000 OPDP members specifically.

n. EOCCO's affiliate ODS has experience as a Medicare Advantage contractor. ODS Community Health, Inc., a subsidiary of ODS Health Plan, Inc., currently holds two contracts with CMS under contract numbers H3813 and S5975.

Under contract H3813, we offer Medicare Advantage Preferred Provider Organization (PPO) plans in the community and a Medicare Advantage Employer Group Waiver Plan (EGWP) to the Oregon Public Employees Retirement System (PERS) retirees that are eligible for Medicare. The service area for these plans is the entire State of Oregon. ODS is currently the only statewide Medicare Advantage PPO operating in all counties in Oregon.

Under contract S5975, we offer an Employer Group Medicare Part D Prescription Drug Plan (PDP) to PERS retirees eligible for Medicare. The service area for this plan is the entire United States.

o. EOCCO's affiliate ODS Community Health Inc. is a wholly owned subsidiary of ODS Health, Plan Inc. ODS Health Plan, Inc currently holds an Insurer's Certificate of Authority with the State of Oregon. At this time, EOCCO is not licensed as an insurer with the Oregon Insurance Division, nor does it expect to be so licensed in the future.

p.

(1)
EOCCO's affiliate, ODS under our commercial plan, has instituted pay-for-performance initiatives as part of a Medical Home demonstration program. To be eligible, providers must demonstrate that their treatment group maintains a baseline quality, or an improvement from baseline, and also at least meet the NCQA Quality Compass 50th percentile for commercial PPO's. In addition, providers must meet minimum targets within the following metrics: diabetes care, control of hypertension, cholesterol management for patients with cardiovascular conditions, and also have patient surveys completed for overall patient experience.

EOCCO's affiliate GOBHI has researched the financial incentive payment models currently used by payers for recognition of value-based care provided by hospitals, clinics and primary practices. No matter the type of incentive payment (e.g., direct, bundled, risk adjusted for the full range of healthcare services, for coordination, or just based on performance), the models require data collection and analysis to assess efficiency and effectiveness. The design of the payment process/mechanism, in conjunction with the data analysis, will determine performance, cost/savings and up-down payment adjustments, (i.e., savings rewards, or adjusted payments) and, ultimately, the effectiveness of the model being used once we have sufficient data. EOCCO will work with local community health entities to design and adjust the incentive payment model (or hybrid) to best meet Triple Aim objectives.

EOCCO's affiliate GOBHI's contract with the Addictions and Mental Health Division of DHS prescribes the payment methodology, so GOBHI has not been authorized to consider or implement alternative payment methodologies up to this point.

Overall we are committed to significantly reducing fee-for-service payments and aim to expand the use of alternative payment methods in the near future. The alternative payment methods will include provisions to both improve the quality and reduce the cost of care through several pay-for-performance initiatives. In addition to instituting performance-based reimbursement, we will make reasonable efforts to ensure transparency of provider costs, provider payments, clinical outcomes, quality measures and other information necessary to discern the value of health services delivered.

(2)
EOCCO's affiliate ODS has extensive experience coordinating physical, behavioral health, and oral healthcare in diverse treatment settings. Our Case Managers (CM) and Care Coordinators (CC) facilitate the exchange of information and coordination among providers. Medical and behavioral health CM's and CC's share a common reporting structure, clinical database and rounds, and frequently consult with and cross-refer to each other to ensure all dimensions of a member's care are addressed. We have developed innovative clinical systems that integrate oral and medical healthcare, including an oral health coaching program which encourages pregnant members to obtain extra cleanings.

(3)
The examples below show that we have demonstrated experience and capacity for engaging members and providers in improving the health of the community. We will use the tools and experiences we have gained over the years by modifying existing programs and creating new programs specific to the EOCCO population.

Engaging community members and health care providers in improving the health of the community – We employ a number of methods to identify members who would benefit from our comprehensive population health programs: predictive modeling, including risk scores, physician referrals, member self-referrals, a nurse advice line, claims triggers, such as emergency department encounters, and internal referrals from case management, behavioral health and pharmacy services. Members who participate in our one-on-one support programs receive regular sessions with clinical staff, customized mailings and access to interactive decision-making tools and resources. When a member is identified for participation in a condition-specific health program, we send information that describes the services we provide. These include reminders for needed

care which are targeted at members with sub-optimal medication adherence and/or lapses in recommended visits, screenings and procedures as well as access by phone or email to our multi-disciplined clinical staff to participate in one-on-one care management support. Nearly all member interventions related to specific conditions include a provider component, such as the medical and pharmacy report we send to the member's healthcare provider to promote communication at their next office visit. The report is member-specific and chart-ready.
Our health coaches use an interpreter service for members whose primary language is not English. Our language line service covers a wide variety of languages, but the most common request is Spanish. Member materials for each of our health coaching programs are comprehensive and, in 2012, we plan to translate the materials for our Diabetes Care Program into Spanish.
Members who are enrolled in health coaching are stratified based on results of a Patient Activation Measure (PAM) survey. PAM is an evidence-based survey comprised of 13 questions that assess an individual's knowledge, skills and confidence around managing their own health and healthcare. Overall in 2011, of our members for whom we had an interim or final PAM survey to compare with their initial survey (completed before health coaching began), interim and final PAM scores migrated from low activation levels (1 and 2) to higher activation levels (3 and 4). Our health coaches were able to reduce the number of low activation level PAM's by 46 percent.
Our experience shows that members who engage in our one-on-one support programs have better outcomes. During 2011, 63 percent of members who enrolled in diabetes coaching received an eye exam compared with 53 percent of those not enrolled; 94 percent of those enrolled in diabetes coaching received a hemoglobin A1c test during the measurement period compared with 90 percent of those not enrolled in the program. Our experience also shows a declining trend in asthma-related emergency department visits among ODS members who are enrolled in our respiratory care program when compared to those who are not.

Provider engagement – In 2011, we implemented a Systems of Care initiative with Legacy Health and Salem Health systems. In 2012, our focus is on the patient-centered medical home and Healthy Babies' campaign, in addition to establishing quality metrics that are risk-adjustable, actionable and evidence-based. We are also expanding our systems of care initiatives to include the OHSU, Peace Health and St. Charles healthcare delivery systems.

Provider network assessment – Every two years, we assess the racial and linguistic makeup of our health plan membership to ensure the availability of practitioners to meet our members' regional and cultural needs. Our last review was in 2011 and focused on clinicians' linguistic and cultural competencies to determine any need for adjustment to our provider network. Our assessment included analysis of the following: national and State of Oregon census data to determine regional service areas with significant minority cultural populations, our call center interpreter services utilization from 1/1/11 to 6/30/11, and member complaints from 7/1/10 to 6/30/11 to determine if there were any language, ethnic, racial or cultural barriers to accessing care. We also surveyed our primary care providers to identify those who speak languages in addition to English. As a result of this assessment we did not identify any adjustments needed for our OHP provider network.

Addressing Health Disparities– EOCCO's affiliate ODS continuously assesses the impact of all organizational policies and programs on racial and ethnic health disparities by working with and supporting community partners. Furthermore, we promote integrated approaches, including evidence-based programs and best practices to reduce these disparities. We will leverage HHS'

Communities Putting Prevention to Work program *(CPPW)* in service area communities (small, rural, and tribal areas) to promote environmental changes that make healthy living easier. These could include improving the means for safe and active transportation for pedestrians, bicyclists and mass transit users, ensuring provision of healthy food and beverage options in schools, limiting exposure to secondhand smoke, and increasing available tobacco cessation resources. One specific example is the Head Start program which promotes the social and cognitive development of children by providing educational, health, nutritional, social and other services to enrolled children and families. The Head Start program helps parents make progress toward their educational, literacy and employment goals, and engages them in their children's learning. In addition, ODS is an active participant in the Disparities Leadership Program (DLP) led by the Disparities Solutions Center at Massachusetts General Hospital (MGH) in Boston, Massachusetts. DLP is an educational program that assists organizations in implementing practical strategies to identify and address racial and ethnic disparities in health care, particularly through quality improvement measures. EOCCO's affiliate ODS continues to engage in best practices-sharing in our mission to improve the health of communities by collaborating with its members and external groups to reduce healthcare disparities.

q. We are still defining the details of the EOCCO organizational structure, but we have identified the key personnel for each of the known affiliates below. Resumes have been included as a separate attachment. Please refer to Exhibit A

GOBHI:

- Chief Executive Officer: Kevin M. Campbell
- Interim Chief Financial Officer: David Baker
- Chief Medical Officer: Laurence Colman, M.D.
- Chief Information Officer: Morris Volkov
- Chief Administrative or Operations Officer: Todd Jacobson

ODS:

- Chief Executive Officer: Robert Gootee
- Chief Financial Officer: David Evans
- Chief Medical Officer: William E Johnson, MD, MBA, FACS, FICS
- Chief Information Officer: Sue Hansen
- Chief Administrative or Operations Officer: Robin Richardson

r. We are still defining the details of the EOCCO organizational structure. Organizational charts for each known affiliate have been included as a separate attachment. Please refer to Exhibit B

s. We will be deferring complete submissions the following documents until the readiness review:

- Section 1, Standard #1 Table B-1 Participating Provider Table
- Section 2, Standard #2 Response

A.II. Community Engagement in Development of Application

Since its inception in 1995, EOCCO's affiliate GOBHI has been committed to a model that delegates risk and management of local services to the local communities. This model set the stage for GOBHI's deep level of engagement in the communities it serves from the outset. The organization has a history of working with local communities in order to plan and develop services locally that traditionally have

been provided out of community. This history includes the habit of bringing emerging new best practices in health care to its constituents. As healthcare reform started to take shape in Oregon, GOBHI went to its communities to begin the discussion. In December 2010, GOBHI hosted its first healthcare reform community forum with a national consultant (Dale Jarvis) sharing information about the possible models that are being examined on the national level. This forum gathered over 100 healthcare leaders, elected officials, public health officials, etc. from all over the seventeen counties that GOBHI serves. Since that first forum, GOBHI has hosted a series of these large forums. In addition, between Kevin Campbell, the GOBHI CEO, Sandy Ryman, the GOBHI integration manager and other key staff, more than 186 meetings have been conducted throughout the counties served by GOBHI, including two additional counties - Tillamook and Klamath.

Most recently, GOBHI participated as a sponsor of six community workshops with a registered attendance of more than 900 people. Three consumer town hall meetings in Astoria, The Dalles and Baker City were also hosted. These gatherings attracted 50 participants. (A copy of the meeting notice is included in Exhibit C.)

Additionally, GOBHI conducted a round of community meetings with the specific intent to discuss the CCO Application effort for all of the constituents in every one of the seventeen counties within GOBHI's service area together with Klamath and Tillamook Counties. The schedule was as follows:

CCO COMMUNITY MEETING
SCHEDULE April 2012

DATE	TIME	COUNTY	HOST CITY
Thursday, 19th	12 Noon	Umatilla	Pendleton
	4:00 PM	Morrow	Heppner
Friday, 20th	7:00 AM	Union	La Grande
	10:00 AM	Baker	Baker City
	3:00 PM	Malheur	Ontario
Saturday, 21st	11:30 AM	Grant	John Day
	3:00 PM	Harney	Burns
Monday, 23rd	8:30 AM	Wasco	The Dalles
	12 noon	Gilliam	Condon
	3:00 PM	Wheeler	Fossil
Tuesday, 24th	9:00 AM	Klamath	Klamath Falls
	6:00 PM	Lake	Lakeview
Wed., 25th	7:00 PM	Douglas	Reedsport
Thursday, 26th	9:30 AM	Clatsop	Astoria
	12 noon	Columbia	St. Helens
	3:00 PM	Tillamook	Tillamook
Friday, 27th	10:00 AM	Hood River	Hood River
	3:00 PM	Sherman	Wasco
Saturday, 28th	Noon	Wallowa	Enterprise

Kevin Campbell personally traveled to each of the county meetings, referenced above, to facilitate the discussion and listen to those who attended. While he could have chosen to delegate this responsibility, he committed to traveling more than 3,200 miles spanning the state to underscore GOBHI's commitment to creating a Coordinated Care Organization for a broad range of constituencies and partnerships.

The audience attending the county meetings spanned the full spectrum of professions as represented in the following roster:

Children's Grant Manager	FQHC Director
Primary Care Physician	Public Health Worker
Commission on Children and Families Director	DHS Self Sufficiency Program Manager
Community Health Worker	DHS Self Sufficiency Program Coordinator
Residential Treatment Facility Manager	Hospital Administrator
Community Mental Health CFO	Hospital CFO
Mental Health Family Health Coordinator	Non Profit Disability Services Director
Community Mental Health Program Director	Medical Clinic Director
Court Appointed Special Advocate Director	MH Association Lobbyist
County Commissioner	MH Children's Therapist
News Paper Editor	Justice of the Peace
Registered Nurse	ESD Superintendent
Hospice Nurse	School Superintendent
Clinical Health Nurse	Rural Health Clinic Manager
Mental Health Family Clinical Director	Psychologist
School Board Chair	Medical Clinic Finance Director
Public Health Nurse	ESD Early Childhood Director
Public Health Director	MH Advisory Board Chair
State Association Director	MH Advisory Board Member
County Administrator	County Health and Human Services Director
Surgeon	Foster Parent
Transportation District Director	Community Resident
Therapeutic Foster Care Coordinator	Retired Registered Nurse
School Based Health Clinic Nurse	Hospital CFO
Hospital Director of Nursing	Hospital COO
Department of Human Services District Manager	Chiropractor
DHS Child Welfare Worker	Autism Alliance Director
Commission on Children and Families Board Member	Oregon Health Network Board Member
Child Psychiatrist	Alcohol and Drug Residential Program Manager
Fully Capitated Health Plan Director	Physician's Assistant
County Commissioner Candidate	Human Resources Director
Dental Care Organization Manager	Health Care Consultant
County Judge	School of Nursing Program Director
Developmental Disabilities Services Coordinator	Children's Day Treatment Program Director
MH Advisory Board Member	Dual Diagnosis Program Coordinator
Hospital Board Member	Special Education Teacher
DHS Child Welfare Manager	School Principal
Assistant to Board of County Commissioners	Hospital Compliance Director

Local Alcohol & Drug Prevention Committee Chair	Real Estate Agent
Interested Citizen	Rancher
Parent of Disabled Child	Small Business Owner
School Board Member	Foster Parent
Teacher	Mental Health Organization Executive Director
FQHC Board Member	Children Advocacy Center Director
Not for Profit MH Board Chair	State Representative
Circuit Court Judge	Community Action Team Director
Banker	Office of Rural Health
Insurance Agent	Head Start Manager
Dentist	School District Representative
School Based Health Clinic Director	City Police Chief
Information Technology Director	Sherriff's Department Deputy
Minister	State Police Sergeant
DHS District Manager	Community Corrections Director
Student	Alcohol and Drug Program Manager
Hospital Board Chair	Nurse Practitioner
MH Consumer	Psychiatric Nurse Practitioner
ESD Wrap Around Coordinator	Community College Vice President
Primary School Teacher	Area Health Education Center Board Member
Business Development Director	

The key topics raised by those who participated included the following:

- Philosophy should be 100% Access 0% Disparity;
- County Commissioners concerned about managing risk;
- Education reform and healthcare reform need to be aligned at community level;
- How can Public Health fit in?;
- How can we better coordinate efforts between Public Health and Primary Care?;
- Hot spotting is working;
- Doctors very interested in Direct Primary Care Methodology;
- Subcapitation payments have worked well for Mental Health Programs;
- Way too many Comprehensive plans required at community level;
- How will payments be made in the future?;
- Governance and Planning must occur at local level to insure systemic efficiency;
- County Commissioners need to be part of governance;
- More trust for Not for Profit Agencies than For Profit Businesses;
- Addictions treatment is underfunded;
- Starting new programs cost money;
- Small Counties must stick together;
- Administrative costs need to be kept low;
- Not all services can be measured by medical coding;
- Must take services to patients;
- Care extenders essential to being able to see more patients;
- Wrap around treatment saves money and produces better outcomes;
- Electronic Medical Records must communicate with each other;
- Hospitals not comfortable with change moving this fast;

- Collaboration preferred to competition in selecting CCO;
- Integration of Dental care essential to successful CCO;
- Healthcare reform must extend beyond Medicaid and Medicare to benefit the entire community;
- Would like to be able to buy Oregon Health Plan benefit at a comparable cost;
- Clinic in Fossil Oregon serving 1,050 people in a county of 1400 has 65 different entities to bill;
- How can community best protect itself from catastrophic loss?;
- Who will pick CCO?;
- Will multiple CCO's be picked for one community?;
- Will community be able to choose its own CCO?;
- Need to protect existing infrastructure;
- Need to know how much of OHP money is being spent inside vs. outside the county;
- What is OHP money being spent on and could costs be prevented?;
- Impact of Adverse Childhood Experiences (ACE's) need to be understood by community;
- Dental prevention can work;
- Integrated Pre-natal care is a good place to start;
- Purchasing Air Ambulance subscriptions for entire OHP population makes sense;
- Eastern Oregon should not be divided up;
- Tax payers put a lot of money into Healthcare through Health Districts and Hospital Districts;
- Availability of Community ownership of CCO to avoid business as usual;
- Capitated payments to doctors have traditionally been too low;
- Regions is composed almost entirely of Type A and Type B hospitals making costs disproportionately higher;
- Diagnostic risk adjusters only reward CCO's for having more sick people;
- Too many people go out of town for their healthcare;
- Obesity, Diabetes and smoking are major health challenges;
- Need to find ways to better motivate patient to take care of themselves;
- Need to pay for outcomes not volume;
- We have a provider shortage;
- We do a lot of work that we don't get paid for;
- County government willing to contribute to CCO if local governance is developed;
- Rural hospitals must be protected;
- Heath departments are already doing much community planning with little money;
- We must begin coordinating care for babies differently;
- Transportation to appointments is expensive;
- Transportation Brokerages want to be part of solution;
- Flexible money needed to solve problems quickly;
- School nutrition programs are a cause of concern;
- We must work to keep seniors safe in their homes;
- House calls may be more efficient than the way we are doing things now;
- Prevention of child abuse is essential to better outcomes;
- Appreciate CEO of company coming out to talk to people;
- Appreciate knowing who to call when problems arise;
- Many people are interested in governance and advisory committees;
- Wait list for programs like Head Start make no sense;
- System must focus on prevention;
- Savings generated must be return to community not disappear in profits;

- Difficult to find services for children with special needs;
- County boundaries matter because that is where people vote and pay taxes;
- We need to take school based health clinics and expand them to the public;
- All children need to have preventative dental care as soon as possible;
- Failures in healthcare and education end up costing more money in prisons;
- People appreciate collaboration at both community and regional level;
- Seeing consumers and commissioners on GOBHI great comfort;
- Local control for each County is very important.

A key message that resonated from one meeting to the next was the ability for policymakers, county officials, consumers, physicians and mental health professionals to know who to contact as questions arise throughout this evolutionary transformation period. That person, of course, is Kevin Campbell, GOBHI CEO. Representative Cliff Bentz made expressions of appreciation to the CEO for his willingness to be on the front line to listen, craft solutions and build collaborative partnerships. A brochure outlining GOBHI's commitment and interest in applying to become a CCO was developed for the purpose of creating a visual representation for attendees at each of these community activities to carry away from events. Support documentation for the meetings, together with the brochure, is referenced in Exhibit C. In addition to those meetings, Sandy Ryman has attended over 100 meetings since May, 2010 with representatives of all the GOBHI counties to discuss integration and the potential for the development of a CCO.

The multiple letters of support from a myriad of providers - county governments, mental health partners and others - underscore GOBHI's commitment to community engagement. The broad cross section of support represented in these letters underscore GOBHI's long term commitment to building relationship and delivering services at the local level.

GOBHI's fifteen year history as a Mental Health Organization has provided the opportunity for strong relationship building and collaboration for the rural counties of Oregon. Those relationships and commitment to collaboration will serve GOBHI well in its commitment to expand its mission to participate in the Eastern Oregon Coordinated Care Organization. GOBHI's commitment is to every person in rural Oregon throughout its entire service area.

ODS Community Health has had numerous conversations with Ray Gibbon, CEO, St Alphonsus-Baker City Medical Center. Mr. Gibbon convened a meeting of Eastern Oregon hospital executives on March 30, 2012 to discuss the proposed EOCCO. Four hospitals endorsed the proposal as a result of this meeting:
St Alphonus Medical Center-Baker City
St Alphonus Medical Center-Ontario
Pioneer Memorial Hospital-Heppner
Blue Mountain Hospital-John Day

On April 23, 2012, ODS Community Health met with Mike Shirtcliff, DMD, CEO of Advantage Dental to discuss the working relationship between EOCCO and Advantage Dental. As a result of that meeting, Advantage Dental has provided a letter of support for this application.

