Executive Summary

As demonstrated by our performance over the last seven and a half years as a CCO serving southwest Oregon, AllCare meets or exceeds all minimum eligibility requirements for this RFA, including the following criteria: Our company has over 22 years of experience serving OHP members in southwest Oregon as a capitated-risk based contractor. Our CCO governing structure includes a CCO Board that oversees three Community Advisory Councils (one in each of the three counties we serve) and a Clinical Advisory Panel that serves all three counties. Our governance structure complies with ORS 414.625(1)(o) and has approved submission of this Application to extend our CCO contract through 2024.

AllCare Health, Inc. is the parent company of AllCare CCO, Inc. and through its affiliate, AllCare Health Plan, Inc., has a certificate of authority to transact insurance in the State of Oregon from the State Department of Consumer and Business Services (DCBS) and issues health benefit plans as defined in 743B.005 in Oregon, including AllCare Advantage, a Medicare Advantage Plan in southwest Oregon. AllCare MediGap, a Medicare Supplemental Health Plan, has notified the Oregon DCBS that it has terminated this plan and is no longer issuing policies, all current members will continue to receive benefits until they choose to leave the Plan.

AllCare currently serves all zip codes in Josephine, Jackson, and Curry Counties. Due to the unique geographic configuration of Douglas County that is adjacent to Josephine County, AllCare also serves two zip codes in that County at the request of the OHA. We have requested continuation of this service area. AllCare CCO has innovated in the following initiatives advocated by the OHA and Governor Brown:

- Since 2013, AllCare has invested more than $9 million in the SDoH and community services, including housing for the homeless, early childhood development, food and nutrition services, and school health clinics. Our success is due in large part to the strong community partnerships we have nurtured over time.
- As a physician/provider owned entity, AllCare began its transition to a legal "Benefit Company" in 2016 and in 2017 became the only CCO to obtain Certified B Corp™ status in Oregon. Certification was obtained through the nonprofit, B Lab.
- AllCare created and successfully implemented seven separate Value Based Payment (VBP) Models for primary care, appropriate medical specialties including maternity and pediatrics, behavioral health (mental health and addiction services), oral health, hospitals and skilled nursing care, and our non-emergent transportation contractor, ReadyRide. Our VBP models have been voluntarily adopted by more than 85% of our PCPs, 90% of our behavioral health providers, and 100% of our oral health providers.

AllCare CCO, Inc. and its parent company, AllCare Health, Inc., are dedicated to building business and community relationships based on trust, mutual respect, and fair-mindedness. We seek to develop mutually advantageous solutions that balance the overall interests of all parties concerned, including OHP members, their families, providers, our community partners, and the Oregon Health Authority.

Section 3: Procurement Requirements

3.2.c: AllCare CCO Full County Coverage Exception Requests

Introduction: AllCare is requesting continuation of its current service area that includes all of Jackson, Josephine, and Curry Counties, together with two zip codes in adjacent southern Douglas County. AllCare was asked by the OHA in 2012 to serve Douglas County zip codes 97410 and 97442 which we accepted as part of our contract. This service area reflects the natural transportation corridors and historical health care referral patterns of the resident population who have relied upon Josephine County physical health, behavioral health, and oral health providers to meet their health care needs.

As of March 2019, 470 Douglas County OHP Members were enrolled in AllCare. This represents 1.38% of the total Douglas County OHP population. Due to the low number of Members involved, this does not reflect any effort on AllCare's part to minimize financial risk, nor create any adverse selection such as red-lining of high risk areas.

Instead, continuation of this service area request will preserve long standing provider relationships between the residents of Azalea and Glendale, OR and the provider network in Josephine County. It will ensure timely access to needed services for southern Douglas County residents who would otherwise have to drive to Roseburg or farther to receive the care they need. During winter, this presents a safety problem due to transportation corridors between Roseberg and Glendale and Azalea that encompass mountainous terrain that is often unsafe due to snow and ice. Access, continuity of care, and safety are the primary reasons for maintaining AllCare CCO's service area boundaries.

(1) Serving Less than full County will allow the Applicant to achieve the transformational goals of CCO 2.0 (as described in this RFA) more effectively than county-wide coverage in the following areas:
- **Community engagement, governance, and accountability**: OHP residents of Azalea and Glendale OR, Douglas County, are eligible to participate in AllCare's governance structure involving the Josephine County CAC and the AllCare Board. This includes eligibility to participate as a Board and/or CAC representative, access to open public meetings program, and community engagement in the programs we fund throughout the service area to improve individual and community health.
- **Behavioral Health integration and access**: Our OHP residents from Azalea and Glendale, OR have long been served by our behavioral health contractor, Options for Southern Oregon, whose corporate offices and clinics are located in Grants Pass, Josephine County, OR. Options offers mental health crisis management as well as screening, assessment, and treatment for the full range of behavioral health diagnoses. This includes integration of behavioral health clinical personnel in the Women's Health Center in Grants Pass, providing braided maternity and behavioral health services for integrated pre-natal and post-natal care. Options also operates a fully integrated physical health presence within one of its behavioral health clinics in Grants Pass serving those with Severe and Persistent Mental Illness which is available to our Douglas County OHP members who might

otherwise have little or no access to such services. This is a Tier 5 PCPCH Clinic. Our Douglas County members would not have convenient or timely access to such programs if they were excluded from our service area.

- **Social Determinants of Health and Health Equity**: Our OHP residents from Azalea and Glendale, OR, also benefit from our community-based programs funded through our SDoH and HE initiatives. This includes our investments in supportive housing, health equity training of over 4,000 providers, volunteers, and peer supports within 81 organizations across Southern Oregon who serve our OHP members across the continuum of care, and over 175 projects in support of early childhood development, nutrition, non-emergent medical transportation, parenting classes and economic development/workforce capacity initiatives.

- **Value-Based Payments and cost containment**: AllCare was an early adoptor of VBP models and currently deploys seven models including primary care, pediatrics, maternity, behavioral health, oral health, certain specialties, and facilities (hospitals and skilled nursing). OHP Members residing in Azalea and Glendale benefit from our VBP models which incentivize providers across the continuum of care to support the triple aim designed to improve individual health, improve community health, and reduce costs by eliminating unnecessary duplication of services through greater care coordination across care settings.

- **Financial viability**: AllCare offers a financially viable alternative for care delivery compared to higher cost options available elsewhere in Douglas County due to shorter driving times, easier access to pharmacies, and easier access to provider clinics and hospital services.

(2) Serving less than the full County provides greater benefit to OHP members, Providers, and the Community than serving the full County: The benefits of serving southern Douglas County through AllCare's provider network in Josephine County include the following:

- The population in southern Douglas County is insufficient to economically support the full array of primary, specialty and hospital services at the local level and would require inconvenient transportation options to access other Douglas County resources compared to services available in Grants Pass, only 10-15 minutes away.

- Southern Douglas County OHA Members have long-standing health care provider relationships that precede the CCO model of care, dating back to the 1980s and 1990s. Interruption of those provider relationships will disrupt the continuity of care, launch the transitions of care process to switch CCOs, and potentially create unintended outcomes that could negatively impact quality of care such as reduced access to pharmacies, peer supports, traditional health services, oral health, and inpatient care settings; and

(3) The exception request is not designed to minimize financial risk and does not create adverse selection, e.g. by red-ling high risk areas: As stated above, AllCare CCO was asked by the OHA in 2012 to add two southern Douglas County zip codes to our service areas and we would very much like to continue to serve this population. There is no effort on our part to minimize our financial risk nor is there any intent to create adverse selection. This is a rational approach for all involved and should be continued under the CCO 2.0 contract between AllCare CCO and the Oregon Health Authority.

Attachment 2 - Application Checklist

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

Application Submission Materials, Mandatory Except as Noted

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

Attachment 3 - Application Information and Certification Sheet

Legal Name of Proposer: <u>AllCare CCO, Inc.</u>

Address: <u>1701 NE 7th Street, Grants Pass, OR 97526</u>

State of Incorporation: <u>Oregon</u> **Entity Type:** <u>Benefit Company</u>

Contact Name: Douglas L. Flow, PhD, CEO **Phone**: <u>541-471-4106</u>
Email: <u>Doug.Flow@AllCareHealth.com</u>

Oregon Business Registry Number: <u>613638-92</u>

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

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

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

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

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

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

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

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

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

   a. the "Specially Designated Nationals and Blocked Persons" list maintained by the Office of Foreign Assets Control of the United States Department of the Treasury found at:

https://www.treasury.gov/ofac/downloads/sdnlist.pdf., or

b. the government wide exclusions lists in the System for Award Management found at: https://www.sam.gov/portal/

9. Applicant certifies that, to the best of its knowledge, there exists no actual or potential conflict between the business or economic interests of Applicant, its employees, or its agents, on the one hand, and the business or economic interests of the State, on the other hand, arising out of, or relating in any way to, the subject matter of the RFA, except as disclosed in writing in this Application. If any changes occur with respect to Applicant's status regarding conflict of interest, Applicant shall promptly notify OHA in writing.

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

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

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

Signature: _____ Title: <u>CEO</u> Date: _4-19-19_
    (Authorized to Bind Applicant)

State of Oregon

) ss:

County of Josephine

Signed and sworn to before me on <u>April 19, 2019</u> (date) by <u>Douglas L. Flow</u> (Affiant's name).

_____
Notary Public for the State of Oregon

My Commission Expires: <u>September 20, 2021</u>

OFFICIAL STAMP
MARINA SONYA MARSCHALL
NOTARY PUBLIC-OREGON
COMMISSION NO. 966538
MY COMMISSION EXPIRES SEPTEMBER 20, 2021

Attachment 4 - Disclosure Exemption Certificate

Douglas L. Flow, PhD, CEO, ("Representative"), representing AllCare CCO, Inc. ("Applicant"), hereby affirms under penalty of False Claims liability that:

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

2. I am aware that the Applicant has submitted an Application, dated on or about April 22, 2019 (the "Application"), to the State of Oregon in response to Request for Application #OHA-4690-18 for CCO 2.0 (the RFA). I am familiar with the contents of the Application.

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

4. I have checked Box A or B as applicable:

   A. [X] The Applicant believes the information listed in Exhibit A to this Exhibit 4 is exempt from public disclosure (collectively, the "Exempt Information"), which is incorporated herein by this reference. In my opinion, after consulting with a person having expertise regarding Oregon's Public Records Law, the Exempt Information is exempt from disclosure under Oregon's Public Records Law under the specifically designated sections as set forth in Exhibit A or constitutes "Trade Secrets" under either the Oregon Public Records Law or the Uniform Trade Secrets Act as adopted in Oregon. Wherever Exhibit A makes a claim of Trade Secrets, then Exhibit A indicates whether the claim of trade secrecy is based on information being:

      1. A formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information that:

         i. is not patented,
         ii. is known only to certain individuals within the Applicant's organization and that is used in a business the Applicant conducts,
         iii. has actual or potential commercial value, and
         iv. gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.

                                    Or

      2. Information, including a drawing, cost data, customer list, formula, pattern, compilation, program, device, method, technique or process that:

         i. Derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclosure or use; and

      ii. Is the subject of efforts by the Applicant that are reasonable under the circumstances to maintain its secrecy.

B. ☐ Exhibit A has not been completed as Applicant attests that are no documents exempt from public disclosure.

5. The Applicant has submitted a copy of the Application that redacts any information the Applicant believes is Exempt Information and that does not redact any other information. The Applicant represents that all redactions on its copy of the Application are supported by Valid Claims of exemption on Exhibit A.

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

Representative's Signature

Douglas L. Flow, PhD, CEO

Exhibit A: List of Exempted Information

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

Section Redacted	ORS or other Authority	Reason for Redaction
All Exhibits to Attachment 12	**ORS 646.461 to 646.475 (Oregon Uniform Trade Secrets Act)**	**1. All Pro-Forma Exhibits to Attachment 12 contain Trade Secrets.**
		2.
		3.
		4.
		5.

Attachment 5 - Responsibility Check Form

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

1. Does Applicant have available the appropriate financial, material, equipment, facility and personnel resources and expertise, or ability to obtain the resources and expertise, necessary to demonstrate the capability of Applicant to meet all contractual responsibilities?

   YES ☒ **NO** ☐

2. Within the last five years, how many contracts of a similar nature has Applicant completed that, to the extent that the costs associated with and time available to perform the contract remained within Applicant's Control, Applicant stayed within the time and budget allotted, and there were no contract claims by any party? Number: 1

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

Response:

3. Within the last three years has Applicant (incl. a partner or shareholder owning 10% or more of Applicant's firm) or a major Subcontractor (receiving 10% or more of a total contract amount) been criminally or civilly charged, indicted or convicted in connection with:

   • obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract,

   • violation of federal or state antitrust statutes relating to the submission of bids or proposals, or

   • embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property?

   YES ☐ **NO** ☒

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

Response:

4. Within the last three years, has Applicant had:

   • any contracts terminated for default by any government agency, or

   • any lawsuits filed against it by creditors or involving contract disputes?

YES ☐ **NO** ☒

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

Response:

5. Does Applicant have any outstanding or pending judgments against it?

YES ☐ **NO** ☒

Is Applicant experiencing financial distress or having difficulty securing financing?

YES ☐ **NO** ☒

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

YES ☒ **NO** ☐

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

Response:

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

YES ☐ **NO** ☒ .

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

Response:

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

YES ☒ **NO** ☐.

If "NO," please explain.

Response:

8. Pay Equity Certificate. This certificate is required if Applicant employs 50 or more full-time workers and the prospective Contract price is estimated to exceed $500,000. [This requirement does not apply to architectural, engineering, photogrammetric mapping, transportation planning or land surveying and related services contracts.] Does a current authorized representative of Applicant possess an unexpired Pay Equity Certificate issued by the Department of Administrative Services?
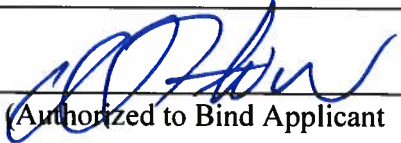
YES ☒ **NO** ☐ **N/A** ☐.

Submit a copy of the certificate with this form.

Response: Please see *EXHIBIT 5.1 - Pay Equity Certificate*. The Certificate of Completion is issued to AllCare's Chief Financial Officer, Twila Farris.

AUTHORIZED SIGNATURE

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

Applicant Name:	RFA: OHA 4690-19
AllCare CCO, Inc.	Project Name: CCO 2.0

Signature: _____ Title: <u>Chief Executive Officer</u> Date: 4-19-19
  (Authorized to Bind Applicant

Exhibits:

- *EXHIBIT 5.1 - Pay Equity Certificate*

EXHIBIT 5.1 - Pay Equity Certificate

Certificate of Completion

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

Twila Farris

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On *3/11/2019*

EXHIBIT 6.1 - Resumes

- Douglas L. Flow, PhD - Chief Executive Officer
- Twila Farris - Chief Financial Officer
- Lyle Jackson, MD - Chief Medical Officer
- Justin Zesiger - Chief Information & Technology Officer
- Will Brake - Chief Operating Officer
- Cynthia Ackerman, RN - Chief Compliance Officer

Douglas L. Flow, PhD

Professional Experience

AllCare Health, Chief Executive Officer

Inc. 1996 - Present

- Responsible for all functional oversight and strategic planning for over 200 employees and 1,400 contracted providers of physical health, behavioral health, and oral health in Southwest Oregon. Works closely with a 21 member Board of Governors, three Community Advisory Councils in Josephine, Jackson, and Curry Counties, as well as the Board of Directors for each of the Company's seven affiliates, including:
  - **AllCare CCO, Inc**. providing Medicaid services to 47,000 enrollees in the State's Oregon Health Plan;
  - **AllCare Health Plan, Inc**., a health insurance company that provides Medicare services to 3,000 elderly and disabled clients through its Medicare Advantage Plan and its Medicare Supplemental Plan;
  - **Program of All-inclusive Care for the Elderly (PACE)** that provides comprehensive health services for individuals age **55 and over**, who live independently, and who are sufficiently frail to be categorized as "nursing home eligible" by their state's Medicaid program;
  - **AllCare Management Services, LLC** is the employer of all AllCare Health staff and contracts out administrative, financial, and technical services to its affiliates;
  - **AllCare Independent Physician Association, Inc**, facilitates commercial insurance contracts for individual provider offices on a group basis; AllCare IPA members are also shareholders of AllCare Health, Inc;
  - **AllCare Development, LLC**, a property development and management entity;
  - **AllCare eHealth Services, LLC**, offers health care providers in physical health, behavioral health, and public health access to electronic medical records systems, and revenue cycle management services on a subscription bases.

Prior Experience

Managed Care: **1986-1992** Executive experience with three Health Maintenance Organizations, responsible for sales and marketing, provider contracting, member services, medical quality assurance, financial performance, personnel, information services and board development.

  - **SelectCare Health Plan, Longview, WA 1992-1996**
    - **Regional Vice President**
    - **HMO Administration**
  - **Group Health Cooperative, Tri-Cities, WA 1988-1992**
    - **Executive Director**
  - **New Mexico Health Plan, Albuquerque, NM 1986-1988**
    - **Chief Operating Officer**

Public Health: 1982-1986 Responsible for federal and state health planning activities, contract management for an eight-county rural health service area extending from Canada south to Oregon. Services included recruitment and training for an extensive network of consumer and provider volunteers to conduct public hearings for proposed hospital and nursing home construction, new services, and medical equipment technology. Directed development of an annual eight-county health plan, certificate of need documents, health manpower studies, and special reports. Reported to a regional board of directors consisting of consumers, providers, and elected officials. Wrote annual grant for renewed federal and state funding.

- o **Central Washington Health Systems Agency, Yakima, WA: Chief Operating Officer**

 Academic Experience: 1980-1982

- o **Central Washington University, Ellensburg, WA: Assistant Professor**
- o **San Francisco State University, San Francisco, CA: Lecturer**

Education

1980   PhD   Public Health, Oregon State University, Corvallis, OR

1973   M.A.   Community Health/Psychology, California State University, Sacramento, CA

1972   B.A.   Psychology/Biology, California State University, Sacramento, CA

Twila M. Farris

PROFESSIONAL ACCOMPLISHMENTS

- 3+ years of insurance industry consulting, advisory services and regulatory filing preparation
- 10+ years of external audit experience for both private and public companies
- Successfully managed and directed all financial statement audits for insurance clients including Health, P&C, Life, Fraternal, Captives and RRGs
- Successfully assisted as part of the "Champion" team the implementation of a "paperless" audit system
- Lead various training sessions in software conversions and changes in auditing standards

PROFESSIONAL EXPERIENCE

August 2013 – Present

AllCare Health, Inc.

Chief Financial Officer

- Provide leadership, direction and management of the Finance and Accounting team
- Provide strategic recommendations to the CEO and members of the Executive Team
- Manage the processes for financial forecasting and budgets and oversee the preparation of all financial reporting
- Maintain compliance with GAAP, SAP, applicable federal and state regulatory laws and tax laws
- Report financials and key projects to the Finance Committee and Board of Governors
- Manage Treasury and Investment portfolios
- Evaluate and advise on the impact of long term business and financial planning
- Establish and develop relations with senior management and external partners and stakeholders
- Manage financial and regulatory audits

January 2010 – July 2013

Millennium Consulting Service, LLC – Raleigh, NC

Director, Consulting Services

- Preparation and review of statutory filings for 15+ insurance companies
- Consulting on statutory accounting and reporting for insurance companies
- Consulting on financial analysis of health and life insurance providers
- Provide quality reviews for insurance companies in regarding to their statutory filings
- Research of Captive and RRG rules for various states
- Provide SAP and GAAP research and guidance for clients

January 1999 – December 2009

Brown Smith Wallace, LLC – St. Louis, MO

Audit Manager - July 2006 – December 2009

- Managed over 6000 total hours of SAP and GAAP insurance audits (including property & casualty, life & health and fraternal) from January 2006 – July 2008. Responsible for maintaining research library for insurance department including researching SAP to ensure all department personnel was up-to-date on all changes related to the industry. Involved in development of the audit team within this niche area as well as responsible for establishing policies and procedures for insurance audits.
- Manage all phases of audit, review and other engagements for various industries including insurance, not for profit, manufacturing, professional services, retail, distribution and employee benefit plans.
- Supervise and coordinate scheduling and staffing of client services.
- Establish and maintain client relationships.
- Responsible for quality control reviews for insurance and not for profit engagements.
- Served on numerous "Champion" teams for software implementations and audit standard changes.
- Involved in the firm's peer review and inspection procedures.
- Served on the firm's Technical, Peer Review and Sales Task Force Committees.
- Involved in development of marketing plan and marketing materials.

Audit Supervisor - July 2004 – June 2006

- Supervised and coordinated scheduling and staffing of client services. Audited and reviewed financial statements in conformity with GAAP, SAP, DOL and ERISA. Supervisor over all insurance audits performed by company. Performed independent technical reviews of financial statements and reviewed staff and senior prepared account analysis and work papers. Served on Technical and Peer Review Committees and numerous "Champion" teams. Involved in recruiting and intern management.

Audit Senior - January 2001 – June 2004

- Performed audit, review and compilation procedures from planning through financial statement preparation. In-charge auditor for all insurance engagements. Performed detail review of staff work papers and staff prepared financial statements. Supervised and trained new staff and interns. Established and was responsible for maintaining client relationships. Served on "Champion" team for software conversion and implementations.

EDUCATION

- University of Missouri – St. Louis
  Bachelor of Science - Accounting

Lyle T. Jackson, MD

Overview: Over thirty years of experience as a practicing physician in family health; served as past president of the Josephine County Medical Society, former Chief of Staff and Chief of Medicine at Southern Oregon Medical Center and Past Alternate Delegate for the Oregon Medical Association. Board certified by the American Board of Family Practice 1977-2007 and the National Board of Medical Examiners in 1975.

Professional Experience

AllCare Health, 2000 - Present

Grants Pass, OR

Chief Medical Officer

- Responsible clinical decision support, quality improvement and utilization management
- Evidence based guidelines research and development
- Compliance
- Prior authorization and protocols
- Formulary management and oversight
- Overall clinical leadership of the AllCare Health, Inc and its Affiliates

Siskiyou Community Health Clinic, 2002 – 2004
Grants Pass, OR

- Served as part time Medical Director for this federally designated safety net clinic serving Grants Pass and Cave Junction, Oregon

Independent Family Practitioner, 1977 – 2000
Grants Pass, OR

Education

Broadlawns-Polk County Medical Center, University of Iowa, 1974-1977
Des Plains, Iowa

- Family Practice Residency Program

University of Illinois College of Medicine, 1970-1974
Chicago, Illinois

- Medical School

University of Illinois 1967-1970
Champaign, Illinois

- BS, Biology
- Magna Cum Laude

St. Joseph College 1966-1967
Rensselaer, IN

Licenses

State of Oregon 1977 – Present

Active Status: License # MD 10535

Certifications

Board Certified
- American Board of Family Practice 1977
- Recertified 2001 – 2007
- Certified National Board of Medical Examiners 1975

Professional Organizations

- American Academy of Family Practice 1977-Present
- Oregon Academy of Family Practice
- Oregon Medical Society
- Josephine County Medical Society

Hospital Affiliations

- Three Rivers Community Hospital, Grants Pass, OR 1977 – 2000
- Josephine Memorial Hospital, Grants Pass, OR 1977 – 2000
- Retired in good standing from active medical staff 2000

Offices Held

- Past President, Josephine County Medical Society, Grants Pass, OR
- Past Chief of Staff and Chief of Medicine, Southern Oregon Medical Center (Now Three Rivers Community Hospital) Grants Pass, OR
- Past Alternate Delegate, Oregon Medical Association

Justin Zesiger

Overview: Health Information Technology professional with over twenty years of experience ranging from customer service to corporate leadership. Leading the AllCare Health, Inc. technology department(s) serving 5,000 portal users, 200 employees, 80 independent provider practices, 60 Electronic Health Record clinics, and 3 county offices. Experienced HIPAA Security Officer charged with protecting all members Protected Health Information (PHI). Skilled and experienced in program administration, project management, and contract and regulatory compliance for Oregon CCO (Coordinated Care Organization) Medicaid and Medicare Advantage. Deep knowledge of current desktop to enterprise level software, hardware, data systems, networks, security and telephony. In the capacity of my job duties I have regularly met with various dignitaries including Oregon State Governors and Members of Congress.

Professional Experience

AllCare Health 2001 - Present

Chief Information Officer/IT Director 2008 - Present

- Responsible for 2M IT annual operating budget
- Major stakeholder in organizations capital asset budget for IT related expenses
- Designed and operationalized two ground up data center build projects and a third collocated disaster recovery site
- Designed Headquarter construction of physical security, surveillance, power supply/generation, and Data Center cooling, fire suppression, and infrastructure.
- Governmental reporting and compliance oversight and IT audit respondent for the OHA Information Systems Capabilities Assessment (ISCA), Healthcare Effectiveness Data and Information Set (HEDIS), financial, and other audits
- HIPAA Security Officer
- Reports to CEO and presents to multiple Board of Governors
- Sit on Oregon Health Authorities (OHA) Health Information Technology Group (HITAG), originally formed as a conduit for CCO CIOs and other high ranking HIT professionals to report HIT initiatives to former Oregon State Governor John Kitzhaber.
- Negotiates high value contracts
- Maintain high standards of data security, privacy, availability, integrity, analytics, and performance for all information systems and data
- Author corporate and IT policy
- Implemented Ticketing, Source Control, Change Management, and User Acceptance Testing processes
- Lead a 15 employee HIT and IT Operations team comprised of Database Administrator, EDI Developer, Web Developer, Data Analyst, Business Analyst, Project Manager, Systems Administrator, Desktop Support, Lead, Supervisor, and Manager roles

Sr. Systems Administrator/Systems Administrator 2002-2008

- Created a virtualized server and network infrastructure to host Greenway's PrimeSuite as a Value Added Reseller (VAR) and Business Alliance Partner (BAP).

Solving for, and providing Greenway's first proof of concept of a multi tenancy/VPS (Virtual Private Server) hosted environment eventually hosting for 60 clinics with Greenway replicating our model

- Active Directory migration and administration
- Exchange migration and administration
- Server Administrator for over 200 servers
- Network engineering and administration
- Virtualization (ESX) administration
- Storage Area Networks (SAN) administration
- Worked with products, vendors, and appliances including Microsoft, VMWare, Citrix, Bay Networks/Nortel, Cisco, Foundry, Brocade, IBM, HPE, Dell, Barracuda, Aruba, F5, Fatpipe, ShoreTel, APC, Schneider Electric, and others
- Provider Portal hosting and administration for over 5,000 community users

Information System Specialist 2001-2002

- When hired, "IS Specialist" was the only Information Technology title, duties were equal parts Systems Administration and Desktop Support
- Install, configure, and maintain employees PC hardware and software
- Patch and update management for end user devices and servers
- NT Domain user administrator
- Exchange administrator
- File Share Administrator
- WAN administration of a channelized DS3 fiber optic connection providing 28 PTP T1s through a CSU/DSU nest and Bay Networks ASN router stack
- Network administration for the first regional private provider network created to submit referrals, authorizations, and view claims status over in house developed Provider Portal
- Independent provider office customer service, support, and site visit for troubleshooting, repair, and upgrades
- First week on the job, prevented the proliferation of NIMDA virus throughout the provider community by re-engineering and firewalling the existing public/private network

William R. Brake

Professional Experience

AllCare Health, Chief Operating Officer, Medford, June 2014 - Present
- Responsible for Provider Services, Contracting, AllCare IPA, Credentialing, Member Services, AllCare eHealth, and AllCare Billing Service.
- Manage nine Value Based Payment Models for 520 providers in three counties
- Second year as Chair the OHA Metrics and Scoring Committee
- Ex officio member of the OHA Health Plan Quality Metrics Committee
- Member of the OHA Health Equity Metrics workgroup

Trek Enterprises, **Inc., dba Togo's Great Sandwiches, Medford, Owner,** 2010 - 2014

- Owned two franchise locations in Medford, OR
- Oversaw build-out of new stores
- Launched a new brand in the market
- Produced higher than average sales
- Regularly achieved 100% scores from the Jackson County Health Department

Executive Practice Management, **Inc., Medford**, **Owner**, 2007 –2009

- Created company from ground up
- Assisted medical groups in becoming business savvy, self-sufficient, and financially sound
- Developed and presented many educational seminars focused on medical group operations, healthcare regulation, human resource management, and customer service
- Conducted medical group audits, development, and business reviews

Providence Health System - Medford, Chief Operating Officer, 1996 –2007
Led operations, strategic direction, and governance of a multi-specialty group practice consisting of 50 providers including Internal Medicine, Family Practice, Pediatrics, OB/GYN, General and Vascular Surgery, and Cardiology in eleven locations with a staff of over 220

- Managed a twelve-member leadership team
- Oversaw finance, budgeting, accounting, hiring, coaching, mentoring, and quality
- Grew the group from 13 to 50 providers
- Stabilized the group financially
- Maintained expenses to benchmark levels
- Acquired four local medical practices into PMG
- Designed and managed the construction of four new clinics
- Achieved patient satisfaction scores of 90.5, ranking 84th percentile in the nation
- Developed and maintained trusting relationships with physicians and providers

Executive Director, Physicians Health Alliance IPA, **Medford**, OR, 1997 - 2000

Manager, Managed Care Contracting – Providence Health Plan, **Medford**, OR, 1996 - 1997

OB/GYN Health Center, Group Practice Administrator, Medford, 1994 –1996

- Administered the six-physician practice with five midwifes, a full lab, ultrasound, and a staff of 33
- Managed operations, strategic direction, and day-to-day management of staff
- Significantly increased physician compensation
- Stabilized expenses – reduced overhead by 12%
- Eliminated debt

Roseville Orthopedic Surgery & Sports Medicine, **Group Practice Admin.,** CA, 1990 - 1994

- Administered five orthopedic surgeons, a radiology department, and a staff of 16
- Managed operations, strategic direction, and day-to-day management of staff
- Increased physician compensation
- Developed a new income allocation formula
- Eliminated debt
- Designed and moved clinic to new office space

Chan & Zietlin Medical Group, Group Practice Administrator, CA, 1993 - 1994 (Concurrent)

- Administered five internal medicine, two family practice physicians, and staff of 20
- Managed operations, strategic direction, and day-to-day management of staff
- Eliminated debt in preparation for sale of medical group
- Negotiated with Sutter Health System and UC Davis for sale of practice
- Reduced overhead by 17%

Education and Affiliations

- Sierra College, American River College – Business Administration
- Professional, Academy for Healthcare Management
- Certified GE Work Out & Change Facilitator
- Studer Healthcare Customer Service Program Trainer
- Facilitated year-long process to develop United Way's 5-year strategic plan (volunteer)
- Member of Board of Directors for the Anna May Foundation
- Second year as Chair the OHA Metrics and Scoring Committee
- Ex officio member of the OHA Health Plan Quality Metrics Committee
- Member of the OHA Health Equity Metrics workgroup

Cynthia Ackerman, RN, CHC

Professional Experience

Over twenty-five years of experience in inpatient medical/surgical nursing, health plan quality improvement and utilization management, corporate Compliance, HIPAA and FWA program development and delegated entities oversight; care coordination program development and team leadership. Currently serves as the Chief Compliance and Quality Officer for AllCare Health Plan, Inc.

Education

Columbia State Community College, Columbia, Tennessee, AAS in Nursing– May, 1990
Graduated Magna Cum Laude, Class President
West Virginia University, Morgantown, West Virginia, General Studies – 1976-1977

Certifications

2007 – current - Certified in Health Care Compliance through Health Care Compliance Association
1990-current – Active Oregon RN license in good standing

Professional Activities

2017 – Current: Rogue Community College Foundation Board member.
2014 – Current: Active participant of the OHA's Operations Bench Advisory Workgroup; Comprised of CCO executives who make recommendations to the CCO CEO Workgroup
2014 – 2015: Grants Pass Rotary
2013 – Current: An executive member and Board co-chair of the Jefferson Regional Health Alliance (JRHA). A consortium comprised of CCOs, hospitals, FQHCs, A & D vendors, County Health Departments and Behavioral Health entities.
2013 – Current: Participate in the OHA Ombudsman Advisory Council
2013 SB 450 Task Force – appointed by Governor John Kitzhaber, Co-chair
2012 Outcomes, Quality and Efficiency Metrics Work Group – appointed by Governor John Kitzhaber, **1998 – current: OHA sponsored Contractor's Work Groups monthly meetings:** Quality Health Outcomes, Enrollment/Disenrollment, Rates and Actuarial

Experience

AllCare Health, Inc., Chief Compliance Officer
July 2015 – current
- Responsible for OHA and CMS contracts and program audits;
- Developed Quality Programs, Performance Improvement Projects, Policies and Procedures according to OHA, Oregon statutes and CFRs;
- Developed Compliance and FWA Program elements, internal dashboard reporting, Policies and Procedures according to OHA Oregon statutes and CFRs;
- Arranges and facilitates mandatory Compliance and FWA annual training for internal staff, delegated entities and BOG;
- Oversees, mentors, assists in Health Care Transformation program development for 9 employees in key areas of the SDoH and Equity: Oral Health Manager, Compliance and Quality Director, 3 Josephine County Health Department employees (WHNP, 1 RN, 1

Licensed Dietician), Community Engagement Manager, Education K-12 Manager, Social Determinants of Health (SDoH) Manager and Curry County Service Area Manager;

- Acts as the CEO Representative for the OHA CCO CEO monthly meetings (OHA/CCO Leadership and CCO CEO Planning Sessions);
- Participates in COHO (Coalition for a Healthy Oregon) as the primary representative from AllCare CCO. COHO is comprised of 6 CCOs and is involved in healthcare policy development at the State level and demonstrating positive outcomes in the communities served.

AllCare Health, Inc., Vice President of Community Engagement and Government Affairs December 2013 – July 2015

- Developed processes to engage stakeholders in the region to participate in the Health Care Transformation activities bridging medical care with non-medical entities;
- An integral participant in the strategic development of the re-branding of Mid Rogue to AllCare Health in June 2015.
- Hired and provided oversight to AllCare's Education Coordinator – responsible for interacting and further development and certification of two Education Hubs in Coos-Curry and Josephine-Jackson counties
- Provided oversight to the teams responsible for collaborating with various stakeholders, Community Advisory Councils to develop the 2013 Community Health Assessments and 2014 Community Health Improvement Plan
- Developed internal teams to identify key social determinants of health impacting the communities served which led to AllCare funding staff positions, sponsorships, housing projects and public safety initiatives.
- Hired and provided oversight to the Josephine County Public Health initiative – 4 clinical staff (WHNP, RD, 2 RNs) to increase access to medical screening and preventative care for women and children and STI diagnosis and treatment.
- Served as key contact for CMS and Oregon Medicaid contracts and was responsible for reporting requirements and audit activities.

AllCare CCO and AllCare Medicare Advantage – Health Management Services Director and Government Programs Officer 2011 – December 2013

- Responsible for program development and oversight of the Case Management, Utilization Management, Disease Management, Health/Wellness/Prevention and Quality divisions.
- Instrumental in the development and implementation of the CCO application and Health Care Transformation Plan.
- Continued to decrease ER, inpatient and readmits through the development and implementation of the Transitions of Care program
- Through focused Transitions of Care program development and work, decreased ER use by 13%, decreased readmits by 50% and decreased initial inpatient stays by 5%.
- Participated in the executive leadership during a time where OHP membership increased from 22,000 January 2013 to over 46,000 January 2014.

EXHIBIT 6.2 – Contact List

	NAME	PHONE	EMAIL
The Application Generally	Josh Balloch, VP Government Affairs	541-471-4106	Josh.Bollach@allcarehealth.com
Attachments 2-5	Twila Farris, CFO	541-471-4106	Twila.Farris@allcarehealth.com
Attachment 6 General Questions	Twila Farris, CFO	541-471-4106	Twila.Farris@allcarehealth.com
Attachment 7 Provider Participation and Operations	Will Brake, COO	541-471-4106	Will.Brake@allcarehealth.com
Attachment 8 Value Based Payment	Will Brake, COO	541-471-4106	Will.Brake@allcarehealth.com
Attachment 9 Health Information Technology	Justin Zesiger, CIO	541-471-4106	Justin.Zesiger@allcarehealth.com
Attachment 10 Social Determinants of Health and Health Equity	SDoH: Cynthia Ackerman, Chief Compliance Officer Health Equity: Will Brake, COO	541-471-4106	Cynthia.Ackerman@allcarehealth.com Will.Brake@allcarehealth.com
Attachment 11 Behavioral Health	Athena Goldberg, Director of Behavioral Health	541-471-4106	Athena.Goldbert@allcarehealth.com
Attachment 12 Cost and Financial	Twila Farris, CFO	541-471-4106	Twila.Farris@allcarehealth.com
Attachment 13 Attestations	Cynthia Ackerman, Chief Compliance Officer	541-471-4106	Cynthia.Ackerman@allcarehealth.com
Attachment 14 Assurances	Cynthia Ackerman, Chief Compliance Officer	541-471-4106	Cynthia.Ackerman@allcarehealth.com
Attachment 15 Representations	Cynthia Ackerman, Chief Compliance Officer	541-471-4106	Cynthia.Ackerman@allcarehealth.com
Sample Contract	Twila Farris, CFO	541-471-4106	Twila.Farris@allcarehealth.com
Each Exhibit to the Sample Contract	Twila Farris, CFO	541-471-4106	Twila.Farris@allcarehealth.com
Rates and Solvency	Twila Farris, CFO	541-471-4106	Twila.Farris@allcarehealth.com
Readiness Review	Cynthia Ackerman, Chief Compliance Officer	541-471-4106	Cynthia.Ackerman@allcarehealth.com
Membership and Enrollment	Will Brake, COO	541-471-4106	Will.Brake@allcarehealth.com

Phone: (503) 986-2200
Fax: (503) 378-4381

Articles of Incorporation—Business/Professional

Secretary of State
Corporation Division
255 Capitol St. NE, Suite 151
Salem, OR 97310-1327
FilingInOregon.com

Check the appropriate box below:

☒ BUSINESS CORPORATION
(Complete only 1, 2, 3, 4, 5, 6, 8, 9, 10)

☐ PROFESSIONAL CORPORATION
(Complete all Items)

FILED

JUL 01 2009

OREGON
SECRETARY OF STATE

REGISTRY NUMBER: 613638-92
For office use only

In accordance with Oregon Revised Statute 192.410-192.490, **all information on this form is publicly available, including addresses.**
We must release this information to all parties upon request and it will be posted on our website.   For office use only

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

1) **NAME OF CORPORATION:** MID ROGUE INDEPENDENT PHYSICIAN ASSOCIATION, INC.

NOTE: For a BUSINESS CORPORATION, the name must contain the word "Corporation," "Company," "Incorporated," or "Limited," or an abbreviation of one of such words.   For a PROFESSIONAL CORPORATION, the name must contain the words "Professional Corporation," or abbreviations thereof, i.e., "P.C.," or "Prof. Corp."

2) **NAME OF THE PERSON WHO WILL ACCEPT LEGAL SERVICE FOR THIS BUSINESS (REGISTERED AGENT)**

B. Kevin Burgess

3) **REGISTERED AGENT'S PUBLICLY AVAILABLE ADDRESS (Must be an Oregon Street Address, which is identical to the registered agent's business office. Must include city, state, zip; No PO Boxes.)**

425 SE Jackson Street

Roseburg, OR 97470

4) **ADDRESS WHERE THE DIVISION MAY MAIL NOTICES**

PO Box 10567

Eugene, OR 97440-2567

5) **OPTIONAL PROVISIONS** (Attach a separate sheet.)

6) **NUMBER OF SHARES** (At least one share must be listed.)

500

Professional Corporation Only

7) **IF RENDERING A LICENSED PROFESSIONAL SERVICE OR SERVICES, DESCRIBE THE SERVICE(S) BEING RENDERED.**

n/a

8) **WHO IS FORMING THIS BUSINESS? (INCORPORATORS)** (List names and addresses of each incorporator.) (Attach a separate sheet if necessary.)

Douglas Flow, Ph.D., PO Box 10567, Eugene, OR 97440-2567

9) **EXECUTION/SIGNATURE(S)** (All Incorporators must sign.) (Attach a separate sheet if necessary.)
By my signature, I declare as an authorized authority, that this filing has been examined by me and is, to the best of my knowledge and belief, true, correct, and complete. Making false statements in this document is against the law and may be penalized by fines, imprisonment or both.

Signature

Printed Name

Douglas Flow, Ph.D.

FEES

| Required Processing Fee | $ 50 |
| Confirmation Copy (Optional) | $5 |

Processing Fees are nonrefundable

Please make check payable to
"Corporation Division."

NOTE:
Fees may be paid with VISA or MasterCard. The card number and expiration date should be submitted on a separate sheet for your protection.

10) **CONTACT NAME** (To resolve questions with this filing.)

Cindy Kent

DAYTIME PHONE NUMBER (Include area code.)

(541) 984-0213

MID ROGUE INDEPENDENT PHYSICIAN

111 (Rev. 8/07)

FILED

OCT 30 2014

OREGON
SECRETARY OF STATE

For office use only

REGISTRY NUMBER: 613638-92

In accordance with Oregon Revised Statute 192.410-192.490, the information on this application is public record. We must release this information to all parties upon request and it will be posted on our website.

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

1. **ENTITY NAME:** Mid Rogue Independent Physician Association, Inc.

2. **THE FOLLOWING AMENDMENT(S) TO THE ARTICLES OF INCORPORATION IS MADE HEREBY:** State the article number(s) and set forth the article(s) as it is amended to read. (Attach a separate sheet if necessary.)

   1) Name of Corporation: AllCare CCO, Inc.

3. **THE AMENDMENT WAS ADOPTED ON:** September 27, 2014

   (If more than one amendment was adopted, identify the date of adoption of each amendment.

4. **PLEASE CHECK THE APPROPRIATE STATEMENT:**

   ◉ Shareholder action was required to adopt the amendment(s).

   The vote was as follows:

Class or series of shares	Number of shares outstanding	Number of votes entitled to be cast	Number of votes cast FOR	Number of votes cast AGAINST
Common	100	100	100	0

   ◯ Shareholder action was not required to adopt the amendment(s). The amendment(s) was adopted by the board of directors without shareholder action.

   ◯ The corporation has not issued any shares of stock. Shareholder action was not required to adopt the amendment(s). The amendment(s) was adopted by the incorporators or by the board of directors.

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

Signature:	Printed Name:	Title:
	DOUGLAS L. FLOW	CEO

CONTACT NAME: (To resolve questions with this filing)

Michael D. Crew

ALLCARE CCO, INC.

FEES

Required Processing Fee $100

Processing Fees are nonrefundable. Please make check payable to "Corporation Division".

Free copies are available at FilinginOregon.com using the Business Name Search program.

05/14)

61363892-15577434   AMDART

Articles of Amendment - Business/Professional Corporation

Secretary of State - Corporation Division - 255 Capitol St. NE, Suite 151 - Salem, OR 97310-1327 - http://www.FilingInOregon.com - Phone: (503) 986-2200

FILED

JUL 26 2016

OREGON SECRETARY OF STATE   For office use only

REGISTRY NUMBER: 613638-92

In accordance with Oregon Revised Statute 192.410-192.490, the information on this application is public record. We must release this information to all parties upon request and it will be posted on our website.

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

1. **ENTITY NAME:** AllCare CCO, Inc.

2. **THE FOLLOWING AMENDMENT(S) TO THE ARTICLES OF INCORPORATION IS MADE HEREBY:** State the article number(s) and set forth the article(s) as it is amended to read. (Attach a separate sheet if necessary.)

   * see attached Exhibit A *

3. **THE AMENDMENT WAS ADOPTED ON:** June 27, 2016

   (If more than one amendment was adopted, identify the date of adoption of each amendment.

4. **PLEASE CHECK THE APPROPRIATE STATEMENT:**

   ◉ Shareholder action was required to adopt the amendment(s).
   The vote was as follows:

Class or series of shares	Number of shares outstanding	Number of votes entitled to be cast	Number of votes cast FOR	Number of votes cast AGAINST
Common	100	100	100	0

   ◯ Shareholder action was not required to adopt the amendment(s). The amendment(s) was adopted by the board of directors without shareholder action.

   ◯ The corporation has not issued any shares of stock. Shareholder action was not required to adopt the amendment(s). The amendment(s) was adopted by the incorporators or by the board of directors.

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

   Signature: _____

   Printed Name: Douglas Flow

   Title: Executive Director

CONTACT NAME: (To resolve questions with this filing)

Michael D. Crew

PHONE NUMBER: (Include area code)

(503) 224-6440

Articles of Amendment - Business/Professional Corporation (05/14)

ALLCARE CCO, INC.

61363892-17187357   AMDART

EXHIBIT A TO ARTICLES OF AMENDMENT
ALLCARE CCO, INC.

State the article number(s) and set forth the article(s) as it is amended to read:

ARTICLE 5:

Corporation shall be authorized to engage in any lawful business which corporations incorporated under ORS Chapter 60 are permitted to engage, and shall conduct its business in a socially and environmentally responsible manner as a benefit company governed in part by ORS 60.750 to 60.770.

2019 RESTATED BYLAWS

FOR

ALLCARE CCO, INC.

April, 2019

TABLE OF CONTENTS

2019 RESTATED BYLAWS
ALLCARE CCO, INC.
Effective April ____, 2019

These Restated Bylaws are intended to serve also as an agreement between the sole shareholder of AllCare CCO, Inc. and AllCare Health, Inc. pursuant to ORS 60.265 and to comply with all requirements for performance as a Coordinated Care Organization under Oregon law.

1. Offices.

1.1. **Principal Office.** The principal office of AllCare CCO, Inc. ("AllCare") shall be located in Grants Pass, Oregon. AllCare may have such other offices in or out of the State of Oregon, as AllCare's Board of Governors may designate or as the business of AllCare may require from time to time.

1.2. **Registered Office.** The registered office of AllCare may, but need not be, identical with the principal office in the State of Oregon, and the address of the registered office may be changed from time to time by AllCare's Board of Governors upon compliance with the requirements of the Oregon Business Corporation Act for change of the registered office.

2. Shareholder.

2.1. **Qualification.** Only AllCare Health, Inc. ("Holding") is qualified to be a shareholder of AllCare.

2.2. **Annual Meeting.** Holding shall hold an annual meeting each year during the month of June or thereafter, at a time and place determined by Holding's Board of Governors, for the purpose of confirming all nominations by the AllCare Board of individuals to act as governors on the AllCare Board and for the transaction of such other business as may come before the meeting. The annual meeting of Holding shall be held within the State of Oregon.

2.3. **Chair to Preside Over Meetings.** Pursuant to paragraph 3.4 of these Restated Bylaws, the Chair of the Board of AllCare's Board of Governors shall serve as chair for the meeting. The Chair shall determine the order of business and shall have the authority to establish rules for the conduct of the meeting, subject to the other rules enumerated in these Restated Bylaws. If the Chair is unavailable to chair a meeting, either Holding's Vice-Chair or, in the event of the unavailability of the Holding's Vice-Chair, the Community Vice-Chair shall preside at the meeting.

2.4. **Special Meetings.** Special meetings of Holding shall be held upon the call of Holding's Chair or Board of Governors.

2.5. **Voting.** Holding shall act through Holding's Board of Governors.

2.6. Notice. Written or printed notice stating the date, time, and place of the meeting and, in the case of a special meeting, the purpose or purposes for which the meeting is called, shall be delivered to the shareholder not less than 10 nor more than 60 days before the meeting date, either personally or by mail, by or at the direction of the secretary or the persons calling the meeting. However, if notice is mailed other than by first class or registered mail, the notice must be mailed not less than 30 days nor more than 60 days before the meeting date. Notice of an annual or regular meeting shall include a description of any of the following matters, if the shareholder will be asked to approve the matter or matters at the meeting: governor conflict of interest; indemnification of officers, employees, or agents; amendment of the Bylaws or Articles of Incorporation; merger; sale of assets other than in the ordinary course of business; or dissolution.

2.7. Action Without a Meeting. Any action required or permitted to be taken at a meeting of the shareholder may be taken without a meeting if the shareholder consents in writing, setting forth the action taken.

3. Board of Governors.

3.1. General Powers. The business and affairs of AllCare shall be managed by the AllCare Board of Governors. Without limitation of its authority under these Restated Bylaws or the Oregon Business Corporation Act, AllCare's Board of Governors is expressly authorized to adopt rules, policies, and procedures to govern the operations of AllCare.

3.2. Number, Tenure, and Qualifications.

3.2.1. *Classifications.* AllCare's Board of Governors will consist of 21 governors, divided into 4 defined classifications.

3.2.1.1. The first classification is Governors of Holding's Board. Eleven governors must satisfy these requirements, nine of whom must be Class A shareholders of Holding.

3.2.1.2. The second classification is members of the Community Advisory Councils (CACs) of Jackson, Curry, and Josephine counties, as described in Schedule 4.2.1.2. One governor must be selected from each county's CAC, for a total of three, at least one of which must qualify as a member of the community at large.

3.2.1.3. The third classification is members of the Clinical Advisory Panel (CAP), as described in Schedule 3.2.1.3. One governor will be a hospital representative; one governor an alcohol and drug treatment representative; one governor a dental health representative; one governor a mental health representative who is a mental health or chemical dependency treatment provider; one governor a representative of other medical providers, and one governor at large from among the CAP members, for a total of six.

3.2.1.4. The final classification is members of the general public who do not qualify in any of the other three categories. One governor will be selected from this category.

3.2.2. *Nominations.* Beginning with governors whose term begins on or after August 1, 2013, governors will be nominated for appropriate open governor seats as follows:

3.2.2.1. Holding will nominate candidates for the governor seats to be filled by members of Holding's Board, and the governor seat to be filled by a member of the general public.

3.2.2.2. Each of the three CACs may nominate a candidate from among its members to fill their respective CAC governor seats. At least one CAC nominee must qualify as a member of the community at large.

3.2.2.3. The CAP may nominate six candidates to serve the respective CAP governor seats, with one nominee from the CAP members at large, and the remainder from each health care discipline described in paragraph 3.2.1.3. Nominees for governor positions identified with a specific health care discipline must be selected solely by other CAP members of the same health care discipline. For example, only hospital CAP members may participate in selecting the hospital representative nominee.

3.2.3. *Selection.* AllCare's Board of Governors shall, at its annual meeting, select from the slate of nominees, those individuals who shall thereafter serve as governors until they are replaced or resign. Notwithstanding the selections by the AllCare Board, Holding may reject any such selections and nominate and appoint governors of its choice, provided: (i) they qualify and satisfy the classification requirements in paragraph 3.2.1; and (ii) the Board of Governors collectively satisfies all requirements of paragraph 3.2.1 and ORS 414.625. As of the effective date of these Restated Bylaws, ORS 414.625 requires the following:

3.2.3.1. Persons that share in the financial risk of the organization constitute a majority of the governance structure;

3.2.3.2. The major components of the health care delivery system participate in governance;

3.2.3.3. At least two health care providers in active practice participate in governance, including:

3.2.3.3.1. A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and

3.2.3.3.2. A mental health or chemical dependency treatment provider;

3.2.3.4. At least two members from the community at large participate in governance; and

3.2.3.5. At least one member of the community advisory council participate in governance.

3.2.4. *Terms.* Governors shall serve staggered terms. To implement staggered terms, governors seated August 1, 2013 will serve the following special terms: seven of the initial governors will serve one-year terms; seven will serve two-year terms; and seven will serve three-year terms. Thereafter, governors will serve three year terms. The Formation Board of Governors will determine which governor seats will serve 1, 2, and 3 year terms, respectively, when seated August 1, 2013. Governors may not serve more than two consecutive terms without a minimum one year break; except that, the initial one year Formation Board term shall not count as a term for this purpose.

3.2.5. *Term Continuation.* Notwithstanding anything in paragraphs 3.2.1 through 3.2.4 to the contrary, each governor shall serve, and his or her term shall continue, until the earlier of the effective date of resignation, the date the governor position is eliminated, or the date a replacement is elected.

3.3. Annual Meeting. An annual meeting of AllCare's Board of Governors shall be held without notice following the annual meeting of Holding. AllCare's Board of Governors may provide, by resolution, the time and place, either within or without the State of Oregon, for additional regular meetings. The resolution shall state the time and place for the meeting.

3.4. Regular Open Meetings. Regular meetings of AllCare's Board of Governors shall be held as determined by AllCare's Board of Governors. The Chair of the Board of AllCare's Board of Governors shall act as the chair of any regular or special meeting of the Board. Holding will be given notice of the time of regularly scheduled Board of Governors meetings. All meetings of the Board of Governors shall be open to the public to attend, except for those portions of the regular meetings which the Board declares to be held in executive session. The Board shall notify the public of the time and place of scheduled regular meetings.

3.5. Special Meetings. Special meetings of AllCare's Board of Governors may be called by or at the request of AllCare's Chair, any two AllCare governors or Holding. The person or body calling the meeting shall fix the date, time, and place (which shall be within the State of Oregon) for the meeting. Special meetings shall also be open to the public to attend, except for those portions of such meetings which are held in executive session.

3.6. Notice of Special Meetings. Notice of any special meeting shall be given at least two days in advance of the meeting, either orally by telephone or in person, or by written notice delivered personally, by e-mail or mailed to each governor at the governor's address shown in AllCare's records. If delivered personally or by e-mail, the notice shall be considered to be

delivered the earlier of the date received or, in the case of e-mail, 24 hours after being sent. If mailed, the notice shall be deemed to be delivered on the second day following deposit in the United States mail. Any governor may waive notice of any meeting. Attendance at a meeting shall constitute a waiver of notice of the meeting, except where a governor attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. Neither the business to be transacted nor the purpose of the meeting must be specified in the notice or waiver of notice. The Board shall notify the public of the time and place of special meetings.

3.7. Quorum. A majority of the governors in office immediately before the commencement of the meeting shall constitute a quorum for the transaction of business at any meeting, except that no quorum shall exist and no action may be taken unless at least five governors who are Holding shareholders are present at the meeting.

3.8. Manner of Acting. The act of a majority of the governors present at a meeting at which a quorum is present shall be the act of AllCare's Board of Governors. Governors shall be deemed to be present at a meeting where all governors participating may simultaneously hear each other during the meeting, irrespective of whether or not they are present in the same location, such as by telephonic conference or interactive computer conferencing.

3.9. Action Without a Meeting. Any action required or permitted to be taken at a meeting of AllCare's Board of Governors may be taken without a meeting upon written consent signed by all the governors then serving stating the action taken. Any action taken without a meeting shall be reported to the public at the next regularly scheduled meeting of the Board.

3.10. Vacancies. Any vacancy occurring on AllCare's Board of Governors may be filled by the affirmative vote of the majority of the remaining governors; provided that at any given time the composition of AllCare's Board of Governors shall, to the extent reasonably possible, be consistent with the requirements of 3.2.3. If there is only one remaining governor, the remaining governor may appoint the person or persons required to fill any vacancies. If there are no remaining governors, the vacancies may be filled by Holding. A governor elected to fill a vacancy shall be elected for the unexpired term of that governor's predecessor in office.

3.11. Presumption of Assent. A governor of AllCare who is present at a meeting of AllCare's Board of Governors when action is taken shall be presumed to have assented to the action taken unless (i) his or her dissent is entered in the minutes of the meeting; (ii) he or she files a written dissent with the person presiding at the meeting before the adjournment of the meeting; or (iii) he or she sends a written dissent by registered mail to the secretary of AllCare immediately after the adjournment of the meeting. The right to dissent shall not apply to a governor who voted in favor of the action.

3.12. Removal. A governor may be removed with or without cause by Holding, in its sole discretion; provided that, to the extent reasonably possible, after the removal and the filling of any vacancy caused by the removal, the composition of AllCare's Board of Governors shall be consistent with the requirements at 3.2.3.

3.13. <u>Resignation</u>. Any governor of AllCare may resign at any time by giving written notice to AllCare's Board of Governors, the Chair, or the secretary of AllCare. Any such resignation shall take effect at the time specified therein, or, if the time be not specified therein, upon its acceptance by AllCare's Board of Governors.

3.14. <u>Compensation</u>. By resolution of AllCare's Board of Governors, the governors may be paid their expenses, if any, of attendance at each meeting of AllCare's Board of Governors and may be paid a fixed sum for attendance at each meeting of AllCare's Board of Governors or a stated salary as governor.

3.15. <u>Composition</u>. Notwithstanding anything in this paragraph 3 to the contrary, Holding and AllCare's Board of Governors shall ensure the composition of AllCare's Board of Governors is and remains consistent with the requirements of 3.2.3. Notwithstanding this paragraph 3.15 or any other paragraph in these Restated Bylaws, the fact AllCare's Board of Governors does not at any given time satisfy the stated composition requirements does not render it unable to act, or otherwise limit its authority, or make any act voidable.

4. **Officers**.

4.1. <u>Number</u>. The officers of AllCare shall be a Chair of the Board and secretary, each of whom shall be elected by AllCare's Board of Governors. Except for the Shareholder Vice-Chair or other officers, such as the Community Vice-Chair, treasurer and assistant officers may be elected or appointed by AllCare's Board of Governors. The Chair and Shareholder Vice-Chair shall be Josephine County based Class A shareholders of Holding and subject to a contract to provide medical services on Corporation's behalf. The Chair, Shareholder Vice-Chair, Community Vice-Chair, secretary and treasurer shall comprise the Executive Committee of AllCare's Board of Governors. The Executive Committee shall prepare the budget for approval by AllCare's Board of Governors and perform any other duties and exercise the authority assigned by AllCare's Board of Governors, to the extent permitted by applicable law.

4.2. <u>Election and Term of Office</u>. The officers shall be elected annually by AllCare's Board of Governors at its annual meeting. If the election of officers is not held at this meeting, the election shall be held as soon thereafter as reasonably practical. Each officer shall hold office until that officer's successor has been duly elected and qualified, or until the officer's death, or until the officer resigns or is removed, whichever occurs first. The Formation Board of Governors shall elect the initial officers at its first meeting.

4.3. <u>Removal and Resignation</u>. Any officer or agent elected or appointed by AllCare's Board of Governors may be removed by majority vote of all governors then serving on AllCare's Board of Governors, with or without cause, whenever in its judgment the best interests of AllCare would be served. Any officer of AllCare may resign at any time by giving written notice to AllCare's Board of Governors, its Chair or its secretary. Resignations take effect at the time specified in the written notice, or, if the time be not specified, upon its acceptance by AllCare's Board of Governors.

4.4. <u>Vacancies</u>. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by AllCare's Board of Governors for the unexpired portion of the term.

4.5. <u>Salaries</u>. The salaries of the officers, if any, shall be fixed from time to time by AllCare's Board of Governors, subject to approval at the annual meeting of the shareholder. Officers are not prohibited from receiving a salary solely because they are also a governor of AllCare.

4.6. <u>Chair of the Board</u>. The Chair shall be the principal executive officer of AllCare and, subject to the control of AllCare's Board of Governors, shall in general supervise the business and affairs of AllCare. The Chair shall preside at all meetings of AllCare's Board of Governors. The Chair may sign certificates for shares of AllCare, and any deeds, mortgages, bonds, contracts, or other instruments which AllCare's Board of Governors has authorized to be executed, except in cases where the signing and execution are expressly delegated by law, by AllCare's Board of Governors or by these Restated Bylaws to some other officer or agent of AllCare; and in general shall perform all duties incident to the office of Chair and any other duties prescribed by AllCare's Board of Governors.

4.7. <u>Shareholder Vice-Chair</u>. In the absence of the Chair or in the event of the Chair's death, inability or refusal to act, the Shareholder Vice-Chair (or in the event there be more than one Vice-Chair, the Vice-Chairs, in the order designated at the time of their election, or in the absence of any designation, then in the order of their election) shall perform the duties of the Chair, and when so acting, have all the powers of and be subject to all the restrictions upon the Chair. Any Vice-Chair may sign, with the secretary, certificates for shares of AllCare; and shall perform any other duties prescribed or assigned by the Chair or AllCare's Board of Governors.

4.8. <u>Community Vice-Chair</u>. The Community Vice-Chair shall be a person elected to that position pursuant to paragraph 4.2 of these Restated Bylaws, and such person may not be a shareholding of Holding. The Community Vice-Chair shall perform the duties assigned to him or her by either the Board of Governors or the Chair of the Board. At the request of the Chair or Shareholder Vice-Chair or upon their absence for any reason, the Community Vice-Chair shall act as the chair of any meeting called pursuant to these Restated Bylaws.

4.9. <u>Secretary</u>. The secretary or the secretary's designee shall:

4.9.1. Keep or cause to be kept at the principal office, or such other place as AllCare's Board of Governors may order, a book of minutes of all meetings of governors and Holding showing the time and place of the meeting, whether the meeting was regular or special and, if a special meeting, how it was authorized, the notice given, the names of those present at governors meetings, and a brief description of the proceedings.

4.9.2. Keep or cause to be kept, at the principal office or at the office of AllCare's transfer agent, a share register, or a duplicate share register, showing the name of Holding and its address, the number of shares held by Holding, the number and date of

the certificate issued for such shares and the number and date of cancellation of certificates surrendered for cancellation.

4.9.3. Give or cause to be given notice of shareholder and governor meetings as required by these Restated Bylaws. If AllCare elects to have a seal, the secretary shall keep the seal and affix it to all documents requiring a seal.

4.9.4. In general perform all duties incident to the office of secretary and the duties prescribed by the Chair or AllCare's Board of Governors.

4.10.   Treasurer. The treasurer or the treasurer's designee shall:

4.10.1. Be responsible for the funds of AllCare, pay them out only on the checks of AllCare signed in the manner authorized by AllCare's Board of Governors, deposit and withdraw funds in the depositories authorized by AllCare's Board of Governors, and keep full and accurate accounts of receipts and disbursements in books maintained at AllCare's principal office.

4.10.2. In general perform all the duties incident to the office of treasurer and the duties prescribed or assigned by the Chair or AllCare's Board of Governors.

4.10.3. Make an annual report to AllCare's Board of Governors regarding the fiscal status of AllCare.

4.11.   Benefit Governor. The Board of Governors shall appoint one of its members to act as the Benefit Governor. The Benefit Governor shall serve at the pleasure of the Board of Governors and shall, in addition to the duties, rights and privileges, and immunities that other governors of AllCare have, has the powers, duties, rights, privileges, and immunities set forth in ORS 60.762.

5.   Contracts, Loans, Checks, and Deposits.

5.1.   Contracts. AllCare's Board of Governors may authorize any officer or officers, agent or agents to enter into any contract or execute and deliver any instrument in the name of and on behalf of AllCare.

5.2.   Loans to Corporation. No loans shall be contracted on behalf of AllCare and no evidences of indebtedness shall be issued in its name unless authorized by a resolution of AllCare's Board of Governors.

5.3.   Checks, Drafts, Etc. All checks, drafts or other orders for the payment of money, notes or other evidences of indebtedness issued in the name of AllCare, shall be signed by the officers or agents designated by, and in the manner prescribed by, AllCare's Board of Governors.

5.4. Deposits. All funds of AllCare not otherwise employed shall be deposited from time to time to the credit of AllCare in the banks, trust companies or other depositories designated by AllCare's Board of Governors.

5.5. Execution of Documents. AllCare's Board of Governors may, except as otherwise provided in these Restated Bylaws, authorize any officer or agent of AllCare to enter into any contract or execute any instrument in the name of and on behalf of AllCare. Unless authorized by AllCare's Board of Governors, or unless inherent in the authority vested in the office under the provisions of these Restated Bylaws, no officer, agent or employee of AllCare has the power or authority to bind AllCare by any contract or engagement, or to pledge its credit, or to render it liable for any purpose or for any amount.

6. Certificates for Shares and Their Transfer.

6.1. Certificates for Shares.

6.1.1. Certificates for shares shall be in the form designated by AllCare's Board of Governors, shall state the name of the person to whom the shares represented by the certificate are issued, and shall state the number and class of shares and the designation of the series, if any, represented by the certificate. If AllCare is authorized to issue different classes of shares or different series within a class, the designations, relative rights, preferences and limitations determined for each series and the authority of AllCare's Board of Governors to determine variations for future series shall be summarized on the front or back of each certificate, or each certificate may state conspicuously on its front or back that AllCare shall furnish shareholders with this information on request in writing and without charge.

6.1.2. Each certificate for shares shall be signed by AllCare's Chair or a Vice-Chair, and its secretary or an assistant secretary. The certificates may bear the corporate seal.

6.1.3. If the officer who signed a share certificate no longer holds office when the certificate is issued, the certificate is nevertheless valid.

6.1.4. AllCare may in its discretion issue certificates for fractional shares, but shall not be required to do so.

6.2. Transfer on the Books. Upon surrender to AllCare of a certificate for shares duly endorsed or accompanied by proper evidence of succession, assignment or authority to transfer, and subject to any limitations on transfer appearing on the certificate or in AllCare's stock transfer records, AllCare shall issue a new certificate, cancel the old certificate and record the transaction upon its books. AllCare's Board of Governors is authorized to impose restrictions on the transfer of shares to the extent permitted by law.

6.3. Lost, Stolen, or Destroyed Certificates. In the event a certificate is represented to be lost, stolen or destroyed, a new certificate shall be issued upon presentation of proof of the

loss, theft or destruction, and after satisfaction of reasonable requirements imposed by AllCare's Board of Governors.

6.4. <u>Transfer Agents and Registrars</u>. AllCare's Board of Governors may from time to time appoint one or more transfer agents and one or more registrars for the shares of AllCare who will have only the powers and duties specified by AllCare's Board of Governors.

7. <u>**Fiscal Year**</u>. AllCare's Board of Governors will set AllCare's fiscal year.

8. <u>**Dividends**</u>. AllCare's Board of Governors may declare and AllCare may pay dividends on its outstanding shares as provided in the Oregon Business Corporation Act as amended from time to time.

9. <u>**Seal**</u>. If AllCare's Board of Governors elects to provide a corporate seal, it shall be circular and shall have inscribed the name of AllCare, the state of incorporation, and the words, "Corporate Seal – Oregon."

10. <u>Waiver of Notice - Delivery of Notice</u>.

10.1. <u>Waiver of Notice</u>. Whenever any notice is required to be given to Holding or any governor under these Restated Bylaws or the Oregon Business Corporation Act, a written waiver, signed by the person or persons entitled to notice, whether before or after the time stated, will be deemed equivalent to giving notice.

10.2. <u>Form of Notice</u>. Whenever, under the Oregon Business Corporation Act or these Restated Bylaws, notice is required to be given to any governor or shareholder, it shall not be construed to mean only personal notice, but shall include notices as defined below.

10.2.1. *Governor Notice*. Required notice to a governor may be given in writing by mail, e-mail or fax, addressed to the governor at the address as it appears on the records of AllCare, or at the last known business or residence address of the governor, prepaid. If mailed, the notice shall be deemed to be delivered on the second day following deposit in the United States mail, and if transmitted by e-mail or fax shall be deemed to be given upon the earlier of personal receipt by the governor or 24 hours following the completed transmittal.

10.2.2. *Shareholder Notice*. Required notice to Holding shall be given in writing by mail, e-mail, or fax, addressed to Holding at the address as it appears on the stock record books or similar records of AllCare, or at the last known business or residence address of Holding, prepaid. If mailed, the notice shall be deemed to be delivered on the second day following deposit in the United States mail, and if transmitted by e-mail or fax shall be deemed to be given upon the earlier of receipt by Holding or 24 hours following the completed receipt of the transmittal.

11. **Amendment of Bylaws**.

11.1. Amendment. Either Holding or AllCare's Board of Governors may amend or repeal AllCare's Bylaws unless:

11.1.1. The Articles of Incorporation or the Oregon Business Corporation Act reserves this power exclusively to Holding in whole or part;

11.1.2. Holding, in adopting, amending, or repealing a particular bylaw, provides expressly that AllCare's Board of Governors may not amend or repeal that bylaw; or

11.1.3. The bylaw either establishes, amends, or deletes a supermajority shareholder quorum or voting requirement.

11.2. Recordation. When an amendment or new bylaw is adopted, it will be copied in the minute book with the original Bylaws in the appropriate place. If any bylaw is repealed, the fact of repeal and the date on which the repeal occurred will be stated in the minute book in the appropriate place.

12. **Deadlock**. If a deadlock occurs in the vote of the governors and the deadlock cannot be resolved by agreement of the parties, the deadlock shall be resolved by Holding.

13. **Indemnification of Governors and Officers**.

13.1. Governors and Officers. AllCare shall indemnify to the fullest extent permitted by law, any person who is made, or threatened to be made, a party to or witness in, or is otherwise involved in, any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative, investigative, or otherwise (including any action, suit or proceeding by or in the right of AllCare) by reason of the fact that:

13.1.1. The person is or was a governor or officer of AllCare or any of its subsidiaries;

13.1.2. The person is or was serving as a fiduciary within the meaning of the Employee Retirement Income Security Act of 1974 with respect to any employee benefit plan of AllCare or any of its subsidiaries; or

13.1.3. The person is or was serving, at the request of AllCare or any of its subsidiaries, as a governor or officer, or as a fiduciary of an employee benefit plan, of another corporation, partnership, joint venture, trust or other enterprise.

13.2. Employees and Other Agents. AllCare may indemnify its employees and other agents to the fullest extent permitted by law.

13.3. Advances of Expenses. The expenses incurred by a governor or officer in connection with any threatened, pending or completed action, suit or proceeding, whether civil,

criminal, administrative, investigative, or otherwise, which the governor or officer is made or threatened to be made a party to or witness in, or is otherwise involved in, shall be paid by AllCare in advance upon written request of the governor or officer, if the governor or officer:

13.3.1. Furnishes AllCare a written affirmation of his or her good faith belief that he or she is entitled to be indemnified by AllCare; and

13.3.2. Furnishes AllCare a written undertaking to repay the advance to the extent that it is ultimately determined by a court that he or she is not entitled to be indemnified by AllCare. Advances shall be made without regard to the person's ability to repay such expenses and without regard to the person's ultimate entitlement to indemnification under this paragraph or otherwise.

13.4. Nonexclusivity of Rights. The rights conferred on any person by this paragraph are in addition to any rights to which a person may otherwise be entitled under any articles of incorporation, bylaw, agreement, statute, policy of insurance, vote of shareholders or Board of Governors, or otherwise.

13.5. Survival of Rights. The rights conferred by this paragraph continue after a governor, officer, employee or agent of AllCare ceases serving in such capacity; and inure to the benefit of their heirs, executors, and administrators.

13.6. Amendments. Any repeal of this paragraph will be prospective only and no repeal or modification of this paragraph shall adversely affect any right or protection that is based upon this paragraph and pertains to an act or omission that occurred prior to the time of the repeal or modification.

14. Transactions Between Corporation and Interested Governors.

14.1. Conflict of Interest. A transaction with AllCare in which a governor of AllCare has a direct or indirect interest is not voidable by AllCare solely because of the governor's interest in the transaction if either (1) the material facts of the transaction and the governor's interest were disclosed or known to AllCare's Board of Governors or a committee of AllCare's Board of Governors, and AllCare's Board of Governors or the committee authorized, approved or ratified the transaction; or (2) the material facts of the transaction and the governor's interest were disclosed or known to the shareholders entitled to vote and they authorized, approved or ratified the transaction; or (3) the transaction was fair to AllCare. Authorization, approval or ratification occurs if a majority of the governors on AllCare's Board of Governors or on the committee, who have no direct or indirect interest in the transaction, vote to authorize.

14.2. Disqualification. A governor of AllCare is not disqualified from contracting with AllCare as vendor, purchaser, or otherwise; nor shall any contract or arrangement entered into by or on behalf of AllCare in which any governor is in any way interested be voided on that account, provided that the contract or arrangement has been approved or ratified by a majority of AllCare's Board of Governors (without counting the interested governor, although the interested governor may be counted toward a quorum), or has been approved or ratified by Holding, and

the interest was disclosed or known to those who approve or ratify the transaction; provided, however, that a transaction may not be authorized, approved or ratified by a single governor.

15. Miscellaneous.

15.1. Books and Records. AllCare shall keep correct and complete books and records of account and shall keep minutes of the proceedings of its shareholders and Board of Governors and shall keep at its registered office a record of its shareholders, giving the names and addresses of all shareholders and the number and class of shares held by each. The records of AllCare shall be open to inspection by the shareholders or the shareholders' agents or attorneys in the manner and to the extent required by applicable law.

15.2. Protection From Liability. THE FOLLOWING SHALL, TO THE GREATEST EXTENT PERMITTED BY LAW, BE ABSOLUTELY PRIVILEGED AND SHALL NOT GIVE RISE TO ANY CLAIM FOR DAMAGES: all matters, at all stages of the investigation, decision making, and review process, relating to professional qualifications or professional conduct, including credentialing, decredentialing, investigations, discipline, suspensions, voluntary or automatic resignations, and terminations. All direct and indirect participants in these activities are entitled to these protections, including assistants to committees, chairs, officers, practitioners, consultants, aides, witnesses, attorneys, reviewer(s), hearings officers, members of AllCare's Board of Governors, any other corporate agent, and any person or entity responding to the requests, providing information, or otherwise assisting any of the processes or proceedings.

16. Committees.

16.1. Creation of Committees. AllCare's Board of Governors may create one or more committees and appoint members of AllCare's Board of Governors, or others, to serve on the committees. Committees may be standing or ad hoc, and may include, as examples only, Care Coordination and Integration, Quality and Performance Improvement, Utilization Management, Finance, and Provider Services. Each committee must have two or more members, who serve at the pleasure of AllCare's Board of Governors.

16.2. Selection of Members. The creation of a committee and appointment of members to it must be approved by a majority of all the governors in office when the action is taken.

16.3. Authority. Unless limited by the Articles of Incorporation, each committee may exercise the authority conferred upon it by AllCare's Board of Governors. However, a committee may not:

16.3.1. Authorize distributions of cash or assets;

16.3.2. Approve and action that the Oregon Business Corporation Act requires be approved by Holding;

16.3.3. Fill vacancies on AllCare's Board of Governors or on any of its committees;

16.3.4. Amend the Articles of Incorporation;

16.3.5. Adopt, amend, or repeal Bylaws;

16.3.6. Approve a plan of merger not requiring shareholder approval;

16.3.7. Authorize or approve reacquisition of shares, except according to a formula or method prescribed by AllCare's Board of Governors; or

16.3.8. Authorize or approve the issuance or sale or contract for sale of shares or determine the designation and relative rights, preferences, and limitations of class or series of shares, except that AllCare's Board of Governors may authorize a committee (or a senior executive officer of AllCare) to do so within limits specifically prescribed by AllCare's Board of Governors.

16.4. <u>Operation</u>. All committees appointed by AllCare's Board of Governors will operate in accordance with policies, procedures, and rules adopted by AllCare's Board of Governors.

17. <u>Ancillary Organizations</u>. ORS 60.265 and SB 1580 require or permit Coordinated Care Organizations to create and support certain ancillary organizations to assist in fulfilling the organization's purposes. AllCare is creating the Community Advisory Councils and Clinical Advisory Panel described in **Schedules 3.2.1.2** and **3.2.1.3**, and the County Commissioner Council described in **Schedule 17**, pursuant to this authority. Each shall be structured, act, and fulfill the purposes described in these Restated Bylaws and their charters. Their charters must be approved by AllCare's Board of Governors before becoming effective. The ancillary organizations are advisory only. They may make nominations and recommendations to AllCare's Board of Governors consistent with their charters and as otherwise requested by AllCare's Board of Governors. No ancillary organization has authority to act on behalf of AllCare, and AllCare's Board of Governors may not delegate such authority to them. The ancillary organizations report and answer to AllCare's Board of Governors as and when required by AllCare's Board of Governors. AllCare's Board of Governors retains the authority to disband, or suspend the activities of, any ancillary organization at any time so long as doing so is not inconsistent with the requirements of ORS 60.265 or SB 1580.

ADOPTED effective April 10 , 2019.

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Susan Seereiter, Secretary

Schedule 3.2.1.2.
Community Advisory Councils

This schedule sets out the structure of the AllCare Health Plan Community Advisory Councils (CACs), and may be amended by AllCare's Board of Governors in its sole discretion.

1. **Number of CACs.** There shall be one CAC for each of the following areas (each, a "CAC Area"):

1.1. Jackson County;

1.2. Curry County; and

1.3. Josephine County plus Douglas County ZIP Codes 97410 and 97442

2. **CAC Charter.** The Board has established a charter briefly describing the structure, purpose, and activities of the CACs. The Board may revise the Charter at any time in its discretion, but only after requesting and considering input from the three CACs. The CAC charter, together with this **Schedule 3.2.1.2**, should be interpreted consistent with the requirements and purposes in ORS 60.265 and Senate Bill 1580.

3. **Structure of Each CAC.**

3.1. Councilors. Each CAC will consist of 7 to 11 councilors, as determined from time to time by the Board in its discretion.

3.2. Application. All nominated candidates will be asked to complete an application, disclosure of conflicts of interest, and authorization for performance of background check.

3.3. Membership. Each CAC shall include at least:

3.3.1. One representative of the CAC Area's county health department, selected by the CAC Area's Board of County Commissioners and approved by AllCare's Board of Governors;

3.3.2. One representative of local government, selected by the CAC Area's Board of County Commissioners and approved by AllCare's Board of Governors; and

3.3.3. Sufficient AllCare Health Plan members residing within the CAC Area to make the plan members a majority of the CAC's councilors. These councilors will be selected by AllCare's Board of Governors, subject to the approval of the CAC Area's Board of County Commissioners.

3.4. Quorum. A majority of the councilors in office immediately before the commencement of a CAC meeting constitutes a quorum for the transaction of business at any

meeting of the CAC, except that no quorum shall exist and no action may be taken unless at least one councilor selected as a health department representative and one councilor selected as a local government representative are present at the meeting.

3.5.   Manner of Acting. The act of a majority of the councilors present at a meeting at which a quorum is present shall be the act of the CAC. Councilors are deemed to be present at a regular or special meeting in which all councilors participating may simultaneously hear each other during the meeting, irrespective of whether or not they are present in the same location, as by a telephonic conference.

3.6.   Term. Councilors will serve three-year terms. A councilor may not serve more than two consecutive terms without a minimum one year break in service.

3.7.   Removal.

3.7.1. A councilor serving in the capacity of an AllCare Health Plan member automatically terminates as a councilor upon termination as a member of AllCare Health Plan.

3.7.2. AllCare's Board of Governors may remove a councilor at its sole discretion.

3.7.3. Notwithstanding 3.7.1 and 3.7.2, AllCare's Board of Governors shall take reasonable steps to assure that the composition of each CAC is and remains consistent with the requirements of 3.3 of this schedule.

3.8.   Officers. Each CAC shall annually elect a Chair and Vice-Chair, which it may replace at any time in its discretion.

3.9.   Nomination to Board of Governors. Each CAC may nominate one councilor for service on AllCare's Board of Governors, subject to approval of AllCare's Board of Governors.

3.10.   Expenses. AllCare will reimburse each councilor for his or her travel costs and other reasonable out-of-pocket expenses incurred in service of the CAC.

Schedule 3.2.1.3.
Clinical Advisory Panel

This schedule sets out the structure of the AllCare Health Plan Clinical Advisory Panel (CAP), and may be amended by AllCare's Board of Governors in its sole discretion.

1. **CAP**. There is one CAP for AllCare Health Plan.

2. **CAP Charter**. The Board has established a charter briefly describing the structure, purpose, and activities of the CAP. The Board may revise the charter at any time in its discretion, but only after requesting and considering input from the CAP. The CAP charter, together with this **Schedule 3.2.1.3**, should be interpreted consistent with the requirements and purposes in ORS 60.265 and Senate Bill 1580.

3. **Structure of CAP**.

3.1. Panelists. Provider organizations who share risk under the OHA Agreement between Corporation and the State of Oregon are eligible to serve as a panelist. The CAP will consist of up to 20 panelists, as selected from time to time by the Board of Governors in its discretion. AllCare's Board of Governors shall consider requests to serve from all eligible provider organizations, and reject requests only upon determining the organization is not eligible, the CAP already has the maximum number of participating panelists, or for other cause clearly stated in the notice of rejection.

3.2. Membership. The Board intends that the CAP include at least one representative from within the AllCare Health Plan service area in each of the following stakeholder categories:

> 3.2.1. Hospital services;
>
> 3.2.2. Mental Health services;
>
> 3.2.3. Addiction services;
>
> 3.2.4. Federally Qualified Health Centers;
>
> 3.2.5. Physician services; and
>
> 3.2.6. Dental services.

3.3. Quorum. Sixty-seven percent of the panelists serving as of the commencement of a CAP meeting constitute a quorum for the transaction of business at any meeting of the CAP.

3.4. Manner of Acting. The approval of two-thirds of the panelists present at a meeting at which a quorum is present is required to approve any action of the CAP. Panelists are deemed to be present at a regular or special meeting in which all panelists participating may

simultaneously hear each other during the meeting, irrespective of whether or not they are present in the same location, as by a telephonic conference.

3.5.　Term. Panelists will serve three calendar-year terms. For this purpose service during any portion of a calendar year is deemed service for the entire year. A panelist may serve unlimited consecutive three year terms if reappointed.

3.6.　Removal. AllCare's Board of Governors may remove a councilor for cause by written notice specifying the reason for removal.

3.7.　Officers. The CAP shall annually elect a Chair and Vice-Chair, which it may replace at any time at its discretion.

3.8.　Board Nomination.

3.8.1. The CAP may nominate six panelists for service on AllCare's Board of Governors:

3.8.1.1. a hospital representative;

3.8.1.2. a representative of another medical provider;

3.8.1.3. a representative of an A&D provider;

3.8.1.4. a representative of a mental health provider;

3.8.1.5. a representative of a dental provider; and

3.8.1.6. an at large member from among the CAP members.

Nominees shall be selected by majority vote of each of the five specified provider types; except that, the at large member shall be selected by majority vote of all CAP members present at the meeting. For this purpose, the Board shall designate each panelist as a single provider type, and each panelist may cast a single vote for a panelist in its provider type and one for the at large nominee. Nominees shall serve on AllCare's Board of Governors only upon approval of AllCare's Board of Governors.

Schedule 17.
County Commissioner Council

This schedule sets out the structure of the AllCare Health Plan County Commissioner Council (CCC), and may be amended by AllCare's Board of Governors in its sole discretion.

1.   **CCC**. There is one CCC for AllCare Health Plan.

2.   **CCC Charter**. AllCare's Board of Governors has established a charter briefly describing the structure, purpose, and activities of the CCC. The Board of Governors may revise the charter at any time in its discretion, but only after requesting and considering input from the CCC. The CCC charter, together with this **Schedule 17**, should be interpreted consistent with the requirements and purposes stated in ORS 60.265 and Senate Bill 1580.

3.   **Structure of CCC**. The Board of County Commissioners from Jackson, Josephine, and Curry counties shall each hold a permanent seat on the CCC. The Board of County Commissioners from each county may occupy its seat with the commissioner or representative it designates, with the designated commissioner or representative changing from meeting to meeting at its discretion. The council members may from time to time select a chair to preside over the meetings, with the chair's term set at the council member's discretion.

4.   **Quorum and Manner of Acting**. Representatives from two of the three counties shall constitute a quorum, with a majority vote required to take action. The CCC's actions may include recommendations to the Board of Governors, but the CCC may not bind or act on behalf of AllCare.   .

EXHIBIT 6.4 - Organizational Structure for Affiliated Entities

Family of Companies
Corporate Structure

AllCare Health, Inc.
Oregon Benefit Company
Oregon SOS registry: 431199-99
ABN: AllCare Health 1229958-97

Governance:
14 member Board of Governors

Ownership:
63 shareholder A (voting)
34 shareholder B (non-voting)
1 shareholder C (voting)

AllCare Development, LLC
Registry 1029546-90
Contract: Real property deeds
Governance: 14 member Board of Governors
Certified (B)

AllCare Independent Physician Association, Inc.
Registry 986548-91
ABN: AllCare IPA 1400701-94
Contract: N/A
Facilitates commercial insurance contracts for individual provider offices
Governance: 9 member Board of Governors

AllCare eHealth Services, LLC
Registry 431236-94
Contract: Greenway Health™
Electronic health record, billing, & care coordination services
Governance: 9 member Board of Governors

AllCare Management Services, LLC
Registry 431200-96
Contract:
- AllCare CCO, Inc.
- AllCare Health Plan, Inc.
- AllCare eHealth Services, LLC
- AllCare Independent Physician Association, Inc.
- AllCare Development, LLC

Employer of all AllCare Health Staff
Governance: 14 member Board of Governors

AllCare Health Plan, Inc.
Registry 397944-82
ABN: AllCare Advantage 1058216-98 AllCare MediGap 1058228-94
Contract:
- CMS Medicare Advantage
- Oregon DCBS Cert #953485
Governance: 14 member Board of Governors

AllCare CCO, Inc.
Registry 613638-92
ABN: AllCare CCO 151933190
Contract: OHA
Manages the Oregon Health Plan in Jackson, Josephine, Curry Counties, & Glendale & Azalea in Douglas County
Governance: 21 member Board of Governors

AllCare PACE, LLC
Registry 1459847-95
Contract: TBD
Program of All-Inclusive Care for the Elderly
Governance: TBD

Contract for IT and administration services

Contract for claims, IT, and administration services

Brand Management_ACHH\C\ACHHC-Family of Companies Flow Chart | Current as of 2.1.19
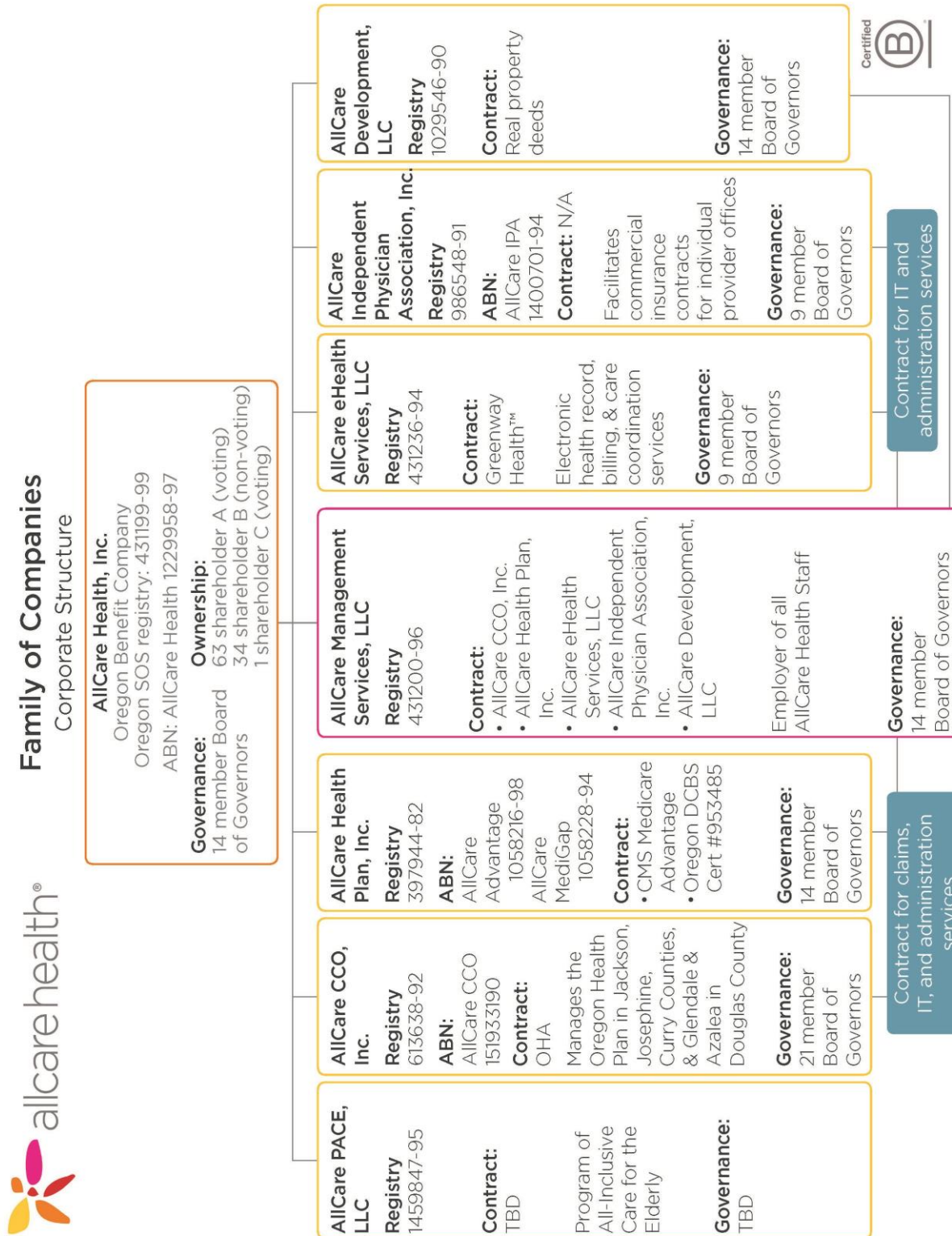
allcare health®

EXHIBIT 6.5 - Example Subcontract between AllCare CCO and AllCare Management Services.

MANAGEMENT AND ADMINISTRATIVE SERVICES AGREEMENT

THIS MANAGEMENT AND ADMINISTRATIVE SERVICES AGREEMENT ("**Agreement**") is entered into by and between AllCare CCO, Inc. ("**CCO**"), an Oregon corporation, and AllCare Management Services, LLC ("**AMS**"), an Oregon limited liability company, effective as of _____, 2018 ("**Effective Date**").

RECITALS

A.   **CCO is a credentialed coordinated care organization which contracts with the state of Oregon through the Oregon Health Authority ("OHA") to provide managed Health Care Services to Members ("OHA Agreement") enrolled in CCO's Medicaid plan ("Plan").**

B.   **AMS is an Oregon limited liability company that provides management and staffing services to health care professionals, health care facilities, insurance companies, and business organizations that serve the healthcare industry.**

C.   **AMS and CCO desire to enter into this Agreement for provision of administrative and management services to CCO, as more fully described herein and in accordance with the terms and conditions of this Agreement.**

AGREEMENT

1.   Delegation and Authority. CCO hereby delegates to AMS the authority to perform certain administrative and management services described in this Agreement ("**Services**"). AMS shall have no duty or power to act on behalf of CCO other than as expressly provided for in this Agreement. Nothing in this Agreement is intended to subvert or modify in any manner whatsoever the contractual and legal obligations, responsibilities, and rights of CCO to administer the Plan. AMS is a first tier and related entity of CCO and CCO shall maintain oversight of AMS' provision of services hereunder.

1.1   *Subcontractor Accountability. To the extent AMS, with the prior written consent of CCO, subcontracts with a third party to perform any service hereunder, AMS shall enter into a written contract with the subcontractor that (i) contains all provisions required by applicable law, (ii) is consistent with the terms of this Agreement and the OHA Agreement, (iii) ensures CCO is a third-party beneficiary to the agreement if the OHA Agreement or applicable law require CCO to retain the right to audit and oversee the subcontractor's performance of the subcontracted services, and (iv) if the subcontractor will receive or create protected health information ("**PHI**" as that term is defined at 45 CFR § 160.103) of any Plan enrollees, the subcontractor has entered into a business associate agreement with AMS.*

2.   General Description and Scope of Services. AMS shall provide the Services generally described below. The Services are more particularly described in ***Exhibit A*** attached hereto.

   2.1   *Administrative and Management Personnel.* AMS shall provide administrative and management personnel (**"Personnel"**) requested by, and reasonably acceptable to CCO, for the purpose of fulfilling the various services described throughout this Section 2. Personnel shall provide services to CCO in accordance with written job descriptions developed by AMS and approved by CCO. In addition, Personnel shall perform tasks and functions reasonably delegated from time to time by the CEO, COO or CFO of CCO, or such other person identified by CCO as having such authority.

   2.2   *Employer-Related Functions and Obligations.* AMS shall be and remain throughout the duration of this Agreement, the employer of all Personnel. As such, AMS shall provide Personnel-related functions and Services.

   2.3   *Business Office and Furnishings.* AMS shall provide office space, suitable furnishings and supplies reasonably required to perform the Services.

   2.4   *Corporate Services*. AMS shall provide corporate services including general administrative and financial and accounting services.

   2.5   *Account and Plan Administration*. AMS shall provide account and Plan member (**"Member"**) administration services for the Plan, including Member enrollment, billing and collection services, and general claims administration.

   2.6   *Member Services.* AMS shall provide services for Members and providers over the phone and in person, quote benefits, confirm Member eligibility, provide appropriate information and resources to Members and providers concerning grievances, complaints and appeals and process the same.

   2.7   *Medical Case Management*. AMS shall provide medical management services for the Plan.

   2.8   *Compliance and Quality Services*. AMS shall provide regulatory and other compliance oversight and quality assurance services for the Plan.

   2.9   *Sales, Marketing and Provider Services*. AMS shall provide Plan sales and marketing services and healthcare provider relations services.

   2.10 *Other Services*. Upon the mutual written agreement of the parties, AMS will provide additional Services reasonably necessary for the efficient and successful operation the Plan. Any such additional Services shall be described by way of amendment to ***Exhibit A***.

3.   Obligations of AMS.

   3.1   *Exclusions List Screening. AMS shall screen all current and prospective owners, legal entities, officers, directors, employees, contractors, and agents ("**Screened Persons**") against (i) the United States Department of Health and Human Services/Office of Inspector General List of Excluded Individuals/Entities (available through the Internet at http://www.oig.hhs.gov), and (ii) the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://www.epls.gov) (collectively, the "**Exclusion Lists**") to ensure that none of the Screened Persons (1) are currently excluded, debarred, suspended, or otherwise ineligible to participate in Federal healthcare programs or in Federal procurement or non-procurement programs, or (2) have been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7(a), but have not yet been excluded, debarred, suspended, or otherwise declared ineligible (each, an "**Ineligible Person**"). If, at any time during the Term of this Agreement any Screened Person becomes an Ineligible Person or proposed to be an Ineligible Person, AMS shall immediately notify CCO of the same upon AMS obtaining knowledge thereof.*

   3.2   *Compliance Obligations. Throughout the term of this Agreement, AMS shall maintain compliance with following:*

      3.2.1   *Laws. Any and all state and federal laws, rules and regulations directly or indirectly applicable to the performance of any obligation hereunder, including but not limited to: (i) all Medicare laws, rules, regulations and "**CMS**" (Centers for Medicare and Medicaid Services) instructions as applicable to administration of the Plan; (ii) Oregon laws, rules, and regulations pertaining to administration of the Oregon Health Plan and any other state-regulated health insurance program; (iii) Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84; (iv) the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR Part 91; (v) the Rehabilitation Act of 1973; (v) the Americans with Disabilities Act; (v) HIPAA; (vi) the HITECH Act; and (vii) all federal fund laws, (each a **Law** and collectively **Laws**).*

         3.2.2.1 The parties acknowledge that federal regulations relating to the confidentiality of individually identifiable health information subject covered entities and their business associates to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder ("**HIPAA**"), including the Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information (collectively "**Privacy and Security Regulations**"). Moreover, covered entities and business associates are further subject to the Health Information Technology for Economic and Clinical Health Act ("**HITECH Act**"), Title XIII of Division A of the American Recovery and Reinvestment Act of 2009 and

regulations promulgated thereunder (the "**Omnibus Rules**"). HIPAA, the Privacy and Security Regulations, HITECH Act, and Omnibus Rules are collectively referred to as the "**HIPAA Rules**." The parties acknowledge that CCO is a *Covered Entity* as defined by the HIPAA Rules and AMS is a *Business Associate* as defined by HIPAA. The parties are required by the HIPAA Rules to execute a Business Associate Agreement which is attached hereto as ***Exhibit C***. In addition, AMS acknowledges that it shall require any subcontractor of AMS that qualifies as a 'subcontractor' under the HIPAA Rules to execute a BAA with AMS prior to providing any Services hereunder.

3.2.2.2 AMS recognizes the importance of preventing and reporting incidents of healthcare fraud, waste or abuse, and that the failure to do so could expose AMS to civil or criminal sanctions. CCO places great importance upon complying with fraud, waste and abuse, statutes, rules and regulations. To that end, AMS shall ensure all Personnel participate in fraud, waste and abuse training on no less than an annual basis. Records of training and training participation shall be maintained in accordance with Section 3.5. In the event of a state or federal investigation where fraud or abuse is alleged, AMS shall immediately notify CCO and AMS shall comply with all lawful requests made during or after the completion of such investigation.

3.2.2.3 Any provision of Law which invalidates or is otherwise inconsistent with the terms of this Agreement, or which would cause one or both of the parties to be in violation of Law, will supersede those terms of this Agreement. In addition, in the event the performance by either party of any term, covenant, condition, or provision of this Agreement shall, in the good faith belief of legal counsel to a party, place in jeopardy the (i) licensure or any certification of either party, or (ii) ability of CCO to fully comply with the terms of the OHA Agreement, then the parties shall promptly meet and confer to resolve the matter through amendment of this Agreement. If the parties are unable to resolve the matter within fifteen (15) days after notice from the other party, either party may then terminate this Agreement.

3.2.2 *OHA Agreement and Requirements. AMS shall ensure that the Services are performed in a manner that is consistent with the obligations of CCO under the terms of the OHA Agreement. Requirements specific to participation in the Oregon Health Plan and AMS' obligations related thereto in performance of the Services are more particularly described in **Exhibit D** attached hereto.*

3.2.3 *Policies and Procedures. AMS shall (i) at all times during the Term comply with CCO policies and procedures, and (ii) within ninety (90) days of hiring or contracting with any Personnel or subcontractor, provide a copy of CCO policies and procedures to such individual(s). In the event AMS has policies*

and procedures applicable to performance of the Services, AMS shall provide a copy of the same to CCO for its inspection and review.

3.2.4 *Accreditation Standards. AMS shall comply with the standards required by the National Committee for Quality Assurance ("NCQA") or other nationally recognized review agency identified by CCO from time to time.*

3.3 *Standards. AMS shall use commercially reasonable efforts to further the mission of CCO in fulfilling its obligations under the OHA Agreement, responsibilities to Plan Members, and proper and appropriate administration of the Plan and agrees to maintain high professional standards in the performance of AMS's duties under this Agreement. AMS shall ensure Personnel receive ongoing training and education as necessary to fulfill the duties and obligations of AMS hereunder.*

3.4 *Insurance. AMS shall maintain the following policies of insurance during the Term of this Agreement: (i) workers' compensation coverage in accordance with the requirements of state law; (ii) comprehensive general liability in a minimum amount of $1,000,000 per occurrence for bodily injury and death and $3,000,000 in the annual aggregate, including cyber liability or comparable coverage, and property damage of not less than $100,000 per occurrence and $500,000 in the aggregate; (iii) standard liability protection against any loss, liability, or damage as a result of the operation of a motor vehicle for business purposes in the minimum amount required by state law; (iv) errors and omissions coverage a minimum amount of $1,000,000 per occurrence and $2,000,000 in the annual aggregate. If requested to do so by CCO, AMS shall provide certificates evidencing required coverage. All insurance shall be maintained without interruption to cover acts and omissions that may occur at any time during the term of this Agreement. This Section shall survive termination of this Agreement.*

3.5 *Records and Information.*

3.5.1 *Record Maintenance. AMS shall maintain all financial records related to the performance of Services in accordance with generally accepted accounting principles or National Association of Insurance Commissioners accounting standards. In addition, AMS shall maintain any other records, books, documents, papers, plans, records of shipment and payments and writings of AMS, whether in paper, electronic or other form, that are pertinent to the Plan ("**Records**" whether in reference to AMS or CCO) in such manner to clearly document AMS's performance of its obligations set forth in this Agreement. AMS shall retain and keep accessible all Plan-related Records pertaining to performance of the Services hereunder, for the longer of (i) ten (10) years following final payment and termination of the Plan; (ii) the period required by applicable law; or (iii) until the conclusion of any audit, controversy or litigation arising out of or related to the Plan during the time which Services were provided by AMS hereunder.*

3.5.2 *Governmental Access to Records. AMS shall provide timely and reasonable access to Records to: (i) the Oregon Health Authority; (ii) the Oregon Secretary of State's Office; (ii) CMS; (iii) the Comptroller General of the United States; (iv) the Oregon Department of Justice Medicaid Fraud Control Unit; (v) the Office of Inspector General, and (vi) all of their duly authorized representatives, to perform examinations and audits, make excerpts and transcripts, and evaluate the quality, appropriateness, compliance with Laws, and timeliness of Services performed pursuant to this Agreement. AMS shall, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit. The rights of access in this Section 3.5.2 are not limited to the retention period specified in Section 3.5.1 but shall last as long as the Records are retained.*

3.5.3 *CCO Access to Records. The CEO and board of governors of CCO and/or their designees shall have the right to inspect and copy (i) all Records pertaining to performance of the Services at any time during normal business hours, and (ii) all Records of CCO in the custody or possession of AMS, for the purpose of auditing AMS' performance of the Services and for any other reasonable purpose.*

3.5.4 *Confidentiality. AMS shall not disclose or use any confidential or proprietary information of CCO other than in the performance of the Services. Confidential information includes but is not limited to, contracts, marketing information, policies and procedures, reimbursement information, Member information including PHI, any nonpublic financial information of CCO, trade secrets, and any other information which a reasonable person would expect to be treated as proprietary or confidential. AMS shall use the same level of care and discretion to prevent unauthorized disclosure or use of CCO's confidential information as AMS uses with its own similar information, but no less than a commercially reasonable level of care. Upon termination of this Agreement, all confidential information of CCO including information pertaining to the Plan, in whatever form, shall be returned to CCO or if incapable of being returned, destroyed.*

3.5.5 *Survival of Provisions. The obligations of AMS described in this Section 3.5 shall survive termination of this Agreement.*

4. CCO Obligations.

4.1 *Provision of Policies and Other Information. CCO shall provide AMS with current copies of all policies and procedures with which AMS is expected to comply in performing the Services, which by this reference are incorporated herein. CCO may periodically update policies and procedures applicable to performance of the Services and will provide updates to AMS in such event.*

4.2   *Monitoring and Oversight. CCO shall regularly monitor AMS' performance of the Services to ensure compliance with CCO policies and procedures, applicable Laws and the OHA Agreement. In the event CCO determines performance of the Services is not in conformance with the requirements hereunder, CCO shall provide prompt written notice to AMS.*

5.   Compensation. CCO shall pay AMS for the Services as specified in **Exhibit B** hereto. The parties intend that compensation paid for the Services provided hereunder are reflective of fair market value, taking into consideration the scope of the Services, commitment of Personnel to perform the Services and matters incident thereto. The parties represent that no consideration has been given to the volume or value of any referrals or other business between the parties in determining the fair market value of the Services being provided hereunder.