As a next step in engaging the community EOCCO's affiliates ODS and GOBHI will be hosting community meetings in each of the 12 counties we are proposing to serve. Employees of both GOBHI and ODS will be in attendance. The community meetings will serve as a forum to educate members, providers and representatives of the community about EOCCO. During these meetings we plan to

engage the community to obtain ideas for how a CCO could best serve the needs of each local community. Notices were sent to over 90% of eligible Medicaid members in each county along with notices sent to both members of the community at large and with providers. The meeting announcement, agenda and a FAQ (frequently asked questions) document for these community meetings are included in Exhibit H. Additionally we have included the schedule and location of the community meetings below:

Wheeler County – Wed., June 13 – 11:30 – 1:00 pm	Wheeler Co. Family Services 401 4th Street, Fossil
Gilliam County – Wed., June 13 – 5:30 – 7:00 pm	Gilliam Co. Courthouse 221 S. Oregon Street, Condon
Sherman County – Thurs., June 14 – 5:30 – 7:00 pm	Sherman Co. Senior & Community Ctr. 300 Dewey Street, Moro
Morrow County – Fri., June 15 – 7:30 – 9:00 am	Community Counseling Solutions 120 S. Main Street, 2nd Floor, Heppner
Umatilla County – Fri., June 15 – 11:30 – 1:00 pm	Oxford Suites 2400 SW Court Place, Pendleton
Lake County – Mon., June 18 – 5:30 – 7:00 pm	Lake County Senior Center 11 N. G Street, Lakeview
Harney County – Tues., June 19 – 11:30 – 1:00 pm	Harney District Hospital 557 W. Washington, Burns
Grant County – Tues., June 19 – 6:00 – 7:30 pm	The Outpost 201 W. Main Street, John Day
Union County – Wed., June 20 – 11:30 – 1:00 pm	Transit Center 2204 E. Penn Street, La Grande
Wallowa, Baker, Malheur – Wed. & Thurs., June 20-21	More Details to follow

Section 1 – Governance and Organizational Relationships

A.1.1. Governance

A.1.1.a.

The governance structure of EOCCO has not been finalized, but the framework for governance, the membership and role of the CAC, and the inter-relationship of the governing boards with the CAC's, will be guided by the following:

EOCCO has been formed as a LLC (Limited Liability Corporation). Those organizations that have contributed capital will have a majority interest in the CCO. At this time, GOBHI and ODS Community Health have agreed to equally capitalize EOCCO as 50/50 partners, but have also agreed to extend offers to other interested parties in the communities that EOCCO

will serve. Other possible capital partners include, but are not limited to, community hospitals and hospital districts, physician organizations, dental care organizations and county governments.

At the highest level, there will be a regional governance structure that will include those organizations that have contributed capital to the organization. The regional governance structure will also include representatives of the various local governance boards, and the community advisory councils, and include the chair of the Clinical Advisory Panel. The regional governance will include two active health care providers including a physician or nurse practioner identified as a primary care provider, a mental health or chemical dependency provider and at least two members from the community at large.

There will be a local governance structure in each county or, in some cases, groups of counties that will have oversight of finances and budgets within their respective service areas. The local governance will help direct the distribution of funds, and will make recommendations on how future investments in healthcare should be used within their respective communities. Those recommendations will ultimately be approved by the regional governance board. The local governance will include the same types of individuals as identified above in the regional governance structure.

All meetings of the EOCCO governing body will be open to the public except in cases when executive sessions are permitted pursuant to the organization's bylaws. Meeting minutes and financial and performance report will be distributed to each local governance board, CAC and the CAP. Each meeting of the EOCCO will provide time for public comment.

A.1.1.b.

EOCCO will be governed through a federated model. The EOCCO service area is intended to be 12 counties in Eastern Oregon. EOCCO will seek input from each county for membership on a county-based CAC. We envision each CAC to be comprised of members of the regional governing board, county government, local social service and education organizations, local businesses and consumers with interest and expertise.

A.1.1.c.

Each CAC will elect a member to serve as a member of the local governing board and regional governance board. The governing board will share with each CAC financial, access, quality and other performance reports that compare and contrast county-level metrics with those of the entire EOCCO and other regional and national benchmarks. Each CAC will provide recommendations to the local governing board concerning plans to improve performance metrics and establish priorities for resource deployment for special projects designed to address unique community needs and related issues that will improve population health.

A.1.1.d.

EOCCO's affiliate GOBHI brings expertise in meeting the needs of members with severe and persistent mental illness. GOBHI will be part of the regional governing structure and part of the CAC's. The EOCCO regional and local governance structure and community advisory councils will consider the needs of all covered populations, including those with severe and persistent mental illness and those receiving LTC services.

A.1.2. Clinical Advisory Panel

A.1.2.a.

EOCCO intends to form a regional Clinical Advisory Panel (CAP) representative of the physical, mental/behavioral and dental health provider communities in the EOCCO service area. The chair of the CAP will also serve on the regional governing board.

A.1.2.b.

N/A

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

A.1.3.a.

We have not yet completed MOU's with Type B AAA's or the DHS local APD offices that operate in each of the proposed service areas. We have the key contact list from OHA that identifies each Type B AAA and APD office and intend to have MOU's in place prior to the contract effective date.

A.1.3.b.

We have identified the Type B AAA's or DHS local APD offices in each of the proposed service areas, and have initiated an outreach call to each office to begin dialogue on completing the MOU. We are confident that MOU's will be in place prior to the contract effective date.

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

A.1.4.a.

All local CMHP's are currently contracted with EOCCO's affiliate GOBHI and we anticipate a continuing contractual relationship as the system changes. In addition, these organizations serve on the Governing Board of GOBHI (as well as a representation of local elected officials, consumers and other local leaders) and, as such, have been deeply involved in the design of the model and the decision to participate in a CCO. In most cases, these CMHP's are also the Local Mental Health Authority or have involved their Local Mental Health Authority in GOBHI's plans from the outset. Numerous community forums and discussions have been held through the region for the past year in order to ensure understanding and support for this application.

A.1.4.b.

EOCCO's affiliate GOBHI has been deeply involved with the transitional and ongoing care coordination and discharge needs of its covered members (all of whom have serious mental health service needs) since 1995. In addition, GOBHI provided statewide leadership in the Children's System of Care Transformation and was able to redirect a large percentage of the funding from intensive residential care to community based services. This enabled GOBHI to double the number of children seen with less funding and better outcomes. GOBHI again provided leadership to the statewide effort to launch the Adult Mental Health Initiative during the last two years, with similar outcomes. The organization continues to demonstrate an on-going commitment towards developing local, community based alternatives for care.

A.1.4.c.

EOCCO's affiliate GOBHI, through its member CMHP's, has well-established processes for coordinating with its Community Emergency Service Agencies and other local partners in order to meet the needs of members who experience a mental health crisis.

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

A.1.5.a.

Establishment of Social and Support Service Relationships:
Effective and collaborative relationships with local social and support services are well established and ongoing throughout the EOCCO service area. Prevention, detection and early intervention are key components to achieving the triple aim within the EOCCO (ODS/GOBHI) service area where careful attention will be paid to expanding the scope of the relationships of these partners as well as integrated into local and regional efforts. Over the years relationships have been built with a number of community partners to deliver programs and services that advance Triple Aim objectives. The EOCCO also has extensive relationships to support members through a variety of services to meet their unique needs

EOCCO's affiliate, GOBHI, is a not for profit corporation established by the Community Mental Health Programs (CMHPs) in the twelve county service area. Each CMHP has been engaged in risk based, sub-capitated contractual relationship with GOBHI which has necessitated working in close coordination with their community partners, for more than fifteen years. These social service relationships were initially established to provide local alternatives to institutional care for high needs individuals, families and/or their children with a wraparound approach. Specific examples are provided in Exhibit D.

Maintaining Social and Support Service Relationships.
The EOCCO will keep a special focus on identifying and reaching out to Individuals, families and children at risk in the communities it serves. These relationships are detailed in Exhibit D. The working relationships with DHS, Oregon Youth Authority, Juvenile Departments, Corrections, schools and school-based health clinics, ESDs, tribal clinics and groups, foster care homes, (many of which are EOCCO therapeutic foster homes) pediatric health service providers, Public Health and a variety of other community nonprofits are ongoing due to the need for continued support for individuals, families and their children. These efforts also ensure easy access to appropriate and culturally sensitive programs and services. Please note CMHPs meet with many of these on a regular weekly or monthly basis. The EOCCO has always had a community focus and will continue these efforts through the already existing involvement with the Oregon Investment Board education initiatives.

Careful attention will be paid to expanding the scope of the relationships of these partners as the goals of the triple aim are integrated into the local efforts. In addition, the EOCCO plans to invite these partners to become members of the Community Advisory Councils in order to ensure real, ongoing integration at the local community level. Collectively both GOBHI and ODS have been developing their own unique community partnerships. We will leverage these partnerships for the benefit of the greater EOCCO population.

Examples of Newly Established Projects: (See additional detail in Exhibit D)

- EOCCO's affiliate, GOBHI, has made a strong commitment to continue to support the existing Community Health Improvement Projects (CHIPs) and has provided $25,000 to Morrow County Public Health upon learning the initial Office of Rural Health funding was running out. A similar commitment has been made to Grant County to match the Office of Rural Health staffing funds, thereby providing a full time position for speedy startup.

- EOCCO is strongly committed to integrating the Oregon CCO initiative with the Oregon Education Reform requirements. In addition to ongoing efforts in Umatilla County, EOCCO's affiliate, GOHBI, has provided $20,000 to the North Central ESD for a joint project in Wheeler County. The intent of the project is to provide community based staffing to assure that the 0-5 year old population meets the standards for both CCO health metrics as well as Early Learning Council goals for Readiness to Learn. Creation of this alignment project will act as an incubator for determining the approach in other EOCCO counties.

- All CMHPs in the EOCCO service area have initiated "hot spotting" projects. The CMHPs have pulled together local primary care providers, hospitals, dentists, and public health departments to establish processes for identifying and providing services to frequent and intense users of health services. EOCCO's affiliate, GOBHI, provided an initial list of GOBHI and "open card" members for the group to prioritize and then begin to work with starting last fall. The groups are at various stages in offering services to Oregon Health Plan members who need support in changing their health behaviors.

- EOCCO has collaborated with the OEA Choice Trust/OEBB over the past four years on the design of school employee workplace wellness programs and services to help motivate and empower employees to improve their health and well-being in a supportive environment, resulting in positive, sustainable changes in lifestyle choices that will have a long lasting impact on wellness. These programs go beyond the school setting to students, parents and communities, with educators serving as role models, as well as health educators even community wellness facilitators.

- *Since 2009 the EOCOO, ODS has been a Corporate sponsor of We Can!*™ (Ways to Enhance Children's Activity & Nutrition), a national initiative designed to give parents, caregivers and entire communities a way to help children ages 8 to 13 maintain a healthy weight through improved food choices, increased physical activity and reduced screen time. Created by the National Institutes of Health *We Can!* provides families and communities with science-based educational materials and curricula to prevent children from becoming overweight and obese.

- Tooth Taxi, created in 2008 through a unique partnership and support of OEA Choice Trust, The Dental Foundation of Oregon and ODS, is a mobile state-of-the art dental clinic with two operatory units and staff that provide free dental care and oral health education to uninsured and underserved children. Since its launch in the fall of 2008, the Tooth Taxi has visited 157 schools and sites throughout the state of Oregon. It has served more than 10,000 children and delivered over $2 million in dental services.

- The ODS Children's Program, created as a solution for the great number of children in Oregon who are not able to access dental care. The Children's Program (TCP) is a partnership brought together in 2008 between dentists in Oregon, Willamette Dental, Kaiser, OEBB and ODS to provide basic dental services to uninsured children. A teacher, school nurse, pediatrician, hospital ER, or county health department comes across children (ages 5-18) with dental needs can refer them to the program (There is no fee to the patient). The services provided include: preventive, diagnostic, pain

relief, and basic restorative care. The program is funded through a 1.5% withhold on all OEBB claims.

Since 2008 the ODS College of Dental Sciences has provided services on its campus, as well as off-site within the EOCCO service area. Off-campus services include visits to long-term care facilities, community clinics, and correctional facilities, to provide dental care for those without access to these services.

A.1.6. Community Health Assessment and Community Health Improvement Plan

A.1.6.a

EOCCO will use the *Mobilizing for Action through Planning and Partnership (MAPP)* to complete a community health assessment (CHA). Using the MAPP model, we will work collaboratively within the service area to assess and improve community health and quality of life. This would include partnering with community nonprofit organizations, foundations, healthcare institutions, healthcare professionals, libraries, religious organizations, schools, social service agencies and other entities that provide public health services to share information about health issues with community residents.

As part of the MAPP process, we will establish a *Steering and Partners Committee,* including representation from the service areas' Community Advisory Council (CAC), to assist the local public health system in completing the following community assessments:

- *Forces of Change*, which identifies factors, events and trends causing changes in community health and quality of life
- *CDC Local Public Health System Assessment Survey,* which formally evaluates how public health services are being provided in the community
- *Community Strengths and Themes Assessment*, which seeks input from residents about healthcare and quality of life issues
- *Community Health Status Assessment*, during which data about health and quality of life is compiled and shared in a report

Information from these four assessments would be used to identify priority health issues that should be addressed to improve service area health.

The first phase of this process would include educating stakeholders and potential participants about the MAPP & CHA process and its benefits. Once the individual MAPP process steps are complete, coalition members, working along with the CAC, would formulate goals and strategies to address priority issues, develop a written plan and work together to implement that plan.

In addition, EOCCO plans to use input from other sources to gain insight into the evolving needs of the community, including the use of an area hospital's community needs assessment summary. We may also solicit other public input from, for example, community centers, local Chambers of Commerce or Granges to gather information and secure EOCCO provider and program referrals. Evaluation forms can also be distributed and collected at the conclusion of any community education program or meeting. We may also use data from the state, health-related agencies and community organizations, as well as hospital-based reports,

documents and surveys, to determine how best to contribute to the overall community health needs assessment.

Our CHA process will be evergreen and reviewed, at a minimum, annually. We will make updates to portions of the assessment at different times throughout a four-year cycle as more current data become available, new issues emerge, or significant events occur in the community.

Sources:

CDC Assessment Initiative, Community Health Assessment Practice Guidance
National Association of County and City Health Officials
NC Dept. of Health and Human Services
New Your State Department of Health
Access Now, Washington State Department of Health

The CAC will engage diverse populations in the CHA process through multiple avenues. The CAC and PAC are designed to include members of diverse cultural backgrounds with varied health status. The CHA uses demographic data to identify major cultural groups within the EOCCO service area. The CAC will engage members of these cultural groups in the CHA through outreach to community organizations and community leaders. CAC will engage individuals with SPMI and individuals in LTC by reaching out to APD offices, NAMI, and community mental health organizations.

Section 2 – Member Engagement and Activation

A.2.1. Member and Family Partnerships

A.2.1.a.

Members are actively engaged in their individualized treatment plans at all levels. At the individual provider, clinic or PCPCH level, practitioners will discuss treatment options for achieving agreed-upon goals. Development of a treatment plan is a collaborative process, including member identification of desired outcomes and choosing among medically-appropriate treatment options to achieve those outcomes. Members who require complex care are assigned a team lead to put together a multidisciplinary care team. Members will actively choose who will be involved in the team, including family and support persons. Behavioral health providers will assist members with a chemical dependency and/or mental illness to develop and expand natural systems of support to promote improved self-efficacy and reduce reliance on professional caregivers.

We will work with our service area system partners to establish Patient Advisory Committees (PAC) to help the EOCCO respond to the needs of patients, extended family and care givers, and to seek ways to improve patient/staff relationships. The PAC will have equitable representation from across the EOCCO community. It will provide insight for patient issues and concerns related to improvement of patient-centered care and quality-driven outcomes. Through the efforts of the PAC, patients will be better informed which will lead to better treatment results.

Our Goals for this effort:

- Identify and present the needs and concerns of CCO patients to PAC quarterly.
- Act as a liaison between the CCO population and the provider network.
- Promote patient empowerment and involvement in their own healthcare issues.
- Utilize patient encounter data and patient satisfaction surveys.
- Develop and provide patient education to be used in the community at large.
- Collaborate with OHA's Living Well network to advocate for improved patient-provider dialogue and relationship building.

A.2.1.b.

Initial enrollment information – New plan members will receive an ID card, member handbook and a Health Risk Assessment (HRA) questionnaire. The member handbook provides a comprehensive introduction to the plan, and comes in the primary language of the household. The handbook also informs members about the process for accessing care and services, along with their rights and responsibilities. The member handbook is approved by the DMAP materials coordinator to ensure that we are communicating in plain language.

Exceptional needs care coordination (ENCC) – Our medical management team includes designated staff members who focus on care coordination for our OHP members with exceptional needs. We use the following methods to continually identify members who may require ENCC services:

- Health risk assessments from new OHP members
- Monthly DMAP eligibility reports
- Utilization review processes when a DMAP member is admitted through the emergency department
- Monthly claims report of members who have reached a specific threshold for accumulated paid charges
- Referrals from providers, case workers, and internal departments such as customer service, behavioral health services or health coaching

We mail health risk assessments to our newly enrolled OHP medical members and follow-up with a second mailing to non-respondents. Our exceptional needs care coordination nurse reviews each returned health risk assessment to identify healthcare needs. In 2011, she assisted 230 members in ongoing medical and social needs. These included hospital discharge planning, coordinating services in home health, home infusion, skilled nursing facility and acute rehabilitation, coordinating post hospital discharge care for neonatal intensive care babies, educating frequent users of the emergency department and members who did not have a primary care provider to help them find a medical home, referring members needing dental care to our OHP dental coordinator, and helping members navigate the healthcare system and understand their health plan. In addition, she referred 182 members to our health coaching programs, and 14 enrolled in one of the programs for asthma, diabetes, heart disease, depression, musculoskeletal or maternity.

Health communications – EOCCO's affiliate ODS has a robust and comprehensive array of collateral material available in multiple formats and delivered through various channels to our members. These resources also include interactive tools to assist with informed decision making and patient-provider communication. Examples include:

- Partnering with your provider
- The patients' role in their care
- Patient activation and behavior
- Health care disparities, rights and responsibilities
- Leveraging your health team

Population health programs – Each month, we mail welcome letters to members describing the services we offer in our population health programs. The letters cover general preventive screenings; reminders for needed care (targeted at members who have had lapses in recommended visits, screenings and procedures, and sub-optimal medication adherence), and phone or email access to one-on-one health coaching from our multi-disciplined clinical staff, which include RN's, Dieticians, Naturopaths and Behavioral Health Specialists. Members may respond to the invitation by phone, by email or by returning the response card in the mail. Those participating in one-on-one coaching receive regular sessions with clinical staff, as well as customized mailings. The frequency of outbound contact is determined by the member's individual needs and motivational level.

We use the Patient Activation Measure (PAM) survey as the initial assessment to further stratify risk. PAM is an evidence-based survey made up of 13 questions that assess an individual's knowledge, skills and confidence around managing their own health and healthcare. By understanding participants' "activation levels", health coaches can better segment and tailor programs to meet the individual needs of the member. Higher levels of activation are strongly correlated with improved self-care behaviors. Individual cases are moved to the maintenance phase based on best-practice criteria as members complete their plans, and reach their personal health goals.

We use an annual evaluation process to demonstrate the overall prevalence of chronic conditions in our member populations. This analysis is used to establish programs that reflect the burden of illness. In addition to epidemiologic trends, we assess stratification metrics for cost and utilization to support and focus on our chosen conditions for health coaching and chronic condition management interventions. Recent evaluations clearly support the relevance of our diabetes, cardiac, depression and respiratory care-specific programs to the member populations, respectively.

Engaging members in culturally and linguistically appropriate ways – We provide all Healthcare Services staff (case managers, care coordinators, behavioral health staff, health coaches and support staff) with annual cultural diversity training that addresses ethnicity, age-related concerns, linguistic/language needs and preferences, physical and mental disabilities and sexual orientation. The training is provided through in-person presentations, written material and webinars. The training content is documented in the ODS Cultural Diversity Resource Manual.

We provide multilingual customer service during regular business hours through Language Line Services, which offers assistance in 140 different languages. We also have a dedicated phone number for our Spanish-speaking members. If our Spanish-speaking representatives are busy assisting other members, the caller is routed to our general customer service lines, and an interpreter will assist with the call. This process is explained in Spanish on the recorded greeting members hear when they call the dedicated number. We continually

evaluate the number of calls received through the dedicated line to determine whether additional Spanish-speaking representatives are needed. Representatives that interface with hearing-impaired customers are trained to use the Oregon Relay service.

Section 3 – Transforming Models of Care

A.3.1. Patient-Centered Primary Care Homes

A.3.1.a.

- Clinics will have access to ongoing technical assistance and training through the Patient Centered Primary Care Home Institute, through Oregon Quality Corporation and through other community pilots (e.g. High Value Patient-centered Care collaborative). Ongoing practice support, training and monitoring will be made available as needed.
- We will work with practices to provide electronic, real-time notification of emergency department visits and hospitalizations, and, with other partners such as Quality Corporation, provide combined reports of utilization for enrolled members.
- As with our existing providers, we will continue to provide consultation and support of ongoing provider concerns through our customer service and provider contracting departments.
- The Quality Corporation will translate member data and provide actionable information that can be used to improve care and reduce costs. Quality and utilization data will be shared through a secure provider web portal. Primary care providers will also be eligible to receive annual individualized reports on the healthcare services they provide, based on the aggregation of claims data.
- We will develop a provider encounter toolkit to assist providers in communicating in a linguistically- and culturally-appropriate fashion. See response A.3.5.c.

A.3.1.b.

We will actively engage EOCCO members in their transitions among care settings through a comprehensive effort of community coalitions and learning interventions. We will support EOCCO populations with an emphasis on improving care coordination across settings. Participating service area coalition members will include interdisciplinary representatives from acute care hospitals, physician practices, long-term care facilities, mental health, senior care, home health agencies, and hospice organizations, as well as consumers and local and state officials.