6.   Term and Termination.

6.1   *Term. This Agreement shall be effective as of the Effective Date and shall continue until the end of the first calendar year in which it is executed, and thereafter, continue for a period of one year ("**Initial Term**"), unless earlier terminated hereunder. Upon expiration of the Initial Term, unless or until terminated, this Agreement shall automatically renew for successive renewal terms of twelve (12) months (each a "**Renewal Term**") upon the same terms hereof, but subject to adjustment of the compensation set forth in **Exhibit B** as may be necessary to reflect then current fair market values for the Services. The Initial Term and any Renewal Term(s) are together the "**Term**" of this Agreement.*

6.2   *Termination. This Agreement may be terminated as follows:*

6.2.1   *Without Cause. Either party may terminate this Agreement without cause upon written notice to the other party at least one hundred eighty (180) days prior to termination, subject to adjustment as may be reasonably necessary to comply with any Contract provisions that may be impacted thereby.*

6.2.2   *With Cause. Either party may terminate this Agreement on thirty (30) days written notice (**Notice Period**) to the other party in the event of a breach of this Agreement. Unless, prior to the end of the Notice Period, the party in breach cures the breach to the reasonable satisfaction of the other party, this Agreement will terminate automatically at the end of the Notice Period. If AMS is the party in breach and such breach cannot be cured prior to expiration of the Notice Period, or if otherwise requested by CCO, AMS may, no later than the date specified in the written notice of breach, submit a proposed compliance plan (**Compliance Plan**) to CCO. The Compliance Plan shall identify (i) the steps AMS will take to correct the non-compliance, and (ii) a date by which such activities will be completed (**Completion Date**). CCO reserves the right to accept or reject the Compliance Plan in its sole discretion, based upon the nature and severity of the breach. If AMS has not remedied the breach by the end of the Notice Period or Completion*

Date as applicable, this Agreement will terminate. Notwithstanding the procedures described in this Section 6.2.2, if CCO rejects the Compliance Plan and reasonably determines that the breach cannot be cured by the end of the Notice Period, CCO may terminate this Agreement immediately upon notice.

6.2.3 _Immediate Termination_. *This Agreement may be terminated immediately by either party, upon written notice to the other party, as follows:*

6.2.3.1 If the other party engages in any act that would subject either party to criminal liability in the reasonable opinion of a party.

6.2.3.2 Upon dissolution of either party.

6.2.3.3 Upon or following: (i) the insolvency of a party; (ii) the filing of a voluntary or involuntary petition by or on behalf of a party under federal bankruptcy law; (iii) upon a party entering into an agreement with creditors for the liquidation of its assets; or (iv) upon the appointment of a receiver or trustee to take charge of all the assets of a party.

6.2.4 <u>Immediate Termination by CCO</u>. This Agreement may be terminated immediately upon notice to AMS:

6.2.4.1 *Upon the cancellation, termination or expiration of the OHA Agreement, or, in the event the OHA Agreement is in immediate jeopardy of being terminated and CCO reasonably determines immediate termination is necessary in order to avoid termination of the OHA Agreement.*

6.2.4.2 *In the event that AMS fails to take action required under Law with respect to an Ineligible Person.*

6.2.5 _Mutual Agreement_. *By the mutual written agreement of the Parties, on such terms as are set forth therein.*

6.3 _Consequences of Termination_. *Upon termination of this Agreement, the rights and obligations of the parties shall terminate, except (i) for liabilities or obligations of each party which are accrued as of the effective date of termination; (ii) for obligations of CCO to pay AMS compensation for Services rendered prior to termination of this Agreement; (iii) obligations that survive termination of this Agreement as expressly stated herein or, where such obligations by their nature naturally extend beyond the effective date of termination until fulfilled; and (iv) as otherwise expressly agreed by the parties to the contrary. Upon termination or expiration of this Agreement, AMS shall cooperate with and shall not interfere in the transfer of responsibilities of AMS to CCO or a successor entity designated by CCO.*

7. <u>Indemnification.</u> Each of the parties agrees to be liable for its own conduct and to indemnify the other Party against any and all losses therefor. In the event that loss or damage results from the conduct of more than one party, each party agrees to be responsible for its own proportionate share of the claimant's total damages under the laws of the State of Oregon. This Section shall survive termination of this Agreement.

8. <u>Relationship of the Parties.</u> Nothing in this Agreement shall create, nor be construed to create, a partnership or joint venture between CCO and AMS, and neither Party shall have any right, power or authority to create any obligation, expressed or implied, on behalf of the other unless expressly provided in this or another agreement between the parties. The parties are independent contractors.

9. <u>Miscellaneous Provisions.</u>

9.1 *<u>Notices</u>. Any notice required or permitted to be given under this Agreement shall be given in writing and shall be deemed given upon delivery by hand or sent by facsimile transmission or email, or upon deposit in the United States mail, certified, return receipt requested, postage prepaid, to the parties at the following addresses:*

If to AllCare Health CCO, Inc.:	**If to AllCare Management Services, LLC:**
1701 NE 7th Street	1701 NE 7th Street
Grants Pass, Oregon 97526	Grants Pass, Oregon97526

Either party may change its address for notice purposes by giving written notice of the change in accordance with this Section.

9.2 *<u>Entire Agreement and Amendment</u>. This Agreement (and all attachments and exhibits hereto) contains the entire understanding between the parties as it relates to the subject matter hereof. This Agreement shall inure to the benefit of, and be binding upon the parties, their respective successors, heirs, legal representatives or personal representatives. Subject to 3.2.2.3, no amendment or modification to the terms of this Agreement is valid unless made in writing and signed by each of the parties hereto.*

9.3 *<u>Governing Law</u>. This Agreement shall be construed and enforced in accordance with the laws of the State of Oregon.*

9.4 *<u>Dispute Resolution</u>. The parties shall in good faith attempt to resolve any dispute arising out of relating to this Agreement by informal negotiation. If any dispute cannot be resolved in such manner after reasonable efforts by both parties, upon the written request of either party, the dispute shall be submitted to binding arbitration. Arbitration shall be conducted by a single arbitrator mutually agreed upon by the parties, in accordance with the rules of the Arbitration Service of Portland, Inc. If the parties are unable to agree upon an arbitrator, the presiding judge of the Josephine County Circuit Court shall select an arbitrator. Arbitration shall be conducted in Josephine County Oregon. The decision of the arbitrator shall be final and judgment on any award rendered by the arbitrator may be entered*

in any court having proper jurisdiction. Each party shall pay an equal share of the costs of the arbitration services, provided that the arbitrator shall have the authority to award costs and expenses, including reasonable attorneys' fees, to the substantially prevailing party.

9.5   *Waiver of Breach. The waiver by any party of a breach of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach by any party. All waivers shall be in writing to be effective.*

9.6   *Assignment. Neither party may assign its interest in this Agreement or delegate its duties without the prior written consent of the other party, which shall not be unreasonably withheld.*

9.7   *Severability. If any term of this Agreement is held to be invalid or unenforceable, it shall be severed from this Agreement and the balance of the Agreement shall be reasonably construed to carry out the intent of the parties as evidenced by the terms of this Agreement.*

9.8   *No Third-Party Beneficiaries. Nothing contained in this Agreement is intended, nor shall it be construed to create rights for the benefit of third parties.*

9.9   *Captions. Captions contained in this Agreement are inserted only as a matter of convenience, and in no way define, limit, or extend the scope or intent of this agreement or any provision hereof.*

9.10   *Counterparts. This document may be executed in two or more counterparts, each part taken together constituting the whole.*

9.11   *Time Essence. Time is of the essence in the performance of this Agreement.*

9.12   *Exhibits. Attached to this Agreement are the following Exhibits:*

Exhibit A – Services and Reporting
Exhibit B – Compensation
Exhibit C – Business Associate Agreement
Exhibit D – OHP Exhibit

Each and every Exhibit hereto is incorporated by this reference.

The parties hereto have caused this Agreement to be duly executed by their duly authorized officers as of the Effective Date.

AllCare Health CCO, Inc.   **AllCare Management Services, LLC**

_____   _____

By: _____   By: _____

Title: _____   Title: _____

Date: _____   Date: _____

EXHIBIT A

SERVICES

AMS shall provide the following Services to CCO, the scope and description of which is subject to change by mutual agreement of the parties:

1. Personnel-Related Services.

    1.1   *Provide a comprehensive benefit package to Personnel consistent with that of other similarly situated AMS employees.*

    1.2   *Provide human resources support services including, but not limited to: job description development including market evaluation; pre-employment screening including background and reference checks; Exclusion List screening; employment offers and new hire orientation; scheduling; performance review, advancement and discipline, in accordance with AMS employment-related policies as reasonably approved by CCO; payroll and benefits management.*

    1.3   *Remain responsible for income and employment tax reporting and withholding on wages paid to Personnel. AMS shall hold CCO harmless from any and all employment-related taxes, fees, penalties and/or interest that may be imposed upon CCO as a result of the Services performed by Personnel pursuant to this Agreement.*

2. Corporate Services.

    2.1   *General business administration and corporate compliance.*

    2.2   *Management information systems, equipment, maintenance, service and support.*

    2.3   *Finance and accounting services including: accounting, bookkeeping, and operational and capital budgeting and analysis; implementation of accounting systems and software, and internal accounting and financial controls; processing of accounts receivable (including collections efforts in accordance with CCO policies), accounts payable and cash disbursements; financial reporting (consistent with CCO requests and legal requirements as those may change from time to time); management of CCO cash and investments pursuant to CCO directions; preparation of CCO state and federal tax filings. All revenues of CCO shall be used exclusively for such purposes as CCO directs and shall not be used for any other purposes, except upon prior approval by the CCO board of governors.*

    2.4   *Contract management for the Plan, including creating, negotiating and renegotiating as necessary, in conjunction with AMS's legal consultants, contracts with providers, vendors and such other third parties as necessary and directed by*

CCO; executing contracts for which AMS has the legal authority to do so. Contract management services also includes monitoring the different providers needed to adequately provide a comprehensive network for the Plan and pursue additional providers to maintain a full provider network.

3.   Member Services.

3.1   *Confirm Member eligibility, take appeals and complaints, provide information on referral and appeals for providers and members.*

3.2   Provide phone coverage for Members and provider access 8 am – 8 pm, 5 days a week. Provide an answering service from 8 pm to 8 am year around including holidays; if an urgent call is received from a facility or provider the answering service contacts the Member Services Director for resolution.

4.   Medical (Case) Management Services. Staff within Population Health and Utilization Management departments work with Members to coordinate care and help them achieve their best health outcomes.

5.   4.1 Help Members coordinate care between all their healthcare providers and healthcare services.

6.   4.2 Offer clinical programs with a focus on Member education for both acute and chronic disease states.

7.   4.3 Work to help Members to connect with community partners to resolve problems that affect their health but are not traditionally thought of as healthcare related. These social determinants of health include issues around access to adequate food, housing and transportation.

8.   Compliance and Quality Services.

8.1   *Oversee all aspects of CCO's quality program included but not limited to accountability for timeliness requirements for appeals and grievances, quality improvement plan, performance improvement projects, quality improvement projects, provider credentialing, and chronic condition improvement projects.*

8.2   *Retain the service of NCQA HEDIS auditors and software vendors for HEDIS, CAHPS and HOS surveys. Ensure that the Chief Quality Officer (the key contact for state and federal contracts, among other things) participates in state and federal meetings as necessary or required.*

5.3   Appoint a Compliance Officer who shall provide oversight and accountability of all elements of an effective compliance program for the Plan, including working with quality in focus areas such as Fraud, Waste & Abuse (FWA) and civil rights complaints, health equity and disparities issues and

training. Oversee and manage delegated functions with vendors and accountability of the delegates as required by applicable Law. Monitor internal Plan compliance with state and federal contracts and the OARs, CFRs and ORS. Organize and project-manage external audits with contracted vendors. The Compliance Officer reports directly to the Board of Governors.

9. Claims Administration: Services including but not limited to, (i) Plan benefit configuration and all included components, including but not limited to, preparation, updates/amendments, and maintenance of Plan documents, fee schedules and service/procedure codes; filing Plan documents with applicable regulatory agencies when required; claims adjudication; claims payments; claims EDI support services; claims call center; IBNR reporting and ad-hoc reporting as necessary.

10. Provider Relations: Ensure that each provider office can be efficient and have access to information related to Member eligibility, prior-authorizations, claim status, policies and procedures and tools that assist with day to day processes.

11. Develop Alternative Payment Models. Provide program management and oversight for the Alternative Payment Models. Services include program design, development of educational material for participants, educational sessions for program participants, production of quarterly progress reports for providers, and ongoing interaction with program participants to address issues.

REPORTING REQUIREMENTS

1. *Financial Reporting. AMS agrees to promptly provide to the CCO board of governors the following financial reports and filings: (i) a monthly accounting of all revenues and expenses of the Plan, (ii) all revenues of AMS with respect to AMS's performance of its obligations under this Agreement, (iii) copies of all filings and submissions made by AMS on behalf of CCO, if any, and (iv) copies of annual audited financial statements of AMS.*

2. *General Reporting. From time to time AMS may require reports from CCO pertaining to the performance of Services hereunder and such other matters relating to delegated functions hereunder, as AMS requests.*

EXHIBIT B

COMPENSATION

For all management services described in Exhibit A, CCO shall pay AMS a monthly fee based upon the total number of lives enrolled for coverage on the fifteenth (15th) of each calendar month as set forth below. Payments shall be made no later than the 15th day of each month for that month's services, with interest accruing on any late payment at the simple rate of 5% per annum.

CCO enrolled lives, $_____ PMPM

EXHIBIT C

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") is entered into on January 1st 2018, by and between **AllCare Health CCO, Inc.** ("Covered Entity") and **AllCare Management Services, LLC** ("Business Associate").

RECITALS:

A.   Covered Entity is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information (collectively "Privacy and Security Regulations"). Covered Entity and Business Associate are further subject to the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), Title XIII of Division A of the American Recovery and Reinvestment Act of 2009 and regulations promulgated thereunder (the "Omnibus Rules"). The Privacy and Security Regulations and Omnibus Rules will collectively be referred to as the "HIPAA Rules."

B.   Covered Entity has engaged Business Associate to provide certain functions, activities and services (collectively, "Services") to Covered Entity pursuant to the terms of that certain agreement entered into by and between the parties on or about January 1st, 2018 (the "Underlying Agreement").

C.   Business Associate's performance of the Underlying Agreement and provision of the Services, may involve the use and/or creation of Protected Health Information and Electronic Health Information (collectively, "PHI") that is confidential and must be afforded special treatment and protection pursuant to the HIPAA Rules.

D.   Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to this Agreement in compliance with the HIPAA Rules and all other applicable laws and regulations.

E.   As part of the Privacy Rule, Covered Entity must enter into a contract with Business Associate containing specific requirements as set forth in, but not limited to, Title 45, Sections 164.308(b), 164.314(a), 164.502(e), and 164.504(e) of the Code of Federal Regulations ("CFR") and contained in this Agreement, prior to the disclosure of PHI.

NOW, THEREFORE, Covered Entity and Business Associate agree as follows:

ARTICLE I.
Definitions

12.   1.1.   Meaning of Terms. The following terms shall have the meaning ascribed to them in this Section:

(a)   BREACH means the acquisition, access, use or disclosure of PHI in a manner not permitted under the Privacy Rule which compromises the security or privacy of the PHI.

(b)   BUSINESS ASSOCIATE has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations.

(c)   COVERED ENTITY has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations

(d)   DESIGNATED RECORD SET means a group of records maintained by or for Covered Entity that is: (i) the medical records and billing records about Individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) used in whole or in part, by or for Covered Entity to make decisions about Individuals. For these purposes, the term record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for Covered Entity.

(e)   ELECTRONIC PROTECTED HEALTH INFORMATION ("EPHI") means Protected Health Information that is transmitted or maintained by or in electronic media, as defined by 45 CFR § 160.103.

(f)   HHS means the United States Department of Health and Human Services.

(g)   HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended or modified by HITECH or other applicable laws or regulations.

(h)   HITECH ACT means the Health Information Technology for Economic and Clinical Health Act of 2009, as amended, and its implementing regulations.

(i)   INDIVIDUAL means the person who is the subject of the PHI, and shall have the same meaning as the term "individual" as defined in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

(j)   LIMITED DATA SET has the same meaning as the term "limited data set" in 45 CFR § 164.514(e)(2).

(k)   MARKETING has the same meaning as the term "marketing" in 45 CFR § 164.501.

(l)   PARTIES means Business Associate and Covered Entity.

(m)   PRIVACY RULE means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR § 160 and § 164, as amended or modified by the HITECH Act or other applicable laws or regulations.

(n)   PROTECTED HEALTH INFORMATION OR "PHI" has the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. References to PHI shall include EPHI unless specifically stated otherwise.

(o)   REQUIRED BY LAW has the same meaning as the term "required by law" in 45 CFR § 164.103.

(p)   SECRETARY means the Secretary of the Department of Health and Human Services ("HHS") or his or her designee.

(q)   SECURITY INCIDENT has the same meaning as the term "Security Incident" in 45 CFR § 164.304, which generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(r)   SECURITY RULE means the Security Standards for Protecting Electronic Health Information at 45 CFR § 160, § 162 and § 164, as amended or modified by the HITECH Act or other applicable laws or regulations.

(s)   SUBCONTRACTOR has the same meaning as the term "Subcontractor" in 45 CFR § 160.103.

(t)   TRANSACTION STANDARDS means the standards adopted by the Secretary under 45 CFR Part 162.

(u)   UNSECURED PHI means PHI that is not secured through the use of technologies and methodologies that render such PHI unusable, unreadable, or indecipherable to unauthorized individuals, as described by the Secretary in guidance.

1.2.   Other Terms. Other capitalized terms shall have the meaning ascribed to them in the context in which they first appear. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR Parts 160, 162, and 164. Any reference to a regulation or section in the Code of Federal Regulations ("CFR") shall include any corresponding regulation subsequently issued regardless of the date of issue.

ARTICLE II.
General Terms

2.1.   Interpretation of Provisions. In the event of an inconsistency between the provisions of this Agreement and the mandatory terms of the HIPAA Rules (as may be expressly amended from time to time by the HHS or as a result of final interpretations by HHS, an applicable court, or another applicable regulatory agency with authority over the Parties), the HIPAA Rules shall prevail.

2.2. <u>Provisions Permitted by HIPAA Rules</u>. Where provisions of this Agreement are different from those mandated by the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of the Agreement shall control.

2.3. <u>Relationship of Parties</u>. In providing the Services to Covered Entity, Business Associated will be acting as an independent contractor and not as an agent or employee of Covered Entity. None of the provisions of this Agreement or the Underlying Agreement are intended to create, nor shall be deemed or construed to create, any relationship other than that of independent entities contracting with each other for the purposes set forth in this and the Underlying Agreement. None of the provisions of this Agreement shall establish or be deemed or construed to establish any partnership, agency, employment agreement or joint venture between the Parties.

ARTICLE III.
<u>Obligations and Activities of Business Associate</u>

3.1. <u>Limits on Use and Disclosure</u>. Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement or as Required By Law. Further, Business Associate shall use and disclose PHI in accordance with Covered Entity's Notice of Privacy Practices as provided by Covered Entity to Business Associate pursuant to Section 6.1.

3.2. <u>Safeguards</u>. Business Associate agrees to use reasonable and appropriate administrative, physical and technological safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to EPHI, to: (a) prevent use or disclosure of the PHI other than as provided for by this Agreement, and (b) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by the Security Rule. Business Associate represents and warrants that it has implemented, and during the term of this Agreement shall maintain, comprehensive written privacy and security policies and procedures and the necessary administrative, technical and physical safeguards appropriate to the size and complexity of Business Associate's operations and the nature and scope of its activities. Business Associate will comply with the Security Rule requirements set forth in 45 CFR §§ 164.308, 164.310, 164.312, and 164.316, all of which are hereby incorporated into this Agreement.

3.3. <u>Application of Privacy Provisions</u>. Business Associate may use and disclose PHI that Business Associate obtains or creates only if such use or disclosure is in compliance with each applicable requirement of 45 CFR § 164.504(e), relating to business associate agreements. The additional requirements of Subtitle D of HITECH (42 U.S.C. § 17921 et. seq.) that relate to privacy and that are made applicable with respect to Covered Entity shall also be applicable to Business Associate and are hereby incorporated into this Agreement.

3.4. <u>Mitigation of Harm</u>. Business Associate agrees to mitigate, at its cost, any harmful effect that arises out of any use or disclosure of PHI by Business Associate, or any agent or Subcontractor of Business Associate, in violation of the requirements of this Agreement or the HIPAA Rules, regardless of the fault or negligence of Business Associate or the agent or Subcontractor, as appropriate. All such efforts shall be subject to the prior written approval of Covered Entity.

3.5.   Report of Improper Use or Disclosure or of Security Incidents. Business Associate agrees promptly to report to Covered Entity any actual or suspected breach of security, intrusion, or unauthorized use or disclosure of the PHI not provided for by this Agreement, or of any Security Incident of which Business Associate becomes aware. Such report shall be in writing and shall be reported to Covered Entity as soon as practicable after Business Associate becomes aware of such use or disclosure, but in no event later than five (5) business days thereafter; provided however, Business Associate hereby acknowledges to Covered Entity, and Covered Entity hereby acknowledges notice from Business Associate, of the ongoing existence and occurrence from time to time of attempted but Unsuccessful Security Incidents (as defined hereafter) for which notice to Covered Entity by Business Associate shall not be required. "Unsuccessful Security Incidents" includes but is not limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the foregoing, so long as no such incident results in unauthorized access, use or disclosure of PHI. Business Associate shall take prompt corrective action to cure any such deficiencies and any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

3.6.   Notification of Breach of Unsecured PHI. In addition to the general obligations of Business Associate under Section 3.5 regarding reporting the improper use or disclosure of PHI and Security Incidents, Business Associate shall also promptly notify Covered Entity of a Breach of Unsecured PHI. A Breach shall be treated as discovered by Business Associate as of the first day on which such Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or other agent of Business Associate. Business Associate's notification shall be in writing and shall include identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been subject to the Breach. Business Associate shall include the following information in its notification of Breach to Covered Entity:

(a)   A description of the Breach, including the date of the Breach and the date of the discovery of the Breach, if known;

(b)   A description of the types of Unsecured PHI that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, credit card numbers, diagnosis, disability code or other types of PHI were involved);

(c)   Any steps that Individuals should take to protect themselves from potential harm resulting from the Breach;

(d)   A description of what Business Associate is doing to investigate the Breach, to mitigate the harm to Individuals and to protect against further Breaches; and

(e)   Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll free telephone number, an e-mail address, Web site or postal address.

In the event that some of the above-listed information is not known by Business Associate at the time of notification of Covered Entity of the Breach, Business Associate shall provide such information to

Covered Entity as soon as it becomes available to Business Associate, but in no event later than thirty (30) days after Business Associate discovers such Breach. Business Associate shall also provide such assistance and further information with regard to the Breach to Covered Entity as reasonably requested by Covered Entity. The Parties understand and agree that, while Covered Entity is ultimately responsible for all Breach notifications to Individuals, the Secretary, and the media, as applicable, Covered Entity may, in its sole discretion delegate responsibility for notifications to Individuals, to Business Associate at Business Associate's sole expense. Whether or not Covered Entity delegates notification responsibilities to Business Associate, Business Associate shall in all events be responsible for any and all costs related to notification of Individuals or next of kin (if the individual is deceased) of any breach of unsecured PHI caused by Business Associate or any Subcontractor of Business Associate.

3.7. <u>Agents and Subcontractors</u>. Business Associate shall ensure that any Subcontractor or agent that creates, receives, maintains or transmits PHI on behalf of Business Associate agrees in writing to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to PHI, in accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2). Such written agreement shall also require the agent or Subcontractor to implement reasonable and appropriate administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that it creates, receives, maintains or transmits on behalf of Covered Entity.

3.8. <u>Availability of Internal Practices, Books and Records</u>. Business Associate shall make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary in a time and manner designated by the Secretary, for purposes of determining Covered Entity's compliance with the Privacy Rule and the Security Rule. Notwithstanding this provision, no attorney-client or other applicable legal privilege will be deemed waived by Covered Entity as a result of complying with any such request. Business Associate shall promptly provide Covered Entity with a copy of any PHI received from, or created or received by Business Associate on behalf of, Covered Entity that Business Associate provides pursuant to any governmental inquiry.

3.9. <u>Compliance with Covered Entity Obligations.</u> To the extent Business Associate carries out one or more of Covered Entity's obligations under the Privacy Rule, Business Associate shall comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligation(s).

3.10. <u>Access to Records</u>.

(a) Business Associate shall provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set to Covered Entity in order to meet the requirements under 45 CFR § 164.524 with regard to providing an Individual with a right to access the Individual's PHI. In the event that Business Associate maintains EPHI, and in the event an Individual requests an electronic copy of his or her EPHI maintained by Business Associate, Business Associate shall provide such electronic copy as requested, in conformance with the requirements of the Privacy Rule.

(b) Business Associate shall, at the request of Covered Entity and in the time and manner designated by Covered Entity, make PHI maintained by Business Associate available to

Covered Entity for use and disclosure pursuant to a valid written authorization and maintain appropriate documentation for the period, including, but not limited to, copies of any written authorization by an Individual or his or her legal representative, to enable Covered Entity to fulfill its obligations under the Privacy Rule, including but not limited to 45 CFR § 164.508.

(c)   If any Individual requests access to, or the release pursuant to an authorization or otherwise of, PHI directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within three (3) days of the request. Covered Entity shall have sole authority and responsibility to approve or deny such a request, and shall notify Business Associate, in writing, of its decision to approve or deny any such request.

3.11.   <u>Amendments to PHI</u>. Business Associate agrees in the time and manner designated by Covered Entity to make PHI in a designated record set available for any amendments that Covered Entity agrees to make pursuant to 45 CFR § 164.526 or to otherwise allow Covered Entity to comply with its obligations under 45 CFR § 164.526. If any Individual requests an amendment of PHI contained in a Designated Record Set directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within three (3) days of the request. Covered Entity shall have sole authority and responsibility to approve or deny such a request, and shall notify Business Associate, in writing, of its decision to approve or deny any such request.

3.12.   <u>Documentation and Accounting of Disclosures</u>.

(a)   Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Such documentation shall be kept with regard to all disclosures of PHI except the disclosures described in 45 CFR § 164.528(a)(1), as amended. For each such disclosure, Business Associate shall document the following information: (i) the date of the disclosure; (ii) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably states the basis for the disclosure.

(b)   Business Associate shall provide to Covered Entity or an Individual, in the time and manner designated by Covered Entity, information collected in accordance with subsection (a) of this Section, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. In the event that a request for an accounting is delivered directly to Business Associate or its agent or Subcontractor by an Individual or a party other than Covered Entity, Business Associate shall within three (3) days of such request forward it to Covered Entity in writing. Business Associate shall, unless otherwise directed by Covered Entity or as Required By Law, supply an accounting of disclosures of PHI only to Covered Entity. Business Associate hereby agrees to implement an appropriate recordkeeping process to enable it to comply with the requirements of this Section 3.12.

3.13.   <u>Requests for Restrictions and Confidential Communication</u>.   Business Associate will promptly comply Covered Entity's request to restrict the use or disclosure of PHI under 45 CFR

§164.522(a), or for a confidential communication of PHI under 45 CFR §164.522(b). Covered Entity shall notify Business Associate when the restriction or confidential communication requirement becomes effective and terminates.

3.14.   Certain Disclosures. Business Associate shall comply with an Individual's request not to disclose his or her PHI to a Health CCO for Payment or Health Care Operation purposes if the Individual paid for the service in accordance with 45 CFR §164.522(a)(1)(i)(A).

3.15.   Disclosure of Minimum PHI. Business Associate agrees that it and its agents and Subcontractors shall request, use and/or disclose, to the extent practicable, only the Limited Data Set of PHI necessary, or if needed, the minimum amount and content of PHI necessary, to meet the requirements of Business Associate's obligations to Covered Entity. Upon issuance of guidance by the Secretary on what constitutes "minimum necessary" for purposes of 45 CFR § 164.502(b) (pursuant to 42 U.S.C. § 17935(b)(1)(B)), Business Associate agrees that it and its agents and Subcontractors shall request, use and/or disclose only the "minimum necessary" PHI as described in such guidance.

3.16.   Training. Business Associate shall provide appropriate training to its workforce in security, privacy, and confidentiality issues and regulations relating to PHI.

3.17.   Response to Subpoena. Business Associate shall promptly notify Covered Entity if it receives a subpoena or other legal process seeking the disclosure of PHI. Such notification shall be provided in a timeframe that allows Covered Entity a reasonable amount of time to respond to the subpoena, object to the subpoena, or to otherwise intervene in the action to which the subpoena pertains.

3.18.   Notification of Claims. Business Associate shall promptly notify Covered Entity upon notification or receipt of any civil or criminal claims, demands, causes of action, lawsuits, or governmental enforcement actions arising out of or related to this Agreement or the PHI, regardless of whether Covered Entity and/or Business Associate are named as parties in such claims, demands, causes of action, lawsuits, or enforcement actions.

3.19.   Recordkeeping and Document Retention. Business Associate shall retain any documentation it creates or receives relating to its duties under this Agreement for the duration of this Agreement. Covered Entity shall have the right to reasonably access and copy and such documentation during the term of the Agreement. At the termination of this Agreement, Business Associate shall, at Covered Entity's election, return or, if feasible, destroy all such documentation.

3.20.   Transaction Standards. If Business Associate conducts any transaction for Covered Entity for which a standard has been adopted by the Secretary under 45 CFR Part 162, the following shall apply:

(a)   Business Associate, its agents and Subcontractors, shall conduct all transmissions of data required under the Agreement that are subject to the Transaction Standards in compliance with the Transaction Standards, as they may be amended from time to time. With respect to any such Transactions, neither Party shall: (i) change the definition, data condition, or use of a data element or segment in a Transaction Standard; (ii) add any data elements or segments to the maximum defined data set; (iii) use any code or data elements that are either marked "not used" in the Transaction Standard's implementation specification or are not in the Transaction

Standard's implementation specification(s); or (iv) change the meaning or intent of the Transaction Standard's implementation specification(s).

(b)   Each Party, at its own expense, shall provide and maintain the hardware, software, services and testing necessary to effectively and reliably conduct the applicable Transaction Standards.

3.21.   <u>Prohibition on Certain Uses and Disclosures</u>. Business Associate shall not use or disclose PHI for any purpose other than specifically permitted by this Agreement. Specifically, but without limitation, Business Associate shall not use or disclose PHI for fundraising or marketing purposes, and shall not directly or indirectly receive remuneration in exchange for PHI (which does not affect payment from Covered Entity for Business Associate's Services).

3.22.   <u>Compliance with ORS 646A.600</u>. Business Associate acknowledges that certain PHI may also be "personal information" as defined under ORS 646A.602(11) and if applicable, will impose certain obligations upon Business Associate as described in ORS 646A.604. Business Associate agrees to comply with such law to the extent applicable and, to the extent of any conflict between such Oregon law and the HIPAA Rules, Business Associate shall comply with the more restrictive protection requirements.

ARTICLE IV.
<u>Permitted Uses and Disclosures by Business Associate</u>

4.1.   <u>Use or Disclosure to Perform Functions, Activities, or Services</u>. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform those functions, activities, or services that Business Associate performs for, or on behalf of, Covered Entity, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity. Any such use or disclosure shall be limited to those reasons and those individuals as necessary to meet the Business Associate's obligations. In all circumstances, Business Associate shall limit such uses and disclosures to the minimum amount of PHI that is necessary to fulfill those obligations.

4.2.   <u>Disclosures to Workforce</u>. Business Associate shall not disclose PHI to any member of its workforce unless necessary to fulfill a purpose described in Section 4.1 and unless Business Associate has advised such person of Business Associate's obligations under this Agreement and of the consequences for such person and for the Business Associate of violating this Agreement.

4.3.   <u>Appropriate Uses of PHI</u>. Except as otherwise limited in this Agreement, Business Associate may use PHI for the following purposes: (a) the proper management and administration of the Business Associate; (b) or to carry out the legal responsibilities of the Business Associate; or (c) to report violations of the law to appropriate Federal and State authorities consistent with 45 CFR § 164.502(j)(1).

4.4.   <u>Appropriate Disclosures of PHI</u>. Except as otherwise limited in this Agreement, Business Associate may disclose PHI to a third party to carry out the functions described in Section 4.1 or for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the

purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

4.5.   Data Aggregation Services.   If Business Associate provides data aggregation services, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B), except as otherwise provided by this Agreement.

ARTICLE V.
Obligations of Covered Entity

5.1.   Notice of Privacy Practices.   Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice.

5.2.   Change or Revocation of Permission.   Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.   Business Associate shall comply with any such changes or revocations.

5.3.   Restrictions on Use or Disclosure.   Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522.   Business Associate shall comply with any such restrictions.

5.4.   No Request to Use or Disclose in Impermissible Manner.   Except as necessary for the management and administrative activities of the Business Associate as allowed in Sections 4.3 and 4.4, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

ARTICLE VI.
Term and Termination

6.1.   Term.   The Term of this Agreement shall be effective as of the date first documented above, and shall terminate when all PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, or created or received by any Subcontractor or agent of Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity.

6.2.   Termination with Cause.   If Covered Entity reasonably determines that Business Associate or subcontractor has materially breached this Agreement, Covered Entity shall:

(a)   Provide Business Associate with thirty (30) days written notice of the alleged breach and an opportunity for Business Associate to cure the breach or end the violation, immediately after which time this Agreement and the Underlying Agreement shall be automatically terminated if the breach is not so cured; or

(b)   Immediately terminate this Agreement and the Underlying Agreement if cure is not possible; or

(c)   Report the violation to the Secretary if neither termination or cure is feasible.

6.3.   <u>Judicial or Administrative Proceedings</u>. Either party may terminate this Agreement and the Underlying Agreement, effective immediately, if: (a) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA, the HIPAA Rules, or other security or privacy laws; or (b) a finding or stipulation that the other party has violated any standard or requirement of HIPAA, the HIPAA Rules, the HITECH Act or any other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

6.4.   <u>Changes in Law</u>. In the event of passage of a law or promulgation of a regulation or an action or investigation by any regulatory body which would prohibit the relationship between the Parties, or the operations of either party with regard to the subject of this Agreement, the Parties shall attempt in good faith to renegotiate the Agreement to delete the unlawful provision(s) so that the Agreement can continue. If the Parties are unable to renegotiate the Agreement within thirty (30) days, the Agreement and any other agreement or relationship between the Parties related to the Services shall terminate immediately, upon written notice of either party.

6.5.   <u>Effect of Termination.</u>

(a)   Except as provided in paragraph (b) of this Section 6.5, upon termination of this Agreement for any reason, Business Associate shall, at the option of Covered Entity and the expense of Business Associate, either return or destroy all PHI received from Covered Entity, or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of Subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI. If Business Associate is directed to destroy the PHI, Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed.

(b)   In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. Upon Covered Entity's approval, which shall not be unreasonably withheld, Business Associate may retain the PHI, but shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

ARTICLE VII.

<u>Indemnification and Insurance</u>

7.1.   <u>Indemnification</u>. Business Associate shall defend and indemnify Covered Entity from and against any and all claims, damages, liabilities, fines, penalties, losses and expenses (including reasonable attorney's fees) arising out of or in any way related to any breach by Business Associate of any obligation set forth in this Agreement, including but not limited to losses and damages related to third party claims. Without in any way limiting the generality of the foregoing, Business Associate's obligations of indemnity hereunder shall (a) extend to any Breach committed by any Subcontractor or agent of Business Associate that is in anyway involved in performance of the Services, and (b) require Business Associate to hold

Covered Entity harmless from all costs and expenses reasonably incurred by Covered Entity in fulfillment of its breach notification obligations under state and federal law. In addition:

(a)   If Covered Entity is named a party in any judicial, administrative or other proceeding arising out of or in connection with any non-permitted use or disclosure of Covered Entity's PHI or other breach of this Agreement by Business Associate or any subcontractor or agent under Business Associate's control, Covered Entity will have the option at any time either (i) to tender its defense to Business Associate, in which case Business Associate will provide qualified attorneys, consultants, and other appropriate professionals to represent Covered Entity's interests at Business Associate's expense, or (ii) undertake its own defense, choosing the attorneys, consultants, and other appropriate professionals to represent its interests, in which case Business Associate will be responsible for and pay the reasonable fees and expenses of such attorneys, consultants, and other professionals.

(b)   Covered Entity will have the sole right and discretion to settle, compromise, or otherwise resolve any and all claims, causes of actions, liabilities, or damages against it, notwithstanding that Covered Entity may have tendered its defense to Business Associate. Any such resolution will not relieve Business Associate of its obligation to indemnify Covered Entity under this paragraph.

7.2.   Insurance. If required by Covered Entity, Business Associate shall obtain and maintain insurance coverage against improper uses and disclosures of PHI by Business Associate, naming Covered Entity as an additional insured. The limits of such coverage shall be reasonably acceptable to Covered Entity. Promptly upon written request by Covered Entity, Business Associate shall deliver to Covered Entity a certificate evidencing such coverage.

ARTICLE VIII.
Miscellaneous

8.1.   Assignment. This Agreement shall be binding upon and inure to the benefit of the respective legal successors of the Parties. Neither this Agreement nor any rights or obligations hereunder may be assigned, in whole or in part, without the prior written consent of the other Party.

8.2.   Property Rights. All PHI shall be and remain the exclusive property of Covered Entity. Business Associate agrees that it acquires no title or rights to the PHI, including any de-identified information, as a result of this Agreement.

8.3.   Preemption of Other Agreements and Liability Limitations/Exclusions. Any limitations on liabilities or exclusions from liability previously agreed upon by the Parties, whether written or oral, shall not be applicable to breaches of this Agreement, HIPAA, the HIPAA Rules, the HITECH Act and other confidentiality and privacy requirements regarding PHI under this Agreement. To the extent that any provision of this Agreement conflicts with any other agreement between the Parties, whether written or oral, the provisions of this Agreement shall govern. Furthermore, and by way of example and not

limitation, the termination provisions of this Agreement shall supersede the termination provisions of the Underlying Agreement, including, but not limited to, any limitations on terminating the Underlying Agreement (such as notice periods) or any provisions requiring a period to cure.

8.4.   Right to Cure. Business Associate agrees that Covered Entity has the right, but not the obligation, to cure any and all breaches of Business Associate's privacy, security and confidentiality obligations under this Agreement.

8.5.   Survival. The respective rights and obligations set forth in Sections 6.5 and 7.1 of this Agreement shall survive the termination hereof.

8.6.   Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA and the HIPAA Rules.

8.7.   Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended, and for which compliance is required.

8.8.   Entire Agreement. This document, together with any written schedules, amendments and addenda, constitute the entire agreement of the Parties and supersedes all prior oral and written agreements or understandings between them with respect to the matters provided for herein.

8.9.   Governing Law; Venue. This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon to the extent that the provisions of HIPAA or the HIPAA Rules do not preempt the laws of the State of Oregon. In the event any suit is brought to interpret or enforce any provision hereof, such suit shall be filed and heard exclusively in Josephine County, Oregon.

8.10.   Modifications. Any modifications to this Agreement shall be valid only if made in writing and signed by a duly authorized agent of both Parties.

8.11.   Notice. Any notice required or permitted to be given by either party under this Agreement shall be sufficient if in writing and hand delivered (including delivery by courier) or sent by postage prepaid certified mail return receipt requested, as follows:

If to Covered Entity:	If to Business Associate:
Attn.: Compliance Officer	Attn.: Compliance Officer
1701 NE 7th Street	1701 NE 7th Street
Grants Pass, Oregon 97526	Grants Pass, Oregon 97526

13.   8.12.   Severability. The Parties agree that if a court determines, contrary to the intent of the Parties, that any of the provisions or terms of this Agreement are unreasonable or contrary to public policy, or invalid or unenforceable for any reason in fact, law, or equity, such unenforceability or validity shall not affect the enforceability or validity of the remaining provisions and terms of this Agreement. Should any particular provision of this Agreement be held unreasonable or unenforceable for any reason, then such provision shall be given effect and enforced to the fullest extent that would be reasonable and enforceable.

14. <u>8.13. Waiver of Breach. No failure or delay by either party in exercising its rights under this Agreement shall operate as a waiver of such rights, and no waiver of any breach shall constitute a waiver of any prior, concurrent, or subsequent breach.</u>

15. <u>8.14. Titles. Titles or headings are used in this Agreement for reference only and shall not have any effect on the construction or legal effect of this Agreement.</u>

16. <u>8.15. No Third Party Beneficiaries. It is the intent of the Parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other. It is expressly not the intent of the Parties to create any independent rights in any third party or to make any third-party beneficiary of this Agreement and no privity of contract shall exist between third parties and each party.</u>

Each party to this Agreement warrants that it has full power and authority to enter into this Agreement, and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

Covered Entity:
AllCare Health CCO, Inc.

Business Associate:
AllCare Management Services, LLC

By: _____

By: _____

Title: _____

Title: _____

Date: _____

Date: _____

EXHIBIT D

OHP Exhibit

Oregon Health Plan Contract Provisions

AllCare CCO, Inc. ("Contractor") has entered into a Health Plan Services Contract, Coordinated Care Organization Contract with the State of Oregon, acting by and through its Oregon Health Authority ("OHA"), Division of Medical Assistance Programs ("DMAP") and Addictions and Mental Health Division ("AMH") to provide and pay for Coordinated Care Services (the "OHP Contract"). The OHP Contract requires that the provisions in this Exhibit be included in any subcontracts and contracts with medical providers who provide Covered Services to Enrollees of the Oregon Health Plan Medicaid managed care program ("Members"), as well as subcontracts with entities that provide certain administrative and other services to Contractor. This Exhibit is incorporated by reference into and made part of the agreement between Contractor and AllCare Management Services, LLC ("Provider") for the provision of certain administrative and management services to Contractor ("Agreement"). In the event of a conflict or inconsistency with any term or condition in the Agreement and this Exhibit, this Exhibit shall control.

Provider shall comply with the provisions in this Exhibit to the extent that they are applicable to the goods and services provided by Provider under the Agreement; provided, however, that the Agreement shall not terminate or limit Contractor's legal responsibilities to OHA for the timely and effective performance of Contractor's duties and responsibilities under the OHP Contract. Capitalized terms used in this Exhibit, but not otherwise defined in the Agreement shall have the same meaning as those terms in the OHP Contract, including definitions incorporated therein by reference.

1. <u>OHA</u>. To the extent any provision in the OHP Contract applies to Contractor with respect to the Work Contractor is providing to OHA through the Agreement, that provision shall be incorporated by reference into the Agreement and shall apply equally to Provider.

2. <u>Subcontractor Services</u>. To the extent permitted by law and the Agreement, Provider may subcontract any or all of its obligations under the Agreement, provided that a copy of the subcontract is made available to Contractor upon request to ensure compliance with the OHP Contract, applicable law and regulations, and this Exhibit. No subcontract may terminate or limit Provider's responsibility for the timely and effective performance of its duties and responsibilities under the Agreement.

3. <u>Termination for Cause</u>. In addition to pursuing any other remedies allowed at law or in equity or by the Agreement, Provider's participation the OHP Contract may be terminated by Contractor, or Contractor may impose other sanctions against Provider, if Provider's performance is inadequate to meet the requirements of the OHP Contract.

3. Monitoring. Provider agrees that OHA or Contractor is authorized to monitor compliance with the requirements in the Statement of Work under the OHP Contract and that methods of monitoring compliance may include review of documents submitted by Provider, OHP Contract performance review, Grievances, on-site review of documentation or any other source of relevant information.

4. Hold Harmless. Provider shall not hold OHA nor a Member receiving services liable for any costs or charges related to Contractor-authorized Covered Services rendered to a Member whether in an emergency or otherwise. Furthermore, Provider shall not hold a Member liable for any payments for any of the following: (a) Contractor's or Provider's debt due to Contractor's or Provider's insolvency; (b) Coordinated Care Services authorized or required to be provided under the OHP Contract and the Agreement to a Member, for which (i) OHA does not pay Contractor; or (ii) Contractor does not pay Provider for Covered Services rendered to a Member as set forth in the Agreement; and (c) Covered Services furnished pursuant to the Agreement to the extent that those payments are in excess of the amount that the Member would owe if Contractor provided the services directly. Provider may not initiate or maintain a civil action against a Member to collect any amounts owed by the Contractor for which the Member is not liable to the Provider under the Agreement. Nothing in this paragraph 5 shall impair the right of the Provider to charge, collect from, attempt to collect from or maintain a civil action against a Member for any of the following: (a) deductible, copayment, or coinsurance amounts, (b) health services not covered by the Contractor or the OHP Contact, and (c) health services rendered after the termination of the Agreement, unless the health services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination of the Agreement or unless the Provider has assumed post-termination treatment obligations under the Agreement.

5. Continuation. Provider shall continue to provide Covered Services during periods of Contractor insolvency or cessation of operations through the period for which CCO Payments were made to Contractor.

6. Billing and Payment. Provider shall not bill Members for services that are not covered under the OHP Contract unless there is a full written disclosure or waiver on file signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-3420.

7. Reports. Provider shall provide timely access to records and facilities and cooperate with OHA in collection of information through consumer surveys, on-site reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other information for the purposes of monitoring compliance with the OHP Contract, including but not limited to verification of services actually provided, and for developing and monitoring performance and outcomes.

8. Quality Improvement. In conformance with 42 CFR 438 Subpart E, Provider shall cooperate with OHA by providing access to records and facilities for the purpose of an annual, external,

independent professional review of the quality outcomes and timeliness of, and access to, Services provided under the OHP Contract.

9.   Access to Records. Provider shall maintain all financial records related to the OHP Contract in accordance with generally accepted accounting principles or National Association of Insurance Commissioners accounting standards. In addition, Provider shall maintain any other records, books, documents, papers, plans, records of shipment and payments and writings of Provider, whether in paper, electronic or other form, that are pertinent to the OHP Contract (the "Records") in such a manner to clearly document Provider's performance. Provider shall provide timely and reasonable access to Records to: (a) OHA; (b) the Secretary of State's Office; (c) CMS; (d) the Comptroller General of the United States; (e) the Oregon Department of Justice Medicaid Fraud Control Unit; and (g) all their duly authorized representatives, to perform examinations and audits, make excerpts and transcripts, and evaluate the quality, appropriateness and timeliness of services performed. Provider shall, upon request and without charge, provide a suitable work area and copying capabilities to facilities for such a review or audit. Provider shall retain and keep accessible all Records for the longer of: (a) six years following final payment and termination of the OHP Contract; (b) the period as may be required by applicable law, including the records retention schedules set forth in OAR Chapter 166; or (c) until the conclusion of any audit, controversy or litigation arising out of or related to the OHP Contract. The rights of access in this paragraph 9 are not limited to the required retention period, but shall last as long as the Records are retained.

10.   Clinical Records and Confidentiality of Member Records. Provider shall comply with Contractor's policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act, 42 USC 1320d et. seq., and the federal regulations implementing the Act ("HIPAA"), and complete Clinical Records that document the Coordinated Care Services received by the Members. Contractor shall regularly monitor Provider's compliance with these policies and procedures and Provider shall be subject to and comply with any Corrective Action taken by Contractor that is necessary to ensure Provider compliance.

11.   Reporting of Abuse. Provider shall comply with all patient abuse reporting requirements and fully cooperate with the State for purposes of ORS 124.060 et.seq., ORS 419B.010 et.seq., ORS 430.735 et.seq., ORS 441.630 et.seq., and all applicable Administrative Rules. In addition, Provider shall comply with all protective services, investigation and reporting requirements described in OAR 943-045-0250 through 943-045-0370 and ORS 430.735 through 430.765.

12.   Fraud and Abuse.

12.1. *Certification*. Provider acknowledges that the Oregon False Claims Act (ORS 180.750 to 180.785) applies to any "claim" (as defined by ORS 180.750) that is made by (or caused by) the Provider and that pertains to the Services provided under the Agreement. The Provider certifies that no claim described in the previous sentence is or will be a "False Claim" (as defined by ORS 170.750) or an act prohibited by ORS 180.755. Provider further acknowledges that in addition to the remedies under the Agreement, if Provider makes (or causes to be made) a False Claim or performs (or causes to be performed) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against the Provider.

12.2. *Compliance and Reporting.* Provider shall comply with Contractor's fraud and Abuse policies to prevent and detect fraud and Abuse activities as such activities relate to the OHP, and shall promptly refer all suspected cases of fraud and Abuse to the Contractor, the Medicaid Fraud Control Unit ("MFCU"), and OHA/DHS Provider Fraud Unit ("PAU"). Provider shall permit the MFCU or OHA/DHS PAU or both to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of Provider, as required to investigate an incident of fraud and Abuse. Provider shall cooperate with the MFCU and OHA/DHS PAU investigator during any investigation of fraud and Abuse. Provider shall provide copies of reports or other documentation regarding any suspected fraud at no cost to MFCU or OHA/DHS PAU during an investigation.

13. <u>Certification</u>. Provider certifies that all claims data submissions by the Provider, either directly or through a third party submitter, is and will be accurate, truthful and complete in accordance with OAR 410-141-3320 and OAR 410-120-1280.

14. <u>Mental Health Services and Substance Use Disorder Services</u>.

14.1. *Measures and Outcomes Tracking System*. If Provider provides Mental Health Services and/or substance use disorder services, including those for DUII and methadone programs, Provider shall enroll the Member(s) being treated in the Measures and Outcomes Tracking System (MOTS), formerly known as CPMS, as specified at http://www.oregon.gov/oha/amh/mots/Pages/index.aspx.

14.2. *Community Services*. If Provider provides substance use disorder services, Provider shall provide to Members, to the extent of available community resources and as clinically indicated, information and referral to community services which may include, but are not limited to: child care; elder care; housing; transportation; employment; vocational training; educational services; mental health services; financial services; and legal services.

14.3.   *Child, Family and Young Adult Services*. A Provider that provides child, family, or young adult mental health services and/or substance use services shall comply with Contractor's policies and guidelines for integrated community-based children's mental health services for Members.

14.4.   *Training.*   Where Provider provides substance use disorder services and evaluates Members for access to and length of stay in substance use disorder services, Provider represents and warrants that it has the training and background in substance use disorder services and working knowledge of American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (PPC-2R).

14.5.   *Reporting.* If Provider provides Substance Use Disorder services, Provider shall provide to OHA, within 30 days of admission or discharge, all information required by OHS's most current data system.

15.   State Provisions. Provider shall comply with all State and local laws, rules, regulations, executive orders and ordinances applicable to the OHP Contract or to the performance of Work under the Agreement, including but not limited to the following: (a) ORS Chapter 659A.142; (b) OHA rules pertaining to the provision of integrated and coordinated care and services, OAR Chapter 410, Division 141; (c) all other OHA Rules in OAR Chapter 410; (d) rules in OAR Chapter 309 Divisions 012, 014, 015, 018, 019, 022, 032, and 040 pertaining to the provisions of mental health services; (e) rules in OAR Chapter 415 pertaining to the provision of Substance Use Disorders services; (f) state law establishing requirements for Declaration for Mental Health Treatment in ORS 127.700 through 127.737; and (g) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations. These laws, rules, regulations, executive orders and ordinances are incorporated by reference herein to the extent that they are applicable to the OHP Contract and required by law to be so incorporated. Provider shall, to the maximum extent economically feasible in the performance of the Agreement pertinent to the OHP Contact, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled PETE products (as defined in ORS 279A.010(1)(hh)), and other recycled products (as "recycled products" is defined in ORS 279A.010(1)(ii)).

16.   Americans with Disabilities Act. In compliance with the Americans with Disabilities Act of 1990, any written material that is generated and provided by Provider under the OHP Contract to Members, including Medicaid-Eligible Individuals, shall, at the request of such individuals, be reproduced in alternate formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format. Provider shall not be reimbursed for costs incurred in complying with this provision.

17.   Information/Privacy/Security/Access.   If the items or services provided under the Agreement permits Provider to have access to or use of any OHA computer system or other OHA Information Asset for which OHA imposes security requirements, and OHA grants Contractor access to

such OHA Information Assets or Network and Information Systems, Provider shall comply with OAR 407-014-0300 through OAR 407-014-0320.

18.   Governing Law, Consent to Jurisdiction. The OHP Contract shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding between the OHA (or any other agency or department of the State of Oregon) and Provider that arises from or relates to the OHP Contract shall be brought and conducted solely and exclusively within the Circuit Court of Marion County for the State of Oregon; provided, however, if a claim must be brought in a federal forum, then it shall be conducted solely and exclusively within the United States District Court of the District of Oregon. In no event shall this paragraph 19 be construed as a waiver of the State of Oregon of the jurisdiction of any court or of any form of defense to or immunity from any claim whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the Unites States or otherwise. PROVIDER, BY EXECUTION OF THE AGREEMENT, HEREBY CONSENTS TO THE IN PERSONAM JURISDICTION OF SAID COURTS.

19.   Independent Contractor.

19.1.   *Not an Employee of the State*. Provider represents and warrants that it is not an officer, employee, or agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.

19.2.   *Current Work for State or Federal Government.* If Provider is currently performing work for the State of Oregon or the federal government, Provider by signature to the Agreement represents and warrants that Provider's Work to be performed under the Agreement creates no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency for which Provider currently performs work would prohibit Provider's work under the Agreement or the OHP Contract. If compensation under the Agreement is to be charged against federal funds, Provider certifies that it is not currently employed by the federal government.

19.3.   *Taxes*. Provider shall be responsible for all federal and State of Oregon taxes applicable to compensation paid to Provider under the Agreement, and unless Provider is subject to backup withholding, OHA and Contractor will not withhold from such compensation any amount to cover Provider's federal or State tax obligations. Provider shall not be eligible for any social security, unemployment insurance or workers' compensation benefits from compensation paid to Provider under the Agreement, except as a self-employed individual.

19.4.   *Control*.   Provider shall perform all Work as an independent contractor. Provider understands that OHA reserves the right (i) to determine and modify the delivery schedule for the Work and (ii) to evaluate the quality of the Work Product; however, OHA may not and will not control the means or

manner of Provider's performance. Provider is responsible for determining the appropriate means and manner of performing the Work delegated under the Agreement.

20.   Representations and Warranties. Provider represents and warrants to Contractor that: (a) Provider has the power and authority to enter into and perform the Agreement; (b) the Agreement, when executed and delivered, shall be a valid and binding obligation of Provider enforceable in accordance with its terms, (c) Provider has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Provider will apply that skill and knowledge with care and diligence to perform the Work in a professional manner and in accordance with standards prevalent in Provider's industry, trade or profession; and (d) Provider shall, at all times during the term of the Agreement, be qualified, professionally competent, and duly licensed to perform the Work. The warranties set forth in this paragraph are in addition to, and not in lieu of, any other warranties provided.

21.   Assignment, Successor in Interest. Provider shall not assign or transfer its interest in the Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other matter, without prior written consent of Contractor. Any such assignment or transfer, if approved, is subject to such conditions and provisions as Contractor and OHA may deem necessary, including but not limited to Exhibit B, Part 8, Section 14 of the OHP Contract. No approval by Contractor of any assignment or transfer of interest shall be deemed to create any obligation of Contractor in addition to those set forth in the Agreement. The provisions of the Agreement shall be binding upon and inure to the benefit of the parties, their respective successors and permitted assigns.

22.   Severability. If any term or provision of the OHP Contract, the Agreement or this Exhibit is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provision shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the OHP Contract, the Agreement or this Exhibit did not contain the particular term or provision held to be unlawful.

23.   Limitations of Liabilities. Provider agrees that OHA and Contractor shall not be held liable for any of Provider's debts or liabilities in the event of insolvency.

24.   Compliance with Federal Laws. Provider shall comply with federal laws as set forth or incorporated, or both, in the OHP Contract and all other federal laws applicable to Provider's performance relating to the OHP Contract or the Agreement. For purposes of the OHP Contract and the Agreement, all references to federal laws are references to federal laws as they may be amended from time to time. In addition, unless exempt under 45 CFR Part 87 for Faith-Based Organizations, or other federal provisions, Provider shall comply with the following federal requirements to the extent that they are applicable to the OHP Contract and the Agreement:

24.1. *Federal Provisions*. Provider shall comply with all federal laws, regulations, and executive orders applicable to the OHP Contract or to the delivery of Work under the Agreement. Without limiting the generality of the foregoing, Provider expressly agrees to comply with the following laws, regulations and executive orders to the extent they are applicable to the OHP Contract and the Agreement: (a) Title VI and VII of the Civil Rights Act of 1964, as amended, (b) 45 CFR Part 84 which implements Title V, Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Executive Order 11246, as amended, (e) the Health Insurance Portability and Accountability Act of 1996, as amended, (f) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (g) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (h) the Mental Health Parity and Addiction Equity Act of 2008, as amended, (i) all federal laws requiring reporting of Member abuse; (j) all regulations and administrative rules established pursuant to the foregoing laws, and (kj) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the OHP Contract and the Agreement and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 U.S.C. 14402.

24.2. *Equal Employment Opportunity*. If the OHP Contract, including amendments, is for more than $10,000, then Provider shall comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).

24.3. *Clean Air, Clean Water, EPA Regulations*. If the OHP Contract, including amendments, exceeds $100,000 then Provider shall comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 USC 1251 to 1387), specifically including, but not limited to Section 508 (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under non exempt federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported to OHA, the U.S. Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency. Provider shall include in all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this subparagraph.

24.4. *Energy Efficiency*. Subcontractor shall comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 USC 6201 et seq. (Pub. L. 94-163).

24.5. *Truth in Lobbying*. Provider certifies, to the best of the Provider's knowledge and belief that:

a. No federal appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Provider shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

c. Provider shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and Subcontractors shall certify and disclose accordingly.

d. No part of any federal funds paid to Provider under this Contract shall be used other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the United States Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself.

e. No part of any federal funds paid to Provider under this Contract shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the United States Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

f.   The prohibitions in subsections (d) and (e) of this section shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction an any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

g.   No part of any federal funds paid to Provider under this Contract may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under Section 202 of the Controlled Substances Act except for normal and recognized executive congressional communications. This limitation shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance of that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

24.6.   *HIPAA Compliance*. Provider acknowledges and agrees that Contractor is a "covered entity" for purpose of the privacy and security provisions of HIPAA. Accordingly, Provider shall comply with HIPAA and the following:

a.   Individually Identifiable Health Information ("IIHI") about specific individuals is protected from unauthorized use or disclosure consistent with the requirement of HIPAA. IIHI relating to specific individuals may be exchanged between Provider and Contractor and between Provider and OHA for purposes directly related to the provision of services to Members which are funded in whole or in part under the OHP Contract. However, Provider shall not use or disclose any IIHI about specific individuals in a manner that would violate (i) the HIPAA Privacy Rules in CFR Parts 160 and 164; (ii) the OHA Privacy Rules, OAR 407-014-0000 et.seq., or (iii) the OHA Notice of Privacy Practices, if done by OHA. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: https://apps.state.or.us/cf1/FORMS/, form number ME2090 Notice of Privacy Practices, or may be obtained from OHA.

b.   Provider shall adopt and employ reasonable administrative and physical safeguards consistent with the Security Rule in 45 CFR Part 164 to ensure that Member Information is used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with applicable State and federal laws and the terms and conditions of the OHP Contract and the Agreement. Security incidents involving Member Information must be immediately reported to the Contractor's privacy officer and to the Oregon Department of Human Services' ("DHS") Privacy Officer.

c.   Provider shall comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the DHS Electronic Data Transmission Rules, OAR 410-001-0000 through 410-001-0200. If Contractor intends to exchange electronic data transactions with OHA in connection with claims or encounter data, eligibility or enrollment information, authorizations or other electronic transactions, Provider shall comply with OHA Electronic Data Transmission Rules.

d.   If Provider reasonably believes that the Contractor's or OHA's data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Provider shall promptly consult Contractor or the OHA HIPAA officer.

24.7.   *Resource Conservation and Recovery*. Provider shall comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency.

24.8.   *Audits*. Provider shall comply with applicable audit requirements and responsibilities set forth in the OHP Contract and applicable state or federal law.

24.9.   *Debarment and Suspension*. Provider represents and warrants that it, or any person owning more than 5% of Provider's equity, is not excluded by the U.S. Department of Health and Human Services Office of the Inspector General or listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension."

24.10.   *Drug-Free Workplace*. Provider shall comply with the following provisions to maintain a drug-free workplace:

a.   Provider certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in Provider's workplace or while providing services to Members. Provider's notice shall specify the actions that will be taken by Provider against its employees for violation of such prohibitions;

b.   Establish a drug-free awareness program to inform its employees about: the dangers of drug abuse in the workplace, Provider's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations;

c. Provide each employee to be engaged in the performance of services under the Agreement a copy of the statement mentioned in subparagraph 24.10.a above;

d. Notify each employee in the statement required by subparagraph 24.10.a that, as a condition of employment to provide services under the OHP Contract the employee will: abide by the terms of the statement, and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

e. Notify OHA and Contractor within ten days after receiving notice under subparagraph 24.10.d from an employee or otherwise receiving actual notice of such conviction;

f. Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988;

g. Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs 24.10.a through 24.10.f;

h. Require any subcontractor to comply with subparagraphs 24.10.a through 24.10.g;

i. Neither Provider, nor any of Provider's employees, officers, agents or subcontractors may provide any service required under the Agreement while under the influence of drugs. For purposes of this provision, "under the influence" means: observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Provider or Provider's employee, officer, agent or subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Provider or Provider's employee, officer, agent or subcontractor's performance of essential job function or creates a direct threat to Members or others. Examples of abnormal behavior include, but are not limited to: hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to: slurred speech, difficulty walking or performing job activities;

j. Violation of any provision of this subparagraph 24.10 may result in termination of Provider's participation in the OHP Contract.

24.11. *Pro-Children Act*. Provider shall comply with the Pro-Children Act of 1994 (codified at 20 USC Section 6081 et. seq.).

24.12. *Clinical Laboratory Improvements*. Provider and any laboratories used by Provider shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438, which require that all laboratory testing sites providing services under the OHP Contract shall have either a Clinical Laboratory Improvement Amendments ("CLIA") certificate of waiver or a certificate of registration along with a CLIA identification number. Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

24.13. *OASIS*. To the extent applicable, Provider shall comply with the Outcome and Assessment Information Set ("OASIS") reporting requirements and patient notice requirements for skilled services provided by Home Health Agencies, pursuant to the CMS requirements published in 64 FR 3764, 64 FR 3748, 64 FR 23846, and 64 FR 32984, and such subsequent regulations as CMS may issue in relation to the OASIS program.

24.14. *Patient Rights Condition of Participation*. To the extent applicable, Provider shall comply with the Patient Rights Condition of Participation that hospitals must meet to continue participation in the Medicaid program, pursuant to 42 CFR Part 482. For purposes of this Exhibit, hospitals include short-term, psychiatric, rehabilitation, long-term, and children's hospitals.

24.15. *Federal Grant Requirements*. Provider shall not expend any of the funds paid under the Agreement for any item or service not covered under the Oregon Health Plan ("OHP").

24.16. *Title II of the Americans with Disabilities Act*. Provider shall comply with the integration mandate in 28 CFR 35.130(d), Title II of the Americans with Disabilities Act and its implementing regulations published in the Code of Federal Regulations.

24.17. *Disclosure of Business Transactions*. Provider shall provide within 35 days of a request by the Secretary, OHA, or Contractor full and complete information regarding: (a) Provider's ownership of any subcontractor with whom Provider has had business truncations totaling more than $25,000 during the 12-month period prior to the date of the request; and (b) any significant business transaction between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request. A significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a Provider's total operating expenses. (See 42 CFR § 455.101 and § 455.105).

25.   <u>Marketing</u>. Provider shall not initiate contact nor Market independently to potential Clients, directly or through any agent or independent contractor, in an attempt to influence an OHP Client's Enrollment with Contractor, without the express written consent of OHA. Provider shall not directly or indirectly engage in door-to-door, telephonic, mail, electronic, or other Cold Call Marketing practices to entice a Client to enroll with Contractor, or to not enroll with another OHP contractor. Provider shall not seek to influence a Client's Enrollment with the Contractor in conjunction with the sale of any other insurance. Material distributed by Provider may not contain inaccurate, false, confusing or misleading information. Furthermore, Provider understands that OHA must approve, prior to distribution, any written communication by Provider that (a) is intended solely for Members, and (b) pertains to provider requirements for obtaining coordinated care services, care at service site or benefits. Notwithstanding anything to the contrary in this paragraph 25, Provider may post a sign listing all OHP Coordinated Care Organizations to which Provider belongs and display Coordinated Care Organization-sponsored health promotional materials.

26.   <u>Workers' Compensation Coverage</u>. If Provider employs subject workers, as defined in ORS 656.027, then Provider shall comply with ORS 656.017 and shall provide workers' compensation insurance coverage for those workers, unless they meet the requirements for an exemption under ORS 656.126(2).

27.   <u>Third Party Resources</u>.

27.1.   *Provision of Covered Services*. Provider may not refuse to provide Covered Services to a Member because of a Third Party Resource's potential liability for payment for the Covered Services.

27.2.   *Reimbursement*. Provider understands that where Medicare and Contractor have paid for services, and the amount available from the Third Party Liability is not sufficient to satisfy the Claims of both programs to reimbursement, the Third Party Liability must reimburse Medicare the full amount of its Claim before any other entity, including Provider, may be paid. In addition, if a Third Party has reimbursed Provider, or if a Member, after receiving payment from a Third Party Liability, has reimbursed Provider, the Provider shall reimburse Medicare up to the full amount the Provider received, if Medicare is unable to recover its payment from the remainder of the Third Party Liability payment.

27.3.   *Confidentiality*. When engaging in Third Party Resource recovery actions, Provider shall comply with federal and State confidentiality requirements, described in Exhibit E of the OHP Contract.

27.4.   *No Compensation*.   Except as permitted by the OHP Contract including Third Party Resources recovery, Provider may not be compensated for Work performed under the OHP Contract from any other department of the State, nor from any other source including the federal government.

27.5.   *Third Party Liability*. Provider shall take all reasonable actions to pursue recovery of Third Party Liability for Covered Services not recovered by Contractor.   Provider shall maintain records of Provider's actions related to Third Party Liability recovery, and make those records available for Contractor and OHA review.

27.6.   *Right of Recovery*. Provider shall comply with 42 USC 1395y(b), which gives Medicare the right to recover its benefits from employers and workers' compensation carriers, liability insurers, automobile or no fault insurers, and employer group health plans before any other entity including Contractor or Provider.

27.7.   *Disenrolled Members.* If OHA retroactively disenrolls a Member at the time the Member acquired Third Party Liability insurance, pursuant to OAR 410-141-3080(2)(b)(D) or 410-141-3080(3)(a)(A), Provider may not seek to collect from a Member (or any financially responsible Representative) or any Third Party Liability, any amounts paid for any Covered Services provided on or after the date of Disenrollment.

28.   <u>Preventive Care</u>. Where Provider provides Preventive Care Services, all Preventive Care Services provided by Provider to Members shall be reported to Contractor and shall be subject to Contractor's Medical Case Management and Record Keeping responsibilities.

29.   <u>Care Coordination</u>.   Provider shall communicate and coordinate care with 'patient-centered primary care homes' in a timely manner using electronic health information technology when and as available, in accordance with Contractor policies and procedures.   Provider shall maintain individualized care plans to the extent feasible for each Member, in order to address the supportive, therapeutic, cultural and linguistic health of each Member, particularly those with intensive care coordination needs, in accordance with Contractor policies and procedures.

30.   <u>Accessibility</u>.

30.1.   *Timely Access, Hours*. Provider shall meet OHP standards for timely access to care and services, taking into account the urgency of the need for services as specified in OAR 410-141-3220.   This requirement includes that Provider offer hours of operation that are not less than the hours of operation

offered to Contractor's commercial members (as applicable) and non-Members as provided in OAR 410-141-3220.

30.2.   *Special Needs.* Provider and Provider's facilities shall meet the special needs of Members who require accommodations because of a disability or limited English proficiency.

31.   Member Rights.   Provider shall ensure that each Member is afforded the rights guaranteed Members in OAR 410-141-0230 including, but not limited to:

31.1.   *Treating Members with Respect and Equality*. Provider shall treat each Member with respect and with due consideration for his or her dignity and privacy. In addition, Provider shall treat each Member the same as other patients who receive services equivalent to Covered Services.

31.2.   *Information on Treatment Options.* Provider shall ensure that each Member receives information on available treatment options and alternatives in a manner appropriate to the Member's condition and ability to understand.

31.3.   *Participation Decisions.* Provider shall allow each Member to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and decisions regarding coordination of follow up care.

31.4.   *Copy of Medical Records.* Provider shall ensure that each Member is allowed to request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45 CFR 164.524 and 164.526.

31.5.   *Exercise of Rights*. Provider shall ensure that each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Provider, its staff, its subcontractors, its Participating Providers, or OHA treat the Member.

32.   Grievance System. Provider shall cooperate with DHS's Governor's Advocacy Office, the OHA Ombudsman and hearing representatives in all of the OHA's activities related to Members' grievances, appeals and hearings including providing all requested written materials.

33. <u>Authorization of Service</u>. Provider shall follow Contractor's procedures for the initial and continuing authorizations for services as defined in OAR 410-141-0000, which requires that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a Health Care Professional who has appropriate clinical expertise in treating the Member's health or mental health condition or disease in accordance with 42 CFR 438.210. In addition, Provider must obtain authorization for Covered Services from Contractor, except to the extent prior authorization is not required in OAR 410-141-2420 or elsewhere in the OHP Contract Statement of Work.

34. <u>Conflicts of Interest</u>. In addition to the conflicts of interest provisions of Paragraph 19.2 and 24.17 Provider shall abide by the Conflict of Interest Safeguards of the OHP Contract including:

34.1. *Hiring*. Provider shall not offer, promise, or engage in discussions regarding future employment or business opportunity with any DHS or OHA employee (or their relative or member of their household), and no DHS or OHA employee shall solicit, accept or engage in discussions regarding future employment or business opportunity, if such DHS or OHA employee participated personally and substantially in the procurement or administration of the OHP Contract as a DHS or OHA employee.

34.2. *Gifts*. Provider shall not offer, give, or promise to offer or give to any DHS or OHA employee (or any relative or member of their household), and such employees shall not accept, demand, solicit, or receive any gift or gifts with an aggregate value in excess of $50 during a calendar year or any gift of payment of expenses for entertainment. "Gift" for this purpose has the meaning defined in ORS 244.020(6) and OAR 199-005-0001 to 199-005-0035.

34.3. *Pre-contracting*. Prior to the award of any replacement contract, Provider shall not solicit or obtain, from any DHS or OHA employee, and no DHS or OHA employee may disclose, any proprietary or source selection information regarding such procurement, except as expressly authorized by the Director of OHA or DHS.

34.3. *Communication with OHA*. Provider shall not retain a former DHS or OHA employee to make any communication with or appearance before OHA on behalf of Provider in connection with services provided under the OHP Contract if that person participated personally and substantially in the procurement or administration of the OHP Contract as a DHS or OHA employee.

34.4. *Restricted Period*. If a former DHS or OHA employee authorized or had a significant role in the OHP Contract, Provider shall not hire such a person in a position having a direct, beneficial, financial interest in services provided under the OHP Contract during the two-year period following that person's termination from DHS or OHA.

34.5. *Policies and Procedures*. Provider shall develop appropriate policies and procedures to avoid actual or potential conflict of interest involving Members, DHS or OHA employees, and sub-contractors consistent with the polices required under the OHP Contract.

35. <u>Non-Discrimination</u>. Provider shall not discriminate between Members and non-OHP persons as it relates to benefits and services to which they are both entitled. Provider shall not condition the provision of care or otherwise discriminate against a Member based on whether or not the individual has executed an advance directive per 42 CFR 438.6(i)(1); 42 CFR 422.128; or 42 CFR 489.102(a)(3).

36. <u>Record Keeping System</u>. Provider shall, based on written policies and procedures, develop and maintain a record keeping system that: (a) includes sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the Member; (b) conforms to accepted professional practice; and (c) allows the Provider to ensure that data submitted to Contractor is accurate and complete by: (i) verifying the accuracy and timeliness of reported data; (ii) screening the data for completeness, logic, and consistency; and (iii) collecting service information in standardized formats to the extent feasible and appropriate.

37. <u>Enrollment; Unique Provider Identification Number</u>. Each of Provider's Physicians and other qualified providers, if any, shall be enrolled with OHA and have a unique provider identification number that complies with 42 USC 1320d-2(b).

38. <u>Accreditation</u>. If Provider programs or facilities that are not required to be licensed or certified by a State of Oregon board or licensing agency, then such programs or facilities operated by Provider shall be accredited by nationally recognized organizations recognized by OHA for the services provided or The Joint Commission where such accreditation is required by OHA rule to provide the specific service or program.

39. <u>Advocacy</u>. Except as provided in the OHP Contract, Contractor shall not prohibit or otherwise limit or restrict Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member, who is a patient of the professional, for the following: (a) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, that is Medically Appropriate even if such care or treatment is not covered under the OHP Contract or is subject to Co-Payment; (b) any information the Member needs in order to decide among relevant treatment options; (c) the risks, benefits, and consequences of treatment or non-treatment; and (d) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

40. <u>Health Information Technology</u>. Provider shall comply with Contractor's policies and procedures relating to electronic health information exchange to support the exchange of patient health information among Participating Providers. Provider shall be: (a) registered with a statewide or local Direct-enabled Health Information Service Provider (HISP); or (b) a member of 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 Contractor's network.

41. <u>No Actions</u>. Provider represents and warrants that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving Provider, including key management or executive staff, over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare or prescription drug services.

42. <u>Notice of Termination</u>. Provider acknowledges and agrees that Contractor will provide written notice of the termination of Provider's agreement with Contractor to provide Covered Services to Members, within 15 days of such termination, to each Member who received his or her primary care from, or was seen on a regular basis by, Provider.

43. <u>Subrogation</u>. Provider agrees to subrogate to OHA any and all claims the Contractor or Provider has or may have against manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing, pricing or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment or other products.

44. <u>Stop-Loss Documentation</u>. If Provider participates in a Practitioner Incentive Plan under the Agreement that places Provider at Substantial Financial Risk, Provider shall submit stop-loss documentation to Contractor in accordance with Contractor's policies and procedures.

EXHIBIT 6.6 – Schedule Y Organizational Chart

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                          ┌──────────────────────┐
                          │  AllCare Health, Inc.│
                          │  FEIN - 26-1589529   │
                          │        OR            │
                          └──────────┬───────────┘
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AllCare Health Plan, Inc.	AllCare CCO, Inc.	AllCare eHealth Services, LLC	AllCare Management Services, LLC	AllCare Independent Physician Association	AllCare Development, LLC	AllCare PACE, LLC
FEIN - 93-1141742	FEIN - 27-1172596	FEIN - 26-1601090	FEIN - 26-1601041	FEIN - 46-4507991	FEIN - 47-1187902	OR
NAIC Code - 12253	OR	OR	OR	OR	OR	
OR						
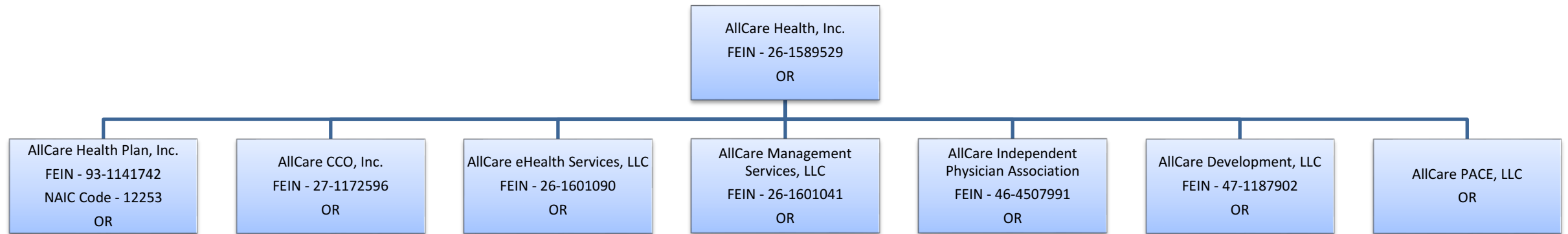
Attachment 6 — General Questions

A. Background Information about the Applicant

   1. Questions

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

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

AllCare CCO, Inc. is a for-profit entity domiciled in the State of Oregon which has elected the status of a Benefit Company pursuant to ORS 60.750-60.770. The company is a wholly owned subsidiary of AllCare Health, Inc. also domiciled in the State of Oregon. Since 2012, AllCare CCO, Inc. has contracted directly with the Oregon Health Authority (OHA) to deliver CCO services as a risk bearing entity on a capitated basis in Josephine, Jackson, and Curry Counties plus two zip codes in Douglas County. AllCare Health Plan, Inc. (an affiliate company within AllCare Health, Inc.) has a certificate of authority to transact health insurance in the State of Oregon under the auspices of the Oregon Department of Business and Consumer Services.

   a. Describe Applicant's Affiliates as relevant to the Contract. AllCare CCO, Inc. maintains a management and administrative services agreement with AllCare Management Services, LLC, (also an affiliate company within AllCare Health, Inc.) to provide all staffing required to carry out its responsibilities as defined in this Application. Please see *EXHIBIT 6.5 – Example Subcontract between AllCare CCO and AllCare Management Services*.

   b. Is the Applicant invoking alternative dispute resolution with respect to any Provider (*see* OAR 410-141-3268)? If so, describe. No

   c. What is the address for the Applicant's primary office and administration located within the proposed Service Area? AllCare is headquartered at 1701 NE 7th Street, Grants Pass, OR, 97526. We also have satellite offices at 3629 Aviation Way, Medford, OR, 97503 in Jackson County, and 580 5th Street, Suite 400, Brookings, OR, 97415 in Curry County.

   d. What counties are included in this Service Area? Describe the arrangements the Applicant has made to coordinate with county governments and establish written agreements as required by ORS 414.153. AllCare CCO contracts with local county government in each of the three counties in our service area as required by ORS 414.153. AllCare contracts with Jackson County for public health and mental health crisis management. In Josephine County, AllCare contracts with Josephine County for public health services and Options for Southern Oregon for all mental health services including mental health crisis management. In Douglas County, AllCare contracts with ADAPT, the mental health authority for Douglas County. In Curry County, AllCare contracts with Curry Community Health for public health services, mobile crisis services and behavioral health services.

e. **Prior history:**

(1) **Is Applicant the Legal Entity that has a contract with OHA as a CCO as of January 1, 2019 (hereinafter called "Current CCO")?** Yes

(2) **If no to 1, is Applicant the Legal Entity that had a contract with OHA as a CCO prior to January 1, 2019?** Not Applicable

(3) **If no to 1 and 2, is Applicant an Affiliate with or a Risk Assuming Entity of a CCO that has a current or prior history with OHA?** Not Applicable

(4) **If no to 1, 2, and 3, what is Applicant's history of bearing health care risk in Oregon?** Not Applicable

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

- **Public Employees Benefit Board:** No
- **Oregon Educators Benefit Board:** No
- **Adult Mental Health Initiative:** No
- **Cover All Kids:** Yes, Contract #156273-1
- **Other (please describe):** NA

g. **Does the Applicant (or an Affiliate of Applicant) have experience as a Medicare Advantage contractor? Does the Applicant (or an Affiliate of Applicant) have a current contract with Medicare as a Medicare Advantage contractor? What is the Service Area for the Medicare Advantage plan?** Yes. Since 2005, its affiliate AllCare Health Plan, Inc., has offered a Medicare Advantage plan in Jackson, Josephine, and southern Douglas counties.

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

i. **Does the Applicant (or an Affiliate of Applicant) hold a current certificate of authority for transacting health insurance or the business of a health care service contractor, from the Department of Consumer and Business Services, Division of Financial Regulation?** Our affiliate, AllCare Health Plan, Inc., holds a current certificate of authority with the Oregon Department of Consumer and Business Services, Division of Financial Regulation (#953485). It offers AllCare Advantage – a CMS Medicare Advantage plan in Jackson, Josephine, and southern Douglas counties.

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

k. Describe Applicant's demonstrated experience and capacity for engaging Community members and health care Providers in improving the health of the Community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among Applicant's enrollees and in Applicant's Community.

AllCare's community engagement experience includes the following major initiatives:

- As a physician/provider owned entity, AllCare began its transition to a legal Benefit Company in 2016 and in 2017 became the only CCO to obtain Certified B Corp™ status in Oregon. Certification was obtained through the nonprofit entity, B Lab. As a B-Corp, AllCare has invested in transitional, low-income housing due to local shortages of affordable or subsidized housing. In the area of childhood nutrition, we have engaged consumers across the communities we serve to teach the benefits of eating healthy and forming positive habits at an early age, including growing vegetable gardens for fresh nutritious food and teaching cooking skills and nutrition. In the area of childhood education, we have invested in skill-building for children, parents and educators to establish constructive patterns of behavior and a more equal starting line for formal education. We have also funded school-based clinics to ensure access to needed medical, dental, and behavioral health services. To ensure timely access to health services, we have removed barriers that prevent people from optimizing their health whether that is providing transportation, funding after-hours care, or bringing services directly to a member's school or residence.
- AllCare has formed a "Health Equity and Inclusivity Team" to review and enhance our internal policies and procedures to address the cultural and linguistic needs of our employees, stakeholders, and members, focusing on key issues of cultural and health equity, workforce diversity, and improvement for underserved populations. To this end, all staff have received health equity and cultural humility training; we have conducted equity surveys of our healthcare offices to determine patient satisfaction and we have increased the number of certified medical interpreters. Most recently we became the third Certified Medical Interpreter Testing Site in Oregon through the Certification Commission for Healthcare Interpreters.
- AllCare has invested over $9 million in the Social Determinants of Health involving more than 175 organizations and/or health events across southwest Oregon including ACES training, the Babe Store, the Maslow Project, and Rogue Retreat – a subsidized transitional housing program, to name a few.
- To reduce our carbon footprint, we work with local governments and construction companies to encourage climate friendly construction decisions as well as increased development of healthy recreational and public areas to greatly improve the built environment.

l. Identify and furnish résumés for the following key leadership personnel (by whatever titles designated). Please Refer to *EXHIBIT 6.1-Resumes* for the following C-level management team.

- Chief Executive Officer
- Chief Financial Officer
- Chief Medical Officer
- Chief Information Officer
- Chief Operations Officer
- Chief Compliance Officer

(resumes do not count toward page limit; each resume has a two page limit)

m. **Provide a chart (as a separate document, which will not be counted against page limits) identifying Applicant's contact name, telephone number, and email address for each of the following.** Please refer to *EXHIBIT 6.2-Contact List*.

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

2. **Required Documents**

- **Background Narrative** See above narrative.
- **Résumés (excluded from pages limit):** *EXHIBIT 6.1-Resumes*
- **Contact list (excluded from pages limit):** *EXHIBIT 6.2-Contact List*

B. **Corporate Organization and Structure**

1. **Questions**

a. **Provide a certified copy of the Applicant's articles of incorporation, or other similar legal entity charter document, as filed with the Oregon Secretary of State or other corporate chartering office.** Please refer to *EXHIBIT 6.3-Articles of Incorporation and Bylaws*.

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

AllCare Health, Inc. owns 100% of all subsidiaries.
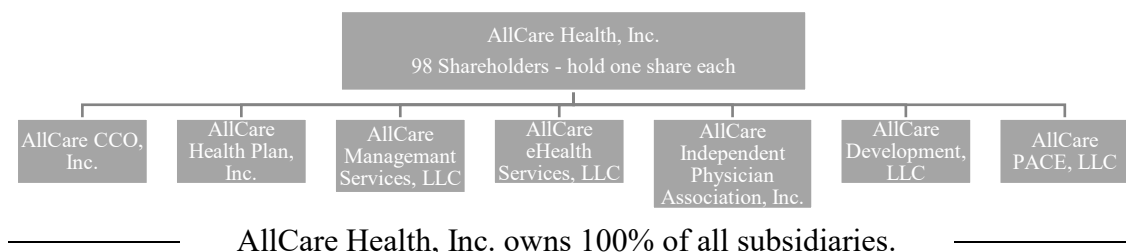
     c. **Describe any licenses the corporation possesses.** Applicant's affiliate, AllCare Health Plan, Inc. holds a certificate of authority with the Oregon Department of Consumer and Business Services, Division of Financial Regulation (#953485). AllCare Health and its subsidiaries are Oregon Benefit Companies and are Certified by B Lab as Certified B Corps™.

     d. **Describe any administrative service or management contracts with other parties where the Applicant is the provider or Recipient of the services under the contract. Affiliate contracts are excluded in this item and should be included under Section C.** Affiliate contract, refer to Section C.

2. **Required Documents**

     ▪ **Articles of Incorporation (excluded from page limit):**
       EXHIBIT 6.3-Articles of Incorporation and Bylaws

     ▪ **Narrative of Items b through d** See above narrative.

C. Corporate Affiliations, Transactions, Arrangements

1. **Questions**

     a. **Provide an organization chart or listing presenting the identities of and interrelationships between the parent, the Applicant, Affiliated insurers and reporting entities, and other Affiliates. The organization chart must show all lines of ownership or Control up to Applicant's ultimate controlling person, all subsidiaries of Applicant, and all Affiliates of Applicant that are relevant to this Application. When interrelationships are a 50/50% ownership, footnote any voting rights preferences that one of the entities may have. For each entity, identify the corporate structure, two–character state abbreviation of the state of domicile, Federal Employer's Identification Number, and NAIC code for insurers. Schedule Y of the NAIC Annual Statement Blank—Health is acceptable to supply any of the information required by this question. If a subsidiary or other Affiliate performs business functions for Applicant, describe the functions in general terms.** Please refer to *EXHIBIT 6.4-Organizational Structure for Affiliated Entities* for Information on Corporate Affiliations and *EXHIBIT 6.6-Schedule Y Organizational Chart*. All seven affiliates are 100% wholly-owned by AllCare Health, Inc. including AllCare CCO, Inc.

     b. **Describe of any expense arrangements with a parent or Affiliate organization. Provide detail of the amounts paid under such arrangements for the last two years. Provide footnotes to the operational budget when budgeted amounts include payments to Affiliates for services under such agreements**. AllCare CCO has a management service agreement with AllCare Management Services, LLC, an affiliated entity. Both AllCare CCO and AllCare Management Services, LLC are 100%

wholly-owned subsidiaries of AllCare Health, Inc. AllCare Management Services, LLC is the administrative entity for AllCare Health and provides management services, claims administration, IT services, enrollment, member services, care coordination, population health, quality, compliance, and provider services for AllCare CCO. The contract is a PMPM model based upon member enrollment as of the 15th of each month. In addition to the PMPM monthly amounts, 10% of the quality bonus pool is paid annually. Amounts paid under this agreement for the prior two years by AllCare CCO to AllCare Management Services were:

- o   YE 2017: $35.00 PMPM
- o   YE 2018: $40.00 PMPM

c.   **Describe Applicant's demonstrated experience and capacity for:**

- **Managing financial risk and establishing financial reserves.** AllCare Health, Inc. was established in April 1994 and has been taking risk as a managed care organization with the Oregon Health Plan since 1996. In addition, AllCare Health Plan, Inc. applied for and received an Insurer's Certificate of Authority for Health Care Services pursuant to ORS CH 750 in 2005. AllCare Health Plan, Inc. has had a Medicare Advantage contract with CMS since 2005.

- **Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350.** AllCare Health, Inc. has successfully established the required reserves for both entities, including the CCO and the Health Plan, in accordance with the Oregon Health Authority and the Department of Consumer and Business Services, Division of Insurance, respectively. The AllCare Health, Inc. and AllCare CCO, Inc. Board of Governors' Finance Committees meet throughout the year to monitor and ensure the reserve requirements are maintained at appropriate levels. The Finance Committees include a retired insurance executive, retired CPA, behavioral health stakeholder CEO, a local public official, and AllCare provider stakeholders. Although AllCare CCO, Inc. is not a DCBS filing entity, from the inception of the CCOs, AllCare's Board of Governors' goal has been to maintain reserves and net worth in accordance with the DCBS requirements. AllCare CCO currently meets and exceeds those reserves and net worth requirements.

2.   **Required Documents**

- ▪ **Item a., an organization chart or listing (excluded from page limit):**
  EXHIBIT 6.4-Organizational Structure for Affiliated Entities
  EXHIBIT 6.6-Schedule Y Organizational Chart

- ▪ **Narrative for Items b and c** See above narrative.

D. Subcontracts

1. **Informational Questions**

    a. **Please identify and describe any business functions the Contractor subcontracts or delegates to Affiliates.** AllCare Management Services, LLC is the administrative entity for AllCare Health and provides management services, claims administration, IT services, enrollment, member services, care coordination, population health, quality, compliance, and provider services for AllCare CCO. The contract is a PMPM model based upon member enrollment as of the 15th of each month. In addition to the PMPM monthly amounts, 10% of the quality bonus pool is paid annually. Please see *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* and *EXHIBIT 6.8-Subcontractors-and-Delegated-Entities-Report*

    b. **What are the major subcontracts Applicant expects to have? Please provide an example of subcontracted work and describe how Applicant currently monitors Subcontractor performance or expects to do so under the Contract.** AllCare CCO maintains major subcontracts with the following entities: Options for Southern Oregon, Inc., a behavioral health organization; Curry Community Health; Jackson County Mental Health; La Clinica Del Valle Family Health Center, Inc.; Capitol Dental Care, Inc., dental care organization; ODS Community Health, Inc., dental care organization; Advantage Dental Services, LLC, dental care organization; Willamette Dental Group, P.C., dental care organization; MedImpact Healthcare Systems, Inc., a pharmacy benefit management company; ReadyRide Services, Inc., non emergent medical transportation company.

    AllCare performs annual on-site audits of each subcontractor to ensure compliance with contract requirements related to operations, reporting, quality, access, member satisfaction and experience of care. Please see *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for a sample contract.

2. **Required Documents**

    Narrative for Items a and b See above narrative.

E. Third Party Liability

1. **Informational Questions**

    a. **How will Applicant ensure the prompt identification of Members with TPL across its Provider and Subcontractor network?**
    - Claims Administration: A monthly report is generated within the claims department that identifies diagnostic codes which may indicate an accident, fall, or other injury. Letters are sent out to members requesting additional information regarding the accident, fall or other injury. Responses that indicate a possible TPL are forwarded to our Subrogation Attorney for review and recoupment. Every claim submitted with "other payer" information is checked with the claims system to ensure member

information reflects a primary payer. AllCare contracts with a Third Party Vendor who provides a proprietary process that identifies other insurers based on claims history and eligibility. The vendor recoups monies from other payers for both pharmacy and physical health claims and returns those dollars to AllCare.

- Member Services: If the claim does not indicate a primary payer, information is forwarded to our Member Services Department who then reaches out to the member to collect accurate information. Member Services then reports that information to the State Health Insurance Group (HIG) Unit. Member Services staff also receive calls initiated by members who will report they have been involved in an accident or other altercation. That information is forwarded to our Subrogation Attorney for review and recoupment.

- Population Health Management: Our utilization management and care coordination team within our Population Health Department identify members who have been involved in an accident, based on service requests, prior authorizations, concurrent review, and utilization data. Where appropriate, that information is forwarded to our Subrogation Attorney for review and recoupment.

b. **How will Applicant ensure the prompt identification of Members covered by Medicare across its Provider and Subcontractor network?** AllCare has direct connectivity with a Medicare Coordination of Benefit (COB) contractor who supplies Medicare payment information for members that are assigned to AllCare. Eligibility files for members are supplied directly from the Oregon Health Authority to the CMS COB contractor.

2. **Required Documents**

   Narrative for Items a and b See above narrative.

F. **Oversight and Governance**

1. **Informational Questions**

   Please describe:

   a. **Applicant's governing board, how board members are elected or appointed, how the board operates, and decisions that are subject to approval by a person other than Applicant.** AllCare CCO, Inc. has a governing board comprised of 21 Board of Governors of which nine are Shareholders of AllCare Health, Inc. One shareholder Governor serves as the chair. There are two vice chairs; one Shareholder and one community member. In addition, the chairs of each of AllCare's three Community Advisory Councils (CACs) of Jackson, Josephine, and Curry Counties serve on the CCO Board with at least one qualifying as a member of the community at large. One member from each of the following constituencies also serve on the Board: the Clinical Advisory Panel (CAP), a hospital representative, a substance use disorder (SUD) representative, an oral health representative, a mental health representative, a medical provider representative, one governor at large from among the CAP members, and at

least one representative of the general public. Members of the Board of Governors may serve a three-year term and may not serve more than two consecutive terms without a minimum one-year break. Any of the AllCare Health, Inc. shareholders can serve as the Board Secretary, Board Treasurer, or Benefit Governor. The CCO Board meets six times per year to oversee including but not limited to: finance, operations, quality, compliance, and member satisfaction.

     The Board is responsible for compliance with all contractual requirements as agreed to within the OHA CCO contract as well as AllCare's underlying provider contracts. The Board is also responsible for CCO investment decisions related to the Social Determinants of Health, Health Equity, and Workforce Capacity initiatives. The CCO Board approves the Community Health Assessment and Community Health Improvement Plan for each of the three counties in our service area. Members of the public may attend CCO Board meetings except for those portions of Board meetings conducted in Executive Session.

b. **Please describe Applicant's key committees including each committee's composition, reporting relationships and responsibilities, oversight responsibility, monitoring activities and other activities performed.** AllCare's Board of Governors (BOG) ultimately holds the responsibility of AllCare's contractual agreements. AllCare's key committees, all of which report to the BOG, are as follows: Finance, Quality Improvement, Pharmacy & Therapeutics, Credentialing, Compliance, Clinical Advisory Panel, and CACs (see 1c). Upon request, an exhibit is available with detailed committee composition, reporting relationships and responsibilities, oversight responsibility monitoring activities, and other activities.

c. **The composition, reporting responsibilities, oversight responsibility, and monitoring activities of Applicant's CAC.** There are three county-based CACs that each have their own charter. AllCare strives to ensure that at least 51% of the CAC membership is comprised of consumer representatives. Each CAC provides CHIP progress reports and community direction related to the SDoH-HE to the Board at its regular meetings and at the annual retreat. The CACs oversee the development of the collaborative Community Health Needs Assessment and the collaborative Community Health Improvement Plans. The CACs have full oversight authority of their Board-authorized budgets to improve their local community's health. The Councils have full decision-making responsibilities over their budget but may not act on behalf of the Board. The Chair of each county's CAC also sits on the AllCare Board of Governors.

2. **Requested Documents**

   Narrative for Items a, b, and c See above narrative.

Attachment 7 - Provider Participation and Operations Questionnaire

1. **Governance and Organizational Relationships**

   a. **Governance**

   (1) **The proposed Governance Structure, consistent with ORS 414.625.** AllCare is governed by a 21 member Board of Governors comprised of representatives from each of the three Community Advisory Councils (CACs) as well as consumers, physical/behavioral/oral health providers, public health, community mental health, social service agencies, hospitals, and Long Term Care (LTC) providers across our three regions. The governing board meets every other month and is responsible for appointing members to the CACs as well as overseeing finances, provider contracting, patient access to care, member services, care coordination, claims, compliance, quality, grievances and appeals, Value Based Payment Models (VBPs), and the Social Determinants of Health and Health Equity (SDoH-HE).

   (2) **The proposed Community Advisory Councils in each of the proposed Service Areas and how the CAC was selected consistent with ORS 414.625.** AllCare has three CACs, one for each of the regions in our service area, including Jackson County, Josephine County (including 2 zip codes in Douglas County), and Curry County. Current members represent consumers, public agencies and providers consistent with ORS 414.625. The distribution of membership by type of representative varies by CAC and varies over time as new representatives are appointed by the Board. Each year the CAC is surveyed anonymously with REAL-D survey to understand our demographics. Each CAC meets every other month and is responsible for overseeing development of the collaborative Community Health Assessment and the collaborative Community Health Improvement Plan (CHIP) to identify and implement preventive care, integrated care, and care coordination initiatives that support the triple aim of better individual health, better community health, at lower cost. The CHA and the CHIP planning process occurs every five years and each CAC reports annually to the Board on the progress of its CHIP. This information is available to the public via our website as well as through the open meeting process.

   (3) **The relationship of the Governance Structure with the CAC, including how the Applicant will ensure transparency and accountability for the governing body's consideration of recommendations from the CAC.** Following OHA's requirements, all CAC meetings are open to the public and allow public comment either in written form or through oral comments. This is a significant effort to improve transparency and accountability. The CAC's are also responsible for funding decisions on community-based projects that focus on the Social Determinants of Health and Health Equity (SDoH-HE) in each County as part of the CHA. Finally, the CACs are accountable to the Board for implementing approved CHIP initiatives in their respective region within the limits of their Board approved budgets.

(4) The CCO Governance Structure will reflect the needs of Members with severe and persistent mental illness and Members receiving DHS Medicaid-funded LTC services and supports through representation on the Governing Board or CAC. AllCare values the experiences of our members and look for opportunities to ensure their voices are heard and perspectives are shared. The Executive Director of our largest provider of mental health services, including the care for SPMI members, is an essential participant on our Board of Governors and, along with AllCare's Behavioral Health staff, regularly reports to the Board on Behavioral Health services, penetration, needs, and outcomes. As a top priority identified in the collaborative CHA, the AllCare Board continuously endorses the allocation of resources to improve these services in our communities.

AllCare has current participation of members with Serious and Persistent Mental Illness (SPMI) on our CACs. It is our goal to facilitate continued representation by those who experience SPMI. AllCare's Behavioral Health staff have worked collaboratively with CAC members in Behavioral Health workgroups to gain insight into opportunities for program development and to address barriers to care.

AllCare meets regularly with our behavioral health subcontractors to develop and implement integrated care management plans that braid behavioral health and physical health into a cohesive individualized treatment plan. This structure will also serve those OHP members receiving DHS Medicaid-funded LTC services and supports that are funded through local Area Agencies on Aging or state DHS Aging and People with Disabilities (APD), and improve our ability to include services such as the following into individualized care plans: home delivered meals, personal care, adult day care, in home agency or client employed caregivers, foster care, assisted living, residential or long term nursing facility placement, and use of flexible spending funds to serve our Intellectual and Developmental Disabilities (I/DD) members when other resources are gone. In addition, this structure will oversee AllCare collaborative activities with local and state agencies on pre-admission screening, private admission assessment, diversion/transition and related activities to support client choice during transitions between hospitals, nursing facility skilled care, and long-term placements for this target population.

b. **Clinical Advisory Panel**

(1) **If a Clinical Advisory Panel is established, describe the role of the Clinical Advisory Panel and its relationship to the CCO Governance and organizational structure**. AllCare established its Clinical Advisory Panel in 2013. It meets three times per year to:
   o Evaluate best clinical practices across the continuum of care;
   o Establish collaboration policies and procedures between primary and specialty care to reduce duplication of services, improve patient satisfaction, and ensure high quality transitions of care across care settings, and;
   o Promote evidence-based diagnostic and treatment services.

The Clinical Advisory Panel is comprised of representatives across the continuum of care, including physical, oral, and behavioral health as well as providers, facilities, pharma, and care coordinators. The CAP chair functions as an advisor to the Board on issues related to clinical practice and the efficient delivery of clinical services to OHP members.

c. **Agreements with Type B Agencies on Aging and DHS local offices for APD (APD).**

   (1) Describe the Applicant's current status in obtaining MOUs or contracts with Type B AAAs or DHS APD office. AllCare has MOUs with Jackson, Josephine, and Curry counties that address the need for improved person-centered care and alignment of services between the local Area Agency on Aging, Rogue Valley Council of Governments (RVCOG), and local county programs for Senior and Disability Services. The MOU outlines the roles and responsibilities of the CCO and the AAA/APD as it relates to serving Medicaid members in long-term care facilities. Roles and responsibilities focus on the following:
   a. Prioritization of high needs members in LTC;
   b. Development of individualized care plans;
   c. Transitional care practices;
   d. Member engagement and preferences; and
   e. Establishing member care teams

   Inherent to each area of focus is definition of data sharing activities, referral practices, risk assessment and screening, person-centeredness, collaboration and communication, team meetings, and shared accountabilities. These MOUs have been in place since 2012 then updated in 2015. AllCare will document and submit by June 30th of each year an update of coordination activities with Type B AAA or State APD district offices within our Service Area.

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

d. **Agreements with Community Partners Relating to Behavioral Health Services.**

   1. **Describe the Applicant's current status in obtaining MOUs or contracts with LMHAs and CMHPs throughout its proposed Service Area.** AllCare has agreements with Jackson County Mental Health, Options for Southern Oregon, ADAPT, and Curry County Mental Health, the Local Mental Health Authorities (LMHA), to provide crisis intervention and crisis management services. For all other mental health services in Jackson and Josephine counties, AllCare contracts with Options for Southern Oregon. In Curry County, we contract for all mental health services with the Curry Community Mental Health Program.

   2. **If MOUs or contracts have not been executed, describe the Applicant's efforts to do so and how the Applicant will obtain MOU(s) or contract(s).** All Mental Health Program MOUs include an "Evergreen" clause for automatic renewal.

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

- **DHS Child Welfare and Self Sufficiency field offices in the Service Area**: AllCare funds a registered nurse in the Public Health department in Josephine County who provides needed health services to clients of DHS Child Welfare and Self Sufficiency Field Offices as well as other public health programs. AllCare also regularly engages and coordinates with all three of our regional Child Welfare Offices for Systems of Care and Wraparound work. We partner with DHS Child Welfare on our quality incentive measure to obtain assessments for children in DHS custody. Lastly, coordination of intensive behavioral health services for our shared members and families who are in behavioral rehabilitative services (BRS).

- **Oregon Youth Authority (OYA) and Juvenile Departments in the Service Area:** AllCare regularly engages and coordinates with all three of our regional Juvenile Departments for Systems of Care and Wraparound work. In addition, our contracted Mental Health providers work very closely with their County Juvenile Justice agencies and even provide some Integrated Mental Health services to AllCare members in the Juvenile Detention programs.