Members will have access to advocates, where appropriate, that include qualified peer wellness specialists (Living Well Leaders), personal health navigators and qualified community health workers. As part of the member's care team, these individuals will provide assistance that is culturally- and linguistically-appropriate to the member's needs to help them access appropriate services and actively participate in their care.

Innovations in this area may include a clinical and operations support team within the service area for on-site and community-based services. This approach would incorporate a distributive-based model, acting as liaison for select high-risk individuals. The support services may take place during office visits, in the home or during transitions of care, to facilitate adherence to the treatment regimen prescribed by the participant's primary care team. Our goals would be to:

- Target high-risk, high-cost members with co-morbid disorders
- Improve clinical and economic outcomes (i.e., morbidity and costs of care)
- Manage the most complex of the complex cases

- Engage a local, community-based pharmacy network to develop a pilot to support member enrollment and engagement, and provide consultations regarding medication management
- Sponsor Living Well workshops, providing peer-to-peer self-management education and support for chronic and complex diseases

A.3.1.c.

We fully support the value of PCPCH's as part of Health System Transformation. Currently, one primary care provider from eastern Oregon has received tier 3 PCPCH certification. This provider is in our network and currently serves as a PCP for 200 members.

When the PCPCH model was announced, we sent a communication to all of our contracted PCP's notifying them of the opportunity, and offered to provide support. The providers in our network indicated an interest in and a willingness to become PCPCH certified, but having the time to complete the application was identified as a barrier. We can provide assurances that our goal is to enroll a significant number of members into PCPCH's.

Our plan to increase the number of enrollees that will be served by certified PCPCH's is based on provider interest and engagement in completing the PCPCH application. We will work with our providers one-on-one to determine what barriers exist to becoming PCPCH certified, and offer them assistance in completing the application process and/or providing reports to identify qualified members.

Our goal by the end of year one is that 10 percent of our members will be served by clinics certified as PCPCH's, and to increase that number by 10 percent each year, with 50 percent of our membership served by certified PCPCH's by the end of five years. Providers that initially become certified as tier 1 or tier 2 will be encouraged to seek tier 3 status over the next 12-24 months. Again, we will work with providers one-on-one to determine barriers to becoming tier 3 certified, and will offer assistance as needed.

Should we run into barriers to achieving a substantial network of PCPCH's, we will consider contractual requirements or payment penalties for providers who have the capability but choose not to become PCPCH certified.

We will require the necessary two-way communication and coordination through specific provider contract language. This is an example of the verbiage we would add to outline this requirement:

Two-Way Communication.
Hospital shall communicate and coordinate with Participating Providers in a timely manner for comprehensive care management of the Member.

A.3.1.d.

We have utilization management procedures in place to facilitate coordination and level of care transitions necessary to meet a member's healthcare needs. This process includes communication with all healthcare providers, including LTC providers and services, and collaboration with the PCPCH. Provider communication at the PCPCH level will take place as part of the transformation. The infrastructure anticipated for EOCCO will allow all CCO participants to receive reliable and accurate member status and to access up-to-date

information about the conditions and requirements of the services being delivered. This interface will allow timely information to be directed into a member's PCPCH. Since community partners forming the CCO will include local Medicaid funded LTC providers they too will have access to the same informational exchange allowing for effective coordination of care between these respective agencies and the EOCCO member's PCPCH.

EOCCO has detailed policies and procedures that require clinical documentation in our internal documentation system of all referrals, and prior authorizations of services, including facility admissions. The EOCCO policies and procedures include tracking of referrals, service authorizations, inpatient clinical review, post discharge follow up and referral to next most appropriate level of care. Inpatient admissions are documented for level of care and length of stay, and include documentation of discharge planning and transitions to post discharge levels of care. There are handoffs to an RN case manager or ENCC depending on the level of intervention and level of risk. This ensures a smooth transition and continuity. The internal team communicates with the providers and community based health teams on prior authorizations and identified needs/risks.

The EOCCO case management policies and procedures include identification and documentation of members with high needs or at risk of high needs. The policy and procedures include the required assessment and development of an individualized plan of care and the timelines for updating the plan of care. Policies and procedures are in place that describes required communication with members and providers regarding prior authorizations and referrals.

Specific evidence based, nationally recognized clinical care guidelines are used for all clinical reviews for prior authorizations, and policies and procedures are in place describing the use of the clinical care guidelines. A policy and procedure is in place for interrater reliability to ensure consistency of decision-making. All transitions are in collaboration and communication with the community health team and specific to the member's care plan which includes member's residing in DHS Medicaid –funded LTC.

EOCCO is studying the feasibility of using an on-call clinician to consult with the PCPCH in support of members in LTC facilities. If deemed feasible and cost-effective, EOCCO will contract with a mid-level practitioner to provide medical triage when an LTC is considering sending a member to the hospital. This could potentially reduce unnecessary ER visits and admissions.

EOCCO will collaborate with state APD offices by developing MOU's for collaboration on members living in LTC facilities.

A.3.1.e.

We fully support and encourage the use of federally qualified health centers, rural health clinics and other safety net providers on a daily basis. We believe these provider types are key to the development of a comprehensive provider network. As an FCHP, EOCCO's affiliate ODS currently has contracts in place with nine rural health clinics and one federally qualified health center in our eastern Oregon counties. 42% of our 10,000 Eastern Oregon medical members already use these types of providers as their assigned primary care provider. Members that do not proactively select a primary care provider upon initial enrollment are often assigned to the rural health clinics and federally qualified health centers

that operate in each respective service area. We will work with these providers to become certified as PCPCH's so that members already assigned to these clinics can benefit from the value of the PCPCH model of care. In the expansion service areas, we will seek out these types of providers for recruitment into our provider network. Our goal is that 50% or more of our members are assigned to these unique provider types.

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

A.3.2.a.

EOCCO affiliate GOBHI has considered the idea of creating Patient Centered Healthcare Homes, utilizing the models in both New York and Missouri. The Healthcare Homes would be within Community Mental Health Programs (CMHPs), but the current Oregon standards can be met by the CMHPs through contracting and coordination with local primary care providers to meet the needs of their specialty population (QII and QIV consumers/members as defined 4-Quadrant Model).

[Note: Please see http://www.thenationalcouncil.org/galleries/resources-services%20files/5.%20Four%20Quadrant%20Diagram.pdf for this national model used in integration of behavioral health and primary care services.] In May 2012, EOCCO affiliate, GOBHI, is working with the Oregon Primary-care Research Network (ORPRN) to initiate a feasibility study to further inform the process by establishing the potential numbers of consumers/members who are appropriate for primary care home services within the CMHP in each county. At this time, there is no intent to create or implement models other than utilizing Oregon's existing PCPCH standards to provide primary care services in a CMHP.

A.3.2.b.

The 4 Quadrant model referenced above is the adopted national standard for assuring primary care services are delivered to those who are severe and persistently mentally ill (SPMI). These people are not normally served in a primary care setting and therefore tend to use the Emergency Room for primary care. Additionally, this population tends to be at high risk for diabetes, high blood pressure, metabolic syndrome and other chronic diseases. This dual-diagnosis population needs to be served where they are the most comfortable and assured of receiving services and that is in the CMHP setting. Assuring they receive primary care services will therefore achieve the triple aim. Changing the model for care within the CMHP will achieve transformation and assure better patient care.

A.3.2.c.

Utilizing regularly scheduled joint case staffing, whether within the CMHP or between the PCPCH and the CMHP is the gold standard for comprehensive care management. All 12 counties in the EOCCO service area have begun "hot spotting" activities. These groups are evolving to now create systems with clearly designated responsibilities to assure timely response to issues as they arise. As an example, EOCCO affiliates GOBHI and ODS are currently involved in coordination with Baker County in planning, promoting, and facilitation provider care teams. One of the primary elements of the care team is promotion of member self-management; and linking members to community and social supports. The

care teams communicate on a real time basis for support and facilitation of the members care plan. The care teams have a process in place for crisis management and is now extending that plan to include a fully integrated team within 48 hours as a follow-up to the crisis.

The care team intends to create care plans specific to the member's needs, based on assessment of the member's unique clinical picture. For non-crisis situations, the care team, which includes members of GOBHI and ODS, meet on a regular monthly basis to discuss identified barriers to care. This "whole person" approach emphasizes health and wellness, assures consumers receive the preventive and primary care they need, and assists them in managing their chronic illnesses. As EOCCO develops their Community Health Teams, these teams will interface with this provider care team and each member who participates in a care plan will be assigned a Community Health Worker (CHW).

A.3.2.d.

EOCCO is studying the feasibility of using on on-call clinician to consult with the PCPCH in support of members in LTC facilities. If deemed feasible and cost-effective, EOCCO will contract with a mid-level practitioner to provide medical triage when a LTC is considering sending a member to the hospital. This could potentially reduce unnecessary ER visits and admissions.

Additionally, through the use of behaviorists, EOCCO intends to work with facilities where members may be tending to act out against staff and/or other patients. Behaviorists will be used to create and train LTC in a member specific behavior care plan. In those cases where it is recognized the member may need special support for a few days, EOCCO is considering the option of assigning a CHW or specially trained CNAs to be with that member in their existing facility on a 24 hour basis. EOCCO recognizes this may be more cost effective than having a member transferred to a hospital or higher level of care for just a few days. Therefore, this is another set of measures intended to provide appropriate member support without transitioning that member to a higher level of care in another institution.

A.3.3. Access

A.3.3.a.

We contract with the majority of available PCP's, PCPCH's, specialists, mental health and chemical dependency providers and facilities known to accept OHP members within each community that we serve. This includes contracting with rural health clinics and federally qualified health centers. Our approach ensures that we cover a broad scope of provider types to meet the needs of our entire population within that community. For 90 percent of EOCCO members, travel time or distance to the provider in urban areas is within 30 miles, 30 minutes or the community standard, whichever is greater. In rural areas, it is within 60 miles, 60 minutes or the community standard, whichever is greater.

In rural areas where major specialties are not available locally, we contract with providers in other states, such as Idaho and Washington, or in bordering counties where referral patterns to specialists have been well-established by the local community. Whenever possible,

members are referred to providers who can provide the level of care required, and are the most convenient in location to where the member lives.

We always refer members to in-network providers, where available. If the member needs services and there is a non-contracted provider that is more convenient in location, we allow the member to seek services from the non-contracted provider if that provider is willing to accept Oregon Medicaid rates, and agrees not to bill the member for balances. These requests are reviewed on a case-by-case basis.

We identify providers that speak languages other than English. Other languages spoken by providers are noted in the provider directory. Additionally, we provide translation services over the phone and at provider appointments. Instructions on how to arrange for these services are given to members and providers.

We have agreements in place with county health departments and support the use of school-based health centers to ensure access to care in non-traditional settings.

The EOCCO network of providers will be adequate to serve Members' health care and service needs, meet access to care standards, and allow for appropriate choice for Members, and include non-traditional health care workers including Community Health Workers, Personal Health Navigators and qualified interpreters.

Geographic Availability: EOCCO is fortunate in having twelve (12) Community Mental Health Programs (CMHPS, some are becoming PCPHSs), six (6) Federally Qualified Health Center sites, and approximately twenty-eight (28) Rural Health Clinics which are geographically well distributed across the EOCCO counties. EOCCO recognizes there is limited geographic access to primary care providers and that many of the proposed communities are in Health Professional Shortage areas. Yet, this set of safety net clinics is a good initial backbone of providers to help ensure access to PCPCH's are available within reasonable distance to serve all EOCCO CCO clients.

EOCCO intends to work closely with OHSU and the AHEC programs to assure medical student, physician assistant, and family medicine resident clinical rotations continue to occur in the communities of Pendleton, Enterprise, Baker City, Ontario, Nyssa, Vale, John Day, Burns and Lakeview. Through these rotations, and in partnership with the existing health districts and hospitals, EOCCO desires to be a part of the community recruitment plan and will discuss potential roles with those community recruiters within the first six months of operation.

Oregon has a voluntary healthcare interpreter registry and an opportunity for interpreters to go beyond the registry and receive formal training to become "qualified" (meaning they have completed the 122 hour training) and certified (completion of a state test). Only two people east of Bend are in the state's registry. This makes it very difficult for the Eastern Oregon CCO to start their work with registered interpreters.

Eastern Oregon CCO will therefore work with the Oregon AHEC Spanish Healthcare Interpreter Training Program. Currently that training program is transitioning to a new learning management system and will be ready with course offerings through the Oregon

Community College system later this year. Use of the Oregon Community College system courses allow for delivery across rural counties in Oregon.

When students go through interpreter training they need local mentors. Sandy Ryman, GOBHI's Integration Manager, was formerly the Northeast Oregon AHEC directory. In 2007 and 2008, there were twelve interpreters trained in Malheur and Umatilla counties. Sandy is currently in the process of working with Cascades East AHEC and has requested the AHEC contact those interpreters to determine their status as potential mentors.

Once interpreters complete the training program they can not only be registered but also "qualified" as interpreters. Testing is required for certification and Oregon's website indicates that throughout the state, there are only 3 certified interpreters. Therefore, the Eastern Oregon CCO will be developing a specific interpreter workforce development plan to identify, recruit, educate and at a minimum, qualify interpreters. The intent of the plan will be to also cross-train some of these interpreters as non-traditional health workers (NTHW) and to utilize these dually trained individuals within the Community Health Care Teams in counties with large Hispanic populations.

There may be special needs, on the part of some plan members, for additional accommodation for access to care. EOCCO does not know the full extent of those needs at this time, beyond those who have been served in the CMHPs. EOCCO will be supporting CMHPs with high numbers of severe and persistently mentally ill to transition to PCPCH to assure access to medical care within those facilities they currently regard as their healthcare home. EOCCO will ask community providers to inform Community Healthcare Teams (CHT) if there are people who have problems with accessing care. The CHTs community health workers will then work with the member and potential providers to find a way to resolve the problem.

The EOCCO will create a Provider Encounter tool kit with contents that can be reproduced and used as needed in the Patient Centered Medical Home office and practice setting. The contents will include but not be limited to encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of diversity issues. Information for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and language skill self-assessment tools. Techniques for talking about sex with a wide range of people, pain management across cultures, and information about different cultural backgrounds. Details on key legal requirements, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet legal requirements, a bibliography of print resources, and a list of internet resources.

A.3.3.b.

The EOCCO currently has a broad network of providers throughout several of the eastern Oregon counties we are proposing to service, with plans to develop and hire a network of non-traditional providers including community health workers, personal health navigators and certified, qualified interpreters. It is our intent that these workers will be based throughout the EOCCO service areas.

Distance is often a barrier to timely and appropriate care in rural areas. Having highly mobile community health workers available to membership in the more remote communities

(including residents of those communities) helps to mitigate the barriers caused by distance. The EOCCO will continue to work with existing regional contractors for medical transportation needs.

Promoting the use of health information technology is critical to overcoming issues associated with distant communities. EOCCO, through its affiliate GOBHI has worked with Oregon Health Network to establish subsidized, fiber optic connectivity in most of the small communities in this region. Use of telemedicine for consulting, training, and care coordination is supported and encouraged. Where need is identified, formal linkages for regular consultation times will be developed. Likewise, EOCCO will work with its service partners to develop a Health Information exchange that will ensure the timely availability of needed information that is easily available to all appropriate providers.

In addition to the outreach activities performed by EOCCO central office staff, community-level outreach will be conducted by Community Health Teams (CHT). Led by a care coordinator, each CHT will develop a network of social service agencies, including community-based and faith-based institutions, and educate these partners about the EOCCO and the services it can provide. (These relationships already exist, as described in A.1.5.a.) An innovative approach that the CHT will incorporate is developing working relationships with facility and retail-based pharmacists to update member contacts and bolster medication adherence efforts, knowing that members often establish strong bonds with these clinical care partners.

Creation of County-based Community Health Teams (CHT) – See Workforce Logic Model Exhibit E:

The CHT's are staffed by Care Coordinators and 12 of Oregon's new non-traditional health workers (NTHW): Community Health Workers (CHW), Peer Wellness Specialists (PWS), and Personal Health Navigators (PHN). Based on those characteristics EOCCO will work with the local governing group to solicit applications from the community as a whole. A local hiring committee will make the selection process. The newly hired individuals will be supported in taking the 80 hour community college class, which will be offered online and face-to-face through Oregon Community College Consortium Healthcare Education Alliance (CCHEA). While taking the course, the NTHWs will also engage in a local community orientation with the community partners to learn about the services available in their community.

It is anticipated that these service entities will provide an on-going source to identify eligible OHP clients and refer them to EOCCO services. The relationship with these entities will be bi-directional as the CHT will use this network to provide needed services to EOCCO clients as well. Having this wealth of information will also place CHTs in the position of providing comprehensive coordinated care and education to individual clients. CHT's also fill an important role of cultural brokerage and linguistic services through use of non-traditional health care workers. An important function of CHTs is to implement strategies to engage persons of diverse populations who may be falling through the "health disparities cracks" and ensure they receive access and quality services comparable to the majority population.

Because of the importance of CHTs in ensuring access to and coordinated care for its populations, EOCCO has prioritized the development of these teams as a critical activity. Once it is authorized as a CCO, EOCCO will immediately begin recruitment for an

appropriate number of care coordinators. Additional team members will be added as needed and, will include to the greatest extent possible, individuals representing underserved populations in an effort to ensure that culturally-appropriate services are being provided. The biggest barrier to establishing these teams (which will provide coordinated care for all covered populations) will be the timely recruitment of qualified team members. Fortunately, EOCCO's existing relationships with a variety of regional and state level agencies (such as AHECs, ORH, ORPRN, OHSU), and its current working collaborations with numerous community-based organizations will assist in these recruitment efforts.

A.3.3.c.

In addition to the outreach activities performed by EOCCO central office staff, community-level outreach will be conducted by Community Health Teams (CHT). Led by a care coordinator, each CHT will develop a network of social service agencies, including community-based and faith-based institutions, and educate these partners about the EOCCO CCO and the services it can provide. (These relationships already exist, as described in A.1.5.a. of this document.)

It is anticipated that these service entities will provide an on-going source to identify eligible OHP clients and refer them to EOCCO services. The relationship with these entities will be bi-directional as the CHT will use this network to provide needed services to EOCCO clients as well. Having this wealth of information will also place CHTs in the position of providing comprehensive coordinated care and education to individual clients. CHT's also fill an important role of cultural brokerage and linguistic services through use of non-traditional health care workers. An important function of CHTs is to implement strategies to engage persons of diverse populations who may be falling through the "health disparities cracks" and ensure they receive access and quality services comparable to the majority population.

Creation of County-based Community Health Teams (CHT) – See Workforce Logic Model Exhibit E:

The CHT's are staffed by Care Coordinators and 12 of Oregon's new non-traditional health workers (NTHW): Community Health Workers (CHW), Peer Wellness Specialists (PWS), and Personal Health Navigators (PHN). Based on those characteristics EOCCO will work with the local governing group to solicit applications from the community as a whole. A local hiring committee will make the selection process. The newly hired individuals will be supported in taking the 80 hour community college class, which will be offered online and face-to-face through Oregon Community College Consortium Healthcare Education Alliance (CCHEA). While taking the course, the NTHWs will also engage in a local community orientation with the community partners to learn about the services available in their community.

Because of the importance of CHTs in ensuring access to and coordinated care for its populations, EOCCO has prioritized the development of these teams as a critical activity. Once it is authorized as a CCO, EOCCO will immediately begin recruitment for an appropriate number of care coordinators. Additional team members will be added as needed and, will include to the greatest extent possible, individuals representing underserved populations in an effort to ensure that culturally-appropriate services are being provided. The biggest barrier to establishing these teams (which will provide coordinated care for all covered populations) will be the timely recruitment of qualified team members. Fortunately, EOCCO's existing relationships with a variety of regional and state level agencies (such as

AHECs, ORH, ORPRN, OHSU), and its current working collaborations with numerous community-based organizations will assist in these recruitment efforts.

There are many individuals today that are eligible for the Oregon Health Plan but do not know how to access services. The EOCCO will develop a member handbook that outlines covered programs & services, designates system changes as well as provide background and information on the benefits of the new delivery system and will distribute to all members.

In addition the EOCCO will conduct community-based outreach activities and work with providers to ensure the populations in our service areas are made aware of the OHP and its services. EOCCO will also recruit two to three communities to pilot intensive community and member-level outreach and support (e.g., mailings, marketing materials, workshops, focus groups and community center informational sessions) to develop a community-based coalition with the goal of improving awareness on transitioning to CCO models of care.

We will provide root-cause analysis to identify what is causing a lack of understanding of the CCO model within the community. This will help us define factors for poor care transition within a service area. From this, we will be able to better select and implement interventions by addressing known drivers for improvement. Newly enrolled members will be educated about the CCO model of care through the member handbook and will be encouraged by both PCP's and the Mental Health providers to select a PCP or PCPCH.

The EOCCO will also maintain and support a provider and patient advisory committee and will expand this to include the integration of patient advisory and outreach via all medical groups and mental health clinics. Regional behavioral health services will also support the Consumer Advisory Council and each County will support and facilitate a Behavioral Health Advisory Committee.

EOCCO Consumer Affairs Coordinators will work with the State Hospital, Therapeutic Foster Care, Juvenile Justice, State Correctional Facilities and related agencies to facilitate and coordinate transitions of care.

A.3.4. Provider Network Development and Contracts

A.3.4.a.