- **Department of Corrections and local Community corrections and law enforcement, local court system, problem solving courts (drug courts/mental health courts) in the Service Area, including for individuals with mental illness and substance abuse disorders:** AllCare supports our contracted mental health providers in collaborating with our local law enforcement agencies, courts, and jails. AllCare staff participate in various community committees to assess the needs of individuals reintegrating back into the community from incarceration. Individuals are provided resources including transportation resources, clothing, personal hygiene items, and when needed meet with an OHP assistor to have coverage re-instated or started for those who qualify. The program was established to fulfill a community need and serves as a community based support, focused on physical, behavioral, and oral health as well as their need for stable housing, employment, training, and other supports that will minimize recidivism and maximize health. AllCare works closely with the Department of Corrections to remove barriers for those needing transportation from jail to inpatient alcohol and drug treatment, court obligated appearances, community service, or other mandated appearances required for their completion and success. AllCare has been added to their ROI removing barriers to care and coordination. We are contracted with Josephine County Community Corrections on a fee for service basis. There are Behavioral Health specialists embedded within the local jail, community correction, and that participate in Mental Health and Drug Court. Crisis Specialists now ride with the Grants Pass Police Department for a specific number of hours monthly to assist with homeless outreach, crisis response, police cross training on trauma informed care, and other necessary relative work.

- **School districts, education service districts that may be involved with students having special needs, and higher education in the Service Area:** AllCare currently supports school-based health care programs offering on-site health assessments and screening for physical, behavioral, and oral health as well as development and implementation of individualized care plans. These programs have operated since 2016 across the service area and focus on the health care needs of all children, not just OHP members. The programs are also designed to address homelessness, food insecurity, and other factors associated with the social determinants of health. In addition, AllCare works with providers, IEP teams, school administration, teachers and families within school districts to obtain necessary skills or items supporting educational growth and success in supporting learning benchmarks. In addition, AllCare has made numerous investments in local schools to: increase staff training on Adverse Childhood Experiences (ACEs), improve student self-regulation and resiliency skills, increase student engagement and attendance, increase student and caregiver preparedness for Kindergarten, and provide for tangible goods to assist with attendance and engagement. AllCare regularly engages and coordinates with all School Districts in our region for Systems of Care and Wraparound work.

  AllCare also worked with two rural high schools to place 'graduation coaches' to improve graduation rates. The coaches provide individual student support and the program is showing favorable initial results.

- **Developmental disabilities programs**: AllCare provides physical, behavioral, and oral health for our OHP members with Intellectual and Developmental Disabilities (I/DD) as well as care coordination planning particularly upon transition from hospital and long-term care facilities to community-based programs and residential facilities. AllCare works closely with local I/DD programs and brokerages to remove barriers for non-covered medical services and SDoH-HE by utilizing health-related services when a need is identified. Needs may be identified by the member, family, medical provider or other entities working with the member. In addition, AllCare supports our "Caring Community" program that focuses on the needs of small children who require collaboration across multiple support service organizations and programs. Another program, The Inter-professional Care Access Network (I-CAN), is an OHSU lead project that works with community partners to help Oregonians overcome health challenges that are exacerbated by social determinants of health. AllCare has partnered with the OHSU nursing faculty and students to address barriers to health and to help bridge healthcare gaps for families in Medford. The program is interdisciplinary and includes the involvement of nurse care coordinators, community health workers, pharmacists, tobacco cessation, and behavioral health clinicians. The partnership has helped identify population health issues in the community and has promoted and encouraged engagement of local resources and agencies. Outcomes have included increased

medication literacy, increased ability to manage pain, increased ability to manage chronic disease, increased access to food, and improved housing status. AllCare regularly engages and coordinates with local I/DD programs and brokerages for Systems of Care and Wraparound work.

- **Tribes, tribal organizations, Urban Indian organizations, Indian Health Services and services provided for the benefit of Native Americans and Alaska Natives:** Portions of AllCare's service areas overlap with the service area of three tribes: the Cow Creek Band of Umpqua Tribe of Indians, the Coquille Indian Tribe, and the Confederated tribes of Coos, Lower Umpqua and Siuslaw Indians. AllCare's Behavioral Health contractor in Jackson and Josephine counties holds an MOU for coordination of care and access to services, warm handoffs, and patient release of information with the Cow Creek Band of Umpqua Indians who have AllCare members primarily in the Douglas County areas served by AllCare. The Coquille Indian Tribe and the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians have been offered by Options for Southern Oregon to negotiate formal MOUs with AllCare and, to date, have declined. However, AllCare's behavioral health contractors do provide care coordination, patient release of information, and crisis services to members of these tribes on an individual basis. In addition, AllCare currently holds contracts with United Indian Health Services in Curry County. There are no tribal health clinics in Jackson or Josephine counties. AllCare's Health Equity Team is engaging the Department of Veteran Affairs Native American Health and Wellness program to develop best practices with the local FQHCs on providing culturally appropriate care.

- **Housing organizations:** AllCare provides grant funding to local housing agencies and programs that offer transitional and permanent affordable housing to the homeless across our service area. Affordable housing has been a priority of AllCare since 2015, as adopted in our current CHIP. AllCare participates in "Operation Welcome Home". This is a collaborative project in Josephine County to increase capacity, effectively coordinate efforts, identify veterans and receive technical assistance as a community to ensure the right resources are being offered to meet the need for supportive housing. Other examples of programs funded by AllCare include:
  - Rogue Retreat which is funded on a PMPM basis for our OHP members in need of transitional and supportive housing.
  - "Hearts with a Mission" which provides temporary housing for homeless teens for which foster care is not an option.
  - "Welcome Home Oregon" focuses on individuals post incarceration.

- **Community-based Family and Peer support organizations:** In addition to our care coordination, integrated health care, and funding to address the social determinants of health, AllCare maintains a strong peer support program particularly to address certain chronic conditions as well as support for OHP members in their efforts to maintain a healthy lifestyle. The majority of our

Traditional Health Workers (THWs) are individuals who have lived experience and are better able to offer peer support for those in times of transition or seeking opportunities to improve one's health. AllCare members can access a wide array of Peer Support Services through our subcontracted Mental Health and contracted Substance Use Disorder (SUD) treatment providers. Members can engage in Peer Run Organizations, Drop-in Centers or Clubhouse that are supported by our Mental Health agencies. AllCare has directly funded Peer Support Organizations, including Compass House, Foundations for Recovery, and a developing Recovery Café.

- **Other social and support services important to communities served:** AllCare provides funding and staff support for the following programs which are examples of a long list of other social services we support through funding as well as staff resources to the following programs:
  o The Babe Store for Maternal and Infant Support is a unique program designed to increase OB/GYN prenatal care during pregnancy and early childhood health care during the first three years of life. The program offers coupons whenever mother and/or child see their PCP, pediatrician, mental health provider, addiction treatment, or dentist. Those coupons can then be redeemed at the Babe Store for diapers, clothing, and infant and childhood "gear". While in the store, our peer support staff engage mothers and children to assess and screen for potential problems in need of outreach and follow-up by our care coordinators and case managers who screen for preventive services such as childhood immunizations among other needs. This is a very popular and successful program and clearly meets the needs of the communities we serve.
  o First Tooth is another highly successful program funded and supported by AllCare within our service area. It teaches PCPs and pediatricians how to apply fluoride varnish while children are having their regular physical health checkups. This program was developed in response to a shortage of oral health providers particularly in the rural areas we serve. It has been highly successful in reducing cavities and improving overall oral health in children.
  o Tobacco Cessation programs, especially those targeted toward the Spanish speaking community and those with SPMI who tend to have high rates of tobacco use, are very successful.
  o Multiple AllCare staff participate on community executive boards, committees both on a local and state level, stakeholder meetings and attend outside agency staff meeting's to discuss AllCare specific members or community needs.
  o AllCare supports community events by allowing staff to participate in 8 hours of volunteer work each year within the community. As a result, multiple community events have been able to continue annually throughout multiple counties.

2. **Member Engagement and Activation**

a. **Describe the ways in which Members and their families and support network, where appropriate are meaningfully engaged as partners in the care they receive as well as in organizational Quality Improvement activities.** AllCare engages its members in the following ways:
   - All new members receive a member handbook, both online and in hardcopy, which outlines their responsibilities to stay healthy and to see their primary care provider at least annually. PCP visits are monitored by the staff and anyone not having an annual visit is contacted and provided assistance to schedule an appointment, secure transportation via our NEMT vendor, address any special needs (medical, cultural, etc.) and/or assign a new PCP that may be a better match.
   - Members with more than 5 ED visits within a given timeframe are contacted by our care coordination team to establish a treatment plan that meets their personal medical, social, and behavioral health needs. That plan is shared with their PCP who partners with the member, their care coordinator, and others to implement the plan. Outcomes are monitored through AllCare's care management software "Essette" and revised as needed.
   - AllCare has an intensive "transitions of care" program that supports members upon discharge from inpatient care settings or transition to lower cost settings or to home. This offers the opportunity for our traditional health workers to visit members face to face to discuss the transition plan and to focus on the member's success in implementing the plan.
   - Project Baby Checks is a home visiting program for new parents.
   - Inter-professional Care Access Network (ICAN) is a program funded by AllCare to support a 0.5 nurse FTE at the School of Nursing who teaches a 12 week course with our care coordination team in West Medford. The course addresses case management techniques for OHP members in need of community supports to address the SDoH, co-morbidities for those with SPMI, and those with development disabilities both physical and behavioral.
   - AllCare provides transportation for both biological parents when a child under the age of 18 years old is in need of medical services thereby supporting co-parenting, family engagement, and cohesion.

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

   - **Encourage Members to be active partners in their health, understanding to the greatest extent feasible how the approach to activate accounts for the social determinants of health:** AllCare is unique in that it encourages face-to-face visits at any of our three administrative offices across our service area. Our Member Services staff address member issues and concerns and directs them toward appropriate resolutions in a timely manner – walk-ins are always welcome. In addition, our website offers a host of educational opportunities on living with

chronic conditions. We cover gym memberships to encourage exercise and offer group education and training in the Living Well program, developed by Stanford University, that has become best practice in healthy living.

- o Our initial Health Risk-Assessment Survey (HRS) asks newly enrolled members if they want to include caregivers or other member representatives as a part of their care plan team. This survey is also completed in the member's preferred language.
- o AllCare offers a program called "Flex Ride" that allows both biological parents to attend their child's clinic visits.
- o Childcare is offered for parents who must attend court appearances so that children are not exposed to hardships their parents face and in local gyms while parents work out.
- o Our population health team plans to develop a member portal for OHP that includes HRS data, secure messaging, and live chat with one's care team, including PCPs.
- o AllCare has invested more than $9 million since 2013 in the social determinants of health to assist OHP members and the communities within which they live to increase access to affordable housing, improve nutritional options, and enhance early childhood development.

- **Engage members in culturally and linguistically appropriate ways:** To ensure linguistically appropriate communication, AllCare offers patient education through Healthwise which is available at a 6th grade reading level. In addition, our Health Equity Team includes a work group whose purpose is to provide effective, understandable and respectful materials that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of our members. The group has three priorities: partner with the community to develop policies and procedures to ensure cultural and linguistic appropriateness; establish goals and accountabilities for all AllCare staff; and evaluate and monitor the impacts on health equity and outcomes to inform service delivery. Care Coordination uses a health education program that supplies appropriate health literate material and videos for members.

- **Educate Members on how to navigate the coordinated care approach and ensure access to advocates including Peer wellness and other Traditional Health Worker resources:** AllCare monitors claims data to identify high cost and/or high risk members. Internal referrals from our UM team, Medical Directors, and enrollment staff also identify members in need of information and education on how to better navigate or coordinate care programs as well as how to access peer supports offered by our THWs. External referrals by hospital, primary care providers, as well as behavioral and oral health contractors assist with our ability to enroll eligible members in chronic disease management programs, transitions of care services upon discharge, and health equity/diversity programs. Our Med-Insight software developed by Milliman, identifies those in need of care management interventions to improve the quality of their health as well as avoid unnecessary costs where possible. Members who are high risk are contacted by our

care coordinators for screening and assessment. Where indicated, a care coordination plan is prepared in collaboration with the member which may include a home visit by our THW team to offer peer support and assess whether there are issues with stable housing, food insecurity, utilities, and other social supports that need to be addressed in the member's individualized care plan.

- **Encourage Members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate:** AllCare's website has excellent information on healthy living, ranging from smoking cessation programs, mental health/depression programs, nutrition advice, pre-natal best practices, early childhood development, and more. Our Health Equity Team has developed wellness and prevention materials that are available in alternative formats, culturally appropriate and in multiple languages to address the unique member preferences across our service area. Cultural appropriateness is supported by the SDoH game that helps people better understand how to navigate systems with limited resources while incorporating cultural perspectives and viewpoints; AllCare participates in the annual "Point in Time" survey on homelessness, and we support efforts within the VA to promote culturally and linguistically appropriate services to our veterans. AllCare has trained multiple staff and community members in being certified facilitators in the Stanford Chronic Disease Self-Management Program (CDSMP) model Living Well, which includes Spanish availability.

- **Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities:** Our Member Handbook and our website contains succinct and easy to understand descriptions of member rights and responsibilities consistent with current OHA guidance and OAR 410-141-3320. In addition, members are always welcome to contact our Member Services staff for more information or meet with staff face to face to learn more. AllCare believes that maintaining communication with our members is imperative. As communication is not always effective for everyone if presented using a single method, we strive to communicate through many available methods, as appropriate. Messaging regarding benefits, services, and member rights and responsibilities, is often shared via social media, our website, direct member letters/mailings, or direct phone communication as appropriate. All members, when joining AllCare, are provided with a New Member Packet that includes information for all benefits they qualify for, including how to obtain medical, mental, and dental services. We also encourage members to reach out to our Member Services department for help with any questions they may have regarding their benefits, rights, and responsibilities. Additionally, we provide online tools to help members attain information when they need it, 24-hours a day.

- **Meaningfully engage the CAC to monitor and measure patient engagement and activation:** OHP members have the opportunity to attend open CAC meetings and share their thoughts through public testimony on current CAC initiatives particularly development and implementation of each County's CHIP. In addition,

staff regularly collect survey information on patient satisfaction around access to care and experience of care as well as health equity and cultural appropriateness. This information is shared with the CACs to monitor and measure patient engagement and activation.

3. **Transforming Models of Care**

In 2018, the Jackson County and Josephine County CACs participated in a collaborative effort to compile a Community Health Assessment (CHA). Facilitated by the Jefferson Regional Health Alliance, participants included two other CCOs, both local hospitals, as well as representatives from public health, behavioral health, and community based social services. The process resulted in six transformation priorities for the next five years, including: substance use, affordable housing, mental health and well-being, poverty and employment, parenting and life skills, and education and workforce development. The CAC in Curry County completed a similar effort at the same time and identified three key areas of focus for their CHIP.

a. **Patient-Centered Primary Care Homes.** Since 2013, AllCare has worked with its primary care network to assist providers with application for the highest PCPCH tier status possible given their patient base and available resources. AllCare has engaged PCPCH trainers to assist our PCPs within the clinic to establish necessary tools, workflows, and administrative processes to support the PCPCH model of care. At this time, 87.6% of our PCP network has successfully achieved at least Tier 3 PCPCH status and all of our school based clinics are PCPCH Tier 2 or higher. This is 28.6 percentage points higher than 2013. We continue to provide resources, training and workflow redesign assistance as a Region-wide Resource to PCPs who apply for higher tier levels as their practices transition to more sophisticated level of integration.

(1) **Describe Applicant's PCPCH delivery system.** AllCare contracts with approximately 95% of the independent physicians, small and large group practices, and FQHCs across our three county service area to meet the primary care needs of our membership and ensure patients receive integrated and coordinated care. We have employed a full time PCPCH Coordinator who assists providers with their transformation needs and we have included PCPCH status within our Value Based Payment Models (VBPs) to reward providers who have transformed their practices to meet PCPCH requirements. This is not limited to primary care. In addition, we have implemented innovative programs including a Tier 3 Maternal Health PCPCH integrated with OB providers in Josephine County. We have worked with Options for Southern Oregon (CMHP) to qualify for Tier 3 PCPCH status in their medical clinic that is co-located within their behavioral health clinic to provide fully integrated physical and behavioral health. In addition, their primary care health clinic achieved PCPCH Tier 5 status. All OHP members have an assigned primary care provider and we have procedures in place to ensure members see their provider at least annually for prevention and wellness care.

(2) **Describe how the Applicant's PCPCH delivery system will coordinate PCPCH Providers and services with DHS Medicaid-funded LTC Provider and services.** To coordinate care for Medicaid-funded LTC patients, AllCare collaborates with the Rogue Valley Council of Governments (AAA/APD) as well as Senior and Disability Services (AAA/APD) in Jackson, Josephine, and Curry counties to share accountability and responsibility around access to and quality of physical health, behavioral health, and oral health needs. The process includes regular inter-disciplinary team meetings, transitional care practices, member engagement, shared accountability, and health promotion and prevention utilizing evidence-based best practices. Provider partners include AllCare's Care Coordination staff, APD case management staff, and community organizations, including behavioral health providers, addiction and recovery providers, long-term care facilities, hospitals, and primary care providers. Referrals are generally made when a member need is identified by a community partner, APD case worker, the CCO, or through member request. The mutual goal of this collaboration is to improve person-centered care, align care and service delivery, and provide the right amount of care at the right time for beneficiaries across the LTC system. The partnership is supported by a Referral Specialist from AAA/APD who serves as our link with Rogue Valley Council of Governments (RVCOG).

(3) **Describe how the Applicant will encourage the use of Federally Qualified Health Centers (FQHC), rural health clinics, migrant health clinics, school-based clinics and other safety net providers that qualify as Patient Centered Primary Care Homes.** AllCare currently contracts with all FQHCs and rural health clinics in southwest Oregon that are recognized as PCPCH providers, including LaClinica de Valle, Rogue Community Health, and Siskiyou Community Health Center. We also fund school based clinics to enhance early childhood development with an integrated delivery model that offers age-appropriate physical health, behavioral health and oral health screening, assessment, and referral. Our goal is to meet our OHP enrollees where they are best able to receive the wellness and prevention services they need in a timely manner. At this time, all of our FQHCs, Rural Health Clinics, Migrant Health Clinics, and most of our school based health centers are fully engaged in the PCPCH model of care.

b. **Other Models of patient-centered primary health care.**

(1) **If the Applicant proposes to use other models of patient-centered primary health care in addition to the use of PCPCH, describe how the Applicant will assure Member access to Coordinated Care Services that provides effective wellness and prevention services, facilitates the coordination of care, involves active management and support of individuals with Special Health Care Needs, is consistent with a patient and Family-centered approach to all aspects of care, and has an emphasis on whole-person care in order to address a patient's physical, oral and Behavioral Health care needs.** Many of our independent, small group, and rural primary care providers do not have the resources, including staff and space, to offer their OHP patients the full range of

wellness, prevention, case management, and care coordination in their clinical settings. In response, AllCare employs a centralized team of OHP case managers, including oral and behavioral health professionals, that works with our contracted providers to deliver these services on their behalf. This allows for a consistent approach that treats all OHP members similarly and it ensures that our primary care providers are operating at the top of their license, particularly in rural areas where manpower shortages are prevalent. Our centralized population health management staff of 50+ employees provide direct care management services in collaboration with members, their care givers, and their PCP, including care coordination, chronic disease management, intensive case management, medication management, utilization management, visiting nurse home visits, transitions of care management, and oversight services to ensure individualized care management plans are achieving the intended goals.

(2) **Describe how the Applicant's use of this model will achieve the goals of Health System Transformation.** The goals of health system transformation are to improve individual health, improve community health, and reduce health care costs through wellness programs, prevention, early intervention, integration, and care coordination. The PCPCH model of care is based on these goals and serves as the foundation for transformation. However, AllCare recognized that the PCPCH model of care could not address all of the transformation goals and over time we have invested in key areas to accelerate the transformation process, including:
   o Centralized care coordination and active management of special health care needs among our high risk OHP members;
   o Development and implementation of seven value based payment models that incentivize all providers across the continuum of care to embrace the PCPCH model of care and AllCare's transformation goals;
   o Investment in the social determinants of health ($9 million since 2013) to increase affordable housing, improve access to healthy diets, and expand programs to improve early childhood development;
   o Improved provider/physician satisfaction to increase retention, and enhance ongoing recruitment efforts; and
   o Assistance that helps providers transition to new and enhanced models of care.

4. **Network Adequacy**

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

   a. **Evaluation Questions**

   (1) **How does the Applicant intend to assess the adequacy of its Provider Network? Please include specific data points used to inform the assessment and the**

methodology for how adequacy will be evaluated. AllCare evaluates network adequacy by applying time and distance standards which vary by provider type (primary care/PCPCH, maternity, behavioral health, hospitals, pharmacy, oral health, and specialists.) AllCare currently reviews distance with a 10 mile standard. This information is collected on an annual basis and submitted to the OHA for review. It is also submitted to CMS annually but collected and reviewed quarterly. Please refer to *EXHIBIT 7.2a Geo Access Report Jackson County*; *EXHIBIT 7.2b Geo Access Report Curry County*; and *EXHIBIT 7.2c Geo Access Report Josephine County*.

(2) How does Applicant intend to establish the capacity of its Provider Network? Please include specific data points used to inform the assessment and the methodology for how capacity will be evaluated. AllCare evaluates the following data points for continuous monitoring of network capacity.
o   Time and distance standards by provider type;
o   Average wait time till next appointment;
o   Ratio of enrollees per provider type in each zip code;
o   Length of time to schedule third next available appointment;
o   Utilization of non-emergency medical transports;
o   Hospital utilization reports regarding admissions and ER usage;
o   Ability of providers to comply with ADA standards;
o   Grievance and appeals;
o   Number of providers no longer accepting new members;
o   Number of providers who have completed a Cultural Competency program;
o   Days of the week providers are open; and
o   Number of providers that offer extended and weekend hours.

(3) How does Applicant intend to remedy deficiencies in the capacity of its Provider Network? AllCare is owned by approximately 80 providers/physicians and has a long history of provider support activities that attract new providers to our service area and retain those who practice in southern Oregon. Our full network of contracted providers totals approximately 1,900 physical, oral, and behavioral health providers. We utilize a multi-system approach to ensure we meet network adequacy and capacity standards, including:
o   Continuous recruitment of new providers (physicians, nurses, therapists, care managers, etc.) from institutions of higher learning and communities inside and outside the state;
o   Scholarships to expand the workforce across the continuum of care;
o   Internships to introduce potential recruits to AllCare, our network of providers, and the communities we serve;
o   Telehealth, particularly in the area of behavioral health and care coordination;
o   Annually update VBP Data Collection to Reflect New Metrics services to reduce provider overhead costs, such as ASP services for electronic medical records, revenue cycle management, and assistance with buying clinic equipment/furnishings for new and aging clinics; and

o Monitor time to next appointment to identify providers with long wait times whose OHP members may need or want to be redirected to another PCP.

(4) How does Applicant intend to monitor Member wait times to appointment? Please include specific data points used to monitor and how that data will be collected. Wait times are monitored through patient survey information that currently focuses on the following:
o Patient satisfaction with experience of care;
o Patient satisfaction with access to care;
o Time to third next available appointment (part of our VBPs);
o For behavioral health we monitor length of time between the initial screening and assessment and initiation of the individualized treatment plan (also part of our Behavioral Health VBP); and
o Wait times are monitored quarterly through self-attestations from the provider regarding wait times to next appointment.

(5) How will Applicant ensure sufficient availability of general practice oral health Providers and oral health specialists such as endodontists? Please provide details on how the full time equivalent availability of Providers to serve Applicant's prospective Members will be measured and periodically validated. Ensuring oral health provider adequacy in southern Oregon is delegated to our oral health contractors who are contractually obligated to meet specific capacity requirements. These requirements are also embedded into our oral health value based payment model (VBP) which is designed to ensure high quality and timely access to needed basic dental services as well as specialty dental services. Oral Health VBP metrics are calculated on a quarterly basis and shared with our oral health contractors to measure progress toward goals. To ensure health parity, AllCare reviews specialty health provider capacity in a similar manner for oral health, behavioral health, and physical health.

(6) Describe how Applicant will plan for fluctuations in Provider capacity, such as a Provider terminating a contract with the Applicant, to ensure that Members will not experience delays or barriers to accessing care. Please refer to our response to item 3 above. In addition, AllCare annually measures the number of providers per 1000 members based on current enrollment (e.g. 50,000 members) as compared to maximum enrollment (e.g. 89,000) across the service area. This offers information to understand fluctuations within the network to successfully meet geo access standards and to assess whether members are experiencing delays or barriers to care by zip code. DSN Provider Report is attached as *EXHIBIT 7.1-DSN_AllCare_Provider_Report* and includes a detailed narrative of AllCare's contracted provider network.

5. **Grievance & Appeals**

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

information is reviewed quarterly or more often if trends are identified. Denials are reviewed quarterly and are compared to historical data while an analysis of the individual complaints/grievances and an analysis of the denials (types, reasons denied, number and identified trends) are generated. In addition to complaints and grievance information, Quality Management staff review data that is not initiated by our membership but rather AllCare staff. AllCare does not rely solely on complaints to reflect real or potential access issues. An example is the internal quality concern or IQC; reflecting care coordinator observations during member and provider interactions. These concerns are researched and reviewed by AllCare Medical Directors for interventions and strategies to address potential and actual access issues. Second opinion data is monitored annually to evaluate members' ease in scheduling specialty care consults. A review of over and under-utilization of health services can provide valuable information on member access to care and indicate when AllCare's staff needs to intervene. For example, over and under-utilization of services may indicate a lack of understanding of benefits by front-office provider staff and reflect unnecessary barriers to getting the appropriate services in the right setting.

AllCare currently utilizes information on wait time, travel distance, and our Non-Emergent Medical Transportation (NEMT) provider, ReadyRide, to monitor patient satisfaction with timely access to care. This information is included within our Value Based Payment Models to incentivize our provider network to focus on patient satisfaction related to access and to reduce patient complaints of access issues.

Our provider relations team is responsible for monitoring access metrics and collaborates with our Quality Grievance and Appeals manager to mitigate emerging issues. This group is also responsible for VBP instruction, Learning Collaboratives between primary care and specialty care providers, Listening Sessions for special member groups (LGBTQ+ and SPMI are examples), monitoring of satisfaction surveys, PCPCH instruction and support. Quarterly reports are generated and forwarded to the Quality Committee, Executive Leadership, and to the Board of Governors.

b. **Network Adequacy (including sufficient number of specialists, oral health and Behavioral Health Providers).** AllCare contracts with approximately 95% of the available health system resources in Jackson, Josephine, and Curry counties to ensure our OHP members have ample choice among available local resources across the continuum of care. In instances where specific specialties and subspecialties are unavailable in the service area or insufficient to meet the demand for care, AllCare arranges transport to other jurisdictions such as Eugene and Portland to ensure our members have access to medically necessary and appropriate health services in a timely manner.

In addition, AllCare contracts with Northern California providers for services not available locally. We also do "single case" agreements to meet an individual member's specific needs that can only be treated by specific facilities. Single case hospital contracts may also precipitate single case SNF contracts near the hospital to address

potential readmission needs during the recovery phase of the member's treatment plan. We also provide "Flex-Rides" for out-of-area care within VA hospitals for our OHP Veterans who need services that are not offered by local VA facilities.

Since adoption of our NEMT contractor, there has been a measurable decline in complaints and grievances related to scheduling issues. Our HEDIS results independently support that positive trend. In the areas of behavioral health and oral health where there has been historic shortages of resources, AllCare has collaborated with our contractors to establish new, integrated mental health clinics to accommodate those with severe and persistent mental health within an integrated behavioral, physical, and oral health care setting (Birch Grove Clinic); and we have worked with our primary care providers to train them to administer fluoride varnish on young children during their annual developmental assessment visits. We have established The Babe's Store which is an innovative way to engage mothers-to-be and new mothers by offering coupons whenever they visit their PCP, OB, or pediatrician which can be redeemed at the Babe's Store for needed items such as diapers, clothes, and other maternal and infant needs. The results have been remarkable in that our complaints and grievances have declined, our patient satisfaction on both "access" and "experience of care" have increased among both members and their providers, and our providers across the continuum of care are more engaged via our VBPs that track, monitor, and reward those who are making a difference.

c. **Appropriate review of prior authorized services (consistent and appropriate application of Prior Authorization criteria and notification of Adverse Benefit Determinations down to the subcontractor level).** Our Utilization Management (UM) team and our Prior Authorization (PA) team collaborate routinely with our compliance team to ensure that service authorizations are following policies and procedures, are timely, and adhere to current state and federal rules and regulations. Our Grievance and Appeals manager monitors trends in prior authorization denials and appeals to quickly identify any upward trends in certain types of complaints or grievances that may be due to recent changes in internal UM/PA processes or procedures. At the same time, our Chief Medical Officer who oversees UM and PA and our Chief Compliance Officer who oversees Grievance and Appeals, collaborate monthly with the Compliance Committee to provide oversight of all factors that impact the grievance and appeal process.

6. **Coordination, Transition and Care Management**

a. **Care Coordination**

(1) **Describe how the Applicant will support the flow of information between providers, including DHS Medicaid-funded LTC care Providers, mental health crisis services, and home and community-based services, covered under the State's 1915(i) State Plan Amendment (SPA) for Members with severe and persistent mental illness, as well as Medicare Advantage plans serving the Fully Dual Eligible Members, in order to avoid duplication of services,**

medication errors, and missed opportunities to provide effective preventive and primary care. AllCare is a founding member and funder of the Jefferson Regional Health Information Exchange (now named Reliance) whose main purpose is to securely share Electronic Medical Record data among health care providers across the continuum of care. This includes primary care, specialty care, behavioral health, oral health, hospitals, and skilled nursing facilities. As stated above, it also includes interfaces with home and community-based services covered under the State's 1915(i) State Plan Amendment for members with severe and persistent mental illness, as well as Medicare Advantage plans serving the Fully Dual Eligible members. Those interfaces include employment of a part time staff person from the Rogue Valley Council of Governments within AllCare's Care Coordination Team to serve as a referral source for local and state agencies as well as regular collaborative meetings involving local agency staff, behavioral health staff, physical health staff, and AllCare care coordination staff for the purpose of developing integrated individualized treatment plans for members with Severe and Persistent Mental Illness (SPMI) as well as Medicare Advantage plans serving the Dual Eligible Members. The purpose is to avoid or minimize costly duplication of services, medication errors, and missed opportunities to provide effective preventive and primary care services.

(2) Describe how the Applicant will work with its providers to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and Community prevention and self-management programs. As a local provider owned CCO headquartered in Josephine County with satellite offices in Jackson and Curry counties, AllCare has deep roots with the local health care provider community, including physical health, behavioral health, and oral health. Many AllCare staff participate in governance and stakeholder meetings among our community-based partners to help guide, educate, and formulate policy and facilitate sustainable funding across the continuum of care and social and educational supports. As a fully capitated health plan since 1996, we have worked with our community partners in public health, behavioral health, and more recently, oral health, to ensure that our OHP members receive high quality care, timely access, and efficient service across our continuum of care.

Our corporate culture is heavily influenced by our physician owners who place the needs of our OHP members and the communities in which their patients live as a top priority. As health care providers, our owners experience the daily impact of poverty, homelessness, food insecurity, and barriers to healthy lifestyles among the OHP members they serve. But our owners also know that "it takes a community" to address the full range of social, health, educational and economic necessities to lead a fully functional and healthy life, particularly in the rural communities we serve.

To support our OHP members and to build healthy communities, AllCare has cultivated long standing relationships and partnerships with most of the health and social service providers in our service area. As stated earlier, we contract with

approximately 95% of independent physical health providers, small group practices as well as larger practices in the communities we serve. In addition, we contract with all hospitals and skilled nursing facilities/long term care facilities in the area. We also have contractual relationships with local public health agencies, local community mental health departments, as well as affordable housing programs and our schools for early childhood development. We fund primary care providers who deliver care in our local public health agencies and community mental health agencies for crisis management services. We fund primary care providers who deliver physical health services within our local behavioral health centers and we fund a behavioral health professional within our contracted OB/GYN clinics. Our goal is to serve OHP members where they are most comfortable accessing the care they need.

Over the last six years, AllCare has expanded its partnerships with community based services with emphasis on affordable housing and early childhood development. We have also led the state in our efforts to address early childhood oral health through support of the "First Tooth" program which focuses on oral health assessments and fluoride varnish applications in the pediatric office setting to help prevent cavities and preserve healthy teeth. One of our primary care providers and Board Member recently commented that she hadn't seen a tooth problem among her younger patients in the last two years. She attributed that to AllCare's support of the First Tooth program that teaches PCPs to do assessments and administer fluoride varnish within their medical clinics as part of a child's annual preventive and wellness checkup – one way AllCare has addressed the shortage of non-emergent dental health services.

An innovative self-management program that AllCare has funded for many years is The BABE Store. The goal of this program is to increase prenatal care and improve early childhood development. The program is very effective and incentivizes eligible OHP members to have early and regular prenatal checkups and to ensure that the newborn child also receives regular developmental assessments years 0 – 3. The delivery model is simple: every time a mother-to-be or a new mother schedules and shows up for an appointment, she receives "coupons" that can be redeemed at The Babe Store for diapers, clothing, etc. While in the store our sales personnel (e.g. Traditional Health Workers) engage the mothers in conversations about being a new mother and offer advice on best parenting practices. If the THWs observe parental interactions with their child/children that may need attention they contact our care coordination team and/or PCP for follow-up and, if indicated, for intervention.

Another key program funded by AllCare is the PAX program that teaches young children how to control their personal behaviors within the classroom, treat their contemporaries with respect, and to improve their ability to be successful in school.

The success of these programs has been AllCare's ability to leverage its community partnerships with local social service programs as well as with our providers and

the patients they serve. As we ramp up our ability to undertake increased responsibility for the State's 1915(i) State Plan Amendment for Members with Severe and Persistent Mental Illness, we will build upon our success in partnering with local organizations that serve the same population. We are currently delivering care coordination services for women set to be released from local jails and who are OHP members with AllCare. One of our THWs meets with the women prior to release to screen and assess their needs as they anticipate reentering society. The THW then coordinates with their assigned PCP and Behavioral Health provider to schedule appointments; contacts our transitional housing partners to arrange a place to stay if needed; arranges appointments with employment counselors to address job opportunities and child care if needed. This is a new program for AllCare and it will likely evolve as we learn more about this subpopulation among our OHP enrollees.

(3) **Describe how the Applicant will develop a tool for Provider use to assist in the culturally and linguistically appropriate education of Members about Care Coordination, and the responsibilities of both Providers and Members in assuring effective communication.** AllCare has developed a training course for our providers and social service partners to ensure culturally and linguistically appropriate communication with all OHP members. To date, all of our staff and all of our provider owners and their staff have completed the training which provides hands on methodologies, policies, procedures as well as tools to ensure health equity for all. The training course is offered on a regular basis and is open to all of our contracted providers in physical, behavioral, and oral health as well as our community based social service partners, public health agencies, and the public. The trainings that have been offered over the last three years include:

- Cultural Humility (5 hours): The training was developed from the CLAS standards in partnership with So Health-E. The intent was to provide participants the ability to:
  o Understand the fundamentals of cultural competency, diversity, and inclusion;
  o Examine their own personal lenses and biases;
  o Examine the concept of cultural humility and the link to life-long learning and service equity;
  o Understand the impact of privilege and unconscious bias on health outcomes for marginalized populations;
  o Examine the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare;
  o Identify current challenges and barriers to providing health care, educational, and social services to culturally, ethnically, linguistically and socially diverse populations in southern Oregon;
  o Learn strategies for providing culturally responsive services and strategies to improve community engagement and increase inclusion of diverse communities.

- Cultural Agility: Provides participants with the skills for adapting to cultural differences while remaining agile during interactions with co-workers and members.
- Health Literacy 1.0: Gives the definition of health literacy and explains how marginal health literacy can be a barrier to a patient's healthcare and health outcomes.
- Implicit Bias: Helps participants understand implicit bias, its effect on healthcare, and how it can be overcome.
- Creating an Affirming setting for Non-Binary (those who don't identify as man or woman) People: Includes important terms, data, and expert-informed practices, and offers suggestions for how an individual can implement simple changes to improve the experiences of patients with non-binary gender identities.
- Health Literacy 2.0: This workshop teaches participants skills to create Plain Language forms. Participants are required to complete Health Literacy 1.0 to register.
- Unnatural Causes: Episode Five-Place Matters – Participants watch "Place Matters" from Unnatural Causes and then discuss why your address is a predictor of your health.
- Social Determinants of Health (SDoH) Game: This training helps participants understand the impacts of the SDoH. The game has three goals: 1) Discuss the SDoH; 2) Build empathy; and 3) Learn in a fun setting. Accredited by CCHI for continuing education.
- Barriers to Care: This training explores the following barriers to care: 1) SDoH; 2) Unconscious Bias; and 3) Language Access.

Beginning in 2018, we added a health equity metric to our seven Value Based Payment Models which asks patients if they feel their provider demonstrated cultural and linguistic sensitivity. This has proven to be an effective tool to identify how well our health equity training is being implemented and how well our OHP members are being served. In addition, we provide training to enhance the number of interpreters across our service area. AllCare is an accredited site for certification commission for healthcare integration training. To date, we have increased our local interpreter workforce from 1 Qualified Spanish Interpreter in 2014 to 91 interpreters as of April 17, 2019.

Language	Count Interpreters
ASL	6
Chinese	1
Chinese Mandarin	1
Japanese	1
Malay, Bahasa Indonesian	1
Marshallese	1
Palauan	1
Persian (Farsi)	2

Persian, Other (Armenian; Dari)	1
Russian	1
Samoan	1
Spanish	70
Spanish, Portuguese	1
Vietnamese	2
Vietnamese and Chinese	1
Grand Total	91

4. **Describe how the Applicant will work with Partners to implement uniform methods of identifying Members with multiple diagnoses and who are served with multiple healthcare and service systems.** AllCare uses the following methods to identify members in need of care coordination across multiple provider types:

o Our centralized care coordination team receives referrals from our physical health, behavioral health, and oral health providers as well as contracted hospitals, LTC facilities, public health, community mental health, and social service agencies when they encounter a person in need. Our team of care coordinators, social workers, and traditional health workers screen and assess the individual's needs, develop a person-centered treatment plan in collaboration with the member as well as their integrated care team. Progress toward goals is monitored by AllCare staff and documented in our care management software "Essette". Progress reports are routinely submitted to the integrated care team for follow-up and revision as needed.

o Our physical health providers are incentivized through our value based payment models to screen their patients on SBIRT to identify behavioral health needs and any patients screening positive are referred to a behavioral health contractor and/or our care coordination team for follow-up.

o Our MedInsight software is a claims based program designed to identify patients with co-morbidities and at risk for hospitalization and/or emergency department visits.

o AllCare's Population Health staff use multiple tools to help coordinate care for our members. Staff utilize information from programs such as PreManage, MedOptimize and MedInsight in tandem with our claims data to identify patients for chronic disease management, wellness programs and to prevent unnecessary emergency department visits. Our care coordination staff monitor reports derived from these tools on a routine basis and reaches out to patients and their provider team for screening and assessment regarding integrated care plans.

o AllCare ensures that representatives of multiple healthcare and social service agencies are appointed to each of our Community Advisory Councils along with our provider/owners. Communication linkages are strong and interagency referral policies and procedures are well defined as well as roles and responsibilities between physical health, behavioral health, oral health and community based programs and services. A good example of cross-agency

collaboration is our collective commitment to address the opioid epidemic among providers of behavioral health, physical health, public health, and the social determinants of health.

o AllCare staff are integrally involved on local, regional, and OHA committees that establish programs, policies, and procedures that impact the full continuum of care in physical, behavioral, and oral health as well as public health, mental health crisis management, local social services and educational programs that address the social determinants of health, and HIT services for data sharing and data management. This involvement ensures that AllCare is apprised of new developments, opportunities for collaboration, and participation in local decision-making that impact and the patients we cooperatively serve.

5. **Describe how Applicant will implement an intensive Care Coordination and planning model in collaboration with Member's PCPCH and other service providers such as Community Developmental Disability Programs and brokerages for Members with developmental disabilities that effectively coordinates services and supports for the complex needs of these Members.** For OHP members on our Medicare plan who require intensive care coordination due to Intellectual; Development Disability (I/DD), AllCare administers an Intensive Care Coordination Program for members with special needs due to aging, blindness, disability and those with complex medical needs, high health care needs, multiple chronic conditions, Special Health Care Needs, Severe and Persistent Mental Illness who are in Long Term Care (LTC). Facilities as well as home and community based services for behavioral health and/or substance abuse services. AllCare's ICC staff and works closely with the members in the I/DD programs and brokerages throughout our region to advocate for members and ensure they have appropriate access to benefits and services. Care coordination for all OHP members with special needs due to aging, blindness, disability and those with complex medical needs, high health care needs, multiple chronic conditions is available through our care coordinators and intensive case managers. This population is identified upon enrollment and outreach is made within 30 days to conduct an HRS. This standardized survey is conducted by AllCare centralized care coordination staff. The survey captures co-morbid conditions, SDoH-HE, Behavioral Health needs, identifies barriers not able to be captured by claims data. The results of the survey are shared with primary care providers and trigger internal care coordination program referrals. Staff collaborate with the member, family and/or caregivers, medical care team, BH agencies, dental providers and other community agencies involved in the member's care to create an individualized care plan.

6. **Describe how the Applicant will meet state goals and expectations for coordination of care for Members with severe and persistent mental illness, receiving home and Community-based services covered under the State's 1915(i) SPA and Members receiving DHS Medicaid-funded LTC services, given the exclusion of DHS Medical-funded LTC services from Global Budgets.** AllCare has implemented a process in order to screen all of our members for a variety of needs including for available State Plan Home and Community Based Services (HCBS). AllCare Population Health employs certified Community

Health Workers to conduct an initial Health Risk-Assessment Survey (HRS) with each new member. If the member is referred for care coordination based on the HRS, additional assessments are conducted within 10 days or as quickly as the member's health condition requires. AllCare's HRS includes questions with regard to a member's ability to complete their activities of daily living (ADL's) and diagnoses that may contribute to impairments of their ADL's, including past or present behavioral health diagnoses or conditions that fall under DHS purview. The HRS is designed not only to identify health risks and barriers to care but to also identify what resources in the community the member might benefit from. This includes possible eligibility for State Plan HCBS (including in-home services) or other community support programs. Members whose responses to the HRS indicate they may need assistance with their ADL's, whether it may be in-home or community-based living, are referred to an AllCare Care Coordination team. The Care Coordination Team includes a RN Care Coordinator (CC), Intensive Case Manager (ICM), Certified Community Health Worker (CHW) and/or another certified traditional health worker who might specialize in specific health conditions. The Care Coordination Team will outreach to the member, and with member's permission, perform an in-home assessment to determine member's specific needs regarding their ADL's and instrumental activities of daily living (IADLs) and determine which diagnosis is the primary driver for the needed assistance. Once the primary diagnosis driving the need is identified the Care Coordination Team will assist the member in navigating the application and assessment process with the appropriate agency.

The primary diagnosis driving the need for assistance is a key component for determining which State Plan or Medicaid funded program, and through which agency, the member should apply. Aging and People with Disabilities (APD) provides in-home, assisted and residential services for people with physical diagnosis and condition that impair their ADLs. The State I/DD Services contracts with either the County or a designated Brokerage to provide in-home, assisted and residential programs to children and adults with intellectual or developmental delays that impair their ADLs. When the primary diagnosis driving the need for assistance is a behavioral health diagnosis the AllCare Care Coordination Department will connect members directly to the most appropriate subcontracted mental health provider. If a member's behavioral health needs are complex or there is question regarding driving diagnosis the Care Coordination Department has access to the Behavioral Health Care Coordinator (BHCC) for consultation and getting the member connected to the appropriate services with the appropriate provider.

Each time a member accesses one of AllCare's contracted behavioral health providers a biopsychosocial evaluation is completed which includes the assessment of member's ability to complete their activities of daily living, need for other in-home service or intensive service needs. A member's need for in-home or intensive services are also identified at these agencies through ongoing case management and intensive care coordination services. When it is identified through an assessment or

ongoing services that a member requires assistance in the home or their needs are too great for outpatient services. Some of these services can also be provided as an attempt to keep the member in the least restrictive setting as possible. The following types of services may be offered:

- Personal Care Attendant Services (PCa20);
- 1915(i) Home and Community Based Service (HCBS);
- Assertive Community Treatment (ACT);
- In-home respite services;
- Skills Training;
- Case Management; and
- Therapeutic Services.

7. **Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, including the use of Traditional Health Workers, especially for Members with intensive Care Coordination needs, and those experiencing health disparities.** AllCare has implemented the following strategies to incentivize care coordination across the continuum of care in southwest Oregon:

- Management of a centralized care coordination team that provides consistent and evidence-based care coordination across the continuum of care in collaboration with primary care providers, behavioral health specialists, oral health, and community based supports;
- Inclusion of incentives within our seven VBP Models to screen and assess the need for care coordination (e.g.: SBIRT) and/or referral to social services to address homelessness, food insecurity, transportation, and utilities;
- Application of transitions of care planning for high risk hospital discharges;
- Identification and outreach by our THW among high risk/high cost OHP members to assess the need for care coordination as identified by our MedInsight claims data, weekly hospital ED usage and discharge reports as well as referrals across the continuum of care;
- Care coordination and care management for OHP members with multiple chronic conditions;
- Application of the "Red, Yellow, Green" sheets for patient self-management of their chronic conditions; and
- Training for all personnel and offered to our provider network and community partners in the areas of health equity, cultural sensitivity, and diversity.

8. **Assignment of Responsibility and Accountability**: **The Applicant must demonstrate that each Member has a Primary Care Provider or primary care team that is responsible for coordination of care and transitions.**

   a. **Describe the Applicant's standards that ensure access to care and systems are in place to engage Members with appropriate levels of care and services beginning not later than 30 days after Enrollment with the CCO.** AllCare offers to assist each OHP member with selection of their Primary Care Provider

within 30 days of enrollment and can assist with scheduling a New Patient Appointment with their chosen PCP as soon as possible. If a current OHP member has not seen their PCP within the last year, our Care Coordination team reaches out to assist with scheduling an appointment and offer assistance with transportation, filling prescriptions, and where indicated, home visits by our THW staff. AllCare staff take the lead in developing and implementing transitions of care plans and care coordination plans in collaboration with the PCPs and other members of the patient's care team.

b. **Describe how the Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for Members to assess individual care needs or to determine if a higher level of care is needed.** In selecting one's PCP, each member is screened by our Member Services staff (sometimes in collaboration with our Health Equity team) to determine if a particular provider is best prepared to satisfy that person's cultural and linguistic preferences either personally or through access to needed interpreter services. We also include input from family and/or caregivers who may also have such preferences and need special support to ensure effective communication and collaboration through implementation of the member's treatment plan, care coordination plan, and/or transitions of care plan.

9. **Comprehensive Transitional Care: The Applicant must ensure that Members receive comprehensive Transitional Care so that Members' experiences and outcomes are improved. Care Coordination and Transitional Care should be culturally and linguistically appropriate to the Members need.**

   (a) **Describe the Applicant's plan to address appropriate Transitional Care for Members facing admission or discharge from Hospital, Hospice, or other palliative care, home health care, adult foster care, skilled nursing care, residential or outpatient treatment for mental health or substance use disorder, the Oregon State Hospital, or other care settings. This includes transitional services and supports for children, adolescents and adults with serious Behavioral Health conditions facing admissions or discharge from residential treatment settings and the state Hospitals.** AllCare and its mental health subcontractors coordinate with the local contracted hospitals, skilled nursing facilities, inpatient rehabilitation programs, residential or outpatient treatment for behavioral health (including the Oregon State Hospital) and other community-based residential care settings to develop and implement individualized transition plans at time of discharge or transfer. The individual transition plans reflect the preferences of the member and/or their caregiver and ensures that each individual receives the social and health service supports he or she needs for a successful discharge and incorporates the discharge treatment plan recommended by the facility in collaboration with the member's PCP. The transition plan reflects the cultural and linguistic needs of the member and their caregiver and ensures effective communication and understanding of the transition expectations. The overriding goal is to mitigate avoidable

readmissions and minimize unnecessary emergency department visits while healing.

(b) Describe the Applicant's plan to coordinate and communicate with Type B AAA or APD to promote and monitor improved transitions of care for Members receiving Medicaid-funded LTC services and supports, so that these Members receive comprehensive Transitional Care. While AllCare is not financially responsible for the cost of long term residential care, we are responsible for our members' physical health, behavioral health, and oral health while in residence. When one of our members in residential care needs physical, behavioral or oral health services, we encourage the facility to contact us and we facilitate, as needed, the scheduling process, transportation, and other supports, including comprehensive Transitional Care, to ensure the member receives the care he/she needs in a timely manner and in the least costly care setting that meets their health needs.

(c) Describe the Applicant's plan to develop an effective mechanism to track Member transitions from one care setting to another, including engagement of the Member and Member's Family care management and treatment planning. Transitions from one care setting to another is monitored through our utilization management and prior authorization process, through weekly hospital discharge planning and ED and Hospital utilization reports, data on NEMT services through ReadyRide, and through claims data. Our care management team together with our provider relations team review the data monthly to identify gaps in care, avoidable readmissions, and unnecessary emergency department visits. Transitions of Care planning is a collaboration between AllCare's care management team and the discharging facility and includes input from the family or caregiver to identify preferences as well as ensure patient satisfaction and high quality outcomes.

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

(a) Describe the Applicant's standards and procedures that ensure the development of individualized care plans, including any priorities that will be followed in establishing such plans for those with intensive Care Coordination needs, including Members with severe and persistent mental illness receiving home and Community-based services covered under the State's 1915(i) SPA. All Special Needs members new to the plan are engaged with a HRS. This standardized survey is conducted by AllCare centralized care coordination staff. The survey captures co-morbid conditions, SDoH-HE,

Behavioral Health (BH) needs, identifies barriers not able to be captured by claims data. The results of the survey are shared with primary care providers and trigger internal care coordination program referrals. Staff collaborate with the member, family and/or caregivers, medical care team, BH agencies, dental providers and other community agencies involved in the member's care to create an individualized care plan. This care plan is amended throughout the duration of care coordination or as needed to address a member's needs. The individualized care plan assists members and their care givers in navigating the healthcare delivery system and in accessing community and social support services as well as regional and statewide resources, including certified/qualified health care interpreters.

(b) **Describe the Applicant's universal screening process that assesses individuals for critical risk factors that trigger intensive Care Coordination for high needs Members, including those receiving DHS Medicaid-funded LTC services.** AllCare's main universal screening process involves a HRS for new members with a priority on those members with Special Needs. In addition, identification of "at risk" members occurs through internal referrals, member request for care coordination, PCP referrals, behavioral health referrals, software tools used to extract claims data to search for members will high ED utilization, readmissions within 30 days, medications, costs, and other criteria that indicate a need for outreach and follow-up. Once members are identified for needed support, AllCare Care Coordinators/Case Managers outreach to those members and assess their need for intensive Care Coordination through use of a standardized screening and assessment tools that are embedded within our care management software "Essette". Based on member and/or caregiver answers to the screening and assessment questions, an individualized care treatment plan is created based on member health and social service needs as well as their individual preferences. This includes identification of SDoH-HE needs and supports.