EOCCO currently has contractual relationships with mental and physical health providers that are willing to integrate care in a coordinated team-based approach. These partnerships address services to children and adults, both within and external to contractual boundaries. As part of EOCCO, ODS and GOBHI are beginning to expand their service delivery reach and develop additional partnerships with physical health, addiction, and dental care providers within and external to the existing service area to ensure a seamless and coordinated transition of care. These conversations have focused on service array, rates, and authorization practices. The goal will be to create a system that provides the member with the greatest convenience to care possible.

As an FCHP, EOCCO's affiliate ODS currently has a comprehensive network of physical health providers in several of the proposed eastern Oregon counties (Baker, Malheur, Union, & Wallowa). The network includes tertiary hospitals and a network of specialists for services that cannot be provided locally. For service areas in which we have medical networks

established, we will be working with our primary care providers and clinics to receive recognition as a patient centered primary care home (PCPCH). (See response A.3.1 a. for additional details about our approach.)

For the proposed expansion service areas (Gilliam, Grant, Harney, Lake, Morrow, Sherman, Umatilla and Wheeler counties), ODS is in the process of building a comprehensive Medicaid provider network to address the needs of the OHP population in those communities. As part of the EOCCO application process, ODS has mailed out OHP contracts to primary care and specialty providers, clinics and hospitals in these eight service area regions. In addition, representatives from the EOCCO have also made trips to the Eastern Oregon region to meet with providers and hospitals to educate and inform them of CCO developments.

In early June 2012, the EOCCO will be holding CCO community town hall meetings in each of the twelve proposed CCO counties. This will help solidify to members and providers in the region of our commitment to the CCO initiative. Additionally we will be meeting with providers one-on-one during this visit to discuss their individual CCO questions/concerns.

EOCCO's affiliate GOBHI currently has a network of established mental health providers throughout the entire proposed service area. In rural areas where major specialties are not available locally, we contract with providers in other states or bordering counties where referral patterns to specialists have been well-established by the community. Whenever possible members are referred to providers who can provide the level of care required and are the most convenient in location to where the member lives. We always refer members to in-network providers where available. If the member needs services and there is a non-contracted provider that is more geographically convenient, we allow the member to seek services from the non-contracted provider if the provider agrees to provide services. These requests are reviewed on a case-by-case basis.

The EOCCO will sustain the existing behavioral health provider network. GOHBI has been consulting with contractors to help them explore new procedures and services such as employing behavioral health teams that align with a coordinated care approach that integrates behavioral, physical and oral health care.

In addition to the outreach activities performed by EOCCO central office staff (described in the previous section), community-level outreach will be conducted by Community Health Teams (CHT). Led by a care coordinator, each CHT will develop a network of social service agencies, including community-based and faith-based institutions, and educate these partners about the EOCCO and the services it provides. (These relationships already exist, as described in A.1.5.a.). An innovative approach that the CHT will incorporate includes establishing working relationships with facility, system and retail-based pharmacists to update member contacts and bolster medication adherence efforts, knowing that members often establish strong bonds with these clinical care partners.

It is anticipated that these service entities will provide an on-going source to identify eligible OHP clients and refer them to EOCCO services. The relationship with these entities will be bi-directional as the CHT will use this network to provide needed services to EOCCO clients as well. Having this wealth of information will also place CHTs in the position of providing comprehensive coordinated care and education to individual clients. CHT's also fill an

important role of cultural brokerage and linguistic services through use of non-traditional health care workers. An important function of CHTs is to implement strategies to engage persons of diverse populations who may be falling through the "health disparities cracks" and ensure they receive access and quality services comparable to the majority population.

Creation of County-based Community Health Teams (CHT), are staffed by Care Coordinators and 12 of Oregon's new non-traditional health workers (NTHW): Community Health Workers (CHW), Peer Wellness Specialists (PWS), and Personal Health Navigators (PHN).

Because of the importance of CHTs in ensuring access to and coordinated care for its populations, EOCCO has prioritized the development of these teams as a critical activity. Once it is authorized as a CCO, EOCCO will immediately begin recruitment for an appropriate number of care coordinators. Additional team members will be added as needed and, will include to the greatest extent possible, individuals representing underserved populations in an effort to ensure that culturally-appropriate services are being provided. The biggest barrier to establishing these teams (which will provide coordinated care for all covered populations) will be the timely recruitment of qualified team members. Fortunately, EOCCO's existing relationships with a variety of regional and state level agencies (such as AHECs, ORH, ORPRN, OHSU), and its current working collaborations with numerous community-based organizations will assist in these recruitment efforts.

Behavioral health care providers are also implementing processes to collaborate better with primary care and other health services.

The EOCCO has coordinated care with out-of-area providers and will continue to do so in the future. The EOCCO will work with other CCOs to help their members receive specialty care services as necessary.

Each community advisory committee, which includes care providers, social service partners and regional/local members, will be involved in defining the characteristics of a NTHW needed to meet the specific geographic, cultural and linguistic needs of their county population. Based on those characteristics EOCCO will work with the local governing group to solicit applications from the community as a whole. A local hiring committee will make the selection process. The newly hired individuals will be supported in taking the 80 hour community college class, which will be offered online and face-to-face through Oregon Community College Consortium Healthcare Education Alliance (CCHEA). While taking the course, the NTHWs will also engage in a local community orientation with the community partners to learn about the services available in their community.

As the rest of the Community Health Team is developed through the addition of Care Coordinators and any other identified, needed resource staff, team members will be identified for further training. Training resources will be identified or developed to customize the NTHW's expertise as either a CHW, PWS and/or PHN.

A.3.4.b.

EOCCO's affiliate GOBHI is currently working on the expansion of its network to include providers that use known practices to decrease in-patient utilization. GOBHI professionals, with the expertise to guide and support providers will provide assistance in this development,

including expansion of supportive housing and employment, system navigation, peer support and intensive outpatient programming. GOBHI has significantly increased communication among providers which has improved monitoring, follow-through and care coordination for each member by enhancing provider awareness and understanding of each other, and their functions. This, along with best practice expansion among GOBHI providers, has led to significant reductions in acute care utilization, residential length of stays, numbers approved and waiting for State Hospital care, and readmissions to State Hospital care after stepping down into a lower level of care.

Early identification and effective outpatient services are keys to reducing inpatient utilization for chemical dependency services. EOCCO will continue to promote SBIRT and provide technical assistance to providers for this intervention (see A.3.6.c). We review all requested outpatient chemical dependency treatment and work with providers to ensure the use of evidence-based services, including case management, medication-assisted services as appropriate, and the use of community supports. We review all requests for inpatient and residential chemical dependency treatment to ensure appropriate level of care, and to facilitate a transition to outpatient treatment with appropriate supports.

A.3.4.c.

EOCCO's affiliate GOBHI will seek out providers that will actively engage in developing an array of services that promote individual choice, respect cultural differences, support recovery, and preserve the dignity of its members. Providers will be approached on their historical achievements in these areas and visions for the future.

The EOCCO will advocate for contractual language that supports the core principles of self-determination for all members. To compliment this EOCCO (GOBHI/ODS) has developed strong relationships with chemical dependency providers throughout the service areas. We already have Medicaid contracts with many providers and will build upon relationships developed through commercial contracts to expand our OHP network in counties where ODS has not previously had Medicaid lives. Contracted providers offer the full range of services from inpatient to residential and outpatient and flexible case management services.

EOCCO's affiliate, GOBHI, already has a highly developed and effective behavioral health provider network spread throughout all twelve counties of the proposed coverage area. In addition to long-standing contracts with community mental health programs, during the past few years GOBHI has developed relationships with Federally Qualified Health Centers, Rural Health Centers and Alcohol and Drug Treatment Programs for improved integration and coordination of physical and behavioral health services.

Throughout this network, the emphasis is on providing treatment in the most appropriate and independent setting, including their own home or independent supported living. Experience has repeatedly indicated that referral to inpatient psychiatric facilities can often be averted through short-term utilization of local respite facilities or placement of Qualified Mental Health Associates in the client's home during periods of destabilizing crisis or decompensation. When psychiatric hospitalization is indicated, GOBHI tracks the individual's status from admission through discharge, and provides assistance to local providers in preparing plans for transition to lower levels of care in the individual's own community.

The success of these efforts is demonstrated by GOBHI having maintained the lowest hospitalization rate of any MHO for over a decade.

Coordination, Transition and Care Management

Care Coordination:

A.3.5.a.

EOCCO will be proactive in supporting information between providers, initially using telephonic outreach and our field-based Community Health Team (CHT). Additionally, we are a proponent of the state's Health Information Exchange (HIE) and will be proactive in implementing the HIE in our service area. EOCCO will use our HIPAA-compliant systems to aggregate different pieces of patient information into a care plan to identify potential duplication of services, and communicate with the various LTC providers on the members' behalf. As a long-time OHP mental health managed care organization, EOCCO's affiliate GOBHI has established relationships with mental health crisis services and community-based services. In addition, the EOCCO will analyze claims data to help prevent medication errors. EOCCO currently participates in the Baker Collaborative, and will apply lessons from this model to other counties within the service area. Members with severe and persistent mental illness (SPMI) work with a lead agency to develop a multidisciplinary, multi-agency care team and service plan. Regular care team meetings serve as a primary conduit to ensure that clinical information is shared among all treating providers. Additionally, the care team develops a plan for sharing information by telephonic consultation or in writing, as needed. The process ensures appropriate release of information and coordination of care, as well as team members' participation in regular reviews and updates of the service plan. This level of cooperation ensures coordinated, efficient, goal-directed services.

A.3.5.b.

EOCCO will use its Community Health Teams to develop partnerships by contacting or meeting face-to-face with providers. Additionally, we will meet with provider representatives as part of the Clinical Advisory Panel (CAP).

We plan to use the University of New Mexico Health Extensions Rural Offices model to develop partnerships between rural college campuses and participating providers' practices to achieve health status improvement. As part of this effort, we will explore leveraging the Oregon Cooperative Extension service, and encourage the local Community Advisory Councils to participate as active partners.
Community-based Cooperative Extension offices across the state can help link community-based resources with EOCCO member needs. Program support through rural college campuses will be available to help respond to community requests, and support the priority areas identified by the community. In addition, community health providers needing practice relief services will be helped through these program resources: Rural/Community Behavioral Health Crisis Management, Rural Grief Counseling, Oral Health and integration of *Living Well* workshops.

For Self-Management programs, EOCCO will primarily use the State's Chronic Disease Self-Management Program (CDSMP), known as *Living Well with Chronic Conditions* (*Living Well*). *Living Well* is composed of three different evidence-based programs that are available in Oregon. *Living Well* is a six-week, peer-led workshop for people with one or more chronic conditions and their support people. *Tomando Control de su Salud* is the

culturally-adapted, Spanish language version of CDSMP. *Positive Self-Management Program* is a seven-week, peer-led workshop designed specifically for people living with HIV/AIDS and their support people.

We will build on existing provider collaborations and assist in the formation of collaborations, where needed, to ensure providers across various domains (acute care, primary care, behavioral health, public health) work together to coordinate systems of care, leverage existing resources and identify and address unmet needs.

A.3.5.c.

EOCCO will create a Provider Encounter tool kit with contents that can be reproduced and used as needed in the PCPCH office and practice setting. The contents will include, but not be limited to, encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help for identifying literacy problems, information for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, language skill self-assessment tools, techniques for talking about gender and sexuality with a wide range of people, pain management across cultures, information about different cultural backgrounds, details on key legal requirements, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards" which serve as a guide on how to meet legal requirements, a bibliography of print resources, and a list of internet resources.

The Minnesota Complexity Assessment Method can also be used by clinicians to guide their assessment of potentially complex patients, to identify disease-related, social and socioeconomic barriers to improved health, and to craft care plans—often involving an expanded healthcare team and community support services—to meet patient needs. The approach is easy to use, promotes an enhanced understanding of the patient's situation, allows for more efficient/effective team conferences and facilitates the development of customized care plans.

A.3.5.d.

EOCCO will work through a local provider collaborative to help communities develop common pathways to identify members with complex needs, and develop multi-agency service teams and service plans. Any participating agency will be able to identify and make a referral to a complex-care team.

Additionally, EOCCO will identify members using predictive modeling, including risk scores for the entire spectrum of medical and preventive management support, through medical, pharmacy and dental claims analysis, member self-referral, physician referrals, nurse advice line and emergency department encounters, as well as internal referrals from case management and behavioral Health. Nearly all member and condition-specific interventions involve a provider component. The member-specific medical and pharmacy information we send to the member, is also forwarded to the member's healthcare provider to promote communication on the subject at the next office visit.

Our outreach to newly identified members will describe the services offered in the program, such as reminders for needed care (targeted at members with lapses in recommended visits, screenings and procedures, and sub-optimal medication adherence), and access by phone or email to multi-disciplined clinical staff to participate in one-on-one care management support. Those participating in formalized one-on-one support, and their care givers, receive regular sessions with clinical staff, as well as customized mailings and access to interactive

decision making tools and resources. Members are further stratified based on results of a Patient Activation Measure (PAM) survey. PAM is an evidence-based survey made up of 13 questions that assess an individual's knowledge, skills and confidence around managing their own health and healthcare.

Our health coaches use an interpreter service for members whose primary language is not English. Our language line service covers a wide variety of languages, but the most common request is Spanish. Member materials for each of our health coaching programs are comprehensive and, in 2012, we plan to translate the materials for our Diabetes Care Program into Spanish.

A.3.5.e.

Coordination of care for SMI members needing non-LTC services will be a primary function of our Community Health Teams. The CHT will help coordinate the interface with clinics and hospitals, and ensure that the LTC community is aware that the CHT is a resource they can use.

In addition, EOCCO will collaborate with service area partners to advocate the following psycho-social rehabilitative services:

- Community living supportive services which lead to independent living and recovery
- Peer specialist supports
- Supported employment

A.3.5.f.

Working with our service area partners, we will create Community Health Teams CHT's staffed by an appropriate number of care management staff and non-traditional health workers (NTHW). The NTHW's will consist of Community Health Workers (CHW), Peer Wellness Specialists (PWS), and Personal Health Navigators (PHN) who have completed Oregon's 80 hour certified curriculum. The CHT's will be based in each county and may cover more than one county to optimize their impact. By offering proactive, personalized prevention and wellness care through a designated care management team, we expect participants to see improvement in the quality of life, and the plan to experience a reduction in the number of emergency care services and utilization of other unexpected healthcare that would have been required in the past.

A.3.5.g.

Upon initial enrollment, all members will receive a welcome letter with a PCP selection card. Following this mailing, we will send a welcome packet with tools to assist the member in their PCP selection. This packet includes a member handbook (in their primary language) with a directory of participating providers who are accepting new patients. Each mailing instructs the member to choose a PCP by either calling customer service or returning the PCP selection card. PCP's that have a relationship established with a new member help them select the PCP's office or clinic as the member's PCP of record. Members are advised that EOCCO will choose a PCP located in their community on their behalf if one is not selected within 30 days.

All new members will have adequate access to PCP's, specialists, hospitals, pharmacies (including medication refills prior to establishing care with a PCP) and all other services provided by the Oregon Health Plan prior to establishing permanent care with a PCP.

Any PCP can see new members and write referrals for them until permanent care is established. If a member has an urgent need for specialty care and has not yet established care with a PCP, the ENCC can write a referral for the member.

A.3.5.h.

It's important to EOCCO that all members are established with a primary care provider on enrollment. New plan members receive an identification card, member handbook and a health risk assessment (HRA) questionnaire. The handbook, provided in the primary language of the household, is a comprehensive introduction to the plan and includes a provider directory that identifies languages spoken in the provider office. Our welcome letter asks members to select and become established with a primary care provider. If the selection does not take place within 30 days of enrollment, we appoint a PCP for the member.

Our exceptional needs care coordinator uses a number of ways to identify OHP members who may require ENCC services: HRA's, monthly OHA eligibility reports, our utilization review process when a DMAP member is admitted through the emergency department, our monthly claims report for members who have reached the threshold for accumulated paid charges, referrals from providers, case workers, and internal referrals. The ENCC nurse assesses individual care needs case by case to determine the appropriate level of service or care. Assistance ranges from coordinating post-hospital discharge care for neonatal intensive care babies to educating members who do not have a primary care provider, from helping members find a medical home to referring members that need dental care to our OHP dental coordinator. In all cases, to the extent possible, the ENCC ensures access to the providers who can appropriately meet the individual's cultural and linguistic needs. Providers are encouraged to contact us when interpreter services are needed during an office visit, which we arrange at no cost to the provider or member.

To assist in conducting culturally- and linguistically-appropriate health screenings we will create a Provider Encounter tool kit with contents that can be reproduced and used as needed in the provider setting (See response A.3.5.c).

A.3.5.i.

EOCCO care coordinators, case managers and ENCC actively participate in discharge planning and follow members' care as they transition from one setting or location to another. Wrap-around services and Assertive Community Treatment help members with serious behavioral conditions successfully navigate transitions of care.

Transitional care will be closely coordinated with EOCCO's Community Health Teams (CHT). An important component of this close management for care transition and all actions of the CHT is the Health Information Exchange which will be ran by Gorge Health Connect (GHC) for EOCCO. GHC will enable the CCO to facilitate electronic health information exchange in a way that allows all providers to exchange patients' health information with any other provider in the CCO. In order to identify high-risk and high-cost patients who demand greater care and more focused care resources, the aggregation of data at a community level will be provided.

Additionally, the CHTs are composed of members within the county they serve. A key role of the CHT is to develop and/or build on existing relationships with the PCPCH, LTC facilities, behavioral health, social service and community service organizations. The intent is that by the time transitions of care occur for at-risk members, the CHT will know the member and their family or support system. The CHT will have been in close contact with the member and their care providers about the specifics of the member's situation. As with all at-risk members, services will be wrapped around the member as necessitated by changes in their state of being and/or their living situation.

The CHTs will insure clinical transitions are smooth but will also assist where social services are needed. There are a variety of options based on the county of residence. Therefore, in partnership with the CCO local governing entity, care providers and the local Clinical Advisory Board (CAP), agreements and protocols will be established to assure facilities will be contacting the CHT for involvement in creating consistency of care through the transition.

EOCCO Care Coordinators will hold joint staffing meetings to review common patients, problem solve and develop joint care plans. The EOCCO will establish procedures for sharing information (i.e. simple lists) of recently discharged patients.

A.3.5.j.

We will develop an MOU with each local APD office detailing care coordination and the exchange of information for members in LTC. Comprehensive care teams will include APD and LTC staff to ensure coordinated care and smooth transitions.

A.3.5.k.

EOCCO will use Community Health Teams to assure close work with the member, their family and all members of their community of care. The Community Health Team (CHT) is based on the model used in Intensive Children's Treatment Support (ICTCS) teams. All placement or discharges to higher levels of care would go through the Community Health Team working with the patient centered primary care homes. The patient and family are ideally involved in the CHT treatment planning. The non-traditional health care worker is available to both the CHT and the primary care homes. The NTHW works with the patient, family and community support members identified by the patient and family during transitions to ensure a connection of all involved parties. If the patient is placed outside the community, then weekly communication using Skype or personal visits are used to ensure the length of care is appropriate for the needs of the patient and that wraparound services are in place prior to discharge.

Our Community Health Teams use a clinical database to effectively track member transitions. In addition to housing member contact information and the names of family and other support team members the database provides automated reminders of required tasks. Through the Health Information Exchange (to be provided by Gorge Connect) technology tools will be used to support ongoing real time data imports which can be incorporated into care plans. Information will include up-to-date community shared information encompassing all aspects of the member's care, including transitions of care. Backing up the clinical database will be the Community Health Teams who will be the primary contact to track member transitions. Therefore, one of EOCCO's first tasks will be the creation of agreements and protocols to assure contact with the Community Health Team care coordinator and use of the patient registry. Embedded in the registry will be the individual care plan which will have reminders, goals and plans specific to each member. Family member contact info and case narrative info will allow the CHT's to monitor and intervene with all entities.

A.3.5.l.

The care coordination team is currently comprised of an RN Case Manager (CM), ENCC nurse, and support staff who work directly with members requiring intensive care

coordination. This team proactively identifies members though review of Health Risk Assessments, claims information, ED reports and utilization management processes, as well as communication with the member's providers and community care team. Each member identified for intensive care coordination is assigned to the RN CM. The CM works directly with the member and the community care team to perform an assessment and develop an individualized care plan, which includes goals and coordination of community-based services. The care plan also includes coordination of mental illnesses, as identified. In addition, our care coordination team will be continuously evaluated to determine if additional team members should be added to improve EOCCO's effectiveness in improving patient outcomes.

A.3.5.m.

Upon enrollment, EOCCO will ask all members to complete and return a Health Risk Assessment (HRA). Each HRA is reviewed by our ENCC for exceptional care needs. We also promote and support screenings in the primary care setting, including SBIRT and ABCD. We further analyze claims data, including large claimant and frequent use of emergency or urgent care services, to assist in the identification of members with exceptional needs. Additionally, we plan to use the Chronic Illness & Disability Payment System (CDPS), the public domain tool used by the OHP, to calculate a risk adjustment score for the EOCCO population. We will combine and classify OHP-provided encounter data and fee-for-service data into the disease categories specified in the CDPS, using primary and secondary ICD9 codes on each claim. A predictive risk report provides measures of a patient's risk of high healthcare expenditures relative to other Medicaid patients. Risk measures are calculated for the following: ambulatory-sensitive conditions (diabetes, respiratory diseases, heart diseases, and gastric diseases); mental health and substance abuse care; functional status (limited activities of daily living); and healthcare utilization (outpatient, ED, inpatient, and prescription drug use).