(c) **Describe how the Applicant will factor in relevant Referral, risk assessment and screening information from local Type B AAA and APD offices and DHS Medicaid-funded LTC Providers; and how will they communicate and coordinate with Type B AAA and APD offices.** AllCare and the Rogue Valley Council of Governments (AAA/APD) as well as Douglas County Senior and Disability Services (AAA/APD) have chosen to coordinate care and share accountability for individuals receiving Medicaid funded long term care services. The process of coordination includes but is not limited to inter-disciplinary care team meetings, transitional care practices, member engagement, shared accountability, and health promotion and prevention utilizing evidence-based best practices. Provider partners include AllCare's care coordination staff, APD case management staff, and community organizations such as behavioral health providers, addiction and recovery services, long term care facilities, hospitals, and primary care providers. Referrals are generally made when a member need is identified by a community

partner, APD caseworker, AllCare staff, or through member request. The partner meetings are designed to meet the needs of members as a team by paying close attention to member/family needs and preferences, determining gaps and providing an interrelated approach to the member. The mutual goal of this collaboration is to improve person-centered care, align care and service delivery and provide the right amount of care at the right time for beneficiaries across the LTC system. Coordination with Rogue Valley Council of Governments is provided by the Referral Specialist. She serves as our link in communication to facilitate quality member services and to allow leadership to make informed decisions about service delivery. The Referral Specialist works with AllCare staff to ensure that the wide selection of evidence-based services are appropriately referred and documented. She maintains the data and prepares the reports for both organizations. The Referral Specialist is also part of our Transitions of Care team and provides the Coleman Care Transitions Intervention outreach.

(d) Describe how the Applicant will reassess high-needs Members at least semi-annually or when significant changes in status occur to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner. The Essette Care Management Software requires ongoing updates throughout implementation of each individualized care plan and prompts the care manager to reach out to members to complete tasks and create interventions for the care plan that is used to automatically reassess and recommend updates to the care plan. In addition, routine monitoring of service requests, prior authorizations, claims data on ED visits and readmissions, as well as our MedInsight software provides weekly/monthly lists of members who are currently on a care coordination plan and who are high utilizers of our health care system, thereby triggering outreach procedures to follow-up with the member and their caregiver to revise and refine their care plan to address emerging and/or reoccurring physical health, behavioral health, oral health, and/or social support needs.

(e) Describe how individualized care plans will be jointly shared and coordinated with relevant staff from Type B AAA and APD with the DHS Medicaid-funded LTC Providers and Medicare Advantage plans serving the Fully Dual Eligible Members. The individualized care plan is shared with other collaborating agencies via secure information sharing databases, such as Jefferson Regional HIE, Reliance IT, and/or Collective Medical Technology which offers an integrated platform to access EDI. This process is also facilitated by our designated liaison with the Rogue Valley Council of Governments whose members represent relevant staff from Type B AAA and APD with DHS Medicaid-funded LTC Providers. Our Fully Dual Eligible Members are typically covered by AllCare CCO for Medicaid and its affiliate, AllCare Health Plan, Inc. for Medicare, allowing our in-house care coordinators to access internal data to address their specific needs.

(11)Describe the Applicant's plan for coordinating care for Member oral health needs, prevention and wellness as well as facilitating appropriate Referrals to oral health services. AllCare has focused on early childhood and maternal oral health in an effort to prevent dental problems later in life. This includes training for primary care providers to apply fluoride varnish in their medical clinics to fight tooth decay and to screen all members for health services and referrals for dental care. It also includes early childhood education within our public school systems to teach youth proper dental care. And it involves application of our value based payment model for our oral health contracted providers that financially incents dentists and their staff to meet or exceed oral health measures for prevention, quality, access, and effectiveness, including care coordination.

(12)Describe Applicant's plan for coordinating Referrals from oral health to physical health or Behavioral Health care. There are three major ways that oral health providers refer to physical health and/or behavioral health, including:

- Federally Qualified Health Centers are integrated service providers that offer physical, behavioral, and oral health services within the same location. For new patients, oral health providers coordinate with their counterparts to complete initial screenings and assessment. If indicated, the oral health staff will refer the patient to a PCP or behavioral health provider as needed.
- Oral health providers routinely screen for diabetes and pregnant women and if indicated, refer to the member's PCP or OB for follow-up.
- Some PCPCH clinics now embed oral health providers to do screenings and assessment as part of their wellness and prevention services.
- Our oral health VBP Model incentivizes our network of dentists and hygienists to screen for medical problems that manifest in dental health issues and make referrals to the appropriate physical health provider and/or behavioral health provider.

b. Care Integration

(1) Oral Health

(a) **Describe the Applicant's plan for ensuring delivery of oral health services is coordinated among systems of physical, oral, and Behavioral Health care.** AllCare contracts with four regional and statewide dental health organizations and one FQHC, who administer a network of contracted dentists and oral hygienists to deliver dental services to our OHP members. These organizations participate in our Value Based Payment Models which incentivize them to meet timely access standards as well as quality and utilization benchmarks which are routinely monitored for contract compliance, including adherence to timely care coordination and referral to their counterparts across the continuum of care. Quarterly reports on dental VBP metrics are reviewed by AllCare staff and forward to individual providers for peer comparison and analysis of progress toward goals.

(b) **Describe Applicant's plan for ensuring that preventive oral health services are easily accessible by Members to reduce the need for urgent or emergency oral health services.** One program AllCare has successfully helped to implement to increase the number of children who receive fluoride varnish to reduce cavities and prevent the need for urgent or emergency oral health services. This program involves training primary care providers and their staff to administer fluoride varnish during each child's annual physical health wellness check. In addition, AllCare has funded school based clinics to screen for physical, behavioral, and oral health needs and refer members accordingly. And finally, AllCare contracts with all FQHCs within our service area where an integrated service delivery model offering physical, behavioral and oral health within a single clinical setting promotes screening, prevention and early intervention of oral health needs among our members.

(2) **Hospital and Specialty Services.** AllCare currently contracts with all available hospitals in southwest Oregon, including Asante Health Services (Medford, Grants Pass, and Ashland), Providence Health (Medford), Curry General Hospital (Gold Beach), and Sutter Coast Hospital (Crescent City, CA). AllCare also contracts with approximately 95% of all other providers, both primary care providers and physical /behavioral/oral health specialists, across the service area.

In addition, AllCare contracts with Northern California providers for services not available locally. We also do "single case" agreements to meet an individual member's specific needs that can only be treated by specific facilities. Single case hospital contracts may also precipitate single case Skilled Nursing Facilities contracts near the hospital to address potential readmission needs during the recovery phase of the member's treatment plan. We also provide "Flex-Rides" for out-of-area care within VA hospitals for our OHP Veterans who need services that are not offered by local VA facilities.

Describe how the Applicant's agreements with its Hospital and specialty care Providers will address:

(a) **Coordination with a Member's PCPCH or Primary Care Provider.** Our contracted hospitals have data sharing agreements with local PCPs, Specialty Care Providers, Behavioral Health Providers, and Oral Health Providers as well as with AllCare. This avoids duplication of diagnostic and treatment procedures; allows for collaboration on individualized care plans; streamlines the referral process between PCPs and Specialists; ensures timely access to needed patient information in a secure and confidential environment; and mitigates avoidable ED visits and preventable readmissions.

(b) **Processes for PCPCH or Primary Care Provider to refer for Hospital admission or specialty services and coordination of care.** AllCare has a robust utilization management and prior authorization process that is designed to ensure requests for services are medically necessary, timely, and provided in

the lowest cost setting when quality outcomes are the same. Prior authorizations must be evaluated within a limited timeframe to ensure timely access to care. There are appeal procedures in place that allow patients and their providers to appeal denials; and there are physicians acting as AllCare's Medical Directors who oversee hospital and specialty referral processes on behalf of our provider network. In addition to our prior authorization processes and procedures, AllCare also has a strong transitions of care team that ensures hospital discharge orders are coordinated with each individual's primary care provider and any specialty care consulting physicians. Where indicated, our Transitions of Care team coordinates with the Care Coordination team if longer term case management is warranted.

(c) **Performance expectations for communication and medical records sharing for Hospital and specialty treatments, at the time of Hospital admission or discharge for after-hospital follow-up appointments.** Communication and medical records sharing begins with the service request and prior authorization process where a member's provider submits a service request online through AllCare's secure and confidential Provider Portal. Most online service requests are auto approved for specialty referrals and hospital admissions, which are then automatically transmitted to the specialist or hospital for scheduling. Services that require prior authorization are manually approved or denied by our utilization management team who reviews medical records and claims history to ensure medical necessity, timeliness of care, and appropriate care setting. Once approved, medical records are securely shared electronically with the specialist and/or the hospital in advance of service delivery. Upon conclusion of service delivery, medical records are updated by the specialist and/or hospital attending physician and shared with the member's primary care team for ongoing treatment and follow-up. The performance expectations for communication and medical records sharing include contractual provisions calling for maximum confidentiality and security of protected health information required under HIPAA and Oregon Administrative Rules.

(d) **A plan for achieving successful transitions of care for Members, with the PCPCH or Primary Care Provider and the Member in central treatment planning roles.** Our current transitions of care planning for hospital discharges has been in place for five years and has proven successful in reducing preventable readmissions and unnecessary emergency department visits post-discharge. This is due in large part to our Care Coordination and Case Management team as well as our highly collaborative process of care between primary, specialty care providers, and our transitions of care team.

c. **DHS Medicaid-Funded Long Term Care Services**

(1) **Describe how the Applicant will:**

(a) **Effectively provide health services to Members receiving DHS Medicaid-funded LTC services whether served in their home, Community-based care or Nursing Facility and coordinate with DHS Medicaid-funded LTC delivery System in the Applicants Service Area, including the role of Type B AAA or the APD Office.** AllCare will effectively provide health services to members receiving DHS Medicaid funded LTC services in their home, community-based care or nursing facility and coordinate with DHS Medicaid-funded LTC delivery system in two ways:

- Through expansion of our current integrated care team of physical health, behavioral health, oral health, and AllCare care coordinators/case managers to add representatives from the DHS Medicaid-funded LTC delivery system to our collaborative care coordination team for the purpose of developing and implementing individualized care plans for this target population; and
- Through our referral specialist within the Rogue Valley Council of Government who provides liaison services between the DHS Medicaid-funded LTC delivery system and AllCare's Care Coordination team.

(b) **Use best practices applicable to individuals in DHS Medicaid-funded LTC settings including best practices related to Care Coordination and transitions of care.** AllCare supports the centralized provision of care coordination as a best practice. This model creates individualized care plans through coordination of multiple agencies, involving varying areas of expertise in order to meet each member's specific needs. Our care delivery model offers a central point of contact for all members of the team, including the client and their caregivers, as well as standardized processes, policies and procedures that ensure accuracy of each care plan, consistency across care settings, and fairness and equity in quality of services delivered.

(2) **Describe how Applicant will use or participate in any of the following models for better coordinating care between the health and DHS Medicaid-funded LTC systems, or describe any alternative models for coordination of care.** There are essentially four models of care delivery for this target population. AllCare currently operates two of the models and plans to implement a third one in early 2020.

(a) **Co-Location: co-location of staff such as Type B AAA and APD case managers in healthcare settings of co-locating behavioral health specialists in health or other care settings where Members live or spend time.** Co-location is one way AllCare currently coordinates care via a Referral Specialist who acts as a liaison across all entities and works directly with our staff in our AllCare offices to ensure that members receive the care and supports they need in a timely manner, by the right provider, and in the right care setting.

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

representation. A Team Approach such as a multi-disciplinary team that includes DHS Medicaid-funded LTC representation is our preferred approach and builds upon the model we have successfully utilized for integrated care planning involving physical health, behavioral health, oral health and community supports such as housing, transportation, and food security.

(c) **Services in Congregate Settings: DHS Medicaid-funded LTC and health services provided in congregate settings, which can be limited to one type of service, such as "in home" Personal Care Services provided in an apartment complex, or can be a comprehensive model, such as the Program for All-Inclusive Care for the Elderly (PACE).** Services in congregate care settings such as a PACE Program serve primarily the dually eligible in need of intensive care management and who live in community based care settings who might otherwise be eligible for more costly nursing levels of care.

(d) **Clinician/Home-based Programs: increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform assessments, plan treatments, and provide interventions to the person in their home, Community-based or Nursing Facility setting.** Our Intensive Care Coordination team provide intensive case management, which offers a mechanism through which registered nurses (RN) perform assessments, collaborate with providers on treatment, and provide recommendations for care plans. Members are assessed in their homes, community-based, or nursing facility setting. We find this model to be successful, particularly for members with Severe and Persistent Mental Illness and members with severe physical and behavioral disabilities. It decreases inappropriate utilization within the healthcare continuum and successfully reduces unnecessary expenses. Additionally, members have increased engagement and improved ability to self-manage their own care.

d. **Utilization management**

Describe how the Applicant will perform the following UM activities tailored to address the needs of diverse populations including Members receiving DHS Medicaid-funded LTC services, Members with Special Health Care Needs, Members with intellectual disability and developmental disabilities, adults who have serious mental illness and children who have serious emotional disturbance.

(1) **How will the authorization process differ for Acute and ambulatory levels of care.** For services that require prior authorization, our UM nurses and Medical Directors apply our policies and procedures equally across all OHP members to ensure equity and fairness for all for both Acute and Ambulatory Levels of Care. Exceptions are made on an individual basis for members with special needs such as those with I/DD, DHS Medicaid-funded LTC clients, and those with severe and persistent mental illness or serious emotional disturbance.

Approvals or adverse determinations of service requests requiring prior authorization are based on medical necessity, benefit package design, and meeting utilization criteria as adopted in guidelines. AllCare employs utilization criteria based on nationally endorsed guidelines that reflect evidence based practices. The guidelines include but are not limited to Oregon Administrative Rules, Prioritized List of Health Services Guidelines, Milliman Care Guidelines, and AllCare policies.

(2) Describe the methodology and criteria for identifying over and under-utilization of services. Measuring over and under-utilization occurs through regular reports generated through our auto-approval process within our Provider Portal and through an annual report developed by our IT team that includes both auto-approved requests for services and requests reviewed by our UM nurses and Medical Directors. As of January 1, 2019, there were 102 specific types of services requests that require prior authorization covering substance use disorders, mental health services, adult outpatient, child outpatient, and peer delivered services, physical health, provider services, diagnostic services, surgical procedures, vision, NEMT, hospital services, pharmacy services, hospice, SNF, home health, hearing, dental, and DME.

7. **Accountability**

   a. **Describe any quality measurement and reporting systems that the Applicant has or will implement in Year 1.** In addition to our seven Value Based Payment Models which are fully described in Attachment 8, AllCare tracks and monitors the following quality metrics as part of its Transformation and Quality Strategy. Current Quality Improvement Strategies and Initiatives include:
      - Through development and implementation of a formalized structure and process, ensure that providers and their staff are educated and well-versed in health literacy and in their ability to remove barriers for their patients and improve health outcomes;
      - Create a formalized structure and process for auditing, monitoring, and oversight for First Tier Entities; (audit of compliance program integrity)
      - Hold listening sessions to address Emergency Room disparity in Native American and SPMI populations; (Health equity survey data)
      - Develop and implement a training program to increase the availability of Medically Certified Interpreters; (internal tracking system)
      - Develop and implement policies to identify and address under and over-utilization of services; (compare AllCare experience to national benchmarks)
      - Incorporate reporting from the PreManage System to provide a more accurate and up-to-date census report on our inpatient members based on all hospitals in the state;
      - Increase utilization of "Truvada" – a medication used to prevent HIV; (measure increase in number of prescriptions and spend for this drug as well as decrease in new HIV cases)

- Formalize process to monitor members' access to second opinions; (measure number of authorization requests for second opinions)
- Increase active utilization of the AllCare Patient Portal by members; (monthly number of logins)
- Formalize a structured process that integrates oral health, behavioral health, and physical health into one care setting for individuals with mental illness in Josephine County similar to Birch Grove in Jackson County;
- Formalize a process to identify Dual Eligible members with special health care needs, stratify by level of risk and refer those in need of community-based social services and supports for care coordination:
- Add a measure to assess provider access to our Value Based Payment models;
- Develop a diabetes care management program that leverages the OHA technology plan requirements to transition to QRDS reporting; (eCQM measures)
- If feasible, modify the risk-based primary care capitation model and the PCP VBP model to increase the value based components to both programs.

b. **Will the Applicant participate in any external quality measurement and reporting programs (e.g., HEDIS reporting related to NCQA accreditation, federal reporting for Medicare Advantage lines of business)?** Annually, AllCare Health Plan, Inc. is required to participate in HEDIS, CAHPS, HOS quality reporting with our CMS contract.

c. **Explain the Applicant's internal quality standards or performance expectations to which Providers and Subcontractors are held.** All contracted providers must be board eligible or certified and credentialed to participate in AllCare's provider network. In addition, contracted provider across the continuum of care are measured on the OHA metrics as well as the AllCare VBP metrics.

d. **Describe the mechanisms that the Applicant has for sharing performance information with Providers and contractors for Quality Improvement.** Through AllCare's VBP program, individual quarterly reports are prepared and shared with each contracted provider. Please see Attachment 8-Value Based Payments for more information.

8. **Fraud, Waste and Abuse Compliance**

a. **Please describe how Applicant currently engages in activities designed to prevent and detect Fraud, Waste and Abuse.** The Compliance Officer conducts an annual company-wide operational risk assessment to determine areas of high, medium and low risk, the confidence level of internal processes mitigating those risks and to identify any gaps in the oversight and monitoring of those operational area. This audit includes personal interviews with staff employees; review of all incident reports filed during the year; review and evaluation of discipline imposed during the prior three years of violations, review of contacts with government agencies receiving fraud and abuse reports from the Company; review of forms and other documentation used in

implementing the Plan; and review of other inquiries as deemed appropriate by the Compliance Officer. Checks against the OIG and GSA exclusion lists are conducted prior to every check run for contracted and non-contracted providers, for new hires and all employees monthly thereafter and all Board and Committee members monthly. Engaging posters have been placed above every coffee station in the AllCare offices that display the ways to report any suspected issue in a confidential non-retaliatory manner. AllCare's Code of Conduct clearly defines the expectations of employees attending mandatory annual trainings for Compliance, HIPAA Privacy/Security, Sexual Harassment to name a few. Failure to attend these trainings are tied to the employee's annual evaluation. AllCare utilizes the Compliance Program Integrity guidance by CMS and AllCare's First Tier, Downstream and Related entities are held to those same standards. An annual schedule of First Tier program audits are included in the annual Compliance Work Plan; if needed, corrective action plans are generated with oversight and regular meetings to assess the work's progress.

b. **Please describe how Applicant intends to monitor and audit its Provider Network, Subcontractors, and delegated entities for potential Fraud, Waste, and Abuse activities.** The purpose of the annual audit addresses the following issues and concerns:
   o Is the Fraud, Waste, and Abuse Plan working?
   o Do staff understand and are acting in accordance with Plan requirements?
   o Is the Plan effectively minimizing fraud and abuse activities?
   o Are personnel reporting violations?
   o Are violations dealt with appropriately and effectively?
   o Is the Plan up-to-date?
   o Does the Plan continue to meet OHA and CMS needs and expectations?
   o Does the Plan meet all applicable rules and regulations?

9. **Quality Improvement Program**

a. **Please describe policies, processes, practices, and procedures you have in place that serve to improve Member outcomes, including evidence-based best practice, emerging best practices, and innovative strategies in all areas of Health System Transformation, including patient engagement and activation.** AllCare's QI Management Program involves the following committees to establish formal processes to develop and implement an effective clinical quality improvement program, promote objective and systematic monitoring and evaluation of clinically related activities, while continuously acts on opportunities for improvement. The Program focuses on provider access, member satisfaction, patient safety, continuity and coordination of care, disease management, clinical pharmacy programs, preventive health, health equity, member rights, quality of service, over/under utilization, and the social determinants of health: sufficient food, housing, utilities, domestic violence, and non-emergent transportation.
   o **Quality Improvement Committee**: Responsibilities include oversight of all quality improvement programs, structure, scope, criteria, and activities related to quality of care, quality of service standards, and professional review protocols by monitoring grievances/appeals, and recommending corrective action when needed.

- o **Compliance Committee**: In conjunction with relevant departments and affiliated providers, develops standards of conduct, policies and procedures that promote allegiance to the organization's compliance program which includes development of internal systems and controls to carry out standards, policies, and procedures as part of daily operations. The Committee also monitors all internal and external audits and implements corrective and preventive action as needed.
- o **Leadership Operations Team**: Comprised of all managers, directors, and C-Level personnel, the Ops Team establishes strategies and methodologies to address key goals and objectives in keeping with state and federal regulations as well as daily business needs. This group provides a management level forum for generating recommendations to the Compliance Committee regarding confidentiality policies and internal practices for protected health information, and provides oversight, guidance and support for business ethics awareness and associated activities.
- o **Pharmacy and Therapeutics Committee**: The committee is responsible for formulary oversight and medication placement, as well as oversight of our drug utilization review processes. It also reviews overall effectiveness of medication utilization trends and identifies quality improvement opportunities related to Pharmacy and medication related processes.
- o **Behavioral Health Quality Review Committee**: Monitors and improves Behavioral Health (BH) utilization through quality chart reviews and development of BH providers.
- o **Credentialing Committee**: The Committee is responsible for primary source verification and initial credentialing and re-credentialing for all providers in our service area. The Committee provides the quality improvement foundational structure in the development of a viable quality-focused provider network, including monthly reports to OIG, SAM, and the Chief Compliance Officer to identify providers that have been sanctioned or excluded from Medicare.

  All Committees report bi-monthly to the Board. The Program is supported by policies and procedures, performance monitoring tools, and educational resources that are reviewed and revised when indicated to reflect current QI activities and address organizational goals and commitments, as well as federal and state regulatory requirements.

b. **Please describe your experience and plan to emphasize and implement wellness and health improvement activities and practices within your organization for Members and staff, including partners and contracts in place to strengthen this aspect of health care.** Preventive Health and Wellness activities are conducted by our Population Health Department staff and include:
- o Content development in multiple areas of prevention and wellness;
- o Writing, editing, and distributing articles, news releases, and web materials;
- o Support for regulatory compliance activities;
- o Worksite Wellness coordination and oversight;
- o Regular review, update and distribution of information on clinical practices in preventive health; and

      o   Regular review, update, and distribution of information on emerging trends in public health and prevention.

c. **Outline your experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data that will be required for meeting regular performance benchmarks to evaluate the value of Health Services delivered by your CCO. Describe how CCO accountability metrics serve to ensure quality care is provided and serve as an incentive to improve care and the delivery of services:** Since 2013, AllCare further developed our Provider Services department to focus on the transformation requirements that allowed innovation to ensure success with the state quality programs. As we developed the department we focused on building a team of people who had expertise in metric measurement, analytics, medical group management, quality and provider training. Over the past 6 years, we have ended up with a very high functioning team who focus on understanding the OHA expectations around quality improvement and how to best ensure that our provider network engages in quality and process improvement. Over this timeframe, we have developed a comprehensive set of policies, procedures and training tools that best support our quality efforts.

Our team has focused on cultivating relationships with our internal data team as well as those outside entities (e.g. Reliance HIE) to ensure that we are able to use all sources of data for the analysis and support of our internal and OHA quality programs.

Through our many Value Based Payment Programs, our team works with our provider network to ensure that they are fully trained and engaged in quality initiatives and programs. We pass through all of the current OHA quality measures to our providers who are engaged in our VBPs. As an adjunct to the OHA measures, we also ensure that our providers are incentivized around Access, Chronic Disease, Children, Health Equity, Oral Health, Mental Health, Pregnant Women, and Patient Satisfaction.

Quite often, OHA staff calls on this AllCare team to assist OHA and other CCOs with technical assistance on these quality initiatives.

d. **Describe your policies and procedures to ensure a continuity of care system for the coordination of care and arrangement, tracking and documentation of all Referrals and prior authorizations.** AllCare's Care Coordination staff utilize a case management program called Essette as our electronic health record for care management and care coordination. All case management and care coordination for members is charted in this system where goals, tasks and interventions are assigned and tracked. This system interfaces with our claims system EZ-Cap which allows for prior authorization, claims, and referral data to populate the member's Essette health record and ensures that staff can monitor and track current requests.

10. Medicare/Medicaid Alignment

a. **Is Applicant under Enrollment and/or Marketing sanction by CMS?** No

b. **Is Applicant currently affiliated with a Medicare Advantage plan?** AllCare Health Plan, Inc. is authorized to transact health insurance in the state of Oregon by DCBS and currently offers a Medicare Advantage Plan in Jackson, Josephine, and southern Douglas counties.

11. Service Area and Capacity

a. **List the Service Area(s) the Applicant is applying for and the maximum number of Members the Applicant is proposing to accept in each area based upon the Applicant's Community Health Assessment and plan for delivery of integrated an coordinated health, mental health, and substance use disorder treatment services and supports and oral health services.** AllCare has requested continuation of its current service area, including all of Jackson, Josephine, Curry, and southern Douglas counties.

AllCare CCO: Maximum Number of Members

County	2019 Enrollment	2020 Capacity Level
Jackson	25,375	57,903
Josephine	19,218	27,670
Curry	3,262	5,723
Douglas zip codes 97410, 97442	481	481
Total	48,336	91,777

b. **Does the Applicant propose a Service Area to cover less than a full County in any County? If so, please describe how.** The OHA, in 2012, requested AllCare serve two zip codes in Douglas County due to natural travel patterns, more timely access to care, and continuity of care based on historical referral patterns.

(1) **Serving less than the full county will allow the Applicant to achieve the transformational goals of CCO 2.0 (as described in this RFA) more effectively than county-wide coverage in the following areas:** The residents of Glendale and Azalea in Douglas County currently benefit from AllCare's community engagement, governance, and accountability activities through an engaged Board and the Josephine County Community Advisory Council. They have long benefited from the integrated behavioral health services delivered by Options for Southern Oregon throughout Josephine County as well as AllCare's investment of more than $9 million to address the Social Determinants of Health particularly in affordable housing. Their providers across the continuum of care participate in AllCare's Value Based Payment models which incentivize providers to provide high quality care, easy access to care, and promote prevention and wellness. And finally, AllCare offers a financially viable alternative for care delivery compared to higher cost options available elsewhere in Douglas County due to shorter driving times, easier access to pharmacies, and easier access to provider clinics and hospital services.

(2) Serving less than the full county provides greater benefit to OHP Members, Providers, and the Community than serving the full county. Our experience serving OHP members in Glendale and Azalea Douglas County since 1996, demonstrates that serving less than the full county provides greater benefit to those members through improved access to care, enhanced safety, and continuity of historical referral patterns for primary, specialty, and hospital services.

(3) The Exception request is not designed to minimize financial risk and does not create adverse selection, e.g. by red-lining high risk areas. Serving two zip codes in Douglas County is the right thing to do for those residents and in no way minimizes AllCare's financial risk nor creates any adverse selection.

12. Standards Related to Provider Participation

a. **Standard #1 – Provision of Coordinated Care Services**

The Applicant has the ability to deliver or arrange to deliver for all the Coordinated Care Services that are Medically Necessary and reimbursable. AllCare has the ability to deliver or arrange for all the Coordinated Care Services that are Medically Necessary and reimbursable. Please refer to *EXHIBIT 7.1-DSN AllCare Provider Report* for description of our entire contracted network of physical health, behavioral health, and oral health providers across the continuum of care and our three county service area.

b. **Standard #2 – Providers for members with Special Health Care Needs.** Care coordination services are available to members identified with special health care needs. This includes the aged, blind, disabled or those who have high health care needs, multiple chronic conditions, mental illness or substance use disorder or who are children/youth placed in a substitute care setting by Children, Adults, and Families (CAF) and the Oregon Youth Authority (OYA) or children receiving adoption assistance from CAF or any member receiving DHS-funded Medicaid LTC or home and community-based service, have access to Primary Care and Referral Providers with expertise to treat the full range of medical, oral and behavioral / substance use disorders. To address the full range of members with special needs, our care coordination program utilizes established guidelines for early identification, assessment and provision of special needs coordination services. The guidelines include multiple report reviews (State Eligibility File #834, the ASU Report, Weekly Pregnancy Report, Chronic Medical Conditions Report, Predictive Modeling Software), external referrals (Provider Portal for medical practitioners/behavioral health specialists, oral health providers), community partners such as DHS, Child Welfare, Authority Case Managers, WIC and OBPC, and internal referrals including member services, utilization management and wellness programs, and medical directors. Member specific information is collected via a Health Risk-Assessment Survey that identifies disease management, functional, safety, health literacy resources, behavioral health, food, transportation, housing, health literacy, cultural and linguistic, coping, abuse and dependency risks and barriers. These members receive program

follow-up and education in self-care management according to their risks, barriers and identified needs by a multi-disciplinary team that may include a combination of medical providers, intensive case managers, care coordinators, social workers, pharmacists, respiratory therapists, and community health workers. Communication is made with care givers, primary care providers and community partners by phone and supports to develop and implement a customized, integrated plan in collaboration with the member and their care giver.

c. **Standard #3 – Publically funded public health and Community mental health services.**

Publicly Funded Health Care Services Program Table

Name of Publically Funded Program	Type of Public Program	County in Which Program Provides Service	Specialty/Sub-Specialty Codes
Community Mental Health Program	Crisis Management	Jackson County	33/209 *MHCS
Community Mental Health Program, Contracted to Options for Southern Oregon	Crisis Management, Screening, Assessment, and Treatment	Josephine County	47/79 *MHCS, MHPP, MHPA
Community Mental Health Program contracted to Curry Community Health	Crisis Management, Screening, Assessment, and Treatment	Curry County	33/209 *MHCS, MHPP, MHPA
Public Health	Immunizations, STDs, Communicable Disease Mgt, HIV Prevention, WIC	Josephine County	33/209 *CPS
Public Health	Immunizations, STDs, Communicable Disease Mgt, HIV Prevention, WIC	Jackson County	47/79 *CPS
Public Health contracted to Curry Community Health	Immunizations, STDs, Communicable Disease Mgt, HIV Prevention, WIC	Curry County	47/79 *CPS

*DSN Protocol Service Categories

(1) Describe how Applicant has involved publically funded providers in development of its integrated and coordinated Application. Publically funded

behavioral health providers were integrally involved in development of this application, specifically related to behavioral health integration (Attachment 11) and various references to behavioral health throughout the application. In addition, a public health representative has been part of the AllCare Board of Governors since 2012, as well as represented on the local Community Advisory Councils in each of the three counties served.

(2) Describe the agreements with counties in the Service Area that achieve the objectives in ORS 414.12(4). If any of those agreements are under negotiation, the Applicant must submit the executed agreement prior to OHA issuing the CCO Contract: AllCare has agreements with each of the three local mental health departments to deliver services as described in ORS 414.153 (4) which specifically address agreed upon outcomes and maintenance of the mental health safety net system as it relates to crisis management. In Curry County the agreement also includes management of members entering or transitioning from the Oregon State Hospital or from residential care, care coordination of residential services, assertive community treatment, and coordination of care for members with mental illness in the criminal justice system. In Jackson and Josephine counties, these services are contracted to and managed by Options for Southern Oregon.

(3) If Applicant does not have signed agreements with counties, as providers of services or as required by ORS 414.152(4), describe good faith efforts made to obtain such agreements and why such agreements are not feasible. Not applicable.

d. **Standard #4 - Services for the American Indian/Alaska Native Population (AI/AN).**

(1) Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population. Southwest Oregon is not home to any federally recognized American Indian Tribe and there are very few members of the local population who identify as American Indian of any tribe nor Alaska Native. For those who do, AllCare is developing a health equity training program that includes tools targeting American Indian and Alaska Native populations, among others. Cultural competency training is required by all of our staff as well as available to our network of contracted providers and our community-based partners and public agencies. To date, 100% of our staff and more than 81 other organizations have participated in this training. We monitor success through patient satisfaction surveys that measure how well members' feel that their specific linguistic, cultural, ethnic, racial, and gender-based identity has been respected. We have also added a new metric to our value based payment models that addresses this issue and rewards those providers that rate high on health equity.

e. **Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities.**

(1) From among the Providers and facilities listed in the DSN Provider Report Template, please identify any that are Indian Health Services or Tribal 638 facilities.

- o United Indian Health Services NPI 1497751572
- o 1600 Weeot Way, Arcata, 9552104734
- o 241 Salmon Ave, Klamath, 95548-0000
- o 1675 Northwest Drive, Crescent City, 95531-8928

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

- **Include your Referral process when the HIS or Tribal 638 facility is not a participating panel Provider.** The referral process is the same for all OHP members across our continuum of care regardless of linguistic, cultural, ethnic, racial, and gender-based identity.

- **Include your Prior Authorization process when the Referral originates from an HIS or Tribal 638 facility that is not a Participating Provider.** The prior authorization process is the same for OHP members across our continuum of care regardless of linguistic, cultural, ethnic, racial, and gender-based identity.

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

(1) Describe Applicant's experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs. AllCare has three in-house Clinical Pharmacists and several Utilization Management medication analysts. To administer the drug benefit, our Pharmacy and Therapeutics (P & T) Committee, in collaboration with internal staff, has created our own drug list based on comprehensive drug and class reviews. The list is updated on a regular basis whenever there is a need for a medication class update that may include introduction of new generic drugs, changes in patient safety or changes in efficacy/effectiveness or new applications of existing drugs.

The P & T Committee has nine members and is represented by providers from all three counties served by AllCare. Members include AllCare IPA providers as well as local, non-IPA providers. The committee meets every other month to evaluate drug list recommendations including review of utilization controls, comparative costs, barriers to member access, and prior authorization processes for providers. External expert opinion is solicited by our local specialists.

AllCare has contracted with MedImpact as its Pharmacy Benefit Manager (PBM) since the mid-1990s. This contract mirrors the transparency requirements of the MedImpact contract with the Oregon Prescription Drug Program as closely as possible. Our contract provides for an annual PBM audit conducted by an independent third party consultant, Milliman, which also conducts an annual

market check. Our pharmacy contract does not contain any "spread arrangement". Instead, all pharmacy claims costs are 100% pass through starting in 2019. The rebates collected by MedImpact are also passed through 100% to AllCare as of 2019.

Through MedImpact, AllCare has access to a nationwide pharmacy network that is delegated; claims adjudication is also delegated to MedImpact. AllCare pharmacy staff manage all service and prior authorizations requests. Service requests are processed 24/7 via extended hours Monday through Friday and on-call coverage over weekends and holidays. Our Member Services department address pharmacy issues raised by members, contracted pharmacies, and contracted prescribing providers across the continuum of care.

(2) Specifically describe the Applicant's:

- **Ability to use a Restrictive Formulary as long as it allows access to other drug products no on the formulary through some process such as Prior Authorization.** Criteria for adding drugs to the formulary include FDA approval, ensuring members and their providers have reasonable choice of drugs, ensuring the formulary covers all therapeutic classes, and lower cost compared to other equally effective options. In addition, formulary approved drugs must also be proven to be safe, provide value (e.g.: reduce ED visits and/or reduce costs elsewhere across the continuum of care) and be effective. If a member, through their prescribing provider, requests a drug that is not on the drug list due to safety issues, efficacy, or cost, AllCare ensures that there is a pathway for the member to access the desired drug through the prior authorization review process.

- **Formulary development that includes FDA approved drug products for each therapeutic class and at least one item in each therapeutic class of over-the-counter medications sufficient to ensure the availability of covered drugs with minimal prior approval intervention by providers of Pharmaceutical Services, e.g. pharmacies.** AllCare Clinical Pharmacists prepare new medication evaluations and class reviews for medication categories and disease states. All reviews and evaluations are evidence-based; pharmacists use clinical trials, meta-analyses and nationally recognized guidelines to prepare their work. From their reviews, recommendations for formulary placement including any utilization edits are presented to AllCare Pharmacy and Therapeutics (P & T) Committee.

  The P & T committee is comprised of physicians, pharmacists, and advance practice nurses. Providers from all three counties are on the committee.

- **Development of clinically appropriate utilization controls.** The P & T committee reviews the materials provided by AllCare's Clinical Pharmacists and votes on the recommendations. Formulary recommendations, including any utilization controls, are based upon efficacy, safety and cost. The AllCare

formulary includes only the most effective and safest medications available with the lowest possible cost at the point of sale. All therapeutic classes are represented on the AllCare drug list, as are over-the-counter medications.

- **Ability to revise a formulary periodically and a description of the evidence based review processes utilized (including how information provided by the Oregon Pharmacy & Therapeutics Committee is incorporated and whether this work will be subcontracted or performed internally:** Formulary development and management is completed by the AllCare Clinical Pharmacists and approved by the AllCare P & T Committee. Triggers to revise the formulary, which is done internally within AllCare, include: FDA approval of new drugs, new generics, new state or federal guidelines, and/or new applications for existing drugs. Recommendations reflect evidence-based reviews and evaluations developed from clinical trials, meta-analyses, and nationally recognized guidelines. The goal is to ensure the most efficacious, safe and cost-effective drugs in each therapeutic class and over-the-counter class available on our drug list via prescription with minimal barriers for our members.

(3) **Describe Applicant's ability to ensure an adequate pharmacy network to provide sufficient access to all enrollees and how Applicant will communicate formulary choices and changes to the network and other medical professionals and how to make non-formulary requests.** This responsibility is delegated to our PBM MedImpact and involves a national network in every state. In accordance with state rules, contracted pharmacies must also be enrolled in Oregon Medicaid to serve Medicaid enrollees. With the exception of Walgreens, all large chain as well as most small independent pharmacies meet this criteria in Oregon and offer a robust network for AllCare members in southwest Oregon.

(4) **Describe Applicant's capacity to process pharmacy claims using a real-time Claims Adjudication and Provider reimbursement system and capture all relevant clinical and historical data elements for claims paid in their entirety by the CCO and when the coordination of benefits is needed to bill Third Party Liability when the CCO is secondary coverage.** Claims adjudication is delegated to our PBM MedImpact. AllCare pharmacists and UM staff have access to the system and can issue overrides to ensure claims are processed real time. The system captures relevant claims data in a few seconds through the program MedAccess, including member information, coordination of benefits for Third Party Liability, and population based information. The MedImpact system has the ability to seamlessly identify and access the TPL as the primary insurer (e.g.: Medicare) for our dual eligible members.

(5) **Describe Applicant's capacity to process pharmacy Prior Authorizations (PA) within the required timeframes either with in-house staff or through a Pharmacy Benefits Manager and the hours of operation that prescribers or pharmacies will be able to submit Pas.** Prior Authorizations (PAs) are managed

by our in-house pharmacy staff. PAs are accepted 24/7 via Fax or through our on-line Provider Portal. We have a 24 hour turn-around-time response on all PAs. The timeframe begins starting when the PA is actually downloaded into the system, not when staff actually are available to review it. At this time, 95% of all PA requests are responded to within 24 hours of receipt.

(6) Describe Applicant's contractual arrangements with PBM, including:
AllCare contracts with MedImpact as their Pharmacy Benefit Manager (PBM). MedImpact provides the national pharmacy network for AllCare and our members. In addition, MedImpact is responsible for claims adjudication and benefit code configuration. AllCare develops and maintains its drug list and completes all service request authorizations. member and provider support is handled exclusively by AllCare. Claim rates are set contractually and categorized by generic, brand and specialty medications. All rates are 100% pass through with an additional dispensing fee. MedImpact also provides support for supplemental rebates. Rebates are also 100% pass through to the plan. Rebate revenue is not significant, however. In 2018, revenue from rebates amounted to less than 1% of the corresponding drug spend. Our contract requires an onsite annual audit of MedImpact as well as an annual market check for potential rate adjustment. AllCare utilizes the third party consultant Milliman to conduct the market check and also assists the Compliance Officer, Compliance Director and the VP of Population Health with the on-site audit.

- **The contractual discount percentages from Average Wholesale Price (AWP) or the percentage above the Wholesale Acquisition Cost (WAC) the contractor will receive from the PBM including rebate and incentive agreements or other funds received from the PBM by the CCO or any other type of any pricing arrangements between the CCO and the PBM not based on a percentage discount from AWP or the percentage above WAC.** AllCare does not publicize its contractual discount percentages from the Average Wholesale Price nor the percentage above the Wholesale Acquisition Cost. However, the contract will be available to OHA staff during the on-site readiness review.

- **The dispensing fees associated with each category or type of prescription (for example: generic, brand name, mail order, retail choice 90, specialty).** AllCare does not publicize its dispensing fees. However, the contract will be available to OHA staff during the on-site readiness review.

- **The administrative fee to be paid to the PBM by CCO on a quarterly basis including a description of the associated administrative fee for each category or type and a description of the amount and type of any other administrative fees paid to PBM by Contractor.** AllCare does not publicize its administrative fees. However, the contract will be available to OHA staff during the on-site readiness review.

(7) Describe Applicant's ability to engage and utilize 340B enrolled Providers and pharmacies as a part of the CCO, including:

- **Whether Applicant is currently working with FQHCs and Hospitals, and if so,** AllCare is currently contracted with FQHCs and Hospitals who are enrolled in the 340B program.

- **How Applicant ensures the 340B program is delivering effective adjunctive programs that are being funded by the delta between what CCOs pay for their drugs and their acquisition costs.** This is a federal program designed to help the uninsured and underinsured access the drugs they need at substantially discounted prices. While AllCare reimburses contracted 340B providers at regular Medicaid rates (which are typically higher than the discounted rates available through the program) the excess revenues are to be invested in other FQHC and Hospital based programs to better serve the beneficiaries. AllCare is not eligible to be part of the 340B program and does not have any management oversight or contractual authority to monitor how 340B programs expend their 340B funds.

- **How the Applicant is evaluating the impact of these adjunctive programs whether they are generating positive outcomes:** In instances where there are access issues or a lack of providers, AllCare has allowed 340B programs to dispense medications that would not normally be allowed, for example, specialty hepatitis C medications through a non-specialty pharmacy. Many 340B entities have pharmacies that are part of our retail network. With limited exceptions, all 340B pharmacies are contracted the same at the same rates as any other network pharmacy. In our limited arrangements with 340B entities, outside of our network contracts, we have seen success with cultural and linguistic needs being met for members when these locations are in a FQHC.

(8) Describe Applicant's ability and intent to use Medication Therapy Management (MTM) as part of a Patient Centered Primary Care Home. AllCare contracts with willing pharmacies and clinics to provide MTM services in collaboration with the member's PCPCH provider. The pharmacists are credentialed by AllCare and supported in their MTM activities.

(9) Describe Applicant's ability to utilize E-prescribing and its interface with Electronic Medical Records (EMR). "Sure Script" through the MedImpact MedPrescription Program allows our local prescribers interconnectivity with clinic-based Electronic Medical Records systems. This allows our contracted prescribers access to the AllCare's formulary for e-prescribing.

(10) Describe Applicant's capacity to publish formulary and Prior Authorization criteria on a public website in a format usable by Providers and Members. AllCare is in the process of upgrading our Provider Portal and public website to accommodate access to our prior authorization criteria. The upgrades are scheduled

for completion in June, 2019. The updates will be published in Medicare compliant formats.

g. **Standard #7 – Hospital Services**

(1) **Describe how the Applicant will assure access for Members to Inpatient and outpatient Hospital services addressing timelines, amount, duration and scope equal to other people in the same Service Area.** AllCare applies the same policies and procedures for OHP member access to hospital based inpatient and outpatient services as it applies to its Medicare Advantage members across our service area for covered services under OHP. This includes the same referral procedures, prior authorization criteria, discharge planning, transitions of care, and care coordination as appropriate based on age, gender, acuity, and personal preferences.

- **Indicate what services, if any, cannot be provided locally and what arrangements have been made to accommodate Members who require these services.** For hospital services not available in any of our three county service areas AllCare has contractual arrangements with facilities in Eugene and Portland. ReadyRide, our NEMT contractor, provides transportation to and from the venue and our care coordination team monitors quality, outcomes, timeliness, and discharge/transition plans.

- **Describe any contractual arrangements with out of state hospitals.** To meet access standards in southern Curry County, AllCare currently contracts with Sutter Coast Hospital in Crescent City, CA. The contractual arrangements are similar to the arrangements we have with our other hospital providers, offering Curry County OHP members access to a much broader array of inpatient services, specialty care providers, as well as needed diagnostic and treatment services.

- **Describe Applicant's system for monitoring equal access of Members to Referral Inpatient and Outpatient Hospital Services.** For hospital based inpatient and outpatient services that are available only in our Medford contracted hospitals (Asante Health Services and Providence Medical Center), AllCare's Care Coordination staff arrange for ReadyRide to transport patients from Josephine and Curry counties to access specialty care as needed.

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

- **What procedures will be used for tracking Members' inappropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics, or than their Primary Care home.** The Member Handbook and our website describe how and when it is appropriate to access emergency room services, ambulance

services, urgent care and walk in clinics other than one's primary care provider. Our Member Services team helps members make decisions regarding use of non-PCP services and our care coordination team tracks utilization of these services via diagnostic reports by type of facility, cost reports by type of facility, and Hospital ED reports.

- **Procedures for improving appropriate use of ambulance, Emergency Rooms, and urgent care/walk-in clinics.**
  o Member notification via phone and/or mail by our Member Services staff of policies regarding appropriate and inappropriate use of these services;
  o Contact by our care coordination team to initiate a care plan that emphasizes appropriate use of services that meet their health needs in a cost effective and timely manner;
  o Coordination with the member and their PCP to implement the plan, ensuring that appointments are scheduled for ongoing follow-up over the course of the treatment plan; and
  o In some cases, home visits by our Traditional Health Workers.

(3) Describe how the Applicant will monitor and adjudicate claims for Provider Preventable Conditions based on Medicare guidelines for the following: AllCare monitors and adjudicates claims consistent with Medicare guidelines for adverse events and hospital acquired conditions. Adverse Events includes non-coverage for a particular surgical or other invasive procedures to treat a particular medical condition when the practitioner erroneously performs a different procedure altogether, the correct procedure but on the wrong body part, or the correct procedure but on the wrong patient. Medicare, as well as AllCare, does not cover hospitalizations and other services related to these non-covered procedures as defined in the Medicare Benefit Policy Manual, chapter 1, sections 10 and 180 and chapter 16, section 120. Hospital Acquired Conditions include non-coverage for the following:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- State III and IV ulcers
- Falls and Trauma
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Surgical site infection after coronary bypass graft
- Manifestations of poor glycemic control
- DVT/PE after knee, or hip replacement
- Infection after bariatric surgery
- Infection after certain orthopedic procedures of spine, shoulder, or elbow
- Surgical site infection following cardiac device procedures
- Iatrogenic pneumothorax w/venus catheterization

(4) **Describe the Applicant's Hospital readmission policy, and how it will enforce and monitor this policy**: AllCare's readmission review process applies to any claim that involves a readmission within 30 days of the initial discharge at the same hospital. Typically, medical review of records does not occur if the initial admission discharge status was "Left against medical advice nor for readmissions occurring in excess of 30 post initial discharge. Upon review of the member's medical records, the Medical Director determines whether or not the readmission was related and/or avoidable and if so, a letter is sent to the facility to inform them of claim denial. The facility may combine the first and second admission and resubmit the claim. The corrected claim is then processed according to our hospital contract or Medicare methodology if non-contracted. If the Medical Director determines that the readmission was not related and/or avoidable, the claim for the second admission is processed accordingly.

(5) **Please describe the Applicant's innovative strategies that could be employed to decrease unnecessary Hospital utilization.** AllCare currently maintains a robust utilization management and prior authorization policy for hospital inpatient stays. In addition, AllCare financially rewards PCPs and Specialists via VBP models when they refer patients to lower cost settings when quality of care outcomes are equal or better. For example, referral to an ambulatory surgery center rather than an inpatient surgical unit; referral to a free-standing imaging center rather than a hospital radiology department; and data sharing of diagnostic procedures across specialties and care settings to reduce duplication of services and waste.

(6) **Please describe how you will coordinate with Medicare Providers and, as applicable, Medicare Advantage plans to reduce unnecessary ED visits or hospitalization for potentially preventable conditions and to reduce readmission rates for Fully Dual Eligible Members.** Our dually eligible members who qualify for both Medicare and Medicaid coverage receive intensive case management through our care coordination team as needed to promote wellness and self-management of chronic conditions and disabilities. The goal is to prevent unnecessary ED visits, reduce hospitalization, and mitigate readmissions through intensive transitions of care planning and intensive care coordination across the continuum of care.

AllCare Health
Primary Care
Alternative Payment Model
2019

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2019 AllCare CCO PCP Alternative Payment Model

2019 Updated Measures for AllCare CCO's Alternative Payment Model
PCP

New Measures for 2019:
- Patient Portal Utilization
- SBIRT

Modified Measures for 2019:
- Depression Screening
- Days to Third Next Available Appointment
- Cigarette Smoking Prevalence Reduction

Removed Measures for 2019:
- Lipid Profile for Diabetics
- Level 1 & 2 ED Usage
- Satisfaction with Care
- Social Determinants of Health

Attributed
Member Months
8082

EXAMPLE

Quality Measures	Goal*	Numerator	Denominator	Estimated # Needed to Meet Measure	YTD Performance	Points Possible	Points Earned YTD
Colorectal Cancer Screen	51%	77	144	Meeting	53%	5	5
Effective Contraceptive Use	48%	82	146	Meeting	56%	5	5
Depression Screening w/ Follow-up	Y/N				N	5	0
A1c Poor Control	≤ 27.9%	9	40	Meeting	23%	5	5
Smoking Prevalence Reduction	≤29%	19	78	Meeting	24%	3	3
Hypertension Control	67%	23	31	Meeting	74%	5	5
Adolescent WellCare	43%	42	95	Meeting	44%	3	3
PCPCH	0-5			Meeting	3	5	3
SBIRT Reporting	Y/N			Meeting	Y	3	3
Patient Portal Utilization	Y/N			Meeting	Y	3	3
Access to Care Survey Results	85%	88	340	Meeting	84%	5	5
BMI/Nutrition & Activity Counseling	30%			-14	26%	5	0
Third Next Available Appt.	Y/N	Y	Y	Meeting	Y	5	2
ED Utilization for Members w/Mental Illness	≤1115	Per 1,000 Measure	Per 1,000 Measure	Meeting	1089	3	3
BONUS POINTS							
Health Equity	Y/N	Y	Y		Y	5	5
Total Points						**65**	**45**

Tier 1 (50%)	23-30 Points
Tier 2 (75%)	31-39 Points
Tier 3 (100%)	40+ Points

Performance Score	
Total Achieved	**100%**

Helpful Information/Definitions

- *Denominator* – The total number of members who qualify for a specific measure.
- *Numerator* – The total number of members who received a qualifying service to meet the measure requirements.

The *estimated* number of services needed to meet the individual measures is now included on the report. It is important to note that this is an *estimation only* and will change over the course of the year based on a provider's performance on the measure and attributed membership.

Year to Date (**YTD**) performance scores include one month of claims run-out from the end of the reporting period.

Year-end reports will include 3 months of claims run-out to ensure all services have been captured for the performance period.

Challenge Pool: APM funds not paid out to providers will become the "challenge" pool. These funds will be distributed to providers who met the goal on the challenge pool measures.

Attributed Members: AllCare members who have been assigned to a specific provider for at least 6 months and who have been on AllCare for one year. A provider's APM data is derived from Attributed members only.

Member Months: The number of months a member has been with AllCare CCO for the measurement period. The total number of member months (for all of a provider's attributed members) is used to determine the potential APM pay out for a provider.

Per 1000: This calculation equalizes the results so providers are measured on the same basis.
ED Visits/1000 Example:

Provider A	Provider B
Member months: 1,200 (average of 100 members)	Member months: 2,400 (average of 200 members)
# of ED visits: 68	# of ED visits: 136
68/1200 *(12 months in yr*1000) = 680 ED visits/1000 members per year	136/2400 *(12 months in yr*1000) = 680 ED visits/1000 members per year

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You may also refer to The Oregon Health Authority – Office of Health Analytics webpage for more detailed information on the state measures:

http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Measure Definition

Providers attest that they offer access to patients (or patient-authorized representatives) the ability to view online, download, and transmit their health information using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT (Certified Electronic Health Record Technology).