We will coordinate with APD and LTC providers to ensure that the healthcare needs of members receiving LTC services are identified.

A.3.5.n.

EOCCO will coordinate with APD offices and LTC providers as described in A.3.5.m and A.3.7.a to ensure risk assessment and screening information is used to identify members' individual care needs.

A.3.5.o.

EOCCO will develop individual care plans that are based on goals developed between the member, the primary care provider, potentially a mental health clinician, and the CHT Care Coordinator. Priority will go to those members with higher disease burden and complexity as determined by risk scores and assessments. Workflows will be developed to assure members with the most urgent needs are given top priority. On a member-specific basis, the workflows assure that issues are addressed in a prioritized manner to identify treatment gaps of highest urgency.

The members comprehensive care teams will meet according to an established schedule to evaluate progress toward identified treatment goals, strengths, resources and barriers. The member and/or family are critical to the care team. They participate in the care planning process and provide input on identification of the appropriate team members to meet their needs. EOCCO will play an active role in communication with the healthcare team, the member and/or family. Assigned EOCCO staff will participate in regular cross functional team meetings as well as by phone or in writing, as needed, when there are changes in the

member's health status. Additionally, the clinical database program provides automated and configurable reminders to the EOCCO inpatient RN care coordinator, RN case manager, ENCC nurse, and support staff to ensure regular follow-up with the member. Member's with high needs or at high risk will receive the most frequent assessments.

Community Health Teams (CHT) will be staffed by Care Coordinators and Oregon's new non-traditional health workers (NTHW), Community Health Workers (CHW), Peer Wellness Specialists (PWS), or Personal Health Navigators (PHN).

Each community advisory committee will be involved in defining the characteristics of a NTHW needed to meet the specific geographic, cultural and linguistic needs of their county population. Based on those characteristics EOCCO will work with the local governing group to solicit applications from the community as a whole. A local hiring committee will make the selection process.

The newly hired individuals will be supported in taking the 80 hour community college class, which will be offered online and face-to-face through Oregon Community College Consortium Healthcare Education Alliance (CCHEA). While taking the course, the NTHWs will also engage in a local community orientation with the community partners to learn about the services available in their community.

As the rest of the Community Health Team is developed through the addition of Care Coordinators and any other identified, needed resource staff, team members will be identified for further training. Training resources will be identified or developed to customize the NTHW's expertise as either a CHW, PWS and/or PHN.

A.3.5.p.

APD and LTC staff will participate in members' comprehensive care teams. The ENCC will communicate with APD and LTC staff regarding members' treatment needs as provided for in the MOU (see A.3.7.a).

A.3.6. Care Integration

Mental Health and Chemical Dependency Services and Supports

A.3.6.a.

EOCCO has a demonstrated ability to successfully engage providers to service the wide variety of culturally-, linguistically- and socially-diverse backgrounds of our members. We currently have providers in each county that provide mental health, chemical dependency and recovery management services that are specific to that county's diverse population, resulting in local care that is specific to local needs. This allows members to truly have individualized and integrated care regardless of levels of symptoms and condition severity, all of which are in compliance with Oregon State rules and regulations.

To facilitate this we also collect and maintain information from our providers regarding ethnicity, languages spoken, age groups served, and the ability to provide services specific to members with various religious affiliations. We use this information to help members identify providers best able to meet their needs.

A.3.6.b.

EOCCO affiliates GOBHI and ODS have extensive experience providing care coordination to members with serious mental health and chemical dependency conditions. Treatment planning will consider the appropriateness of enhanced support services available under State's 1915(i) State Plan Amendment, as well as natural community supports. GOBHI currently partners with Chemical Dependency providers. Many of GOBHI's current behavioral health organizations include chemical dependency services. Coordination exists as demonstrated by: prevention services (school and community based programs), outpatient services (individual and family counseling, group counseling, transition housing, pain management, co-occurring treatment for dual diagnosis, wrap around services, drug free housing, etc.), residential services (7 AOD Residential Programs that serve: Parents and Children, Adolescents and Adults that provide Co-Occurring treatment including social and medical detox, etc.), recovery services (person centered, family/ally involvement, comprehensive services across the lifespan, services anchored in the community, strengths-based, culturally responsive, peer recovery support, ongoing monitoring and outreach, outcome driven, adequate and flexible cost, etc.).

GOBHI will continue member engagement in treatment and support services through connection with the Community Health Teams (CHT's). The individual is motivated by receiving: brief counseling, motivational interviewing, comprehensive physical and behavioral health screenings, stepped care, education, referral to self-help groups and/or appropriate level of care that is least restrictive, follow-up calls and individual driven treatment planning, etc. GOBHI addresses limited social support systems by providing an individual with a Community Health Team who works with everyone that the client has identified as a support to them, or who meets identified needs (e.g. various community providers, clergy, family, friends, professional providers, teachers, mentors, etc.).

A.3.6.c.

EOCCO provides integrated care and service delivery by proactively identifying members utilizing various modalities: SBIRG, patient registry/"hot spotting," ED and hospital referral, behavioral health referral, schools, Department of Human Services, community programs and the various legal systems/entities. We arrange and facilitate the provision/coordination of care by the Individual Health Care Teams and Community Based Client Care Teams, which includes some of the following components: care management, peer-delivered services, home visits, family involvement, wraparound services, safe and drug-free housing, employment/education support, child care, telemedicine, Skype, P2/NOCCS, ICTS and Self Help. We will coordinate care with other related health services through the Community Health Teams and LTS LTC coordination, as specifically addressed in A. 3.1.d and A.3.5.i.

A.3.6.d.

We have developed, or are in the process of developing, Integrated Care Coordination teams within each of the EOCCO counties. These provide an organized system of integration with mental health, chemical dependency and primary care services across all systems and at all levels of care. Within our catchment areas, we have strong partnerships with culturally-diverse community-based organizations, such as Tribal organizations, minority-based organizations and faith-based organizations. We also access bilingual counselors and programming, as well as translators, when needed.

Oral Health

A.3.6.e.

EOCCO intends to enter into contractual relationships with each DCO serving members in the EOCCO service area. We intend that these contracts will be completed by January 2013. We have the following goals for these relationships:

- To establish clinical data-sharing arrangements to assist in the analysis of utilization and establishing care coordination plans for EOCCO members among physicians, mental health providers and dentists.
- To aggregate and jointly analyze utilization data from EOCCO and contracted DCO's to assess the unique community needs in the counties served by EOCCO, and to use this data analysis to plan community-focused programs, projects and related interventions that require the cooperation and coordination of EOCCO and DCO providers.
- To establish key performance measures for select populations and diagnoses where the coordination of oral and physical health care can most impact the health of EOCCO members and the overall population. Initially, this will be joint undertakings to assure access and appropriate treatment for pregnant women, children and adults with oral health conditions that may deteriorate and cause unnecessary use of hospital emergency services.

A.3.6.f.

EOCCO affiliates have longstanding relationships with local Dental Health providers and will collaborate with representatives from the Eastern Oregon dental community in its planning and organizational process to establish dental homes for regional EOCCO members. DCO's will be encouraged to join the EOCCO governance and individual dentists will be encouraged to participate in its community advisory councils and community-wide information sharing infrastructure. This approach will allow for better collaboration and coordination of dental care and services alongside the member's other health care needs.

EOCCO will work with both Advantage Dental Service and ODS Dental for the delivery of oral health care to members in respective EOCCO counties. Both organizations have been working to enhance dental care for OHP members for over 16 years. Each entity has a network of contracted dental providers across the EOCCO service areas.

Along with its providers and clinic, Advantage Dental has a 24 hour 7 days a week after hour's on-call system to meet the emergency and urgency needs of its patients. Advantage Dental will continue its prevention and general oral health care by having dental hygienists screen children in schools, the HeadStart, and Women Infants and Children (WIC) programs for cavities and by applying fluoride. Advantage Dental will coordinate care with behavior health, physical health and the hospitals to reduce the use of emergency rooms, operating rooms and medications by diverting patients at the right time, to the right place, and for the right care.

ODS Dental has a 24 hour 7 days a week after hour's on-call system to meet the emergency and urgency needs of its patients. ODS Dental will continue its prevention and general oral health care through our contracted dentists. They will continue programs for prevention of

cavities and by applying fluoride. ODS Dental will coordinate care with behavior health, physical health and the hospitals to reduce the use of emergency rooms, operating rooms and medications by diverting patients at the right time, to the right place, and for the right care.

In addition, EOCCO will review dental-related emergency department claims for OHP medical members. The purpose of the review is to ensure appropriate emergency department use and to identify possible access issues to dental providers. An Exceptional Needs Care Coordinator (ENCC) nurse will forward all dental ED claims to the medical director for review, and provide guidance to the member when the services are determined inappropriate for the ED.

If the OHP medical member has ODS OHP dental coverage, the ENCC nurse will refer the case to our OHP dental coordinators, who collaborate with primary care dental offices to authorize and locate access to dentally necessary treatment. In addition, when a member needs to have dental treatment performed in the hospital, our OHP coordinator locates a qualified dentist who has hospital privileges, and coordinates communication between the treating dentist and the member's medical plan to prior authorize the outpatient hospital dental treatment.

EOCCO members also have access to experienced dental health coaches (dental hygienist) to explore oral health concerns, lifestyle issues or other health related questions. The ODS Dental Care program provides support with:

- Questions about periodontal disease
- Questions about specific dental procedures
- Developing healthy habits to improve oral health
- Understanding how oral health affects ones overall health, including chronic conditions

The Dental Care program also offers presentations in the community about the oral health-systemic heath connection. Dental health coaches are available to attend workshops and health fairs in workplaces, schools and in partnership with community agencies to build awareness and share information.

The Baker County Oral Health Collaborative (Oregon Rural Practice-based Research Network (ORPRN) and the Practice-based Re-search in Oral Health (PROH) Network) work collaboratively to address the community's oral health challenges. Community leaders have identified three goals.

- To quantify the severity of oral health problems and unmet dental needs in the community
- To share findings with other community partners and identify feasible and sustainable solutions
- To target funding sources, implement short and long term solutions, and to evaluate their "success"

Hospital and Specialty Services

A.3.6.g.

We will help develop, implement and participate in activities that best support a continuum of care that is seamless and whole to the member. We will provide adequate, timely and

appropriate access to hospital and specialty care for members. We are also committed to improving the flow of information across all lines of health intervention between CCO providers and hospitals. Within our agreements with hospitals and specialty care providers, we will build in provisions for the following:

- Financial support and rewards/incentives consistent with evidence-based health services research and improved patient outcomes
- Standard quality measures that appropriately reflect the delivery of the services
- Collection and sharing of data with all involved providers to help support accurate and reliable quality measures
- Shared electronic medical records
- Communication system that notifies physicians when their patients are admitted to the hospital
- Shared incentives between providers and hospitals
- Instructions for providers and hospitals to coordinate care are covered in the Medical provider manual.

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

A.3.7.a.

We will develop an MOU with each local APD office. The MOU's will specify procedures for sharing information to identify members with complex care needs. Comprehensive care teams will include APD and LTC staff. We will explore options for collocating behavioral health staff in primary care homes and/or LTC facilities, as well as mobile clinicians to provide services where members live.

A.3.8. Utilization management

A.3.8.a.

Our UM activities are tailored to ensure the right care, at the right time, in the right place. Utilization criteria are flexibly applied to take into account members' emotional and cognitive abilities, support systems, and cultural and linguistic needs. UM for acute care is provided concurrently with same-day turnaround, while outpatient UM is performed via pre-authorization of services likely to be unnecessary, overused or misused.

Members are identified for overutilization via emergency department claim referrals and by clinical staff during the prior authorization and inpatient review process. Inpatient members with high needs or potential high need are referred to the OHP RN case manager or the ENCC nurse. The case manager and ENCC communicate with the member and their family, PCMH and community health teams regarding identified member needs and the plan of care.

Pharmacy reports for high cost or over utilized drugs are reviewed monthly and interventions are identified. The claims reports include members with high dollar claims or a trigger diagnosis. Each member identified requires a full assessment of their condition by the OHP RN case manager and/or ENCC nurse.

We identify underutilization through reviews of the member health risk assessment, health coaching referrals, referrals from clinical staff both internal and external to the CCO (hospital personnel, providers), referrals by family members and member self referral. SBIRT, and complex care teams are also used to identify unmet service needs. Each referral requires a

full assessment of member needs and risk level and contact with the member or their family as appropriate.

Requests for services are reviewed by clinical staff on a case by case basis using nationally recognized, evidence based, best practice guidelines specific to the level of care requested. The levels of care include inpatient and outpatient procedure review, inpatient level of care and length of stay review, outpatient home health, hospice, durable medical equipment, home infusion, and outpatient therapy reviews.

Section 4 - Health Equity and Eliminating Health Disparities

A.4.1.

EOCCO strongly supports efforts to increase quality and safely decrease costs, while reducing healthcare disparities and improving the health status of all population groups. We have instituted various approaches to tackling this issue which, in general, raise member awareness; improve cultural and linguistic competence; and develop, disseminate, and implement best practices to eliminate disparities in oral, physical and mental healthcare.

In addition, EOCCO's affiliate ODS is an active participant in the Disparities Leadership Program (DLP) led by the Disparities Solutions Center at Massachusetts General Hospital (MGH) in Boston, Massachusetts. DLP is an educational program that assists organizations in implementing practical strategies to identify and address racial and ethnic disparities in health care, particularly through quality improvement measures. ODS continues to engage in best practices-sharing in our mission to improve the health of communities by collaborating with its members and external groups to reduce healthcare disparities.

A.4.2.

We have taken steps to ensure that our reporting systems collect and analyze accurate demographic data to begin determining where disparities in health services exist. We have adopted minimum standard categories for racial and ethnic data, including enhanced and standardized data on the race, ethnicity, sex, primary language spoken and disability status of plan members.

Section 5 - Payment Methodologies that Support the Triple Aim

A.5.1.

EOCCO is committed to payment reform as a key strategy to correct the adverse incentives created by fee-for-service payments and to achieve the Triple Aim goals of health reform:

1. Improve the lifelong health of all members
2. Increase the quality, reliability, and availability of care for all members
3. Lower or contain the cost of care

We believe that primary care homes are instrumental in achieving these goals by coordinating the needs of patients through a single team of health professionals, providing comprehensive and continuous care for patients and their families, and keeping them healthy and out of acute care settings.

We are currently participating in several statewide medical home initiatives, including differentially incentivizing providers based on the risk of the population served, and the tier level achieved. We plan to work with our participating providers to achieve PCPCH certification.

EOCCO will use Symmetry ETG/ERG software to assign prospective and retrospective scores to members based on the diagnoses on claims and prescription history. These relative risk scores will be

used to stratify the population and to compare relative complexity of the population mix between providers. EOCCO will use this information to risk-adjust the per member per month (PMPM) rate within each PCPCH tier. The difference in the PMPM rates within each tier will be broken out by the top 25 percent versus the remaining 75 percent. Those in the top 25 percent risk-score category will be paid at the higher PMPM level.

Provision of Comprehensive Coordination or Shared Responsibility
The EOCCO practice delivery model will support the Oregon Patient-Centered Primary Care Home (PCPCH) model and development of community health teams (CHT's) in the Eastern Oregon region. The EOCCO is committed to coordinated care with specific attention to preventive care across all levels of service providers. The EOCCO will work with practices to provide electronic, real time notification of emergency department visits and hospitalizations.

The EOCCO community health team(s), working with existing care coordination staff in the twelve Eastern Oregon counties will work with both medical and dental clinics to track, monitor and support patients for effective care while avoiding duplication. The CHT is additional support for all care providers, whether medical or behavioral. EOCCO's CHT will invite local hospital, public health, public safety, education, non-traditional health workers, cultural representatives (if applicable) and social service workers to be participants in the teams and to help guide the unique development of the model in the county. The EOCCO will initially staff the CHTs based on the population density of chronic members.

Provision of Financial Support to PCPCHs
The EOCCO will develop a payment incentive system for establishment of or conversion to a PCPCH and related standards, i.e., providing comprehensive primary care that provides accessible care and ensures that all medical and nonmedical needs can be met. Practice incentives will be an adjustment to the direct payment model rate associated with the PCPCH payment plan. The PCPCH incentive rate will be based upon the incentive rate set by the State of Oregon for the CCO plan. Shared savings amounts may also be established.

To clarify, the PCPCH PMPM rate by tier is for all members not only those members with an "ACA-qualified" condition.

Alignment of Financial Incentives
EOCCO's commitment to ensuring coordinated care across all services includes a clear focus to utilize best practices and appropriate quality measures. The community health teams will include participation and input from providers and stakeholders knowledgeable with multidiscipline healthcare practices that will be merged with local coordinated care approaches. These practices will be based on scientific studies and clinical outcomes analysis studies.

Current, accurate, real time data is essential to data availability and access on (e.g., sharing patient data among providers) and for various data analyses to determine what works well and what does not so that adjustments can be made to the care system to maintain effective care and quality health outcomes.

Community Care Team Coordinators will play a pivotal role in managing clients with chronic conditions.

Section 6 - Health Information Technology

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

A.6.1.a.

EOCCO is a proponent of the state's Health Information Exchange (HIE) and will be proactive in implementing the HIE in our service area. EOCCO will use our HIPAA-compliant systems to aggregate different pieces of patient information into a care plan to identify potential duplication of services, and communicate with the various LTC providers on the members' behalf. As a long-time OHP mental health managed care organization, EOCCO affiliate GOBHI has established relationships with mental health crisis services and community-based services.

EOCCO affiliate ODS currently has significant capabilities in the utilization of Health Information Technology. Patient-centered engagement is performed using email and other mediums. We have a robust and flexible analytics program in place that provides drilled-down health-related data to our healthcare services team so they have comprehensive information for member engagement. Members can create and maintain a personal health record through the myODS portal. Other HIT initiatives are either in process or planned, including integration with provider practice management systems and other biometric data to provide the full view of a patient's health.

A.6.1.b.

There are three components to health IT infrastructure for the CCO: electronic health records, health information exchange and data management and analysis tools. The electronic health record (EHR) captures necessary patient data; supports care-related transactions, such as e-prescribing; and provides clinical decision support that will help ensure that evidence-based medicine is delivered and that providers are aware of the CCO quality and efficiency goals. The EHRs will be capable of supporting secure communication tools and functions that support multi-provider, team oriented care. EOCCO will explore coordinating EHR adoption efforts with the Regional Extension Center (REC) for Oregon O-HITEC. The purpose of O-HITEC is to furnish assistance – defined as education, outreach, and technical assistance – to help providers in Oregon select, successfully implement, and meaningfully use certified EHR technology to improve the quality and value of healthcare. Ensuring alignment of efforts with O-HITEC will be a key enabler of success for EOCCO network providers to adopt and achieve meaningful use of EHR's. There are also providers within the EOCCO network that are not eligible professionals under the EHR Incentive Program, such as mental health providers, longer-term care facilities, who will need additional assistance to implement EHR technology. EOCCO will facilitate a path towards adoption that will meet these rural providers where they are, while assisting in selecting and implementing appropriate technologies. Additionally, EOCCO will survey its contracted providers to determine current or planned adoptions of federal ONC certified EHR's, or to determine the current barriers to adopting an EHR.

A.6.1.c.

Through EOCCO affiliates GOBHI and ODS, EOCCO has two opportunities to share electronic information across its provider network.

ODS is currently a member of an existing Health Information Organization (HIO) managed by The Oregon Quality Corporation. This Quality Corporation database

currently has information for more than 60 percent of the Medicaid population. Quality Corporation generates quality improvement measures for primary care providers in Oregon using a comprehensive data system that includes claims and provider directory information. Quality Corporation creates customized quarterly utilization reports for groups participating in a medical home pilot project. Providers are given secure access to key information about patients in the intervention group including emergency department visits, inpatient hospitalizations, specialty referrals, prescription fills, etc. Quality Corporation also provides roll up aggregated data for the health plans participating in the project. Quality Corporation has developed a detailed project plan to add EMR data to supplement available clinical information in their data warehouse to more closely tie clinical care outcomes to utilization and efficiency outcomes.

EOCCO through GOBHI will explore utilizing the Direct-enabled Health Information Service Provider (HISP) services of Gorge Health Connect, Inc. (GHC), an existing Health Information Organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the EOCCO network using secure messaging developed under the Direct Project. GHC was deeply involved in the development of the Direct Project and one of the first Direct Project pilots in the nation. GHC worked very closely with the state to create strategic and operational plans for statewide health information exchange (HIE) and is well aligned with the phased approach the state is taking for HIE implementation. The HIE will allow EOCCO to identify those patients for whom they are accountable; possess master patient indexes that link a patient's medical record numbers among EOCCO providers; provide registry capabilities so the EOCCO can track the care provided to CCO patients; and assess the degree to which the EOCCO and its providers are appropriately managing cohorts of patients.

GHC will enable EOCCO to facilitate electronic health information exchange in a way that allows all providers to exchange patients' health information with any other provider within the EOCCO. In order to identify high-risk and high-cost patients who demand greater care and more focused care resources, the aggregation of data at a community level will be required. As the level of EHR interoperability and HIE increases, the data repositories of the EOCCO will expand to include data generated by multiple provider entities. EOCCO will use a HIE infrastructure provided by GHC which will enable the identification of patient populations and individuals in need of intervention based on current and historical health information in order to report on quality measures that support shared savings. GHC will provide secure messaging acting as the HISP for certificate management.