This would be a fully integrated Patient Portal. For example: When a patient sends a message via the portal, it goes directly into the EHR or when an office sends a message back to the patient, it must be created in the EHR.

Unit of Measurement: Y/N

Measure Intent and Purpose

Patients and providers benefit when patients play an active role in their health, and patient portals facilitate that involvement. Giving patients better access to their personal information allows them to make informed decisions regarding their care and lifestyle choices, potentially improving care plan adherence and overall wellness.

-Greenway Health

Screening, Brief Intervention and Referral to Treatment (SBIRT)
Alcohol & Drug Misuse
Data Source: Provider Reported/EHR

Measure Source
OHA

Measure Definition

Two rates are reported for this measure:

1. The percentage of patients age 12 and older who received age-appropriate screening.

2. The percentage of patients age 12 and older with a positive full screen who received a brief intervention or referral to treatment *(this is a new component to this measure)*.

Screening in an ambulatory setting is required once per measurement year. This measure does not require screening to occur at all encounters.

Unit of Measurement: Y/N

Measure Formula:

Rate 1

Data elements required denominator: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

Data elements required numerator: Patients who received an age-appropriate screening, using an SBIRT screening tool approved by OHA, during the measurement period AND had either a brief screen with a negative result or a full screen (AUDIT or DAST).

Required denominator exclusions and exceptions: See below.

Note: Although a negative brief screen is numerator compliant, a positive brief screen, by itself, is not numerator compliant. If a patient has a positive brief screen, then a full screen must be completed for numerator compliance on Rate 1. A full screen is numerator compliant, regardless of the result.

Note: Approved SBIRT screening tools are available on the HSD-Approved Evidence-Based Screening Resources/ Tools (SBIRT) page:
http://www.sbirtoregon.org/

The name of the screening tool used must be documented in the medical record. The clinician should interpret the age-appropriate screening tool to determine if the result is positive or negative. Where the screening tool includes guidance on interpreting scores, the clinician should consult that guidance.

Note: The screening(s) and result(s) must be captured as queryable structured data in the EHR.

Required exclusions for numerator: SBIRT services received in an emergency department (Place of Service 23) or hospital setting (POS 21).

Screening, Brief Intervention and Referral to Treatment (SBIRT)
Alcohol & Drug Misuse (cont.)

Rate 2

Data elements required denominator: All patients in Rate 1 denominator who had a positive full screen during the measurement period.

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received a brief intervention, a referral to treatment, or both that is documented within 48 hours of the date of a positive full screen.

> **Brief Intervention**: Examples of brief interventions include assessment of the patient's commitment to quit and offer of pharmacological or behavioral support, provision of self-help material, or referral to other supportive resources.

> A brief intervention of less than 15 minutes can count for Rate 2 numerator compliance. Although clinics may bill for SBIRT services when appropriate, this measure (unlike the earlier claims-based CCO SBIRT measure) does not require use of billing codes to determine whether screening or a brief intervention or referral occurred. Documentation in the medical record (e.g., through checkboxes, flowsheets, or other structured data) that a brief intervention was completed is sufficient.

> Note – Referral to Treatment: A referral is counted for Rate 2 numerator compliance when the referral is made. Numerator compliance is not dependent on referral completion.

Screening, Brief Intervention and Referral to Treatment (SBIRT)
Alcohol & Drug Misuse
(cont.)

Denominator Exclusions and Exceptions – Rate 1 and Rate 2

Required exclusions for denominator

Patients with:

- Active diagnosis of alcohol or drug dependency
- Engagement in treatment
- Dementia or mental degeneration
- Limited life expectancy
- Palliative care (includes comfort care and hospice)

  The exclusions for active diagnosis of alcohol or drug dependency, dementia or mental degeneration, limited life expectancy, and palliative care apply if they occur before the qualifying encounter (that is, before a visit that puts the patient in the denominator for Rate 1).

  The exclusion for engagement in treatment applies if the patient was engaged in treatment before the qualifying visit and up to one year before the start of the measurement year.

Denominator Exceptions: Any of the following criteria also remove patients from the denominator.
- Patient Reason(s)
    - Patient refuses to participate
- Medical Reason(s)
    - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
      OR
    - Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

Depression Screening
Data Source: Provider Reported/EHR

Measure Source

NQF 0418

Measure Definition

Percentage of patients age 12 years and older screened for clinical depression using a standardized tool and follow-up plan documented.

**Screening**: Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

**Follow-up Plan**:

> **Although the PHQ-9 can still be used to evaluate risk for depression, the PHQ-9 _NO LONGER COUNTS_ as a _follow-up_ to a positive PHQ-2 for this measure.**

Documented follow-up for a positive depression screening must include one or more of the following:

- Suicide Risk Assessment
- Referral to practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Unit of Measurement: Y/N
Measure Formula:

> _**Numerator:**_ Patients screened for depression on the date of the encounter, using an age-appropriate standardized tool AND if positive, a **follow-up plan is documented on the date of the positive screen.**

> _**Denominator:**_ Members age 12 years and older before the beginning of the measurement period, with at least one eligible encounter during the measurement period.

> _**Exclusions:**_ Patients with an active diagnosis for Depression or Bipolar Disorder; or if screen is not appropriate, due to patient refusal, emergent medical situation, or patient motivation may impact accuracy of results.

Measure Intent & Purpose

"Major depression, also known as clinical depression, is a serious illness that can be successfully treated when detected. This measure ensures that patients are screened and that if there is risk of depression a follow up plan is created by the patient and their provider. Treating early signs of clinical depression is an important part of avoiding the mental and physical harm that can result from depression." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: Y/N – Data provided to AllCare
2018 AllCare CCO Improvement Target: 55%

Days-to-Third Next Available Appointment
Data Source: Provider Reported Data

Measure Source
AllCare Health CCO
Measure Definition

Days-To-Third Next Appointment is the average length of time in days between the day a patient makes a request for an appointment with a provider and the third next available appointment for **new** patient care visits **to establish care.**

Unit of Measurement: Y/N

Measure Formula:

On a monthly basis, offices will evaluate their number of days to the third next available appointment, *for each provider participating in the APM,* using the formula below. **This information will be submitted to AllCare on a quarterly basis.**

1. Date Measured – The date you will measure your provider's schedule. The example below is prepopulated with the first working day of the month.
2. 1st Appointment – The date of the first available appointment on your provider's schedule
3. 2nd Appointment – The date of the second available appointment on your provider's schedule
4. 3rd Appointment – The date of the third available appointment on your provider's schedule
5. Days to 3rd – This is where the formula is located and will automatically populate the days to next appointment, when you enter the days of each appointment on the spreadsheet.

Example:

Date Measured	1st appointment	2nd appointment	3rd appointment	Days to 3rd			
1/1/2019	1/1/2019	1/2/2019	1/5/2019	4	1st quarter average days to 3rd		
2/1/2019	2/1/2019	2/6/2019	2/8/2019	7	next available appointment:		
3/1/2019	3/1/2019	3/5/2019	3/6/2019	5			**5.3**
4/2/2019					2nd quarter average days to 3rd		
5/1/2019					next available appointment:		
6/2/2019					3rd quarter average days to 3rd		

Days to 3rd next available appointment based off of calendar days (not business days).

Measure Intent & Purpose

The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability.

Performance Target
Providers are tracking and submitting data to AllCare.

Cigarette Smoking _Reduction_ (Bundled Measure)
Data Source: Provider Reported/EHR

Measure Source

OHA CCO Incentive Measure

Measure Definition

This measure is determined through three separate rates:

1. Of all patients with a qualifying visit, how many have their cigarette smoking or tobacco use status recorded?
2. Of all patients with their cigarette smoking or tobacco use status recorded, how many are cigarette smokers?
3. Of all patients with their cigarette smoking or tobacco use status recorded, how many are smokers _and/or_ tobacco users?

Unit of Measurement: %

Measure Formula:

Rate 1:
Of all patients with a qualifying visit, how many have their cigarette smoking or tobacco use status recorded?

> ***Data elements required denominator*:** Medicaid members 13 years old or older by the beginning of the measurement year, who had a qualifying visit with the provider during the measurement period.
> **Data elements required numerator:** members age 13 years or older who had a qualifying visit with the provider during the measurement period, who have their smoking and/or tobacco use status recorded as structured data.

Rate 2:
Of all patients with their cigarette smoking or tobacco use status recorded, how many are cigarette smokers?

> **Data elements required denominator**: Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

> **Data elements required numerator**: Of patients in the Rate 2 denominator, those who are cigarette smokers. See below for additional information on identifying cigarette smoking in the numerator.

(Continued on next page)

Cigarette Smoking *Reduction* (Bundled Measure)
Data Source: Provider Reported/EHR (*continued*)

Rate 3:

Of all patients with their cigarette smoking or tobacco use status recorded, how many are smokers *and/or* tobacco users?

> **Data elements required denominator**: Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

> **Data elements required numerator**: Of patients in the Rate 3 denominator, those who are cigarette smokers *and/or* tobacco users. See below for additional information on identifying tobacco use in the numerator.

Please Note:

- E-cigarettes and marijuana (medical or recreational) should be excluded from both the cigarette smoking rate and the broader tobacco use rate; the measure is focused on cigarettes and other tobacco products.

- In addition, the measure is focused on cigarette and tobacco use, not nicotine use. Patients who are using nicotine replacement therapy (NRT) should also be excluded from the numerator (unless they are also still using cigarettes and/or other tobacco products).

Measure Intent & Purpose

"The intent of the measure is to address tobacco prevalence (including cigarette smoking and other tobacco products, such as chew, snuff, and cigars, and excluding e-cigarettes, marijuana, and those using nicotine replacement products such as patches).

However, due to variation in how EHRs capture smoking and tobacco use data and to ensure comparability of prevalence across EHRs and CCOs, the measure will be looking for two separate rates: (1) cigarette smoking; and (2) tobacco use." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD
2018 AllCare CCO Improvement Target: **≤ 29%**

Colorectal Cancer Screening
Data Source: AllCare Claims

Measure Source

HEDIS

Measure Definition

The percentage of members age 51-75 years old who received a qualifying colorectal cancer screen during the measurement year or specified years prior.

Unit of Measurement: %

Measure Formula:

Numerator: # of members who receive one of the following screens:
Fecal Occult Blood Test (FOBT) in current year - Codes: **82270, 82274, G0328**

Flexible Sigmoidoscopy in measurement period or 4 years prior.
Codes: **45330-45335, 45337-45342, 45345-45347, 45349, 45350, G0104**

Colonoscopy in measurement period or 9 years prior. - Codes**: 44388-44394, 44397, 44401-44408, 45355, 45378-45387, 45388-45393, 45398, G0105, G0121**

Denominator: Members age 51-75 years old

Exclusions: Members who have had *Colorectal Cancer* or a *Total Colectomy*.

Measure Intent & Purpose

"Colorectal cancer is Oregon's second leading cause of cancer deaths. With appropriate screening, abnormal growths in the colon can be found and removed before they turn into cancer. Colorectal cancer screening saves lives, while also keeping overall health care costs down." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD
2018 AllCare CCO Improvement Target: 51%

Controlling Hypertension
Data Source: Provider Reported/EHR

Measure Source

NQF 0018 (OHA Measure Guidelines)

Measure Definition

The percentage of Essential Hypertension patients (18-85 years of age) whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure <140 mmHg and diastolic blood pressure <90 mmHg) during the measurement period. If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."

Unit of Measurement: %

Measure Formula:

Numerator: Members in the denominator whose blood pressure was adequately controlled (The last documented blood pressure reading for the measurement year must be **below** 140 systolic and 90 diastolic).

Denominator: Members 18-85 years of age as of December 31 of the measurement year who had at least one outpatient encounter with a diagnosis of essential hypertension during the first six months of the measurement year or any time prior.
Codes: **I10**

Exclusions:
- Patients with End Stage Renal Disease (ESRD)
- Chronic Kidney Disease, Stage 5
- Dialysis or renal transplant before or during the measurement period
- A diagnosis of pregnancy during the measurement period
- Patients in hospice care during the measurement period

Measure Intent & Purpose

"Research shows that as many as two-thirds of people with high-blood pressure (hypertension) are either undertreated or untreated. Controlling hypertension helps decrease the risk of serious health problems, including heart disease and stroke, which are leading causes of death in Oregon." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD
2018 AllCare CCO Improvement Target: **67%**

HbA1c Poor Control >9% (18-75 yo Type 1 or 2 Diabetes)
Data Source: Provider Reported/EHR

Measure Source
NQF 0059 (OHA Measure Guidelines)

Measure Definition
The percentage of members 18 - 75 years of age with diabetes <u>during or any time prior to the measurement period</u> whose most recent HbA1c level is >9.0% or was missing a result during the measurement year.

Unit of Measurement: %

Measure Formula:

> *Numerator*: Members whose most recent HbA1c level is >9.0% during the measurement year.

> *Denominator*: Patients 18-75 years of age who had a diagnosis of diabetes during or any time prior to the measurement period and who received a qualifying outpatient service during the measurement period.
> Codes: See list of ICD-10 codes pg. 28-30

> *Exclusion:* Patients who were in hospice care during the measurement year.

Measure Intent & Purpose
"Controlling blood sugar levels is important to help people with diabetes manage their disease. It is also a key away to assess the overall effectiveness of diabetes care in Oregon. By improving the quality of care for diabetes, Oregon can help patients avoid complications and hospitalizations that lead to poor health and high costs." – OHA

Performance Targets
2019 AllCare CCO Improvement Target: TBD
2018 AllCare CCO Improvement Target: **≤ 27.9%**

BMI/Counseling for Nutrition and Physical Activity for Children and Adolescents (Bundled Measure)
Data Source: Provider Reported/EHR

Measure Source

OHA CCO Incentive Measure/ NQF 0024

Measure Definition

This measure is determined through the average of three separate rates:

Numerator:

1. Patients 3-17 years of age who had a height, weight and body mass index (BMI) percentile recorded during the measurement period. BMI information can be captured via EHR using ICD-10 codes.

   ICD-10:
   Z68.51 …… less than 5th percentile for age
   Z68.52 …… 5th percentile to less than 85th percentile for age
   Z68.53 …… 85th percentile to less than 95th percentile for age
   Z68.54 …… greater than or equal to 95th percentile for age

2. Patients 3-17 years of age who had counseling for nutrition during a visit that occurs during the measurement period

   ICD-10: Z71.3…… Dietary counseling and surveillance

   CPT: 97802 – 97804

   HCPCS: G0270, G0271, G0447, S9449, S9452, S9470

3. Patients 3-17 years of age who had counseling for physical activity during a visit that occurs during the measurement period, as documented in the EHR.

   ICD-10: Z71.82 ….. Exercise counseling

Denominator: Patients 3-17 years of age with at least one qualifying visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period.

Measure Intent & Purpose

"Over the last three decades, childhood obesity has more than doubled in children and tripled in adolescents. It is the primary health concern among parents in the United States, topping drug abuse and smoking. Childhood obesity has both immediate and long-term effects on health and well-being." - OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD
2018 AllCare CCO Improvement Target: 30%

Effective Contraceptive Use
Data Source: AllCare Claims

Measure Source
OHA

Measure Definition

Percentage of women ages 15 - 50 years old who use effective contraceptive methods during the measurement year. *Evidence of use may include surveillance of a contraceptive method as well as NDC prescription codes in addition to diagnosis and procedure codes.*

Unit of Measurement: %

Measure Formula:

> *Numerator:* All women in the denominator with evidence of one of the following methods of contraception during the measurement period:

- Female Sterilization
- IUD/IUS
- Implants
- Contraception Injection
- Contraceptive Pills
- Patch
- Ring
- Diaphragm

Denominator: All women ages 15 - 50 who are capable of becoming pregnant.

(Continued on next page)

Effective Contraceptive Use (*continued*)
Data Source: AllCare Claims

Partial List of Contraceptive Codes:

(For complete list, please refer to the Numerator Code Table located on the OHA website at: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx)

Code	Description
Z30.011	Encounter for initial prescription of contraceptive pills
Z30.013	Encounter for initial prescription of injectable contraceptive
Z30.014	Encounter for initial prescription of intrauterine contraceptive device
Z30.018	Encounter for initial prescription of other contraceptives
Z30.019	Encounter for initial prescription of contraceptives, unspecified
Z30.2	Encounter for sterilization
Z30.40	Encounter for surveillance of contraceptives, unspecified
Z30.41	Encounter for surveillance of contraceptive pills
Z30.42	Encounter for surveillance of injectable contraceptive
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.431	Encounter for routine checking of intrauterine contraceptive device
Z30.433	Encounter for removal and reinsertion of intrauterine contraceptive device
Z30.49	Encounter for surveillance of other contraceptives
Z30.8	Encounter for other contraceptive management
Z30.9	Encounter for contraceptive management, unspecified
Z79.3	Long term (current) use of hormonal contraceptives
Z97.5	Presence of (intrauterine) contraceptive device
Z98.51	Tubal ligation status
T83.31xA	Breakdown (mechanical) of intrauterine contraceptive device, initial encounter
T83.32xA	Displacement of intrauterine contraceptive device, initial encounter
T83.39xA	Other mechanical complication of intrauterine contraceptive device, initial encounter
T83.59xA	Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system, initial
T83.6xxA	Infection and inflammatory reaction due to prosthetic device, implant and graft in genital tract
0UH97HZ	Insertion of Contraceptive Device into Uterus, Via Natural or Artificial Opening
0UH98HZ	Insertion of Contraceptive Device into Uterus, Via Natural or Artificial Opening Endoscopic
0UHC7HZ	Insertion of Contraceptive Device into Cervix, Via Natural or Artificial Opening
0UHC8HZ	Insertion of Contraceptive Device into Cervix, Via Natural or Artificial Opening Endoscopic
58300	Insertion of intrauterine device (IUD)
11981	Insertion, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
57170	Diaphragm or cervical cap fitting with instructions

Effective Contraceptive Use *(continued)*
Data Source: AllCare Claims

Exclusions: Women who are not capable of becoming pregnant (have had a hysterectomy, bilateral oophorectomy or menopause) and women who were pregnant during the measurement year are excluded from the denominator.

Partial List of Exclusion Codes:

(For complete list, please refer to the Numerator Code Table located on the OHA website at: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx**)**

Z90.710	Acquired absence of both cervix and uterus
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58940	Oophorectomy, partial or total, unilateral or bilateral;
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
Z78.0	Asymptomatic menopausal state
N92.4	Excessive bleeding in the premenopausal period
N95.1	Menopausal and female climacteric states
N95.0	Postmenopausal bleeding
N95.2	Postmenopausal atrophic vaginitis
E89.41	Symptomatic post-procedural ovarian failure
N95.8	Other specified menopausal and perimenopausal disorders
N95.9	Unspecified menopausal and perimenopausal disorder
E89.40	Asymptomatic post procedural ovarian failure
E89.41	Symptomatic post procedural ovarian failure
E28.310	Symptomatic premature menopause
E28.319	Asymptomatic premature menopause
Q50.02	Congenital absence of ovary, bilateral
Q51.0	Congenital absence of uterus

(Continued on next page)

Effective Contraceptive Use *(continued)*
Data Source: AllCare Claims

Measure Intent & Purpose

"Almost 50 percent of pregnancies in Oregon are unintended, and have been for more than three decades. Among women with an unintended pregnancy, 43 percent reported using contraception, but they were using it incorrectly or inconsistently. Fifty-two percent reported using no contraception method at all. This suggests that most women are at risk of unintended pregnancy and are in need of contraception counseling in order to find a method that meets their needs. Most women would benefit from knowing which methods of contraception are the most effective." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD

2018 AllCare CCO Improvement Target: 48%

Adolescent Well Care Visits (12-21 years old)
Data Source: AllCare Claims

Measure Source
CHIPRA #12 (OHA Measure Guidelines)

Measure Definition

The percentage of attributed adolescents ages 12 to 21 that had at least one comprehensive well-care visit during the measurement year.

Unit of Measurement: %

Measure Formula:

> **Numerator**: Members in the denominator receiving at least one comprehensive well-care visit during the measurement year. Members can be seen by any provider type for this measure.
> Codes: CPT: **99383-99385, 99393-99395, ICD-10 Z00.121, Z00.129, Z00.00, Z00.01, Z02.0, Z02.5, Z02.6, Z02.71, Z02.82, Z02.1, Z02.2, Z02.3, Z02.4, Z00.8, Z00.5, Z76.1, Z76.2** Medicare: **G0438, G0439**

> **Denominator**: Attributed adolescents ages 12 to 21 as of December 31 of the measurement year

Measure Intent & Purpose

"Youth who can easily access preventive health services are more likely to be healthy and able to reach milestones such as high school graduation and entry into the work force, higher education or military service. In 2011, just over half of Oregon's eighth and 11th graders had a well-visit in the past year." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD

2018 AllCare CCO Improvement Target: 43%

Disparity Measure:
ED Utilization for Individuals Experiencing Mental Illness
Data Source: AllCare Claims

Measure Source
OHA

Measure Definition

# of ED visits (per 1000) for physical health reasons, by members (age 18 or older) who have a specified mental illness.

Unit of Measurement: #/1000

Measure Formula: # of ED visits (by members who have a specified mental illness)/attributed member months) * 1000 * # of months in time period

> *Numerator:* Number of emergency department visits when the member experiencing mental illness is enrolled with the organization (CCO). Count each visit to an ED that does not result in an inpatient encounter once; count multiple ED visits on the same date of service as one visit.

> *Denominator:* Adult members age 18 or older at the end of the measurement year who are identified as having experienced mental illness. OHA uses claims with a 36-month rolling look back period, for members who had two or more qualifying visits.

> *Exclusions:* Emergency Department visits with a <u>primary</u> diagnosis for mental health and chemical dependency are excluded.

See OHA specification sheet for additional details:
http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Measure Intent & Purpose

"Adults with mental illness have higher rates of preventable health conditions and use the emergency department at much higher rates than the general population. Improved coordination between physical and mental health care reduces unnecessary ED utilization and is a cornerstone of health system transformation." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD
2018 AllCare CCO Improvement Target: ≤ 1,115 ED visits per 1,000 members per

Timely Access to Care - Patient Survey Results
Data Source: AllCare -or- CAHPS Surveys

Measure Source
PCPCH 1.A.3

Measure Definition

Percentage of respondents who had a positive response for the questions "In the last 12 months, when you phoned your healthcare provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?" & "In the last 12 months, when you made an appointment for a check-up or routine care with your healthcare provider, how often did you get an appointment as soon as you needed?"

Unit of Measurement: %

Measure Formula:

> *Numerator:* # of survey respondents who marked "Always" or "Usually" for the specified questions.

> *Denominator:* Total number of survey respondents per provider.

> *Exclusions:* Any surveys where the questions "In the last 12 months, when you phoned your healthcare provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?", "In the last 12 months, when you made an appointment for a check-up or routine care with your healthcare provider, how often did you get an appointment as soon as you needed?" were not answered.

Measure Intent & Purpose

"Improving access to timely care and information helps increase the quality of care and reduce costs. Measuring access to care is also an important part of identifying disparities in health care and barriers to quality care, including a shortage of providers, lack of transportation, or long waits to get an appointment." – OHA

Performance Targets 2019:

85%

PCPCH
Data Source: PCPCH Certification

Measure Source
PCPCH/OHA

Measure Definition

Clinics can be recognized at five different levels, or tiers, depending on the criteria they meet. There are 11 "must-pass" criteria that every clinic must meet in order to be recognized as a primary care home at any level. The other criteria are worth varying amounts of points, and the total points accumulated by a clinic determines their overall tier of PCPCH recognition.

Unit of Measurement: Y/N
Measure Formula:

Tier Level	Point Range	Additional Required Criteria
Tier 1	30 – 60 points	+All must-pass standards
Tier 2	65 – 125 points	+All must-pass standards
Tier 3	130 – 250 points	+All must-pass standards
Tier 4	255 – 380 points	+All must-pass standards
5 STAR (Tier 5)	255 – 350 points	+All must-pass standards +Meet 11 of 13 specified measures +All measures are verified with a site visit

Measure Intent & Purpose

"Strong, effective primary care health homes are foundational to transforming and sustaining high quality healthcare for Oregonians. Evidence shows that team-based primary care will lead to better outcomes and drive down costs. The more quickly Oregon can drive adoption of primary care health homes statewide, the more quickly we will drive achievement of the Triple Aim (improving care, improving health, and reducing cost)." –OHA

Performance Targets

2019 State CCO Incentive Benchmark: Y/N

Health Equity (Bonus Measure)
Data Source: Attestation

Measure Definition

Provider attests that they, and at least 70% of office staff, completed training from the suggested list during the measurement year or have an *OHA Qualified* or *Certified* medical interpreter on staff at their location.

Unit of Measurement: Y/N

Measure Formula:

Provider attests that they and at least 70% of office staff have completed one of the trainings located at the link below:

https://www.allcarehealth.com/doctors-providers/resources/health-equity

*If the practice completes courses that are similar in content to the suggested list, this may also qualify for the measure if approved by AllCare.

OR

Provider attests that they have an *OHA Qualified* or *Certified* Medical Interpreter on staff (For more information, contact Stick Crosby: stick.crosby@allcarehealth.com

Measure Intent & Purpose

To ensure that contracted providers across the continuum of care have access to training that meets state and federal goals and objectives on culturally and linguistically appropriate service delivery; and ensure providers are sensitive to members with cultural, linguist and social differences as they relate to ethnicity, gender, socioeconomics and other areas of diversity.

Performance Targets

2019 AllCare CCO Improvement Target: 70%

APM Challenge Pool

APM funds not paid-out to providers will become the "challenge" pool- these funds will be distributed to providers who meet the goal on the challenge pool measures listed below:

- **Effective Contraceptive Use**
- **Hypertension Control**
- **A1c Poor Control**

EHR/Provider Reported Data
Measure Instructions

Instructions for Provider Tracked Data

Hypertension Control

Denominator: Patients 18-85 years of age who had a diagnosis of essential hypertension and who had an office visit during the measurement period.

Numerator: Patients from the denominator group whose blood pressure at the most recent visit during the measurement period is adequately controlled (systolic blood pressure <140 mmHg and diastolic blood pressure <90 mmHg).

Example: Dr. Smith had 10 patients who had a diagnosis of essential hypertension and had an office visit during the year. 8 of those had blood pressure of < 140/90 at their most recent visit. Numerator = 8, Denominator = 10, Performance percentage = 8/10 or 80%. Please include the numerator and denominator when submitting data.

	Numerator	Denominator	Percentage
Dr. Smith	8	10	80.0%
Dr. Jones	16	22	72.7%
Dr. Miller	11	17	64.7%

HbA1c Poor Control

Denominator: Patients 18-75 years of age who had a diagnosis of Type 1 or Type 2 diabetes and who had an office visit during the measurement period. *Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator; patients with a diagnosis of secondary diabetes due to another condition should not be included.*

Numerator: Patients from the denominator group whose most recent HbA1c level was >9% during the measurement period.

Example: Dr. Smith had 15 patients who had a diagnosis of Type 1 or 2 diabetes and had an office visit during the measurement period. 4 of those had HbA1c levels >9% at their most recent visit.   Numerator = 4, Denominator = 15, Performance percentage = 4/15 or 26.7%. Please include the numerator and denominator when submitting data.

	Numerator	Denominator	Percentage
Dr. Smith	4	15	26.7%
Dr. Jones	8	25	32.0%
Dr. Miller	10	33	30.3%

EHR/Provider Reported Data
Measure Instructions

Depression Screen & Follow-up Plan

Denominator: Patients 12 years of age and older who had an office visit during the measurement period. Patients with an active diagnosis of Depression or Bi-Polar Disorder are excluded from the denominator.

Numerator: Patients from the denominator group who were screened for clinical depression using a standardized depression screening tool and, if the depression screen is positive, a follow-up plan must be documented to qualify for the numerator. Follow-up for a positive depression screening must include one or more of the following: Additional evaluation, Suicide Risk Assessment, Referral to a practitioner who is qualified to diagnose and treat depression, Pharmacological interventions, Other interventions or follow-up for the diagnosis or treatment of depression. The PHQ9 screen does not count as follow up to a positive PHQ2 screen.

Example: Dr. Smith had 122 patients age 12 and older who had an office visit during the measurement period. 4 patients had an active diagnosis of Depression and were not screened. 20 patients were documented as having a negative screen for depression. 11 patients screened positive and had a qualifying follow up plan documented. 6 additional patients screened positive but did not have a qualifying follow up plan documented. Numerator = 20+11=31, Denominator = 122, Exclusions = 4. Performance percentage = 122-4=118, 31/118 or 26.3%. Please include the numerator, denominator and exclusions when submitting data.

	Numerator	Denominator	Exclusions	Percentage
Dr. Smith	31	122	4	26.3%
Dr. Jones	43	174	15	27.0%
Dr. Miller	19	82	7	25.3%

EHR/Provider Reported Data
Measure Instructions

Cigarette Smoking Reduction

Denominator 1: Patients 13 years of age and older who had a qualifying visit with the provider during the measurement period.

Numerator 1/Denominator2: Patients 13 years of age and older who had a qualifying visit with the provider during the measurement period and have their smoking and/or tobacco use status recorded.

Numerator 2: Patients from the denominator group who are cigarette smokers.

Numerator 3: Patients from the denominator group who are tobacco users.

Example: Dr. Smith had 380 patients age 13 and older who had an office visit during the measurement period. 375 of those patients had their smoking and/or tobacco status recorded. Percentage 1 = 375/380 or 98.6%. Of the 375 patients who had their status recorded, 65 are cigarette smokers and 12 use chewing tobacco. Denominator 2 = 375 Numerator 2 = 65 the percentage of members who had their status recorded and are cigarette smokers 65/375 or 17.3%. Denominator 2 = 375 Numerator 3 = 12 + 65 the percentage of members who had their status recorded and use any form of tobacco. 77/375 or 20.5%.

	Denominator 1	Numerator1/ Denominator 2	Percentage 1 (Status Recorded)	Numerator 2 (Cigarette Smokers)	Percentage 2	Numerator 3 (Any type of Tobacco)	Percentage 3
Dr. Smith	380	375	98.6%	65	17.3%	77	20.5%
Dr. Jones	130	118	90.7%	22	18.6%	26	22.0%
Dr. Miller	202	187	92.5%	37	19.8%	46	24.6%

EHR/Provider Reported Data
Measure Instructions

BMI/Nutrition and Activity Counseling

Denominator: Patients 3-17 years of age with at least one qualifying visit during the measurement period.

Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period.

Numerator 2: Patients who had counseling for nutrition during a visit that occurs during the measurement period

Numerator 3: Patients who had counseling for physical activity during a visit that occurs during the measurement period

Example: Dr. Smith had 55 patients age 3 through 17 years old who had an office visit during the measurement period. 50 of those patients had their BMI recorded. Percentage 1 = 50/55 or 90.9%. 24 patients were given counseling for nutrition. Percentage 2 = 24/55 or 43.6%. 13 were given counseling for physical activity. Percentage 3 = 13/55 or 23.6%. A patient can be included in more than one numerator if they received the corresponding qualifying service.

	Denominator	Numerator1	Percentage 1 (BMI)	Numerator 2	Percentage 2 (Nutrition Counseling)	Numerator 3	Percentage 3 (Physical Activity Counseling)
Dr. Smith	55	50	90.9%	24	43.6%	13	23.6%
Dr. Jones	87	74	85.1%	36	41.4%	45	51.7%
Dr. Miller	112	72	64.3%	48	42.9%	59	52.7%

EHR/Provider Reported Data
Measure Instructions

SBIRT (Screening, Brief Intervention, and Referral to Treatment)

Denominator 1: Patients 12 years of age and older who had an office visit during the measurement period.

Numerator 1: Patients who received an age-appropriate screening, using an OHA approved SBIRT screening tool, during the measurement period <u>and</u> had a brief screen with a negative result or a full screen.

Denominator 2: Patients from Denominator 1 who had a <u>positive</u> full screen during the measurement period.

Numerator 2: Patients who received a brief intervention, a referral to treatment, or both. That is documented within 48 hours of the date of a positive full screen.

Example: Dr. Smith had 122 patients age 12 years old who had an office visit during the measurement period. 8 patients had an active diagnosis of Alcohol or Drug Dependency and were not screened. 45 patients were documented as having a negative screen for substance misuse. 15 patients had a positive full screen and received a brief intervention. 7 patients had a positive full screen and were referred to treatment. 4 patients had a positive full screen but did not receive a brief intervention or referral to treatment. Numerator1 = 45+15+7+4=71, Denominator1 = 122, Exclusions = 8. Performance percentage1 = 122-8=114, 71/114 or 62.3%. Numerator2 = 15+7=22, Denominator2 = 15+7+4=26. Performance percentage2 = 22/26 or 84.6%. Please include the numerator, denominator and exclusions/exceptions when submitting data.

	Denominator 1	Numerator 1	Exclusions /Exceptions	Percentage 1 (% Screened)	Denominator 2	Numerator 2	Percentage 2 (% w/intervention or referral to treatment)
Dr. Smith	122	71	8	62.3%	26	22	84.6%
Dr. Jones	96	47	6	52.2%	18	13	72.2%
Dr. Miller	118	62	3	53.9%	33	19	57.6%

Measures with Gift Card Incentives
(Participation is Optional)

Adolescent Well Care:

Incentivizing **members ages 12-21** to be seen for an Adolescent Well Care check by their assigned PCP.

- **$15.00 Subway gift card for the patient**
- **$10.00 Fred Meyer gift card for the office.**
- Office must fill out form with Patient Name, DOB, Member ID#, Date of current well check, Provider, Subway card # and fax to (541) 955-3230

Colorectal Cancer Screen:

Incentivizing members who have had either a Fecal Occult Blood Test (FOBT), a Sigmoidoscopy, or a Colonoscopy by the end of the measurement year.

- The state guidelines are either one fecal occult blood test per calendar year, a flexible sigmoidoscopy within the past 5 years, or a colonoscopy within the past 10 years.

- The top portion of the log is for those patients having procedure in the measurement year. **Those patients will be eligible for a $20.00 Walmart gift card _upon completion _ of their test.** The bottom portion of the log is for those patients you have determined to have had the FOBT within this calendar year or a colonoscopy within the past 10 years.

- Providers will receive **$50.00** for each patient who completes a fecal occult blood test or **$90.00** for each patient who completes a flexible sigmoidoscopy or colonoscopy by the end of the year.

- For each colorectal cancer screening completed, offices will receive a **$10.00 Fred Meyer gift card.**

AllCare Colorectal Cancer Screening Incentive Log (for AllCare CCO members ages 51-75)

Patient Name	Date of Birth	Member ID #	Date of Service	PCP	Walmart Card #	FOBT	Flex Sig/Colon

If Patient received these services prior, please list here (FOBT within calendar year, Flex Sig within past 5 years or Colonoscopy within past 10 years)

Patient Name	Date of Birth	Member ID #	Date of Service	Where was service performed?	Provider	FOBT	Flex Sig/Colon

Adolescent Well Care Incentive Program for AllCare CCO Members Ages 12-21

Patient Name	Date of Birth	Member ID	Date of current of well child check	Provider	Card #

Please Fax to Andi or BreeAnn at 541-955-3230

AllCare Health
Pediatrics
Alternative Payment Model
2019

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2019 AllCare CCO Pediatric Alternative Payment Model

2019 Updated Measures for AllCare CCO's Alternative Payment Model
Pediatrics

New Measures for 2019:
- Patient Portal Utilization
- SBIRT

Modified Measures for 2019:
- Depression Screening
- Days to Third Next Available Appointment
- Cigarette Smoking Prevalence Reduction

Removed Measures for 2019:
- Satisfaction with Care Survey Results
- Well Child Visits

EXAMPLE

Provider Name
PROVIDER XYZ

Attributed Member Months
8,082

Quality Measures	Goal	Numerator	Denominator	Estimated # Needed to Meet Measure	YTD Performance	Points Possible	Points Earned YTD
Access to Care Survey Results	85%	Annual Measure	Annual Measure	Meeting		5	5
Third Next Available Appt.	Y/N			Meeting		5	5
Developmental Screening	67%	25	32	Meeting	78%	5	5
Adolescent Wellcare	43%	42	95	Meeting	44%	5	5
Childhood Immunization Status	71%	200	278	Meeting	72%	5	5
Depression Screening w/ Follow-up	55%	182	351	-11	52%	5	0
BMI/Nutrition & Activity Counseling	30%	99	340	-3	29%	5	0
Effective Contraceptive Use	48%	82	146	Meeting	56%	3	3
Smoking Prevalence	<29%	19	78	Meeting	24%	3	3
PCPCH	0-5			Meeting	4	5	4
ER Visits Level 1&2	≤ 123	Per 1,000 Measure	Per 1,000 Measure		187	3	0
SBIRT Reporting	Y/N	Y	Y	Meeting	Y	3	3
Patient Portal Utilization	Y/N	N	N		N	3	0
Total Points						**47**	**33**
BONUS POINTS							
Health Equity	Y/N				Y	5	5

Tier 1 (50%) 16-21 Points
Tier 2 (75%) 22-27 Points
Tier 3 (100%) 28+ Points

CHALLENGE POOL MEASURES HIGHLIGHTED IN BLUE

Performance Score	
Overall Achieved	100%

Helpful Information/Definitions

- *__Denominator__* – The total number of members who qualify for a specific measure.
- *__Numerator__* – The total number of members who received a qualifying service to meet the measure requirements.

The *__estimated__* number of services needed to meet the individual measures is now included on the report. It is important to note that this is an *__estimation only__* and will change over the course of the year based on a provider's performance on the measure and attributed membership.

Year to Date (YTD) performance scores include one month of claims run-out from the end of the reporting period.

Year-end reports will include 3 months of claims run-out to ensure all services have been captured for the performance period.

Challenge Pool: APM funds not paid out to providers will become the "challenge" pool. These funds will be distributed to providers who met the goal on the challenge pool measures.

Attributed Members: AllCare members who have been assigned to a specific provider for at least 6 months and who have been on AllCare for one year. A provider's APM data is derived from Attributed members only.

Member Months: The number of months a member has been with AllCare CCO for the measurement period. The total number of member months (for all of a provider's attributed members) is used to determine the potential APM pay out for a provider.

Per 1000: This calculation equalizes the results so providers are measured on the same basis.
ED Visits/1000 Example:

Provider A	Provider B
Member months: 1,200 (average of 100 members)	Member months: 2,400 (average of 200 members)
# of ED visits: 68	# of ED visits: 136
68/1200 *(12 months in yr*1000) = 680 ED visits/1000 members per year	136/2400 *(12 months in yr*1000) = 680 ED visits/1000 members per year

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You may also refer to The Oregon Health Authority – Office of Health Analytics webpage for more detailed information on the state measures:

http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Changing healthcare to work for you.

Measure Definition

Providers attest that they offer access to patients (or patient-authorized representatives) the ability to view online, download, and transmit their health information using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT (Certified Electronic Health Record Technology).

This would be a fully integrated Patient Portal. For example: When a patient sends a message via the portal, it goes directly into the EHR or when an office sends a message back to the patient, it must be created in the EHR.

Unit of Measurement: Y/N

Measure Intent and Purpose

Patients and providers benefit when patients play an active role in their health, and patient portals facilitate that involvement. Giving patients better access to their personal information allows them to make informed decisions regarding their care and lifestyle choices, potentially improving care plan adherence and overall wellness.

-Greenway Health

Screening, Brief Intervention and Referral to Treatment (SBIRT)
Alcohol & Drug Misuse
Data Source: Provider Reported/EHR

Measure Source
OHA

Measure Definition

Two rates are reported for this measure:

1. The percentage of patients age 12 and older who received age-appropriate screening.

2. The percentage of patients age 12 and older with a positive full screen who received a brief intervention or referral to treatment *(this is a new component to this measure).*

Screening in an ambulatory setting is required once per measurement year. This measure does not require screening to occur at all encounters.

Unit of Measurement: Y/N

Measure Formula:

Rate 1
Data elements required denominator: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

Data elements required numerator: Patients who received an age-appropriate screening, using an SBIRT screening tool approved by OHA, during the measurement period AND had either a brief screen with a negative result or a full screen (AUDIT or DAST).

Required denominator exclusions and exceptions: See below.

> **Note**: Although a negative brief screen is numerator compliant, a positive brief screen, by itself, is not numerator compliant. If a patient has a positive brief screen, then a full screen must be completed for numerator compliance on Rate 1. A full screen is numerator compliant, regardless of the result.

> **Note**: Approved SBIRT screening tools are available on the HSD-Approved Evidence-Based Screening Resources/ Tools (SBIRT) page:
> http://www.sbirtoregon.org/

> The name of the screening tool used must be documented in the medical record. The clinician should interpret the age-appropriate screening tool to determine if the result is positive or negative. Where the screening tool includes guidance on interpreting scores, the clinician should consult that guidance.

> **Note**: The screening(s) and result(s) must be captured as queryable structured data in the EHR.

> **Required exclusions for numerator:** SBIRT services received in an emergency department (Place of Service 23) or hospital setting (POS 21).

Rate 2

Data elements required denominator: All patients in Rate 1 denominator who had a positive full screen during the measurement period.

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received a brief intervention, a referral to treatment, or both that is documented within 48 hours of the date of a positive full screen.

> **Brief Intervention**: Examples of brief interventions include assessment of the patient's commitment to quit and offer of pharmacological or behavioral support, provision of self-help material, or referral to other supportive resources.

> A brief intervention of less than 15 minutes can count for Rate 2 numerator compliance. Although clinics may bill for SBIRT services when appropriate, this measure (unlike the earlier claims-based CCO SBIRT measure) does not require use of billing codes to determine whether screening or a brief intervention or referral occurred. Documentation in the medical record (e.g., through checkboxes, flowsheets, or other structured data) that a brief intervention was completed is sufficient.

> Note – Referral to Treatment: A referral is counted for Rate 2 numerator compliance when the referral is made. Numerator compliance is not dependent on referral completion.

Screening, Brief Intervention and Referral to Treatment (SBIRT)
Alcohol & Drug Misuse
(cont.)

Denominator Exclusions and Exceptions – Rate 1 and Rate 2

Required exclusions for denominator

Patients with:

- Active diagnosis of alcohol or drug dependency
- Engagement in treatment
- Dementia or mental degeneration
- Limited life expectancy
- Palliative care (includes comfort care and hospice)

  The exclusions for active diagnosis of alcohol or drug dependency, dementia or mental degeneration, limited life expectancy, and palliative care apply if they occur before the qualifying encounter (that is, before a visit that puts the patient in the denominator for Rate 1).

  The exclusion for engagement in treatment applies if the patient was engaged in treatment before the qualifying visit and up to one year before the start of the measurement year.

Denominator Exceptions: Any of the following criteria also remove patients from the denominator.
- Patient Reason(s)
  - Patient refuses to participate
- Medical Reason(s)
  - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
    OR
  - Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

Depression Screening
Data Source: Provider Reported/EHR

Measure Source

NQF 0418

Measure Definition

Percentage of patients age 12 years and older screened for clinical depression using a standardized tool and follow-up plan documented.

Screening: Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Follow-up Plan:

> **Although the PHQ-9 can still be used to evaluate risk for depression, the PHQ-9 NO LONGER COUNTS as a follow-up to a positive PHQ-2 for this measure.**

Documented follow-up for a positive depression screening must include one or more of the following:

- Suicide Risk Assessment
- Referral to practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Unit of Measurement: Y/N
Measure Formula:

> **_Numerator:_** Patients screened for depression on the date of the encounter, using an age-appropriate standardized tool AND if positive, a **follow-up plan is documented on the date of the positive screen.**
>
> **_Denominator:_** Members age 12 years and older before the beginning of the measurement period, with at least one eligible encounter during the measurement period.
>
> **_Exclusions:_** Patients with an active diagnosis for Depression or Bipolar Disorder; or if screen is not appropriate, due to patient refusal, emergent medical situation, or patient motivation may impact accuracy of results.

Measure Intent & Purpose

"Major depression, also known as clinical depression, is a serious illness that can be successfully treated when detected. This measure ensures that patients are screened and that if there is risk of depression a follow up plan is created by the patient and their provider. Treating early signs of clinical depression is an important part of avoiding the mental and physical harm that can result from depression." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: Y/N – Data provided to AllCare
2018 AllCare CCO Improvement Target: 55%

Days-to-Third Next Available Appointment
Data Source: Provider Reported Data

Measure Source
AllCare Health CCO

Measure Definition

Days-To-Third Next Appointment is the average length of time in days between the day a patient makes a request for an appointment with a provider and the third next available appointment for **new** patient care visits **to establish care.**

Unit of Measurement: Y/N

Measure Formula:

On a monthly basis, offices will evaluate their number of days to the third next available appointment, _for each provider participating in the APM,_ using the formula below. **This information will be submitted to AllCare on a quarterly basis.**

1. Date Measured – The date you will measure your provider's schedule. The example below is prepopulated with the first working day of the month.
2. 1st Appointment – The date of the first available appointment on your provider's schedule
3. 2nd Appointment – The date of the second available appointment on your provider's schedule
4. 3rd Appointment – The date of the third available appointment on your provider's schedule
5. Days to 3rd – This is where the formula is located and will automatically populate the days to next appointment, when you enter the days of each appointment on the spreadsheet.

Example:

Date Measured	1st appointment	2nd appointment	3rd appointment	Days to 3rd			
1/1/2019	1/1/2019	1/2/2019	1/5/2019	4	1st quarter average days to 3rd		
2/1/2019	2/1/2019	2/6/2019	2/8/2019	7	next available appointment:		
3/1/2019	3/1/2019	3/5/2019	3/6/2019	5			5.3
4/2/2019					2nd quarter average days to 3rd		
5/1/2019					next available appointment:		
6/2/2019					3rd quarter average days to 3rd		

*__**Days to 3rd__ next available appointment based off of __calendar days__ (not business days).**_*

Measure Intent & Purpose

The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability.

Performance Target

Providers are tracking and submitting data to AllCare.

Cigarette Smoking *Reduction* (Bundled Measure)
Data Source: Provider Reported EHR Measure

Measure Source

OHA CCO Incentive Measure

Measure Definition

This measure is determined through three separate rates:

1. Of all patients with a qualifying visit, how many have their cigarette smoking or tobacco use status recorded?
2. Of all patients with their cigarette smoking or tobacco use status recorded, how many are cigarette smokers?
3. Of all patients with their cigarette smoking or tobacco use status recorded, how many are smokers *and/or* tobacco users?

Unit of Measurement: %

Measure Formula:

Rate 1:
Of all patients with a qualifying visit, how many have their cigarette smoking or tobacco use status recorded?

> ***Data elements required denominator*:** Medicaid members 13 years old or older by the beginning of the measurement year, who had a qualifying visit with the provider during the measurement period.
> **Data elements required numerator:** members age 13 years or older who had a qualifying visit with the provider during the measurement period, who have their smoking and/or tobacco use status recorded as structured data.

Rate 2:
Of all patients with their cigarette smoking or tobacco use status recorded, how many are cigarette smokers?

> **Data elements required denominator**: Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

> **Data elements required numerator**: Of patients in the Rate 2 denominator, those who are cigarette smokers. See below for additional information on identifying cigarette smoking in the numerator.

(Continued on next page)

Cigarette Smoking *Reduction* (Bundled Measure)
Data Source: Provider Reported/EHR (*continued*)

<u>Rate 3:</u>
Of all patients with their cigarette smoking or tobacco use status recorded, how many are smokers *and/or* tobacco users?

> **Data elements required denominator**: Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

> **Data elements required numerator**: Of patients in the Rate 3 denominator, those who are cigarette smokers *and/or* tobacco users. See below for additional information on identifying tobacco use in the numerator.

Please Note:

- E-cigarettes and marijuana (medical or recreational) should be excluded from both the cigarette smoking rate and the broader tobacco use rate; the measure is focused on cigarettes and other tobacco products.

- In addition, the measure is focused on cigarette and tobacco use, not nicotine use. Patients who are using nicotine replacement therapy (NRT) should also be excluded from the numerator (unless they are also still using cigarettes and/or other tobacco products).

Measure Intent & Purpose

"The intent of the measure is to address tobacco prevalence (including cigarette smoking and other tobacco products, such as chew, snuff, and cigars, and excluding e-cigarettes, marijuana, and those using nicotine replacement products such as patches).

However, due to variation in how EHRs capture smoking and tobacco use data and to ensure comparability of prevalence across EHRs and CCOs, the measure will be looking for two separate rates: (1) cigarette smoking; and (2) tobacco use." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD
2018 AllCare CCO Improvement Target: **≤ 29%**

Developmental Screening 12-36 Months
Data Source: AllCare Claims

Measure Source

NQF 1448 (OHA measure guidelines)

Measure Definition

The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age, and by 36 months of age.

Unit of Measurement: %

Measure Formula:

> **Numerator**: Children age 12 months - 36 months who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool during the measurement period. Look back 12 months from member's birthday.

> *To receive credit for this measure, the following CPT code must be used: 96110 (Developmental testing, with interpretation and report)*

> *The Oregon Health Authority recommends using one of the following tools for developmental screening:*
> - *Ages and Stages Questionnaire (ASQ-3), or*
> - *Parents' Evaluation of Developmental Status (PEDS), with or without the Developmental Milestones (DM).*

> **Denominator**: Members who turn 12 months - 36 months of age between January 1 of the measurement year and December 31 of the measurement period

> **Continuous Enrollment**: Continuous enrollment for the 12 months prior to their birthday during the measurement year with one gap of up to 45 days allowed.

Measure Intent & Purpose:

"Developmental screening is an important opportunity to engage families in the process of developmental promotion and should be used in addition to longitudinal and continuous developmental surveillance by knowledgeable health care professionals. Developmental screening significantly increases the accuracy of assessing children's developmental status as compared to clinical impressions or informal check lists alone." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD

Adolescent Well Care Visits (12-21 years old)
AllCare Claims Based Data

Measure Source
CHIPRA #12 (OHA Measure Guidelines)

Measure Definition

The percentage of attributed adolescents ages 12 to 21 that had at least one comprehensive well-care visit during the measurement year.

Unit of Measurement: %

Measure Formula:

> **Numerator**: Members in the denominator receiving at least one comprehensive well-care visit during the measurement year. Members can be seen by any provider type for this measure.
>
> Codes:
>
> **CPT:** **99383-99385, 99393-99395**
>
> **ICD-10: Z00.121, Z00.129, Z00.00, Z00.01, Z02.0, Z02.5, Z02.6, Z02.71, Z02.82, Z02.1, Z02.2, Z02.3, Z02.4, Z00.8, Z00.5, Z76.1, Z76.2**
>
> **Denominator**: Attributed adolescents ages 12 to 21 as of December 31 of the measurement year

Measure Intent & Purpose

"Youth who can easily access preventive health services are more likely to be healthy and able to reach milestones such as high school graduation and entry into the work force, higher education or military service. In 2011, just over half of Oregon's eighth and 11th graders had a well-visit in the past year." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD

2018 AllCare CCO Improvement Target: 43%

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Childhood Immunization Status
Data Source: ALERT Immunization Program Data

Measure Source

HEDIS

Measure Definition

Unit of Measurement: %

Measure Formula:

Numerator: The # of children who turned 2 years of age in the measurement year and had <u>all</u> of the specified vaccinations listed below <u>by their 2nd birthday</u>:

- **DTaP** – at least **four** DTaP vaccinations (DTaP Vaccine administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

- **IPV** – at least **three** IPV vaccinations (Inactivated Polio Vaccine (IPV) Administered Value Set with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth cannot be counted

- **MMR** – **Any** of the following on or before the child's 2nd birthday:
  - At least **one** MMR vaccination (Measles, Mumps, Rubella (MMR) Vaccine Administered Value Set).
  - At least **one** measles and rubella vaccination (Measles/Rubella Vaccine Administered Value Set) and at least one mumps vaccination (Mumps Vaccine Administered Value Set) on the same date of service or on a different date of service.
  - At least **one** measles vaccination (Measles Vaccine Administered Value Set) and at least one rubella vaccination (Rubella Vaccine Administered Value Set) on the same date of service or on a different date of service.
  - History of measles (Measles Value Set), Mumps (Mumps Value Set), or Rubella Value Set) illness.