Integrating behavioral health into the GHC infrastructure will be an important step to improving health and lowering costs. Although behavioral health is a critical component of a person's overall health, mental health and some substance use treatment information is currently not integrated with physical health information. This creates significant gaps in health records, potentially leading to fragmented, lower-quality care. Being able to access and share complete patient health information, including both behavioral and physical treatment records across clinical practice areas, enables the creation of a longitudinal patient record, which can be valuable in providing a complete picture of an individual's overall health.

EOCCO

APPENDIX B – Provider Participation and Operations Questionnaire

Section 1 - Service Area and Capacity

Please see attachment document titled: Service Area Table

Section 2 – Standards Related to Provider Participation

Standard #1 - Provision of Coordinated Care Services

EOCCO will ensure that the capacity of providers is sufficient in numbers and types within all our service areas. We attempt to contract with a majority of all provider types available in each community. Our contracting teams continuously work to directly contract with providers to accept OHP members. This includes contracting with publicly funded programs such as Rural Health Clinics, Federally Qualified Health Centers, School-based Health Centers, County Health Departments and Tribal and Indian Health Centers. Each month, EOCCO will review the number of eligible OHP members and the number of contracted providers to determine if revised access standards are needed. See the attached Table B-1 for a list of participating providers. Please note that the providers in tab titled "In Process" are providers we are currently recruiting for participation in EOCCO. Any missing detail in these tables will be submitted as part of the readiness review. Please see Exhibit F for a description of how EOCCO plans to develop and maintain a network of Community Health Workers, Peer Wellness Specialists, and Navigators.

ADDITIONAL QUESTIONS ABOUT SPECIFIED INTEGRATED CARE SYSTEM COMPONENTS

Standard #2 – Providers for Members with Special Health Care Needs

Please see Exhibit G for a description of provider specialties that can serve members with Special Health Care Needs.

Standard #3 – Publicly funded public health and community mental health services

Please see the document titled: Publicly Funded Health Care and Service Programs Table.

(a) EOCCO affiliates GOBHI and ODS have held and will be holding several public meetings in the proposed service areas to educate the public about CCO's. See response A.II in Appendix A.

(b) As an MHO, EOCCO's affiliate GOBHI has developed contractual arrangements with all community mental health programs within the EOCCO service area. Additionally, GOBHI has contracts or memoranda of agreement with all local mental health authorities in its current EOCCO service area.

(c) As stated in response (b) above, EOCCO anticipates having signed agreements with counties as required by ORS 414.153(4)

Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN)

(a) EOCCO providers have served AI/NA individuals and families. Our experience in serving AI/NA, informs us that coordination of care services for AI/AN members varies greatly depending on an individual's Tribal enrollment and personal level of beliefs and preferences. Cultural preferences and practices are discussed with individuals and their families and service provision is adapted. We respect the role family members have in health decisions and the need to honor and integrate cultural practices in all health care. We recognize that some AI/AN individuals and families may travel back and forth to urban communities and reservation homes and we will utilize our HIE data repository to help with sharing information. We commit to building on our existing outreach to local tribal communities to further foster relationships, listen to health care needs and concerns, and to adapt our service delivery accordingly. As part of our overall commitment to cultural responsiveness and reducing health disparities EOCCO will enhance current services to AI/NA by implementing the following strategies in the first year:

- AI/NA health related cultural practices and beliefs will be included in trainings and cultural consultation will be made available.
- We will invite NA representatives to serve on community health councils and other governance bodies to develop structures that ensure the AI/AN voice in addressing health disparities and improving services to be culturally valued and relevant.

Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities

(a) We realize the complexity involved when working with Tribal Nations, and the need to develop formal and informal relations to effectively work together to ensure health needs are met. We will develop staff liaisons to reach out to each Tribal Nation to better understand specific needs, preferences and opportunities in order to

develop MOU's and contractual relations that enhance resources and improve healthcare outcomes. We are interested in contracting with Tribal Health professionals and paraprofessionals to ensure that the needs of AI/AN's that engage in any provider services are addressed with cultural relevance and sensitivity. We will pay contracted and non-contracted Indian Health Care providers for covered services provided to American Indians or Alaska Natives that are enrolled in our plan. We will pay non-contracted providers at rates equal to those paid to participating providers, and use the same criteria for approving referral or prior authorization requests.

Standard #6 – Integrated Service Array (ISA) for children and adolescents

(a) Each EOCCO county will provide community-based treatment services to all children, adolescents and their families who qualify for Intensive Community-based Treatment and Support Services. Presently, EOCCO's Affiliate GOBHI providers offer a full range of services to this population, which are coordinated by trained Family Care Coordinators (FCC's) with leadership provided by the GOBHI Regional Youth Program. GOBHI has developed a variety of flexible encounter codes to expand services that focus on addressing sensory integration, self-regulation, relational and cognitive health. EOCCO plans to expand on these efforts by developing additional Therapeutic Foster Care homes to aid in serving children and adolescents with severe mental or emotional needs. We will also focus on utilizing "family finding" services for children receiving ISA and those at risk of becoming Child Welfare charges. In addition, we plan to invest efforts on the assessment and treatment of infant mental health, including early identification of attachment and attunement between caregivers and their infants. Services will focus on trainings in child-parent psychotherapy, parent-child interaction therapy, and Neurosequential Model of Therapeutics for "first responders" and mental health clinicians. We also plan to create parent support partners and mental health specialists that can provide education and support to at-risk caregivers and their infants.

(b) Community Resource Teams (CRT's) are established for each child enrolled in Intensive Community Treatment Services (ICTS). These teams are comprised of relevant child-serving systems representatives, as well as family members and other persons important to the child/youth. The teams are the locus of decision making in which the child and family are supported by participants collaborating to achieve optimal outcomes. GOBHI is also a licensed child-placing agency and directly recruits, trains, and certifies therapeutic foster homes.

(c) The CRT is key to assuring that the ISA meets appropriate contemporary standards, and is the forum family members use to guide professionals in the provision of services that have a basis in the strengths of the child and family. The CRT can then deploy/develop services/approaches designed to meet the needs of the child and family. Several EOCCO counties currently participate in the EASA Program (Early Psychosis and Early Assessment & Support Alliance), which provides prompt screening services and ongoing service delivery, when appropriate. Families are also provided a significant level of support. EASA programs provide community education and outreach, and have strong relationships with community partners. EOCCO plans to expand this program in other counties.

Standard #7A– Mental Illness Services

(a) EOCCO's affiliate GOBHI has CMHP's in each of its counties that are contracted on a capitated basis to provide mental health services and share risk for expensive acute care and residential treatment services. GOBHI has successfully encouraged providers to develop a wide range of traditional and innovative community-based services to ensure that the mental health needs of members are assessed early in their development, and treated in the most natural, local and convenient setting appropriate. Traditional community-based services include 24-hour crisis assessment and intervention services; psychiatric assessment and medication management; individual, group and activity therapies; rehabilitative life skills training services and case management. Less traditional and innovative community-based services include peer-delivered services, mentoring, therapeutic foster care, community care coordination resource teams, and in-home family therapy and respite services. The effectiveness of this services array is demonstrated by the lowest psychiatric hospitalization rate in the state and significant savings.

(b) EOCCO's affiliate GOBHI has successfully encouraged its providers to develop a wide-range of traditional and innovative community-based services to ensure that the mental health needs of members are assessed early in their development and treated in the most natural, local and convenient setting appropriate to the needs and safety of the individual. EOCCO will continue to ensure mental health screening for all members via multiple avenues. All members are asked to complete a Health Risk Assessment (HRA) upon enrollment. The HRA includes questions related to depression. We will continue to provide education and screening tools to PCPs to ensure the

PCPCH effectively screens all members. For example, EOCCO affiliate GOBHI sponsors an annual Spring Conference in which training is provided to physicians, and other community partners in their service area. This year, the conference had 11 hours of American Academy of Family Practice Physicians approved CME. EOCCO will continue to encourage, monitor, and provide resources for PCP use of tools, such as the PHQ-2, PHQ-9, and GAD-7. Case Managers and Health coaches at EOCCO affiliate ODS routinely screen for depression using the PHQ-2. Informational packets and consultation will be offered to physicians with patients receiving high doses of pain medicines due to the heightened risk of depression with chronic pain. CHTs will be vigilant for members with un-met mental health needs via the hot-spotting process.

Standard #7B – Chemical Dependency Services

(a) EOCCO will engage with providers in its behavioral health network to provide flexible service plans appropriate to each individual's needs. We currently have providers in each county that provide mental health, chemical dependency and recovery management services specific to that county's diverse population. For members receiving home- and community-based services under the State's 1915(i) SPA, we will integrate chemical dependency services with each member's flexible service plan to optimize the effectiveness of services such as supported housing, supported employment, and peer supports. Our goal is to continue to provide individualized and integrated care, regardless of the level of symptoms and severity of condition that is in compliance with Oregon State rules and regulations.

(b) EOCCO affiliates ODS and GOBHI jointly promote the use of SBIRT in primary care settings. EOCCO will continue this effort and expand it into new service areas. Local collaboratives will provide a pathway for referral and follow-up for members identified in ED's or clinics that need chemical dependency services. Our claims algorithms identify members with frequent ED visits, as well as prescription patterns suggestive of substance abuse, and follow-up is available through our ENCC, case management program, as well as notification of primary care providers. We engage with providers in our behavioral health network to provide flexible service plans appropriate to each individual's needs. This will include home- and community-based services as needed under the State's 1915(i) SPA.

Standard #8 – Pharmacy Services and Medication Management

(a) ODS has successfully managed the Medicaid prescription drug benefit since 2006. Throughout the last five plus years we have administered a benefit that provides a comprehensive prescription drug program that balances the required flexibility of an evolving funding line for Condition/Treatment pairs. We will leverage this experience to administer the EOCCO prescription drug benefit. ODS will ensure that medications are dispensed only for covered services through our formulary design and utilization management provisions. Our clinical teams will routinely evaluate the prescription drug benefit to maintain alignment with the Health Services Commission Prioritized List. Medications that may be used for multiple diagnoses that cross the funding line will be evaluated through a Clinical Review process to confirm the medication will be dispensed for a covered service. These medications will reject at the pharmacy and require verification of the diagnosis from the prescriber prior to payment confirmation. To ensure member safety, we will institute an Emergency Medication Fill protocol to allow members access to small supplies of urgent medications that are undergoing Clinical Review.

(b)

- The ODS formulary promotes safe, efficacious and cost-effective drug products. Medications not listed on the formulary can be accessed through the prior authorization (PA) process under a clinical review. A clinical pharmacist will thoroughly evaluate all non-formulary drug product requests for medical necessity. In this review, the ODS pharmacist will collaborate with the prescriber to establish the medical necessity of the non-formulary drug product. Medical necessity may be established from, but not limited to, instances where formulary alternatives have been ineffective in treatment, or where other products are reasonably expected to cause adverse or harmful reactions to the member. ODS will provide access to non-formulary drug products upon establishment of medical necessity. Additionally, in a continued collaboration with the prescriber, ODS will present opportunities to utilize safe, efficacious and cost-effective formulary drug products when applicable.
- The ODS formulary is developed and maintained using an evidence-based methodology. The framework of this benefit structure incorporates comparative effectiveness research, such as the research of the Drug Effectiveness Review Project (DERP) under the direction of the Center for Evidence-Based Policy at Oregon Health & Science University. Individual products are evaluated from a comparative effectiveness perspective, with primary consideration given to member safety and therapeutic effectiveness. These extensive reviews identify safe and

effective drug products with at least one FDA approved drug product and OTC medications for each therapeutic class available for access with minimal prior approval intervention.

- The ODS formulary, including utilization controls, is developed and maintained using an evidence-based methodology promoting safe and efficacious drug use. The clinical evidence and standards of practice we gather from peer-reviewed medical publications, established national treatment guidelines and expert opinion contribute to the formation of utilization controls that guide safe and efficacious use. To stay on top of the changing healthcare demands, utilization controls are continually updated with new market safety and efficacy information. Utilization controls are employed for a variety of reasons. These are examples of some of our utilization provisions:
  Quantity level limits promote safe and efficacious drug use by aligning utilization with FDA approved dosing and administration guidelines.
  Prior authorizations (PA) ensure proper and safe use of drug therapy. PA's evaluate drug use with respect to guidance from the FDA approved indication, safety parameters, evidence-based criteria that align with the medical literature, and best-practice clinical guidelines.
  Step therapy utilization controls encourage the use of cost-effective therapeutic options as first line agents. Step therapy promotes the use of comparably safe and efficacious profiled drugs at a fraction of the cost of other agents.
- ODS' in-house clinical staff directs formulary management revisions in collaboration with MedImpact, our PBM partner. Depending on the goals of the program, revisions may be made as frequently as weekly to maintain alignment of the formulary with market changes and demands, new market safety information, and new clinical efficacy information. Active maintenance brings enhanced consistency and timely clinical updates to our formularies. The ODS formulary is developed and maintained using an evidence-based methodology. The framework of this benefit structure incorporates comparative effectiveness research, such as the research of the Drug Effectiveness Review Project (DERP) under the direction of the Center for Evidence-Based Policy at Oregon Health & Science University. ODS maintains a Pharmacy and Therapeutics (P&T) Committee to ensure quality through clinical and program management, and to evaluate prescription drugs for recommendations for formulary status. The P&T committee uses evidence-based criteria to create, review and revise drug formularies. Materials developed and presented to the P&T committee for consideration are compiled based on the following evidence-based parameters:
  Safety: member safety is the primary consideration for all formulary decisions.

  Efficacy: the potential outcome of treatment under optimal circumstances.

  Therapeutic Benefit: comparison of relevant drug benefits to current formulary agents of similar use, while minimizing duplications.

  Scientific Evidence: strength of evidence and standards of practice through review of relevant information from peer-reviewed medical publications, established national treatment guidelines and expert opinion, where necessary.

  Cost-Effectiveness: the actual outcome of treatment under real-life conditions, including consideration of total healthcare costs -- not just drug costs -- through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations, where available.

(c) The ODS/MedImpact Pharmacy Network is contracted with 726 of the licensed pharmacies in Oregon and over 63,000 pharmacies nationwide. With an average ratio of 20 pharmacies per county in Oregon, ODS looks forward to providing great pharmacy access to all enrollees. If we find that a non-network pharmacy is essential to providing care for the membership, we will solicit participation and work to enroll the pharmacy in our network. MedImpact, on behalf of ODS, will perform a custom pharmacy solicitation to contract with any requested pharmacies.ODS offers support for formulary changes/choices through individualized member communications that effectively explain changes that adversely impact the member's ability to access drugs. We communicate particular formulary changes at least 30 days prior to the effective date of the change. We use a variety of communication technologies to identify prescription drug coverage decisions and formulary changes for prescribers, pharmacies and members. Targeted communications are delivered to pharmacies and providers

through point-of-service messaging and/or facsimile. With the e-prescribing platform MedPrescription® providers with complementing technology will be able to access a comprehensive formulary and utilization provision listing that integrates real time with a web based e-prescribing software system. The MedPrescription® e-prescribing platform shares essential pre-prescribing intelligence between physicians and ODS/MedImpact, including patient identification, prescription eligibility, basic formulary, and medication history for consenting patients. Member notification is often provided through first-class mail as well as e-mail for applicable clients. Members can also proactively access formulary choices by using the Formulary Lookup tool available through our online member portal, myODS. The Formulary Lookup tool helps members determine what medications are covered by their prescription benefit. Members can search by a drug name or by a general therapeutic category and specific drug class. Within the search results, the formulary table shows whether the medication is formulary or non-formulary, as well as the generic availability of a product and/or lower cost alternatives.

(d) The ODS Rx pharmacy programs provide our customers access to real-time, point of service claims adjudication. Our claims processing and provider payment services are provided through MedImpact's MedAccess claim adjudication system. MedAccess is a proprietary claims adjudication system owned, operated and maintained by MedImpact. We use a single, integrated platform, eliminating the technical complexities that often plague PBM's with multiple systems from acquisitions and mergers. The claims system captures detailed clinical and historical data elements that can be used for utilization management and financial reporting. The adjudication software is tailored to the specific benefits structure of each group, and the claims administration system accurately establishes the defined benefit structure. Therefore, we can load indicators to ensure that the claim adjudicates based on eligibility and coverage The adjudication software then reads the appropriate benefit structure for each claim it receives. The software compares the benefit structure to the claim and evaluates the claim's eligibility and payment status.

(e) ODS manages all of our clinical programs locally. Our in-house clinical staff and prior authorization team oversee all clinical review and PA processing. Prescribers and pharmacies are able to submit requests for prior authorization 24 hours a day/ 7 days a week. Our team guarantees a turn-around time for emergency PA's within 24 hours and Standard Therapeutic PA's within 72 hours of receipt of necessary documentation to make a decision.

(f) ODS is in the process of negotiating new contract terms with our PBM partner, MedImpact, to take effect July 1, 2012. Outlined below are rates that we are currently offering. Revised rates will be relative and/or more competitive than outlined below. The administrative fee will be built into the target loss ratios. We would be happy to provide details on the breakdown of costs after we have developed the rates.

AWP Brand Discount	AWP-17%
Brand Dispensing Fee	$1.45
AWP Generic Discount	AWP-73%
Generic Dispensing Fee	$1.45

(g) The ODS 340B solution includes pharmacy contracting, plan design, compliance and own use account management functions. Our program is supported by a state-of -the-art system in which eligibility feeds into the PBM claims processing system on a daily basis. The automated system verifies that a prescription is on formulary, performs sliding-scale calculations, and can verify if a copayment/coinsurance is due at the point of service. We support a process that utilizes real time and/or retrospective claim review to identify eligible 340B transactions and automates the replenishment of dispensed drugs. A "lesser-of" technology will allow the EOCCO and its patients access to the lowest calculated pricing, including the fully-loaded 340B price, usual and customary, and our network rate. We welcome the opportunity to provide more information regarding our ability to support 340B administration.

(h) The Medication Therapy Management Program (MTMP) will provide adherence support, and apply the programs of the clinical teams of ODS Pharmacy Services and EOCCO to the PCPCH membership. The ODS MTMP outreach to targeted members includes a Prescription Drug Report Card to all identified members, and the opportunity to have a Comprehensive Medication Review with a nurse or pharmacist. ODS will be incorporating an additional provider report in 2012 to advance the collaborative approach of care for members.

Additionally, ODS' condition management program will assist PCPCH members who have multiple chronic disease states and utilize multiple prescription medications. The initiative is focused on improving the management of their medications and potentially decreasing their healthcare expenses. ODS registered nurses and pharmacists will reviewing select medication profiles, encouraging members to take their medications regularly, counseling on potentially adverse drug interactions, and mitigating gaps in care with their providers.

(i) ODS offers an ePrescribing platform (MedPrescriptions®) in partnership with our PBM partner, MedImpact. The MedPrescription e-prescribing platform shares essential pre-prescribing intelligence between physicians and ODS, including patient identification, prescription eligibility, basic formulary, and medication history for consenting patients. MedPrescription interfaces with an e-prescribing connectivity vendor to deliver pre-prescribing services to physicians of our members. These pre-prescribing services are used by physicians at the point of care to prescribe the most clinically-appropriate and cost-effective medications for their patients. Physicians are able to securely access patient-specific information using their practice's e-prescribing technology of choice, providing that technology has passed the certification requirements of Surescripts. Informed prescriptions can then be sent electronically to the patient's pharmacy of choice using the doctor's e-prescribing software.

Standard #9 – Hospital Services

(a) EOCCO's affiliate ODS has contracts in place with each Type A critical access hospital in each community we currently operate as an FCHP. This ensures that OHP members have the same hospital access as other people within the service areas. Due to the rural nature of the EOCCO, some services are not available locally, for example, neonatal intensive care services and severe trauma/injury cases. We have agreements in place with tertiary hospitals in Boise, ID, and in Walla Walla and Richland, WA, to cover the care of services not available at the local hospitals. We will take this same approach for our expanded service areas. We use evidence-based clinical care guidelines to determine medical necessity for procedures that require prior authorization, and for planned facility admissions. Hospital length-of-stay and level-of-care are reviewed concurrently using clinical care guidelines, taking into consideration the member's unique clinical condition. We perform inter-rater reliability for consistency of decision-making, ensuring all clinical staff are using the guidelines appropriately.

(b) On enrollment, we send an ID card, member handbook and a health risk assessment questionnaire to members. The handbook is available online, and provides a comprehensive introduction to the plan and information on accessing care, including after-hours care, and urgent and emergent care. Our handbook instructs members to call their PCP's with questions/concerns at any time, including after-hours and for urgent issues. Our health communication resources include interactive tools to assist with informed decision making and patient-provider communications. We analyze emergency department claims using the NYU Emergency Department Classification algorithm to identify patterns of preventable ED visits. EOCCO clinical supervisors review a monthly report that shows members with multiple emergency department visits, and develop member-specific action plans. We send educational materials to members who access emergency department services regularly, and are developing procedures to provide notification their PCP's. Member educational materials include information about accessing routine and urgent care in lieu of emergency care. The ENCC calls members who access ED services to discuss their treatment needs, identify potential barriers, and educate them about the resources available in lieu of the emergency department. .

(c) We have a policy and procedure in place, based on Medicare guidelines, which our healthcare clinical services team follows to identify potential adverse events and HAC's. We review all inpatient hospital claims that do not include a diagnosis at admission to track potential cases and outcomes. If there is a confirmed Adverse Event or HAC, the related claims are not paid.

(d) Hospital readmissions that happen within 30 days are reported and reviewed by case management. Specific diagnoses, based on national readmission rates, are flagged for post-discharge follow-up by the case management nurse, behavioral health clinician or health coach, depending on the severity and type of condition. A team consisting of a case management RN, ENCC nurse, and support staff follows these members to provide the most appropriate support and access to services. We are currently developing a Baker County Care Coordination Team. This team will work with members to assign a Clinical Complex Care Panel and choose an appropriate Client Care Team, based on their immediate clinical needs. Case management staff will participate on the Complex Care Panel, which will meet monthly to review utilization and systems issues that are barriers to services.

(e) EOCCO will address inpatient hospital costs in several ways based on an analysis of OHP hospital admissions by diagnosis and admit type. The largest components of cost are associated with pregnancy and childbirth, and respiratory care. The bulk of our focus will be in these categories. We are partnering with hospitals to implement the March of Dimes program to reduce c-section rates, and have a maternity care program that focuses on reducing pre-term infants and improving maternal and fetal health. For respiratory care, we will work with members who have chronic lung disease to help prevent exacerbations through better condition management, medication compliance and self care, and through a program that identifies members with chronic lung disease who have depression, which is shown to make exacerbations more frequent and severe. Other areas of targeted concern are admissions for gastrointestinal events and for kidney/renal disease. Here we are examining options for staged and transitional care with case managers to slow the progression of the severity of disease.

Section 3 - Assurances of Compliance with Medicaid Regulations and Requirements

1. **Medicaid Assurance #1 - Emergency and Urgent Care Services.** We maintain policies and procedures for access to urgent and emergent care services that are outlined in our provider manual. We monitor access issues through member complaints, which are reported to the OHA quarterly. We also evaluate access to urgent care services when we conduct our OHP practitioner on-site reviews.
2. **Medicaid Assurance #2 - Continuity of Care.** Our medical management team has policies and procedures in place that outline coordination of care and the process to arrange, document and track all referrals and prior authorization requests. We communicate these policies and procedures in the provider handbook and through information on our website
3. **Medicaid Assurance #3 - Medical Record Keeping.**. We are compliant with federal (HIPAA and HITECH) and state requirements for the protection of member information. We have in place administrative, technical and physical security safeguards to protect member data. Clinical records are maintained and protected in the same manner as other member information. Information is maintained for seven or ten years. Through our provider contracts, we require adherence to the federal and state mandates for recordkeeping, privacy and security. We also communicate the requirements in our Provider Handbooks. Through our Provider Medical Recordkeeping System Quality initiative, we proactively audit offices to ensure the requirements of the program are met.
4. **Medicaid Assurance #4 - Quality Improvement.** Our QI initiatives are documented in an annual work plan and evaluated for their outcomes and effectiveness in a written annual evaluation. Using the eligibility data provided by the OHA in 2012, we will begin to track and report outcomes by race and language for our quality improvement initiatives. We use our provider contracts, provider manual and electronic communications to inform providers about our quality improvement program, policies and procedures. We use a number of methods to monitor provider compliance with our quality improvement program: credentialing monitoring, review of potential adverse outcomes and "never events," and adherence to clinical practice guidelines and evidence-based medical management programs (medical, behavioral health, and pharmacy). We will work with our providers on a Quality Improvement structure that meets the needs of the EOCCO membership using our current QI experiences as a model to move forward.
5. **Medicaid Assurance #5 – Accessibility.** We have policies and procedures and a monitoring system in place to ensure members have access to an adequate network of providers that practice as close to where the member resides as possible. We also have provisions in place to provide services that are not available locally. EOCCO requires its contracted health care professionals to ensure that OHP members receive the same level of care and access to service as non-OHP members. Discrimination against members is expressly prohibited under the terms of our participating provider agreements.
6. **Medicaid Assurance #6 - Grievance System.** We update our OHP complaint and appeal policy each year according to the current OARs and feedback from the OHA. Quarterly, we analyze and report complaints and appeals to the OHA and our Medical Quality Improvement Committee. Our provider manual includes information on our grievance system and how providers can assist members in filing grievances or appeals.
7. **Medicaid Assurance #7 - Potential Member Informational Requirements.** We will make information materials available to any individual or potential member who requests it. Informational materials include, but are not limited to, the EOCCO member handbook, provider directory (including alternate languages spoken by providers and clinics) and a copy of the drug formulary. The member handbook will be provided in the requested language or alternative format of the potential member. Informational materials can be located on the website or by calling customer service.

The member handbook and provider directory are approved by the DMAP materials coordinator to ensure information is written in a culturally-sensitive manner and meets the font and reading level requirements of the OHA.

8. **Medicaid Assurance #8 - Member Education.** We have policies, procedures and processes in place that support the requirements of OAR 410-141-3300. We provide members with plan orientation information, which includes a welcome letter, ID card and member handbook/provider directory within 14 days of the member's effective date. The member handbook is sent in the primary language of the household. We ensure that the handbook meets the informational requirements of OAR 410-141-3300, and that it is reviewed and approved at least annually by the DMAP materials coordinator. For existing members, we provide an annual notice of their rights to request a copy of the member handbook and provider directory.
9. **Medicaid Assurance #9 - Member Rights and Responsibilities.** We have a member rights and responsibilities policy and procedure in place that supports the requirements of OAR 410-141-3320. Member rights and responsibilities are communicated in the member handbook and in the provider manual.
10. **Medicaid Assurance #10 - Intensive Care Coordination.** We have policies and procedures in place that support the requirement for Intensive Care Coordination (ENCC) services. We provide collaborative, integrated intensive care coordination for members who are aged, blind or disabled, have complex care needs, high-health needs, chronic multiple conditions, chemical dependency or mental illness, including members with severe and persistent mental illness receiving home and community based services. The coordination of care for these members is discussed in case rounds with a multidisciplinary team, led by the medical director.
11. **Medicaid Assurance #11 - Billing and Payment Standard.** We will comply with OAR 410-141-0420 Managed Care Prepaid Health Plan Billing and Payment under the Oregon Health Plan. We will use our current software, FACETS Extended Enterprise system, a Trizetto product, to meet the following categories of requirements: member eligibility, including Medicare as primary payer; third party liability investigations based on system triggers; provider eligibility, fee schedule and payment information; authorization documentation and the ability to match claims to valid authorizations; meeting all claims payment requirements for both participating and non participating providers, including turnaround time requirements and requesting additional information when necessary; and tracking coverage of services through the Oregon Health Plan Benefit Package. This list is not exclusive, but representative of the broad categories required under the Billing and Payment Standard. We have policies and procedures in place that support the standards for processing claims and prior authorizations within the timeframes outlined in this OAR, as well as for submission of notice of action letters when services are denied.
12. **Medicaid Assurance #12 - Trading Partner Standard.** We have demonstrated experience working with the OHA as a trading partner for current MCO business. We have experience with completing business-to-business testing, and currently send and receive multiple HIPAA compliant transactions including 820, 834, 835, 837D, 837I, 837P and NCPDP pharmacy transactions. We will work with OHA on implementing any new standards required of CCO's.
13. **Medicaid Assurance #13 - Encounter Data Submission and Validation Standard – Health Services and Pharmacy Services.** Encounter data is created, validated and submitted on a monthly basis following all standards of the HIPAA 837 Encounter Data Submission process. We have a complete integrated and automated system to provide this encounter data submission on behalf of the OHP business.
14. **Medicaid Assurance #14 - Enrollment and Disenrollment Data Validation Standard.** Our core health information system is integrated between enrollment and disenrollment, utilization and claims and is able to collect, analyze, integrate, and report OHP and CCO member enrollment data. We have an extensive electronic eligibility file process which includes controls around processing daily and monthly files. We closely monitor the timeliness for processing enrollment and disenrollment data. Our electronic file processes include many checks and balances. Procedures are documented in detail in both the eligibility and information services departments. We have flexible reporting to support the standardized 834 enrollment format which enables us to report data as required.

EOCCO

APPENDIX C – Accountability Questionnaire

Section 1 – Accountability Standards

C.1.1. Background information

C.1.1.a.

HEDIS – The Healthcare Effectiveness Data and Information Set is used to evaluate the quality of care and service we provide for our members. It is an NCQA requirement for accreditation and is also used to evaluate our Medicare Advantage plan in the CMS star rating. We use HEDIS to measure progress and outcomes for our member care quality improvement projects. Examples are diabetes care, breast, cervical and colon cancer adult screenings, childhood immunizations, follow-up after mental health hospital stays, and Chlamydia screening. While we are not currently performing HEDIS for the OHP membership we will explore doing this for the EOCCO.

CAHPS – The Consumer Assessment of Healthcare Providers and Systems survey is a part of HEDIS and captures members' reports, experiences and satisfaction with specific aspects of care, providers, systems and prescription services.

HOS - The Health Outcomes Survey is currently administered to our Medicare Advantage members and provides a general indication of how well we manage the physical and mental health of our members. While we are not currently performing HOS for the OHP membership we will explore doing this for the EOCCO.

State childhood immunization rates – For the past several years, our health plan has participated in the Oregon Public Health Division's immunization performance measures. We have partnered with the Division to send parent/caregiver reminders for 20-month-old children who are due to receive specific immunizations, resulting in improved coverage and missed shot rates when compared to the baseline.

State asthma care performance measures – We participated in the Oregon Asthma Program's asthma performance measures initiative for the Medicaid population. While we've provided encounter data in the past, today all measures are calculated by the Oregon Asthma Program. Measures focus on emergency department utilization, outpatient follow-up to the hospital visit and medication adherence.

OHP performance measures – In 2011, we reported the HEDIS® Ambulatory Care measure for the categories of emergency department visits and outpatient visits by our OHP members in nine age categories, and will do the same in 2012.

Patient Activation Measure (PAM) – Used in our health coaching programs, PAM is an evidence-based survey made up of 13 questions that assess an individual's knowledge, skills and confidence around managing their own health and healthcare.

Services and programs reporting – We produce multiple reports to help us monitor and manage our services and programs and compare them to quality benchmarks. Examples of these activities include:

- Prior authorizations

- Medical management cost savings
- Behavioral health cost savings
- Health coaching/population health mailings
- Health promotion/wellness
- Complaints and appeals
- Provider credentialing

Reporting systems – Our reporting systems include the Facets claims platform, CareWebQI and CaseTrakker (medical management and case review systems), SAS Analytical & Reporting System, and Visual Cactus (our credentialing database). We also have partnership quality measurement and reporting systems, such as MedAssurant's Quality Spectrum Insight, HEDIS Advantage and Medical Record Review systems.

We provide data and quality measures to regulatory and accreditation agencies, including the State of Oregon, the NCQA, and the Centers for Medicare and Medicaid Services. We also provide data to our large group clients and consulting firms.

C.1.1.b.

We participate in the following external quality measurement and reporting programs:

- HEDIS (includes CAHPS) for our NCQA-accredited Oregon commercial PPO plan – to NCQA
- HEDIS (includes CAHPS and HOS) for our Medicare Advantage Part C plan – to the Center for Medicare & Medicaid Services (CMS)
- CAHPS for our Medicare Advantage stand-alone Part D plan – to CMS
- Medicare Advantage member grievances and appeals – to CMS
- eValue8 RFI – reported to the National Business Coalition on Health
- As an MHO, GOBHI participates in and cooperates with external quality measurement and reporting program, as mandated in MHO contracts, through ACUMENTRA.

C.1.1.c.

We conduct one-on-one education when a provider initially contracts with us to provide services to OHP members. It has been our experience that providers are most responsive to information about the specifics of the OHP program and guidance related to the applicable regulations and requirements. In addition, our provider manual clearly outlines our policies, procedures and performance expectations in the following areas:

- Covered services
- Medical management: referral process, prior authorizations, urgent and emergent services, inpatient admissions, utilization management, coordination of individual care needs and medical necessity criteria
- Credentialing that are based on NCQA, CMS and OHA standards
- HIPAA compliance
- Access to care and appointments
- Medical recordkeeping system
- Participation in our quality improvement program
- Member complaints and appeals
- Claims processing & editing guidelines
- Addressing diverse patient populations in a culturally competent manner

Clinics and hospitals contracted with ODS will be held to standard quality measure methodologies as defined by Quality Corporation. To assure these measures, which are reviewed annually, adhere to national standards, Quality Corporation considers measures as set by NQF, NCQA, and HEDIS.

C.1.1.d.

Quality Corporation currently provides more than two-thirds of all primary care providers in Oregon with quality reports, allowing them to compare their performance to benchmarks, assess variations in care, identify gaps in patient care, and implement systems for improving health care quality. Providers are also given secure web access to key information about patients including emergency department visits, inpatient hospitalizations, specialty referrals, prescription fills, etc. Aggregate quality scores for over 20 primary care measures are provided at the provider, clinic and medical group level, with comparisons to Oregon and national benchmarks. In the future, Quality Corporation has developed a detailed project plan to add EMR data to supplement available clinical information in their warehouse to more closely tie clinical care outcomes to utilization and efficiency outcomes.

Our provider web page has information about the effectiveness of our quality improvement program and our quality initiatives, such as HEDIS and CAHPS. It also has information about our care projects to help members with asthma, cardiac disease, diabetes and depression, and explains how we support our providers in these projects. In 2012, we will create an online provider newsletter that includes articles about our quality improvement initiatives.

C.1.1.e.

Our OHP member handbooks are written at a sixth-grade reading level, and are available in Spanish and English. The handbook currently instructs members to establish a relationship with a primary care provider, and to seek preventive and routine care. We plan to expand on this to include information about our quality improvement activities, and explain how members can participate in and help with our quality improvement program.

Our member web page provides information about the effectiveness of our quality improvement program and our quality initiatives on HEDIS and CAHPS. We also explain how we help members with asthma, cardiac disease, diabetes or depression, and how members are reminded about the importance of childhood immunizations and adult screenings. Please see our response in section C.2.1.e. which describes our quality program initiatives to better serve members with diverse cultural and linguistic needs.

C.1.1.f.

EOCCO will be taking an incremental approach to rolling out pay-for-performance metrics. We will use the 19 claims-based quality measures developed by The Quality Corporation, in conjunction with an additional set of clinical measures approved for clinics certified as PCPCH's. Clinics will be paid based on their PCPCH tier level and their treatment of members.

C.1.1.g.

We will use performance standards to assure that we are providing high-quality care at a lower cost, resulting in better health for all of our members. The following explains our current and future capacity to report on the listed accountability quality measures:

1. **Member/patient experience of care** – We use the CAHPS survey administered by the OHA to identify improvement opportunities in our members' experience and satisfaction with their providers, health plan and healthcare in general. We will continue to do so.
2. **Health and functional status** – To report on this, we will need to expand the health risk assessment (HRA) we mail to new OHP members to include these metrics. We will also need to enhance the collection and storage of HRA data to allow for systematic tracking and reporting on the health status of our OHP population.
3. **Rate of tobacco use** – We will use the CAHPS survey administered by the OHA to obtain the rate of tobacco use among our OHP population. We can also expand our HRA to include survey items about tobacco use. Enhanced collection and storage of HRA data will allow systematic tracking and reporting of the tobacco use rate among respondents.
4. **Obesity rate** – We can add height and weight metrics to our HRA so we can calculate the BMI of OHP respondents.
5. **Outpatient and ED utilization** – In 2011, we reported on 2010 outpatient visits for nine age categories within our OHP population. This year, we will continue to report on 2011 outpatient visits via encounter data. We can report ED utilization using the same process as the measure for potentially avoidable ED visits.
6. **Potentially avoidable ED visits** – We apply the NYU method of identifying potentially avoidable ED use, as well as the MEDICal list of ICD-9 codes for further analysis.
7. **Ambulatory care sensitive hospital admissions** – We are able to report this metric using encounter data.
8. **Medication reconciliation post-discharge** – We are able to report this metric via encounter data.
9. **All cause readmissions** – In year one, we will be able to report this metric via encounter data.
10. **Alcohol misuse – Screening, Brief Intervention, and Referral for Treatment** (SBIRT) – GOBHI and ODS are collaborating on a performance improvement project on SBIRT, focusing on our eastern Oregon service areas. We are able to report on SBIRT utilization via encounter data.
11. **Initiation & engagement in alcohol and drug treatment** – We will report on this metric in year one.
12. **Mental health assessment for children in DHS custody** – We are expecting that the OHA eligibility code will identify children in DHS custody, which would allow us to report on this metric via encounter and administrative data.
13. **Follow-up after hospitalization for mental illness** – We are able to report on this measure.
14. **Effective contraceptive use among women who do not desire pregnancy** – We will explore the collection of data relative to this measure.
15. **Low birth weight** – We would like to investigate this in terms of using vital statistics data to supplement our encounter data.
16. **Developmental screening by 36 months** – Since 2011, we have been participating in the collaborative OHP performance improvement project on Assuring Better Child Health and Development III, piloting the program in our eastern Oregon service areas. In year one, we are able to report on this metric via encounter data.

In addition, we have the capacity to collect race and ethnicity data provided by OHA upon enrollment for the reduction in disparities measure.

Section 2 – Quality Improvement Program

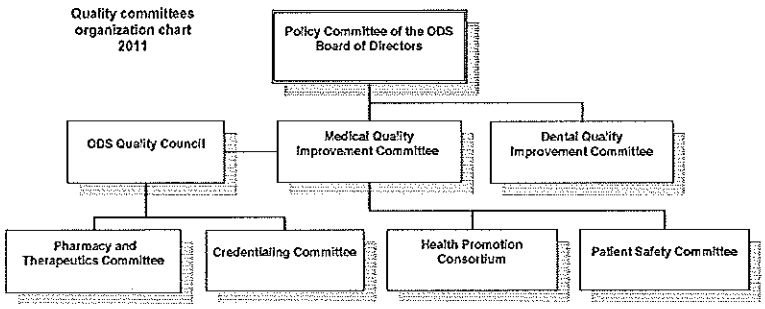
C.2.1. Quality Assurance and Performance Improvement (QAPI)

C.2.1.a.

On behalf of EOCCO the ODS Policy Committee, a subcommittee of the ODS Board of Directors, is responsible for the oversight of our quality improvement (QI) program. It delegates this oversight to the Medical Quality Improvement Committee (MQIC), which monitors and evaluates the healthcare and services provided to members to ensure that they meet current standards of medical practice and service guidelines. We use the Plan-Do-Study-Act (PDSA) model of continuous quality improvement for our QI initiatives. They are documented in an annual work plan, and evaluated for outcomes and effectiveness in a written annual evaluation. Our teams of departmental stakeholders are committed to providing the appropriate resources to ensure an effective quality improvement program. They plan, develop, implement and evaluate QI activities and report findings to MQIC. Our chief medical officer/senior vice president reports QI activities to the ODS Policy Committee at least annually. In collaboration with GOBHI and other provider partners, we will continue to build on this model.

C.2.1.b.

The ODS quality committee structure supports our commitment to maximize health outcomes, high-quality care and service to our members. At the end of 2011, the Committee relationships were as shown below:



MQIC's membership represents ODS' scope of services, and includes decision-making representatives and operational leaders from the majority of our departments. The committee is a decision-making body that has the authority and representation to implement quality improvement activities and initiatives it deems appropriate. In collaboration with GOBHI and other provider partners, we will build on this model.

C.2.1.c. We document our inter-departmental QI activities in an annual work plan, which is reported to MQIC. We update the plan each quarter. For the past 3 years, we have documented our QI activities — our initiatives, goals, outcomes and effectiveness — in a health plan-wide written annual evaluation. The findings of this annual assessment are used to guide the development and prioritization of our QI work plan for the ensuing year.

C.2.1.d.

Our community-based practitioners are important partners in our quality improvement program. Our Medical Quality Improvement Committee, which includes physicians, nurses, pharmacists and behavioral health specialists, monitors and evaluates the healthcare and services provided to our members to ensure that the care and services meet current standards of medical practice and service guidelines.

Our Quality Council is comprised of community clinical practitioners who serve in an advisory capacity to our clinical quality improvement projects, clinical or health coaching programs, clinical studies and program development involving community practitioners. Practitioners on our Quality Council represent the fields of internal medicine, family practice, emergency medicine, general surgery, cardiovascular and thoracic surgery, and clinical psychology.

Our Pharmacy and Therapeutics Committee is comprised of our chief medical officer, community-based physicians and pharmacists, and ODS clinical pharmacists and medical directors. This committee oversees drug formulary decisions to ensure the availability of safe and effective drug choices.

EOCCO will involve practitioners, members and culturally diverse community based organizations in our quality improvement program through the community advisory councils (CAC) established at the local level. We envision each CAC to be comprised of members of the regional governing board, county government, addiction and mental health service, social services and education organizations, local businesses and consumers. EOCCO will use the Community Health Needs assessments and engage the feedback, expertise and participation of culturally diverse community based organizations and leaders to develop our clinical and non-clinical quality improvement initiatives.

As outlined in the governance section, EOCCO will have a Community Advisory Council (CAC) in each county. The duties of the CAC will be as outlined in the CCO enabling legislation with the focus on ensuring the health care needs of the consumers and the community is being addressed. Additionally, each county will have a local governance structure which will include physicians, mental health, addictions, hospitals (if present), members of the community at large and a representative from the CAC. A representative from the local governance structure will be elected to the overall EOCCO board.

Both the CAC and the local governance structure are based in the local community. They will be involved in defining how to meet the specific geographic, cultural and linguistic needs of their county population. Based on those characteristics EOCCO will work with the local governing group to develop standards for local QI oversight, to include any cultural outreach, as needed to assure community cultural and linguistic needs are being met.

Other sections of this document address both member engagement and outreach along with specific actions to address health disparities (see response A.I.p). Additionally, EOCCO intends to provide cultural consultants to assist community groups and providers in assuring supportive outreach and involvement of communities with a diversity of cultures and languages. The EOCCO affiliates have a long history of including culturally diverse community-based organizations and members in its governance and operations, and there are many points of entry for any individual wanting to be involved in or informed about the

planning, design and implementation of EOCCO's quality programs. Local community advisory councils and local quality improvement committees will include representation by service utilizers and/or their families, and community stakeholder organizations. EOCCO's quality plans will be based on and informed by input and comment from all of these sources.

EOCCO is committed to ensuring that all members have equal access to all levels of healthcare, regardless of age, race, ethnic background, religious or sexual preference gender identification. All performance measures and indicators, including but not limited to, ease of access, utilization of services, referral to specialties, clinical outcomes and user satisfaction will be reported by age group, ethnic, racial and/or cultural category, and primary language of the member. EOCCO staff will analyze this data and present findings to the board of directors and the Quality Improvement Council (QIC). When inequities in healthcare utilization and/or outcomes are apparent, the QIC will recommend corrective actions to the board of directors. The QIC will monitor the implementation of appropriate corrective actions and report findings to the board of directors.

Local governing members, through their LQICs, may recommend or mandate corrective actions by providers who are failing to meet contract obligations or performance standards. When provider performance issues are identified, they will be reported to the EOCCO QIC with a description of the corrective actions that are being implemented. While monitoring for initial and ongoing effectiveness of corrective actions is the responsibility of the local governing members, EOCCO's QIC may require and/or provide additional monitoring to ensure the effectiveness of corrective actions.

EOCCO's QIC may also recommend, monitor and audit region-wide corrective action programs to address compliance or performance issues general to all or most providers.

C.2.1.e.

Our quality improvement program includes initiatives that results in better service to members with diverse cultural and linguistic needs, as well as those with complex health issues. Examples include:

- Assessing the adequacy of our provider network to meet the cultural and linguistic needs of our members and developing an improvement plan to better provide for identified healthcare disparities.
- Developing culturally-sensitive outreach programs and providing member materials in alternative languages, such as Spanish. Examples include "Your Growing Child" and "Understanding Developmental Screenings", which help parents comprehend the process and importance of developmental screenings.
- Training for our staff annually that addresses members' cultural diversity, including ethnicity, age-related concerns, linguistic/language needs and preferences, physical and mental disabilities and sexual orientation.
- Providing language-access services in our health coaching and medical management programs

- Providing multilingual customer service via a language line service and a dedicated phone number for Spanish speaking customers, and continually evaluating incoming calls to determine the need to adjust resources.
- Translating member complaint and appeal resolution letters into the member's primary language

Our care coordinators, case managers and exceptional needs care coordinators actively participate in discharge planning and follow members' care as they transition from one setting or location to another. Wrap-around services and Assertive Community Treatment help members with serious behavioral conditions successfully navigate transitions of care.

In addition, ODS is an active participant in the Disparities Leadership Program (DLP) led by the Disparities Solutions Center at Massachusetts General Hospital (MGH) in Boston, Massachusetts. DLP is an educational program that assists organizations in implementing practical strategies to identify and address racial and ethnic disparities in health care, particularly through quality improvement measures. ODS continues to engage in best practices-sharing in our mission to improve the health of communities by collaborating with its members and external groups to reduce healthcare disparities.

C.2.1.f.

Patient safety starts with credentialing, which is the process to determine whether a provider is qualified for initial or continued participation on the EOCCO panel. Our qualification process is comprehensive and includes a Healthcare Integrity and Protection Data Bank report to check the status of licensure and certification actions, exclusions from participation in federal and state health care programs, healthcare-related criminal convictions and civil judgments, and other adjudicated actions or decisions as specified in regulation. Our credentialing program also assures that our CCO providers have completed the state provider enrollment process, and have also been issued a Medicaid number for billing.

An established practitioner or provider on our panel is required to submit a re-credentialing application at least every three years for continued panel participation. To promote safe and appropriate care for our members, the Credentialing Committee performs ongoing monitoring of our contracted providers for quality issues, including the following:

- Malpractice claims history
- Medicaid/Medicare fraud, sanctions and exclusions
- Member complaints
- Site reviews as the result of complaints regarding access
- Potential adverse outcomes
- Quality-of-care concerns
- State and federal licensing disciplinary actions

The credentialing supervisor researches and records quality issues reported by various ODS departments and state licensing boards, as well as from site and medical recordkeeping survey data. Quality issues are filed using a four-tier concern classification system to ensure review at the appropriate level. The Credentialing Committee determines the initial placement of providers on the monitoring or peer review report, and, when all concerns have been satisfactorily addressed and reconciled, the appropriate removal from either monitoring or the peer review report occurs.

C.2.1.g.

Customer satisfaction: clinical, facility, cultural appropriateness – We assess member satisfaction with our services by continually evaluating member complaints and appeals. We customize each member response and disclose any further appeal rights within the timeframes allowed. We also systematically capture and analyze complaints and appeals for trends that show persistent or significant issues, which are reported quarterly to the OHA. Our data collection encompasses access, quality of care, interpersonal care, quality of service, issues relating to post-service appeals and prior authorizations. The objective of our analysis is to identify areas of dissatisfaction and implement initiatives/measures which will have a positive impact.

Periodically, the OHA has administered the CAHPS survey to help the system and each health plan evaluate members' experience and satisfaction with their health plan and with specific aspects of care, including access and primary and specialty care. We have used the CAHPS survey results to implement improvements, such as building on our primary and specialty care provider network, and developing information for our members to help them prepare relevant questions for routine office visits. CAHPS ratings between the surveys administered in 2007 and 2010 showed marked improvement in our scores for provider access and availability.

Fraud and abuse/member protections – We have a comprehensive fraud, waste and abuse detection and prevention program that is designed to detect any sort of fraud, waste and abuse activities. Our program prevents fraud by identifying emerging trends through collaboration with industry groups. If a provider engages in fraud or abuse, we take corrective action against the provider, up to and including termination.

Treatment planning protocol review/revision/dissemination and use with evidence-based guidelines – Our clinical team uses a number of medical management and clinical decision support tools each day to ensure the appropriate use of services. If a provider request does not meet our evidence-based guidelines, we reach out to the provider with appropriate education. Providers may also request a peer-to-peer conference with one of our medical directors. Our goal is to always work in tandem with providers to ensure we are meeting the medical needs of our OHP members. For example, we require chemical dependency providers to provide evaluation and treatment services using ASAM PPC-II-R guidelines. ODSBH clinical staff review ASAM assessments and follow up with the provider when there are questions regarding application of the guidelines or appropriateness of the proposed service plan.

C.2.2. Clinical Advisory Panel

C.2.2.a.

We will convene an active Clinical Advisory Panel (CAP), and the chair of the CAP will serve on the EOCCO governing board.

C.2.2.b.

N/A

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

C.2.3.a.

Our clinicians use clinical care guidelines and provide a summary of the relevant medical literature to offer assistance in evaluating diagnostic tests, determining condition-specific treatments, length-of-stay expectations, and many other aspects of clinical practice.

The systematic reviews that are built into evidence-based guidelines inform providers about specific circumstances in the clinical setting. Evidence-based guidelines can improve the quality of care for members by supporting interventions of proven benefit, while discouraging interventions that are ineffective or potentially harmful.

We use Patient Activation Measures (PAM) in our population health and coaching programs. PAM is an evidence-based survey comprised of 13 questions that assess an individual's knowledge, skills and confidence around managing their own health and healthcare.

C.2.3.b.

We currently use the following quality measures to determine progress in improved outcomes:

- **HEDIS**
- **CAHPS**
- **HOS**
- **State childhood immunization rates**
- **State asthma care performance measures**
- **OHP performance measures**

Please refer to section C.1.1.a. for further reference or details about these measures.

C.2.3.c.

On behalf of EOCCO ODS provides support for wellness and health improvement through a variety of channels, including online resources and mobile content accessible by all members. Through myODS, members have a wide array of web-based decision support tools, information, and resources to help them evaluate treatment options and navigate their healthcare, including the following:

- ODS eDoc – Allows members to email, call or use a mobile app for any non-urgent health concerns or questions related to treatment options and send them directly to board-certified physicians, pharmacists, psychologists, dieticians, fitness specialists and dentists.
- 24-Hour Nurseline – Provides help to members anytime for medical issues ranging from home-care remedies to recommended emergency treatment.
- Dental Optimizer – Is a personalized resource for assessing oral health risks and managing dental costs that impact overall health.
- ODS WorldDoc – Provides a health and symptom evaluator, the ability to take health assessments, medication management resources, as well as a medical library to get information on conditions and treatment options.
- ODS Pilot Rx – Offers prescription price checks and resource tools

These tools help members better understand the benefits and risks of a surgery or other medical procedures (such as an ultrasound or colonoscopy), while still following their provider's treatment plan. Members have easy access to the necessary resources to become better health care consumers and make more well-informed decisions. Behind the innovative tools and resources is a team of health experts – doctors, nurses, counselors, and coaches – who will make sure that members get the most from their health plan.

We provide a broad array of wellness services, including resources and tools to assist organizations in planning, designing and sustaining wellness programs. We can provide support at any point in the development process of their wellness programs.

We also partner with our providers to give support to members at every stage in their health, whether they are already fit or have a chronic health condition. We have easy-to-use online tools that provide continuous access to health-related decision support. Evidence-based care guidelines are used for a variety of population-based screening reminders and prompts when there is a gap in care, and when collateral and educational materials need to be sent to members with specific conditions.

C.2.3.d.

EOCCO's affiliate ODS has extensive experience collecting and reporting on performance benchmarks to demonstrate the value of the healthcare services we provide to our members. We have a team of five full-time analysts dedicated to collecting and reporting on healthcare services data, and seven additional analysts who evaluate performance and service utilization at the group level. Our reporting practice follows a strict peer vetting process to ensure the accuracy, integrity and quality of the data pulled for reporting.

Our reporting systems include the Facets claims platform, CareWebQI and CaseTrakker (medical management and case review systems), SAS Analytical & Reporting System and Visual Cactus, our credentialing database. In addition, ODS has several partnerships within the community to report rates of care and to work on improving the delivery of services.

We have the full capacity to collect the necessary electronic data, as well as the other data that will be required in order to meet the CCO performance benchmarks. ODS was among the first health plans and providers to fully meet the requirements of the State of Oregon's All-Payer, All-Claims (APAC) system. We are experienced in providing on-time data and quality measures to regulatory and accreditation agencies, including the State of Oregon, the NCQA, and the Centers for Medicare and Medicaid Services, as well as to our large group clients and consulting firms.

In order to maximize reporting of our performance, we utilize community resources, such as immunization registries, and perform periodic medical record review to access data that is otherwise unavailable. We also have the capacity to administer health risk assessments and member surveys for the collection of data.

C.2.3.e.

EOCCO will explore offering a clinical and operations support team within the service area for on-site and community-based services. This approach would incorporate a distributive-based model, acting as liaison for select high-risk individuals. The support services may take

place during office visits, in the home or during transitions of care, to facilitate adherence to the treatment regimen prescribed by the participant's primary care team. Our goals would be to:

- Target high-risk, high-cost members with co-morbid disorders
- Improve clinical and economic outcomes (i.e., morbidity and costs of care)
- Manage the most complex of the complex cases

C.2.3.f.

Continuity of care is assured by continued partnering with the PCP or PCPCH to collaborate on transitions of care. We communicate our policies and procedures in our Provider Handbook, and through information on the provider website. Providers are offered a peer-to-peer conversation with the Medical Director when there are questions regarding a referral or a prior authorization denial. Referrals and prior authorizations are tracked in our claims payment system.

EOCCO has detailed policies and procedures that require clinical documentation in the claims payment system of all referrals, and prior authorizations of services, including inpatient admissions. The inpatient admissions are documented for level of care and length of stay. Admissions also include documentation of discharge planning and transitions to post discharge levels of care. There are handoffs to an RN case manager or ENCC depending on the level of intervention and level of risk. This ensures a smooth transition and continuity of care. The internal team communicates with the providers and community based health teams on prior authorizations and identified needs/risks.

All transitions are in collaboration and communication with the community health team and specific to the member's care plan.

EOCCO policies and procedures include tracking of referrals, service authorizations, inpatient clinical review, post discharge follow up and referral to the next most appropriate level of care. Case management policies and procedures include documentation of member needs assessments, an individualized plan of care and updating the plan of care. Policies and procedures are in places that describe communications with members and providers on prior authorizations and referrals. A policy and procedure is in place for interrater reliability to ensure consistency of decision-making.

Creation of County-based Community Health Teams (CHT), are staffed by Care Coordinators and Oregon's new non-traditional health workers (NTHW), Community Health Workers (CHW), Peer Wellness Specialists (PWS), or Personal Health Navigators (PHN). Each community advisory committee, which includes care providers, social service partners and consumer members, will be involved in defining the characteristics of a NTHW needed to meet the specific geographic, cultural and linguistic needs of their county population. Based on those characteristics EOCCO will work with the local governing group to solicit applications from the community as a whole. A local hiring committee will make the selection process. The newly hired individuals will be supported in taking the 80 hour community college class, which will be offered online and face-to-face through Oregon Community College Consortium Healthcare Education Alliance (CCHEA). While taking the

course, the NTHWs will also engage in a local community orientation with the community partners to learn about the services available in their community.

As the rest of the Community Health Team is developed through the addition of Care Coordinators and any other needed resource staff, team members will be identified for further training. Training resources will be identified or developed to customize the NTHW's expertise as a CHW, PWS and/or PHN.

Service Area Description	Zip Code(s)	Maximum Number of Members Capacity Level
BAKER	97814, 97819, 97833, 97834, 97837, 97840, 97870, 97877, 97884, 97905, 97907	3000
GILLIAM	97812, 97823, 97830	250
GRANT	97845, 97848, 97856, 97864, 97865, 97869, 97873	1050
HARNEY	97710, 97720, 97721, 97722, 97732, 97736, 97738, 97758, 97904	1250
LAKE	97620, 97630, 97635, 97636, 97637, 97638, 97640, 97641, 97735	1300
MALHEUR	97901, 97902, 97903, 97906, 97908, 97909, 97910, 97911, 97913, 97914, 97917, 97918, 97920	7000
MORROW	97818, 97836, 97839, 97843, 97844	2200
SHERMAN	97029, 97033, 97039, 97050, 97065	250
UMATILLA	97801, 97810, 97813, 97826, 97835, 97838, 97859, 97862, 97868, 97875, 97880, 97882, 97886	14100
UNION	97824, 97827, 97841, 97850, 97867, 97876, 97883	4500
WALLOWA	97828, 97842, 97846, 97857, 97885	1000
WHEELER	97750, 97830, 97874	250

EOCCO

APPENDIX D – Medicare/Medicaid Alignment Questionnaire

Section 1 - Background Information – Inclusion of Dually Eligible Individuals in CCOs.

Section 2 - Ability to Serve Dually Eligible Individuals

D.2.1.

D.2.2.a.

ODS Community Health, Inc. is a subsidiary of ODS Health Plan, Inc. ODS Health Plan, Inc currently holds two contracts with CMS under contract numbers H3813 and S5975.

Contract H3813 has been in effect since September 1, 2005. Under contract H3813 we offer Medicare Advantage Preferred Provider Organization (PPO) plans in the community and also offer a Medicare Advantage Employer Group Waiver Plan (EGWP) to Oregon PERS (Public Employees Retirement System) retirees eligible for Medicare. The service area for these plans is the entire State of Oregon. ODS is currently the only statewide Medicare Advantage PPO operating in all counties in Oregon.

Contract S5975 has been in effect since the implementation of Part D on January 1, 2006. Under contract S5975 we offer an Employer Group Medicare Part D Prescription Drug Plan (PDP) to PERS retirees eligible for Medicare. The service area for this plan is the entire United States.

In order to provide Medicare benefits to dually eligible Members, EOCCO will apply for the 2014 demonstration plan. Additionally, we will take the proactive approach of filing a dual eligible plan with CMS for the 2014 plan year through our affiliate ODS Health Plan, Inc. This plan will be filed should the demonstration plan not move forward in 2014.

D.2.2.b.

ODS Health Plan, Inc on behalf of EOCCO will file a Notice of Intent to apply for the dual eligible plan with CMS by November 9th, 2012 and submit a CMS application for this plan in late February.

EOCCO will file a Notice of Intent to apply for the dual eligible demonstration plan with CMS and submit a CMS application for this plan as instructed by CMS.

We have the capacity experience and knowledge of operating a Medicare program and will be able to provide benefits to the duals in 2014.

D.2.2.c.

EOCCO will apply for the demonstration. As a backup plan EOCCO's affiliate, ODS Health Plan, Inc will apply for a plan to serve duals in 2014.

	A	B	C	D
1	**Name of publicly funded program**	**Type of public program (i.e. county mental health dept.)**	**County in which program provides services**	**Specialty/Subspecialty Codes**
2	Baker County Health Department	County Health Department/Public Health	Baker	64/505
3	Center for Human Development	County Health Department/Public Health/Community Mental Healt	Union	03/004
4	Grant County Health Department	County Health Department/Public Health/Rural Health Clinic	Grant	14/085
5	Malheur County Health Department	County Health Department/Public Health	Malheur	64/509,513, 5195
6	Wallowa County Health Department	County Health Department/Public Health	Wallowa	47/079
7	Baker HS SBCH	School Based Health Center	Baker	15/101
8	Mountain Valley Mental Health	Community Mental Health Program	Baker	33/369
9	Pine Eagle Clinic	Rural Health Clinic	Baker	14/095
10	Community Counseling Solutions	Community Mental Health Program	Gilliam	33/369
11	North Gilliam County Health District	Rural Health Clinic	Gilliam	09/056
12	South Gilliam Health Center	Rural Health Clinic	Gilliam	09/056
13	North Central Public Health District	Public Health	Gilliam/Wasco/Sherman	22/145
14	Blue Mountain Hospital	Hospital	Grant	14/095
15	Community Counseling Solutions	Community Mental Health Program	Grant	33/369
16	Grant County Health Department and Rural Health Clinic	Public Health	Grant	14/085
17	Strawberry Clinic	Rural Health Clinic	Grant	14/095
18	Harney County Health Department	Public Health	Harney	47/079
19	Harney District Hospital	Hospital	Harney	09/056
20	High Desert Clinic	Rural Health Clinic	Harney	14/095
21	Harney Behavioral Health, Inc	Community Mental Health Program	Harney	33/209 & 445
22	Symmetry Care, Inc	Community Mental Health Program	Harney	33/209 & 445
23	Lake County Mental Health	Community Mental Health Program	Lake	33 & 03/ 369 & 004
24	Lake County Public Health Dept	Public Health	Lake	47/079
25	Lake District Hospital	Hospital	Lake	26/ 165, 166, 168
26	North Lake Clinic	Rural Health Clinic	Lake	14/095
27	Lifeways, Inc	Community Mental Health Program	Malheur	33/092, 093, 207, 445
28	Malheur Memorial Health Center	Rural Health Clinic	Malheur	14/095
29	Columbia River Community Health Services	Federally Qualified Health Center	Morrow	15/081
30	Community Counseling Solutions	Community Mental Health Program	Morrow	33/369
31	Irrigon Medical Center	Rural Health Clinic	Morrow	14/095
32	Morrow County Health District/Heppner Clinic	Rural Health Clinic	Morrow	47/079

	A	B	C	D
33	**Name of publicly funded program**	**Type of public program (i.e. county mental health dept.)**	**County in which program provides services**	**Specialty/Subspecialty Codes**
34	Morrow County Public Health	Public Health	Morrow	47/079
35	Pioneer Memorial Hospital	Hospital	Morrow	14/095
36	Sherman County Health District/Moro Medical Center	Rural Health Clinic	Sherman	14/095
37	Lifeways	Community Mental Health Program	Umatilla	33/092, 093, 207, 445
38	Sunridge MS & Pendleton SBHCs	School Based Health Center	Umatilla	15/101
39	Umatilla Co. Public Health Division	Public Health	Umatilla	64, 47, 22/ 509, 513, 515, 079, 145
40	Center for Human Development, Inc	Public Health	Union	03/004
41	Elgin Family Clinic	Rural Health Clinic	Union	14/085
42	La Grande High SBHC	School Based Health Center	Union	15/101
43	South County Health District-Union Health Center	Rural Health Clinic	Union	14/085
44	Wallowa County Health District	Hospital	Wallowa	47,64,22,33/079, 509, 145, 092
45	Wallowa Valley Center for Wellness	Community Mental Health Program	Wallowa	03, 33/ 016,092,369,445
46	Mid-Columbia Center for Living	Community Mental Health Program	Wasco/Sherman	03, 33/ 004,206,209,092
47	Asher Community Health Center (NE Wheeler District)	Federally Qualified Health Center	Wheeler	15/097
48	Community Counseling Solutions	Community Mental Health Program	Wheeler	03, 33/ 004, 369, 092, 209
49	Mitchell K-12 SBCH c/o Asher Health	School Based Health Center	Wheeler	15/101