- **HiB** – At least **three** HiB vaccinations (Haemophilus Influenzae Type B (HiB) Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. HiB administered prior to 42 days after birth cannot be counted.

- **Hepatitis B** – At least **three** hepatitis B vaccinations (Hepatitis B Vaccine Administered Value Set), with different dates of service on or before the child's second birthday; or history of hepatitis illness (Hepatitis B Value Set).

- **VZV** – At least **one** VZV (Varicella Zoster (VZV) Vaccine Administered Value Set), with a date of service falling on or before the child's second birthday; or a history of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set)

Childhood Immunization Status
Data Source: ALERT Immunization Program Data
(Continued)

Vaccination Codes

Value Set Name	CPT/HCPCS	ICD10 CM Diagnosis
DTaP Vaccine Administered	90608, 90700, 90721, 90723	
Inactivated Polio Vaccine (IPV) Administered	90698, 90713, 90723	
Measles, Mumps and Rubella (MMR) Vaccine Administered	90707, 90710	
Measles/Rubella Vaccine Administered	90708	
Measles Vaccine Administered	90705	
Mumps Vaccine Administered	90704	
Rubella Vaccine Administered	90706	
Measles		B05.0, B05.1, B05.2, B05.3, B05.4, B05.89, B05.9
Mumps		B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
Rubella		B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
Haemophilus Influenzae Type B (HiB) Vaccine Administered	90645-90648, 90698, 90721, 90748	
Hepatits B Vaccine Administered	90723, 90740, 90744, 90747, 90748, G0010	
Hepatitis B		B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51
Varicella Zoster (VZV) Vaccine Administered	90710, 90716	

Denominator: Children who turn 2 years old in the measurement year

Exclusions: *NONE*

Continuous Enrollment: Continuous enrollment for the 12 months prior to their birthday during the measurement year with one gap of up to 45 days allowed.

Measure Intent & Purpose

A basic method for prevention of illness is immunization. Childhood immunizations help prevent serious illnesses such as polio, tetanus and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles. Even preventing "mild" diseases saves hundreds of lost school days and work days, and millions of dollars. - AHRQ

Performance Targets

2019 AllCare CCO Improvement Target: TBD

Effective Contraceptive Use
Data Source: AllCare Claims

Measure Source

OHA

Measure Definition

Percentage of women ages 15 - 50 years old who use effective contraceptive methods during the measurement year. *Evidence of use may include* <u>surveillance</u> *of a contraceptive method as well as* <u>NDC prescription</u> *codes in addition to* <u>diagnosis</u> *and* <u>procedure</u> *codes.*

Unit of Measurement: %

Measure Formula:

> *Numerator:* All women in the denominator with evidence of one of the following methods of contraception during the measurement period:

- Female Sterilization
- IUD/IUS
- Implants
- Contraception Injection
- Contraceptive Pills
- Patch
- Ring
- Diaphragm

Denominator: All women ages 15 - 50 who are capable of becoming pregnant.

(Continued on next page)

Effective Contraceptive Use
Data Source: AllCare Claims
(Continued)

Partial List of Contraceptive Codes:

(For complete list, please refer to the Numerator Code Table located on the OHA website at:
http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx)

Z30.011	Encounter for initial prescription of contraceptive pills
Z30.013	Encounter for initial prescription of injectable contraceptive
Z30.014	Encounter for initial prescription of intrauterine contraceptive device
Z30.018	Encounter for initial prescription of other contraceptives
Z30.019	Encounter for initial prescription of contraceptives, unspecified
Z30.2	Encounter for sterilization
Z30.40	Encounter for surveillance of contraceptives, unspecified
Z30.41	Encounter for surveillance of contraceptive pills
Z30.42	Encounter for surveillance of injectable contraceptive
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.431	Encounter for routine checking of intrauterine contraceptive device
Z30.433	Encounter for removal and reinsertion of intrauterine contraceptive device
Z30.49	Encounter for surveillance of other contraceptives
Z30.8	Encounter for other contraceptive management
Z30.9	Encounter for contraceptive management, unspecified
Z79.3	Long term (current) use of hormonal contraceptives
Z97.5	Presence of (intrauterine) contraceptive device
Z98.51	Tubal ligation status
T83.31xA	Breakdown (mechanical) of intrauterine contraceptive device, initial encounter
T83.32xA	Displacement of intrauterine contraceptive device, initial encounter
T83.39xA	Other mechanical complication of intrauterine contraceptive device, initial encounter
T83.59xA	Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system, initial
T83.6xxA	Infection and inflammatory reaction due to prosthetic device, implant and graft in genital tract
0UH97HZ	Insertion of Contraceptive Device into Uterus, Via Natural or Artificial Opening
0UH98HZ	Insertion of Contraceptive Device into Uterus, Via Natural or Artificial Opening Endoscopic
0UHC7HZ	Insertion of Contraceptive Device into Cervix, Via Natural or Artificial Opening
0UHC8HZ	Insertion of Contraceptive Device into Cervix, Via Natural or Artificial Opening Endoscopic
58300	Insertion of intrauterine device (IUD)
11981	Insertion, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
57170	Diaphragm or cervical cap fitting with instructions

Effective Contraceptive Use
Data Source: AllCare Claims
(Continued)

Exclusions: Women who are not capable of becoming pregnant (have had a hysterectomy, bilateral oophorectomy or menopause) and women who were pregnant during the measurement year are excluded from the denominator.

Partial List of Exclusion Codes:

(For complete list, please refer to the Numerator Code Table located on the OHA website at: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx**)**

Z90.710	Acquired absence of both cervix and uterus
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58940	Oophorectomy, partial or total, unilateral or bilateral;
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
Z78.0	Asymptomatic menopausal state
N92.4	Excessive bleeding in the premenopausal period
N95.1	Menopausal and female climacteric states
N95.0	Postmenopausal bleeding
N95.2	Postmenopausal atrophic vaginitis
E89.41	Symptomatic postprocedural ovarian failure
N95.8	Other specified menopausal and perimenopausal disorders
N95.9	Unspecified menopausal and perimenopausal disorder
E89.40	Asymptomatic post procedural ovarian failure
E89.41	Symptomatic post procedural ovarian failure
E28.310	Symptomatic premature menopause
E28.319	Asymptomatic premature menopause
Q50.02	Congenital absence of ovary, bilateral
Q51.0	Congenital absence of uterus

(Continued on next page)

Measure Intent & Purpose

"Almost 50 percent of pregnancies in Oregon are unintended, and have been for more than three decades. Among women with an unintended pregnancy, 43 percent reported using contraception, but they were using it incorrectly or inconsistently. Fifty-two percent reported using no contraception method at all. This suggests that most women are at risk of unintended pregnancy and are in need of contraception counseling in order to find a method that meets their needs. Most women would benefit from knowing which methods of contraception are the most effective." – OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD

Timely Access to Care - Patient Survey Results
Data Source: AllCare -or- CAHPS Surveys

Measure Source

PCPCH 1.A.3

Measure Definition

Percentage of respondents who had a positive response for the questions "In the last 12 months, when you phoned your healthcare provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?" & "In the last 12 months, when you made an appointment for a check-up or routine care with your healthcare provider, how often did you get an appointment as soon as you needed?"

Unit of Measurement: %

Measure Formula:

> *Numerator:* # of survey respondents who marked "Always" or "Usually" for the specified questions.

> *Denominator:* Total number of survey respondents per provider.

> *Exclusions:* Any surveys where the following questions were not answered:

- In the last 12 months, when you phoned your healthcare provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?
- In the last 12 months, when you made an appointment for a check-up or routine care with your healthcare provider, how often did you get an appointment as soon as you needed?

Measure Intent & Purpose

"Improving access to timely care and information helps increase the quality of care and reduce costs. Measuring access to care is also an important part of identifying disparities in health care and barriers to quality care, including a shortage of providers, lack of transportation, or long waits to get an appointment." – OHA

Performance Targets 2019:

85%

PCPCH
Data Source: PCPCH Certification

Measure Source
PCPCH/OHA

Measure Definition

Clinics can be recognized at five different levels, or tiers, depending on the criteria they meet. There are 11 "must-pass" criteria that every clinic must meet in order to be recognized as a primary care home at any level. The other criteria are worth varying amounts of points, and the total points accumulated by a clinic determines their overall tier of PCPCH recognition.

Unit of Measurement: Y/N
Measure Formula:

Tier Level	Point Range	Additional Required Criteria
Tier 1	30 – 60 points	+All must-pass standards
Tier 2	65 – 125 points	+All must-pass standards
Tier 3	130 – 250 points	+All must-pass standards
Tier 4	255 – 380 points	+All must-pass standards
5 STAR (Tier 5)	255 – 350 points	+All must-pass standards +Meet 11 of 13 specified measures +All measures are verified with a site visit

Measure Intent & Purpose

"Strong, effective primary care health homes are foundational to transforming and sustaining high quality healthcare for Oregonians. Evidence shows that team-based primary care will lead to better outcomes and drive down costs. The more quickly Oregon can drive adoption of primary care health homes statewide, the more quickly we will drive achievement of the Triple Aim (improving care, improving health, and reducing cost)." –OHA

Performance Targets

2019 State CCO Incentive Benchmark: Y/N

BMI/Counseling for Nutrition and Physical Activity
for Children and Adolescents (Bundled Measure)
Data Source: Provider Reported/EHR

Measure Source

OHA CCO Incentive Measure / NQF 0024

Measure Description:

This measure is determined through the average of three separate rates:

Numerator:

1. Patients 3-17 years of age who had a height, weight and body mass index (BMI) percentile recorded during the measurement period. BMI information can be captured via EHR using ICD-10 codes.

    ICD-10:
    Z68.51 …… less than 5th percentile for age
    Z68.52 …… 5th percentile to less than 85th percentile for age
    Z68.53 …… 85th percentile to less than 95th percentile for age
    Z68.54 …… greater than or equal to 95th percentile for age

2. Patients 3-17 years of age who had counseling for nutrition during a visit that occurs during the measurement period

    ICD-10: Z71.3…… Dietary counseling and surveillance

    CPT: 97802 – 97804

    HCPCS: G0270, G0271, G0447, S9449, S9452, S9470

3. Patients 3-17 years of age who had counseling for physical activity during a visit that occurs during the measurement period, as documented in the EHR.

    ICD-10: Z71.82 …… Exercise counseling

Denominator:
Patients 3-17 years of age with at least one qualifying visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period.

Measure Intent & Purpose

"Over the last three decades, childhood obesity has more than doubled in children and tripled in adolescents. It is the primary health concern among parents in the United States, topping drug abuse and smoking. Childhood obesity has both immediate and long-term effects on health and well-being." - OHA

Performance Targets

2019 AllCare CCO Improvement Target: TBD
2018 AllCare CCO Improvement Target: 30%

Level 1 & 2 ED Visits/1000
Data Source: AllCare Claims

Measure Source
HEDIS

Measure Definition

# of level 1 or 2 (low acuity) ER visits by a PCP's members per 1000

Unit of Measurement: #/1000

Measure Formula: # of level 1 or 2 ER visits/attributed member months) X 1000 X # of months in time period

> *Numerator:* # of level 1 or 2 ER visits
> Codes: **99281, 99282**
>
> *Denominator:* Attributed member months

Measure Intent & Purpose
"Emergency departments are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients." – OHA

Performance Targets
2019 State CCO Incentive Benchmark: TBD **2018 State CCO Incentive Benchmark:** ≤123

Health Equity (Bonus Measure)
Data Source: Attestation

Measure Definition

Provider attests that they, and at least 70% of office staff, completed training from the suggested list during the measurement year or have an *OHA Qualified* or *Certified* medical interpreter on staff at their location.

Unit of Measurement: Y/N

Measure Formula:

Provider attests that they and at least 70% of office staff have completed one of the trainings located at the link below:

https://www.allcarehealth.com/doctors-providers/resources/health-equity

*If the practice completes courses that are similar in content to the suggested list, this may also qualify for the measure if approved by AllCare.

OR

Provider attests that they have an *OHA Qualified* or *Certified* Medical Interpreter on staff (For more information, contact Stick Crosby: stick.crosby@allcarehealth.com

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Measure Intent & Purpose

To ensure that contracted providers across the continuum of care have access to training that meets state and federal goals and objectives on culturally and linguistically appropriate service delivery; and ensure providers are sensitive to members with cultural, linguist and social differences as they relate to ethnicity, gender, socioeconomics and other areas of diversity.

Performance Targets

2019 AllCare CCO Improvement Target: 70%

APM Challenge Pool

APM funds not paid-out to providers will become the "challenge pool"- these funds will be distributed to providers who meet the goal on the challenge pool measures listed below:

- **Adolescent Well Care**
- **Childhood Immunization Status**
- **Developmental Screening**

EHR/Provider Reported Data
Measure Instructions

Cigarette Smoking Reduction

Denominator 1: Patients 13 years of age and older who had a qualifying visit with the provider during the measurement period.

Numerator 1/Denominator2: Patients 13 years of age and older who had a qualifying visit with the provider during the measurement period and have their smoking and/or tobacco use status recorded.

Numerator 2: Patients from the denominator group who are cigarette smokers.

Numerator 3: Patients from the denominator group who are tobacco users.

Example: Dr. Smith had 380 patients age 13 and older who had an office visit during the measurement period. 375 of those patients had their smoking and/or tobacco status recorded. Percentage 1 = 375/380 or 98.6%. Of the 375 patients who had their status recorded, 65 are cigarette smokers and 12 use chewing tobacco. Denominator 2 = 375 Numerator 2 = 65 the percentage of members who had their status recorded and are cigarette smokers 65/375 or 17.3%. Denominator 2 = 375 Numerator 3 = 12 + 65 the percentage of members who had their status recorded and use any form of tobacco. 77/375 or 20.5%.

	Denominator 1	Numerator1/ Denominator 2	Percentage 1 (Status Recorded)	Numerator 2 (Cigarette Smokers)	Percentage 2	Numerator 3 (Any type of Tobacco)	Percentage 3
Dr. Smith	380	375	98.6%	65	17.3%	77	20.5%
Dr. Jones	130	118	90.7%	22	18.6%	26	22.0%
Dr. Miller	202	187	92.5%	37	19.8%	46	24.6%

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EHR/Provider Reported Data
Measure Instructions

BMI/Nutrition and Activity Counseling

Denominator: Patients 3-17 years of age with at least one qualifying visit during the measurement period.

Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period.

Numerator 2: Patients who had counseling for nutrition during a visit that occurs during the measurement period

Numerator 3: Patients who had counseling for physical activity during a visit that occurs during the measurement period

Example: Dr. Smith had 55 patients age 3 through 17 years old who had an office visit during the measurement period. 50 of those patients had their BMI recorded. Percentage 1 = 50/55 or 90.9%. 24 patients were given counseling for nutrition. Percentage 2 = 24/55 or 43.6%. 13 were given counseling for physical activity. Percentage 3 = 13/55 or 23.6%. A patient can be included in more than one numerator if they received the corresponding qualifying service.

	Denominator	Numerator1	Percentage 1 (BMI)	Numerator 2	Percentage 2 (Nutrition Counseling)	Numerator 3	Percentage 3 (Physical Activity Counseling)
Dr. Smith	55	50	90.9%	24	43.6%	13	23.6%
Dr. Jones	87	74	85.1%	36	41.4%	45	51.7%
Dr. Miller	112	72	64.3%	48	42.9%	59	52.7%

EHR/Provider Reported Data
Measure Instructions

Depression Screen & Follow-up Plan

Denominator: Patients 12 years of age and older who had an office visit during the measurement period. Patients with an active diagnosis of Depression or Bi-Polar Disorder are excluded from the denominator.

Numerator: Patients from the denominator group who were screened for clinical depression using a standardized depression screening tool and, if the depression screen is positive, a follow-up plan must be documented to qualify for the numerator. Follow-up for a positive depression screening must include one or more of the following: Additional evaluation, Suicide Risk Assessment, Referral to a practitioner who is qualified to diagnose and treat depression, Pharmacological interventions, Other interventions or follow-up for the diagnosis or treatment of depression. The PHQ9 screen does not count as follow up to a positive PHQ2 screen.

Example: Dr. Smith had 122 patients age 12 and older who had an office visit during the measurement period. 4 patients had an active diagnosis of Depression and were not screened. 20 patients were documented as having a negative screen for depression. 11 patients screened positive and had a qualifying follow up plan documented. 6 additional patients screened positive but did not have a qualifying follow up plan documented. Numerator = 20+11=31, Denominator = 122, Exclusions = 4. Performance percentage = 122-4=118, 31/118 or 26.3%. Please include the numerator, denominator and exclusions when submitting data.

	Numerator	Denominator	Exclusions	Percentage
Dr. Smith	31	122	4	26.3%
Dr. Jones	43	174	15	27.0%
Dr. Miller	19	82	7	25.3%

Adolescent Well Care Incentive
(Participation is Optional)

Adolescent Well Care:

Incentivizing **members ages 12-21** to be seen for an Adolescent Well Care check by their assigned PCP.

- **$15.00 Subway gift card for the patient**
- **$10.00 Fred Meyer gift card for the office.**
- Office must fill out form with Patient Name, DOB, Member ID#, Date of current well check, Provider, Subway card # and fax to (541) 955-3230

Adolescent Well Care Incentive Program for AllCare CCO Members Ages 12-21

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Patient Name	Date of Birth	Member ID	Date of current of well child check	Provider	Card #

Please Fax to Andi or BreeAnn at 541-955-3230

AllCare Health
OB/Gyn Specialty
Alternative Payment Model
2019

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Table of Contents
2019 AllCare CCO Obstetrics Specialty Alternative Payment Model

2019 Updated Measures for AllCare CCO's Alternative Payment Model
Obstetrics

Removed Measures for 2019:

- Expanded Access
- Smoking Cessation Counseling

Added Measures for 2019

- Tobacco Use: Screening and Cessation Intervention
- 3rd Next Available Appointment
- Documentation of Current Medications

OB/GYN SPECIALTY

Provider Name
OB PROVIDER

Work RVUs
2882

Measure	Goal	YTD	Possible Points	Points Earned
Generic Rx	85%	87%	2	2
Wait Time from Auth to Appt (Days)	30	28	2	2
Timely Postpartum Visit	50%	48%	3	0
Access to Care	85%	87%	2	2
Satisfaction with Care	85%	90%	2	2
Documentation of Current Medications	Y/N	Y	2	2
Tobacco Use: Screening and Cessation Intervention	Y/N	Y	2	2
3rd Next Available Appointment	Y/N	Y	1	1
BONUS POINTS				
Health Equity	Y/N	N	3	0
Total Points			**19**	**13**

Tier 1 (65%)	*7-9 POINTS*	
Tier 2 (80%)	*10-12 POINTS*	
Tier 3 (100%)	*13+ POINTS*	

Days to Third Next Available Appointment

Measure Definition

Days-To-Third Next Appointment is the average length of time in days between the day a patient makes a request for an appointment with a provider and the third next available appointment for <u>new patients.</u>

Unit of Measurement: Y/N

Measure Formula:

On a monthly basis, offices will evaluate their number of days to the third next available appointment, *for each provider participating in the APM,* using the formula below. **This information will be submitted to AllCare on a quarterly basis.**

1. Date Measured – The date you will measure your provider's schedule. The example below is prepopulated with the first working day of the month.
2. 1st Appointment – The date of the first available appointment on your provider's Schedule for a new patient
3. 2nd Appointment – The date of the second available appointment on your provider's Schedule for a new patient
4. 3rd Appointment – The date of the third available appointment on your provider's Schedule for a new patient
5. Days to 3rd – This is where the formula is located and will automatically populate the days to next appointment, when you enter the days of each appointment on the spreadsheet.

Example:

Date Measured	1st appointment	2nd appointment	3rd appointment	Days to 3rd			
1/1/2018	1/1/2018	1/2/2018	1/5/2018	4	1st quarter average days to 3rd next available appointment:		
2/1/2018	2/1/2018	2/6/2018	2/8/2018	7			
3/1/2018	3/2/2018	3/5/2018	3/6/2018	5			**5.3**
4/2/2018					2nd quarter average days to 3rd next available appointment:		
5/1/2018							
6/1/2018							

***Days to 3rd next available appointment based off of <u>calendar days</u> (not business days).*

Measure Intent & Purpose

The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability.

Performance Target

Providers are tracking and submitting data to AllCare.

Tobacco Use: Screening and Cessation Intervention

Measure Definition

Measure Definition: Patients age 18 years or older are screened for tobacco use and receive tobacco cessation intervention if identified as a tobacco user

Unit of Measurement: Y/N

Measure Formula:

> Provider attests that they screen patients age 18 years or older for tobacco use and provide tobacco cessation intervention if patient is identified as a tobacco user.

Specialty Measure Component

Quality

Performance Targets

Benchmark: Y/N

Documentation of Current Medication

Measure Definition

Measure Definition: Documentation of Current Medication

Unit of Measurement: Y/N

Measure Formula:

> Provider attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration

Specialty Measure Component

Quality

Performance Targets

Benchmark: Y/N

Prescribing Generic Medications
AllCare Claims Based Data

Measure Definition

Measure Definition: Percentage of generic medications prescribed by specialist

Unit of Measurement: %

Measure Formula:
> *Numerator*: Number of generic medications prescribed by specialist

> *Denominator*: Total number of medications prescribed by specialist

Specialty Measure Component

Quality

Performance Targets

Benchmark: 85% or 10% improvement over specialist's baseline score

Wait Time from Authorization Approval to Specialist Appointment
AllCare Claims Based Data

Measure Definition

Measure Definition: Combined average # of days from authorization approval to patient being seen by referred specialist or mid-level provider from the referred specialist's primary office.

Unit of Measurement: #

Measure Formula:

> *Numerator:* Total number of days from authorization approval date to next claim date from referred specialist or mid-level provider from referred specialist's office.

> *Denominator:* Total number of patients with approved authorization to see specialist.

Exclusions:

Patients with approved authorization to see specialist but had no corresponding claim from referred specialist, or another specialist or mid-level provider from the specialist's primary office.

Specialty Measure Component

Utilization and Access

Performance Targets

Benchmark: 30 Days or 15% improvement over specialist's baseline score

Timeliness of Postpartum Care
AllCare Claims Based Data

Measure Definition: % of mothers receiving postpartum care on or between 21 and 56 days after delivery.

Measurement Period: 11/27/2018 – 12/31/2019

Unit of Measurement: %

Measure Formula:

> **Numerator**: Total # of patients in the denominator who received postpartum care on or between 21 and 56 days after delivery.

> **Denominator**: Total # of patients seen by provider who had a <u>live</u> birth during the measurement period.

> **Exclusions**: Members who are not enrolled during the postpartum period.

- Providers have been given the option (at the clinic level) to self-report their data. If this option is not selected, then performance will be based on claims data.

Performance Targets

Benchmark: 50%

Patient Satisfaction - Access to Care

Measure Definition

Measure Definition: Percentage of respondents who chose "Satisfied" for the question "Please rate how satisfied you are with the length of time it took to get an appointment after being referred to this specialist?"

Unit of Measurement: %

Measure Formula:

> *Numerator*: # of survey respondents who marked "Satisfied" for the specified question.
>
> *Denominator*: Total number of survey respondents per Specialist

Exclusions:

Any surveys where the questions "Please rate how satisfied you are with the length of time it took to get an appointment after being referred to this specialist?" and "Please rate how satisfied you are with your healthcare provider" were not answered will be excluded.

Specialty Measure Component

Access

Performance Targets

Benchmark: 85%

Patient Satisfaction - Satisfaction with Care

Measure Definition

Measure Definition: Percentage of respondents who chose "Satisfied" for the question "Please rate how satisfied you are with your healthcare provider."

Unit of Measurement: %

Measure Formula:

> *Numerator*: # of survey respondents who marked "Satisfied" for the specified question.
>
> *Denominator*: Total number of survey respondents per Specialist.

Exclusions:

Any surveys where the questions "How satisfied are you with the length of time it took to get an appointment after being referred to this specialist?" and "Please rate how satisfied you are with your healthcare provider" were not answered will be excluded.

Specialty Measure Component

Quality

Performance Targets

Benchmark: 85%

Health Equity (Bonus Measure)
Attestation

Measure Definition

Provider attests that they, and at least 70% of office staff, completed training from the suggested list during the measurement year or have an *OHA Qualified* or *Certified* medical interpreter on staff at their location.

Unit of Measurement: Y/N

Measure Formula:

Provider attests that they and at least 70% of office staff have completed one of the trainings located at the link below:

https://www.allcarehealth.com/doctors-providers/resources/health-equity

*If the practice completes courses that are similar in content to the suggested list, this may also qualify for the measure if approved by AllCare.

OR

Provider attests that they have an *OHA Qualified* or *Certified* Medical Interpreter on staff (For more information, contact Stick Crosby: stick.crosby@allcarehealth.com

Measure Intent & Purpose

To ensure that contracted providers across the continuum of care have access to training that meets state and federal goals and objectives on culturally and linguistically appropriate service delivery; and ensure providers are sensitive to members with cultural, linguist and social differences as they relate to ethnicity, gender, socioeconomics and other areas of diversity.

Performance Targets

2019 AllCare CCO Improvement Target: 70%

Changing healthcare to work for you.

APM funds not paid-out to providers will become the "challenge" pool- these funds will be distributed to providers who meet the goal on the challenge pool measures listed below.

APM BONUS POOL

Percentage retained by AllCare for Operations Support	Bonus paid out based on achievement
	Challenge pool paid out based on specific measures

For Ob/Gyn Specialties, the challenge pool measures are:

- **Wait Time from Auth to Appointment**
- **Timely Postpartum Care**

AllCare Health
Medical Specialty
Alternative Payment Model
2019

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Table of Contents
2019 AllCare CCO Medical Specialties Alternative Payment Model

2019 Updated Measures for AllCare CCO's Alternative Payment Model
Medical

Removed Measures for 2019:

- Expanded Access

Added Measures for 2019

- Documentation of Current Medications
- Tobacco Use: Screening and Cessation Intervention
- 3rd Next Available Appointment

MEDICAL SPECIALTY

Provider Name   **Work RVUs**

MEDICAL PROVIDER   2882

Measure	Goal	YTD	Possible Points	Points Earned
Generic Rx	85%	87%	2	2
Wait Time from Auth to Appt (Days)	30	28	2	2
Access to Care	85%	87%	2	2
Specialist Addressed Concerns	85%	84%	3	0
Satisfaction with Care	85%	90%	2	2
Closing the Referral Loop	Y/N	Y	3	3
Documentation of Current Medications	Y/N	Y	2	2
Tobacco Use: Screening and Cessation Intervention	Y/N	Y	2	2
3rd Next Available Appointment	Y/N	Y	1	1
BONUS POINTS				
Health Equity	Y/N	N	3	0
Total Points			**22**	**16**
	Tier 1 (65%)	*9-10 POINTS*		
	Tier 2 (80%)	*11-14 POINTS*		
	Tier 3 (100%)	*15+ POINTS*		

Prescribing Generic Medications
AllCare Claims Based Data

Measure Definition

Measure Definition: Percentage of generic medications prescribed by specialist

Unit of Measurement: %

Measure Formula:
   Numerator: Number of generic medications prescribed by specialist

   Denominator: Total number of medications prescribed by specialist

Specialty Measure Component

Quality

Performance Targets

Benchmark: 85% or 10% improvement over specialist's baseline score

Documentation of Current Medication

Measure Definition

Measure Definition: Documentation of Current Medication

Unit of Measurement: Y/N

Measure Formula:

> Provider attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration

Specialty Measure Component

Quality

Performance Targets

Benchmark: Y/N

Tobacco Use: Screening and Cessation Intervention

Measure Definition

Measure Definition: Patients age 18 years or older are screened for tobacco use and receive tobacco cessation intervention if identified as a tobacco user

Unit of Measurement: Y/N

Measure Formula:

> Provider attests that they screen patients age 18 years or older for tobacco use and provide tobacco cessation intervention if patient is identified as a tobacco user.

Specialty Measure Component

Quality

Performance Targets

Benchmark: Y/N

Wait Time from Authorization Approval to Specialist Appointment
AllCare Claims Based Data

Measure Definition

Measure Definition: Combined average # of days from authorization approval to patient being seen by specialist or mid-level provider from the referred specialist's primary office.

Unit of Measurement: #

Measure Formula:

> *Numerator:* Total number of days from authorization approval date to next claim date from referred specialist or mid-level provider from referred specialist's office.

> *Denominator:* Total number of patients with approved authorization to see specialist.

Exclusions:

Patients with approved authorization to see specialist but had no corresponding claim from referred specialist, or another specialist or mid-level provider from the specialist's primary office.

Specialty Measure Component

Utilization and Access

Performance Targets

Benchmark: 30 Days or 15% improvement over specialist's baseline score

Days to Third Next Available Appointment

Measure Definition

Days-To-Third Next Appointment is the average length of time in days between the day a patient makes a request for an appointment with a provider and the third next available appointment for <u>new patients.</u>

Unit of Measurement: Y/N

Measure Formula:

On a monthly basis, offices will evaluate their number of days to the third next available appointment, _for each provider participating in the APM,_ using the formula below. **This information will be submitted to AllCare on a quarterly basis.**

1. Date Measured – The date you will measure your provider's schedule. The example below is prepopulated with the first working day of the month.
2. 1st Appointment – The date of the first available appointment on your provider's Schedule for a new patient
3. 2nd Appointment – The date of the second available appointment on your provider's Schedule for a new patient
4. 3rd Appointment – The date of the third available appointment on your provider's Schedule for a new patient
5. Days to 3rd – This is where the formula is located and will automatically populate the days to next appointment, when you enter the days of each appointment on the spreadsheet.

Example:

Date Measured	1st appointment	2nd appointment	3rd appointment	Days to 3rd			
1/1/2018	1/1/2018	1/2/2018	1/5/2018	4	1st quarter average days to 3rd next available appointment:		
2/1/2018	2/1/2018	2/6/2018	2/8/2018	7			
3/1/2018	3/2/2018	3/5/2018	3/6/2018	5			**5.3**
4/2/2018					2nd quarter average days to 3rd next available appointment:		
5/1/2018							
6/1/2018							

**Days to 3rd next available appointment based off of **calendar days** (not business days).

Measure Intent & Purpose

The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability.

Performance Target

Providers are tracking and submitting data to AllCare.

Closing the Referral Loop

Measure Source

PQRS 374

Measure Definition

Measure Definition: The specialist provides a report to the referring provider regarding the care the referred patient received.

Unit of Measurement: Attestation

Measure Formula:

The specialist attests that they provide a report to the referring provider regard the care provided to the referred patient

Specialty Measure Component

Quality

Patient Satisfaction - Specialist Addressed Concerns

Measure Definition

Measure Definition: Percentage of respondents who answered, "Yes" to the question, "Do you feel that this specialist addressed your concerns?"

Unit of Measurement: %

Measure Formula:
> *Numerator*: # of survey respondents who marked **"Yes"** for the specified question.

> *Denominator*: Total number of survey respondents per Specialist

Exclusions:
Any surveys where the questions "Do you feel that this specialist addressed your concerns?" were not answered, will be excluded.

Specialty Measure Component

Quality

Performance Targets

Target: 85%

Patient Satisfaction - Access to Care

Measure Definition

Measure Definition: Percentage of respondents who chose "Satisfied" for the question "Please rate how satisfied you are with the length of time it took to get an appointment after being referred to this specialist?"

Unit of Measurement: %

Measure Formula:

> *Numerator*: # of survey respondents who marked "Satisfied" for the specified question.
> *Denominator*: Total number of survey respondents per Specialist

Exclusions:

Any surveys where the questions "Please rate how satisfied you are with the length of time it took to get an appointment after being referred to this specialist?" and "Please rate how satisfied you are with your healthcare provider" were not answered will be excluded.

Specialty Measure Component

Access

Performance Targets

Benchmark: 85%

Patient Satisfaction - Satisfaction with Care

Measure Definition

Measure Definition: Percentage of respondents who chose "Satisfied" for the question "Please rate how satisfied you are with your healthcare provider."

Unit of Measurement: %

Measure Formula:

Numerator: # of survey respondents who marked "Satisfied" for the specified question.

Denominator: Total number of survey respondents per Specialist.

Exclusions:

Any surveys where the questions "How satisfied are you with the length of time it took to get an appointment after being referred to this specialist?" and "Please rate how satisfied you are with your healthcare provider" were not answered will be excluded.

Specialty Measure Component

Quality

Performance Targets

Benchmark: 85%

Health Equity (Bonus Measure)
Attestation

Measure Definition

Provider attests that they, and at least 70% of office staff, completed training from the suggested list during the measurement year or have an *OHA Qualified* or *Certified* medical interpreter on staff at their location.

Unit of Measurement: Y/N

Measure Formula:

Provider attests that they and at least 70% of office staff have completed one of the trainings located at the link below:

https://www.allcarehealth.com/doctors-providers/resources/health-equity

*If the practice completes courses that are similar in content to the suggested list, this may also qualify for the measure if approved by AllCare.

OR

Provider attests that they have an *OHA Qualified* or *Certified* Medical Interpreter on staff (For more information, contact Stick Crosby: stick.crosby@allcarehealth.com

Measure Intent & Purpose

To ensure that contracted providers across the continuum of care have access to training that meets state and federal goals and objectives on culturally and linguistically appropriate service delivery; and ensure providers are sensitive to members with cultural, linguist and social differences as they relate to ethnicity, gender, socioeconomics and other areas of diversity.

Performance Targets

2019 AllCare CCO Improvement Target: 70%

APM Challenge Pool

APM funds not paid-out to providers will become the "challenge" pool- these funds will be distributed to providers who meet the goal on the challenge pool measures listed below.

Percentage retained by AllCare for Operations Support	Bonus paid out based on achievement
	Challenge pool paid out based on specific measures

For Medical Specialties, the challenge pool measures are:

- Wait Time from Authorization to Appointment
- Access to Care Survey Results

AllCare Health
Surgical Specialty
Alternative Payment
Model
2019

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2019 AllCare CCO PCP Alternative Payment Model

2019 Updated Measures for AllCare CCO's
Alternative Payment Model
Surgical

New Measures for 2019

- Severe Adverse Event within 30 Days of Procedure
- Documentation of Current Medications
- Tobacco Use Screening and Cessation Intervention
- Opioid Prescriptions
- Third Next Available Appointment

Removed Measures for 2019:

- Readmission/ED Visit within 30 Days of Discharge from Hospital for Related DRG/Diagnosis
- Expanded Access

SURGICAL SPECIALTY

Provider Name	Work RVUs
SURGICAL PROVIDER	2882

Measure	Goal	YTD	Possible Points	Points Earned
Generic Rx	85%	87%	2	2
Wait Time from Auth to Appt (Days)	30	28	2	2
Access to Care	85%	87%	2	2
Opioid Prescriptions	TBD	TBD	2	2
Severe Adverse Event w/in 30 Days of Procedure	TBD	TBD	3	3
Satisfaction with Care	85%	90%	2	2
Lower Cost Settings (Radiology)	45%	42%	3	0
Documentation of Current Medications	Y/N	Y	2	2
Tobacco Use: Screening and Cessation Intervention	Y/N	Y	2	2
3rd Next Available Appointment	Y/N	Y	1	1
BONUS POINTS				
Health Equity	Y/N	N	3	0
Total Points			**24**	**18**

	Tier 1 (65%)	*9-12 POINTS*
	Tier 2 (80%)	*13-16 POINTS*
	Tier 3 (100%)	*17+ POINTS*

Prescribing Generic Medications
AllCare Claims Based Data

Measure Definition

Measure Definition: Percentage of generic medications prescribed by specialist

Unit of Measurement: %

Measure Formula:
> *Numerator*: Number of generic medications prescribed by specialist
>
> *Denominator*: Total number of medications prescribed by specialist

Specialty Measure Component
Quality

Performance Targets
Target: 85% or 10% improvement over specialist's baseline score.

Documentation of Current Medications

Measure Definition

Measure Definition: Documentation of Current Medications

Unit of Measurement: Y/N

Measure Formula:

> Provider attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration

Specialty Measure Component

Quality

Performance Targets

Benchmark: Y/N

Wait Time from Authorization Approval to Specialist Appointment

Measure Definition

Measure Definition: Combined average # of days from authorization approval to patient being seen by referred specialist or another specialist/mid-level provider from the referred specialist's primary office.

Unit of Measurement: #

Measure Formula:

> *Numerator:* Total number of days from authorization approval date to next claim date from referred specialist or another specialist or mid-level provider from referred specialist's office.

> *Denominator:* Total number of patients with approved authorization to see specialist.

Exclusions:
Patients with approved authorization to see specialist but had no corresponding claim from referred specialist, or another specialist or mid-level provider from the specialist's primary office.

Specialty Measure Component

Utilization and Access Management

Performance Targets

Target: 30 Days or 15% decrease from provider's baseline score

Severe Adverse Event within 30 Days of Surgical Procedure

Measure Definition

Measure Definition: Severe Adverse Event within 30 Days of Surgical Procedure

Unit of Measurement: %

Measure Formula:

Numerator: # of patients who return to operation room or have an ER Visit/Hospitalization due to a severe adverse event within 30 days of surgical procedure. Severe Adverse Events include:

Infection or Wound complication, Thrombolic Event (Deep Vein Thrombosis/ Pulmonary Embolism), Stroke/Cerebrovascular accident, Myocardial infarction, Cardiac Arrest, Pneumonia, Death related to procedure

Denominator: Number of patients who are provided a qualifying procedure by specialist

Specialty Measure Component

Quality

Performance Targets

Benchmark: TBD

Opioid Prescriptions

Measure Definition

Measure Definition: Reduction of Opioid Morphine Milligram Equivalent (MME) dosing

Unit of Measurement: %

Measure Formula:
Numerator: Number of patients on opioid doses >=90mg Morphine Milligram Equivalent Dosage per day any day.

Denominator: Number of patients who are provided a qualifying service by specialist during the measurement year.

Specialty Measure Component

Quality

Performance Targets

Benchmark: TBD

Required exclusions for denominator:
Patients with the following diagnoses in the measurement year or in the year prior to the measurement year: neoplasm-related pain (ICD9 338.3, ICD10 G89.3), end-of-life care, palliative care, or hospice care.

Any opioid prescription not paid for by OHA (e.g. cough suppressants)

Patients with medication claims for buprenorphine/buprenorphine products

Tobacco Use: Screening and Cessation Intervention

Measure Definition

Measure Definition: Patients age 18 years or older are screened for tobacco use and receive tobacco cessation intervention if identified as a tobacco user

Unit of Measurement: Y/N

Measure Formula:
> Provider attests that they screen patients age 18 years or older for tobacco use and provide tobacco cessation intervention if patient is identified as a tobacco user.

Specialty Measure Component

Quality

Performance Targets

Benchmark: Y/N

Use of Lower Cost Settings
AllCare Claims Based Data

Measure Definition

Measure Definition: Percentage of procedure dollars performed in a lower cost setting. Lower cost settings are comprised of procedure dollars of radiology done in office or imaging center. Higher cost settings are radiology done in an outpatient hospital setting.

Unit of Measurement: %

Measure Formula:

> *Numerator:* Claims value of procedures ordered by or performed by specialist done at an imaging center or office setting

> *Denominator:* Total claims value of procedures ordered by or performed by specialist

Radiology CPT Codes: 70000-79999

Specialty Measure Component

Utilization and Access

Performance Targets

Target: 60% or 10% improvement over specialist's baseline score

Patient Satisfaction - Access to Care

Measure Definition

Measure Definition: Percentage of respondents who chose "Satisfied" for the question "Please rate how satisfied you are with the length of time it took to get an appointment after being referred to this specialist?"

Unit of Measurement: %

Measure Formula:

> *Numerator*: # of survey respondents who marked "Satisfied" for the specified question.
> *Denominator*: Total number of survey respondents per Specialist

Exclusions:

Any surveys where the questions "Please rate how satisfied you are with the length of time it took to get an appointment after being referred to this specialist?" and "Please rate how satisfied you are with your healthcare provider" were not answered will be excluded.

Specialty Measure Component

Access

Performance Targets

Target: 85%

Patient Satisfaction - Satisfaction with Care

Measure Definition

Measure Definition: Percentage of respondents who chose "Satisfied" for the question "Please rate how satisfied you are with your healthcare provider."

Unit of Measurement: %

Measure Formula:
> *Numerator*: # of survey respondents who marked "Satisfied" for the specified question.
> *Denominator*: Total number of survey respondents per Specialist.

Exclusions:
Any surveys where the questions "How satisfied are you with the length of time it took to get an appointment after being referred to this specialist?" and "Please rate how satisfied you are with your healthcare provider" were not answered will be excluded.

Specialty Measure Component

Quality

Performance Targets

Target: 85%

Days to Third Next Available Appointment

Measure Definition

Days-To-Third Next Appointment is the average length of time in days between the day a patient makes a request for an appointment with a provider and the third next available appointment for <u>new patients.</u>

Unit of Measurement: Y/N

Measure Formula:

On a monthly basis, offices will evaluate their number of days to the third next available appointment, _for each provider participating in the APM,_ using the formula below. **This information will be submitted to AllCare on a quarterly basis.**

1. Date Measured – The date you will measure your provider's schedule. The example below is prepopulated with the first working day of the month.
2. 1st Appointment – The date of the first available appointment on your provider's Schedule for a new patient
3. 2nd Appointment – The date of the second available appointment on your provider's Schedule for a new patient
4. 3rd Appointment – The date of the third available appointment on your provider's Schedule for a new patient
5. Days to 3rd – This is where the formula is located and will automatically populate the days to next appointment, when you enter the days of each appointment on the spreadsheet.

Example:

Date Measured	1st appointment	2nd appointment	3rd appointment	Days to 3rd			
1/1/2018	1/1/2018	1/2/2018	1/5/2018	4	1st quarter average days to 3rd next available appointment:		
2/1/2018	2/1/2018	2/6/2018	2/8/2018	7			
3/1/2018	3/2/2018	3/5/2018	3/6/2018	5			**5.3**
4/2/2018					2nd quarter average days to 3rd next available appointment:		
5/1/2018							
6/1/2018							

**Days to 3rd next available appointment based off of **calendar days** (not business days).

Measure Intent & Purpose

The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability.

Performance Target

Providers are tracking and submitting data to AllCare.

Health Equity (Bonus Measure)
Attestation

Measure Definition

Provider attests that they, and at least 70% of office staff, completed training from the suggested list during the measurement year or have an *OHA Qualified* or *Certified* medical interpreter on staff at their location.

Unit of Measurement: Y/N

Measure Formula:

Provider attests that they and at least 70% of office staff have completed one of the trainings located at the link below:

https://www.allcarehealth.com/doctors-providers/resources/health-equity

*If the practice completes courses that are similar in content to the suggested list, this may also qualify for the measure if approved by AllCare.

OR

Provider attests that they have an *OHA Qualified* or *Certified* Medical Interpreter on staff (For more information, contact Stick Crosby: stick.crosby@allcarehealth.com

Measure Intent & Purpose

To ensure that contracted providers across the continuum of care have access to training that meets state and federal goals and objectives on culturally and linguistically appropriate service delivery; and ensure providers are sensitive to members with cultural, linguist and social differences as they relate to ethnicity, gender, socioeconomics and other areas of diversity.

Performance Targets

2019 AllCare CCO Improvement Target: 70%

Challenge Pool

APM funds not paid-out to providers will become the "challenge" pool- these funds will be distributed to providers who meet the goal on the challenge pool measures listed below.

Percentage retained by AllCare for Operations Support	Bonus paid out based on achievement
	Challenge pool paid out based on specific measures

For Surgical Specialty, the challenge pool measures are:

- **Wait time from Auth to Appt**
- **Access to Care Survey Results**

allcare health

AllCare Health
Dental
Alternative Payment Model
2019

Table of Contents
2019 AllCare CCO Dental Alternative Payment Model

2019 Updated Measures for AllCare CCO's Alternative Payment Model

New Measures for 2019:

- Oral Evaluations for Diabetic Patients
- Health Equity Bonus measure

Removed Measure for 2019:

- Dental Visits for Diabetic Patients

allcare health

Dental Quality Compensation Report - 2019

Provider Name
DCO XYZ

Measure	Goal	YTD	Points Possible	Points Earned
Dental Sealants for children age 6-14	23%	24%	3	3
Dental exam for DHS Children within 60 days	65%	68%	3	3
Increase % of Diagnostic & Preventive Svcs	40%	46%	2	2
Oral Evaluations for Diabetic Patients	45%	41%	2	0
Provider Satisfaction Survey Results	80%	82%	1	1
Access Satisfaction Survey Results	85%	84%	1	0
Documentation of Caries Risk	25%	27%	3	3
% of Pregnant Members with a Dental Visit	47%	52%	2	2
BONUS POINTS				
Health Equity BONUS	Y	Y	3	3
Total Points			**20**	**17**

Challenge Pool Measures

Tier 1 (65%)   *8-10 points*
Tier 2 (80%)   *11-13 points*
Tier 3 (100%)   *14+ points*

Increased Dental Sealants in Children Ages 6-14

Measure Definition

Measure Definition: Number of patients between age 6-14 years old who receive dental sealants

Unit of Measurement: #

Measure Formula:

Numerator: Total number of patients age 6-14 who receive dental sealants

Code: D1351

Denominator: Total number of patients age 6-14 as of December 31 of the measurement year

Number of Days of Claims Run Out

60 Days

Performance Targets

TBD

Dental Exam for DHS Children within 60 Days

Measure Definition

Measure Definition: Percentage of children who receive diagnostic and preventive services within 60 days of OHA/DHS providing notification that the child has entered DHS custody

Unit of Measurement: %

Measure Formula:

> *Numerator:* Total number of children in DHS custody who received diagnostic and preventive services within 60 days
>
> **Codes**: D0100 – D1999
>
> *Denominator:* Total number of eligible members

Performance Targets

TBD

Increased Percentage of Diagnostic and Preventive Services

Measure Definition

Measure Definition: Percentage of members who receive diagnostic and preventive services

Unit of Measurement: %

Measure Formula:

Numerator: Total number of eligible members who received diagnostic and preventive services during the measurement period

Codes: D0100 - D1999, D4910, D4341, D4342, D4355

Denominator: Total number of eligible members

Eligibility Requirements:

Member must be assigned to DCO for a minimum of 6 member months during the measurement period. A member month is defined as being enrolled at least 1 day during a month.

Exclusions:

Children under the age of 1 by the end of the measurement period are excluded from the measure.

Performance Targets

TBD or 3 point improvement over individual DCO baseline performance

Oral Evaluation for Diabetic Patients

Measure Definition

Measure Definition: Percentage of patients age 18 or older diagnosed with Type 1 or Type 2 diabetes who receive an oral evaluation.

Unit of Measurement: %

Measure Formula:

Numerator: Number of Type 1 or Type 2 diabetic patients who received a comprehensive, periodic or periodontal oral evaluation in the measurement year

Denominator: Total number of eligible Type 1 or Type 2 diabetic patients

Codes: D0120, D0150, or D0180

DCO will be provided a list of diabetic patients on a bi-annual basis.

Eligibility Requirements:
Member must be assigned to DCO for a minimum of 6 member months during the measurement period. A member month is defined as being enrolled at least 1 day during a month.

Performance Targets

28%

Satisfaction with Care – Patient Survey Results

Measure Definition

Measure Definition: Percentage of respondents who had a positive response for the question "Please rate how satisfied you are with your dentist"

Unit of Measurement: %

Measure Formula:

> *Numerator:* number of survey respondents who marked "Satisfied" for the specified question

> *Denominator:* Total number of survey respondents per DCO

Exclusions:

Any survey where the question "Please rate how satisfied you are with your dentist" is not answered

Number of Days of Claims Run Out

N/A

Performance Targets

80%

Timely Access to Care – Patient Survey Results

Measure Definition

Measure Definition: Percentage of respondents who had a positive response for the questions:

- "In the last 12 months, were your routine dental appointments scheduled as soon as you wanted?"
- "In the last 12 months, if you had a dental emergency, did you get to see a dentist as soon as you wanted?"

Unit of Measurement: %

Measure Formula:

> *Numerator:* Number of survey respondents who marked "Always" or "Usually" for the specified questions

> *Denominator:* Total number of survey respondents per DCO

Exclusions:

Any survey where "N/A" is marked for the questions "In the last 12 months, were your routine dental appointments scheduled as soon as you wanted?" & "In the last 12 months, if you had a dental emergency, did you get to see a dentist as soon as you wanted?"

Number of Days of Claims Run Out

N/A

Performance Targets

85%

Increased Documentation of Caries Risk via CDT Codes

Measure Definition

Number of caries risk CDT codes documented in the measurement year.

Unit of Measurement: %

Measure Formula:

> ***Numerator:*** Number of Caries Risk CDT codes

> - D0601 – Caries risk assessment, low risk
> - D0602 – Caries risk assessment, moderate risk
> - D0603 – Caries risk assessment, high risk

> ***Denominator:*** Total number of eligible members with a visit during the measurement period.

Eligibility Requirements:

Member must be assigned to DCO for a minimum of 6 member months during the measurement period. A member month is defined as being enrolled at least 1 day during a month.

Number of Days of Claims Run Out

N/A

Performance Targets

TBD

Percent of Pregnant Members Who Had a Dental Visit

Measure Definition

Percentage of members identified as pregnant between 10/1/18 and 9/30/19 who had a dental visit in the measurement year.

Unit of Measurement: %

Measure Formula:

> ***Numerator:*** Members in the denominator with a dental visit in the measurement year.

> ***Denominator:*** Members identified as pregnant between 10/1/18 and 9/30/19

Eligibility Requirements:

Member must be assigned to DCO for a minimum of 6 member months during the measurement period. A member month is defined as being enrolled at least 1 day during a month.

Performance Targets

TBD

Health Equity (Bonus Measure)
Attestation

Measure Definition

Provider attests that they, and at least 70% of office staff, completed training from the suggested list during the measurement year or have an *OHA Qualified* or *Certified* medical interpreter on staff at their location.

Unit of Measurement: Y/N

Measure Formula:

Provider attests that they and at least 70% of office staff have completed one of the trainings located at the link below:

https://www.allcarehealth.com/doctors-providers/resources/health-equity

*If the practice completes courses that are similar in content to the suggested list, this may also qualify for the measure <u>if approved by AllCare</u>.

OR

Provider attests that they have an *OHA Qualified* or *Certified* Medical Interpreter on staff (For more information, contact Stick Crosby: stick.crosby@allcarehealth.com

Measure Intent & Purpose

To ensure that contracted providers across the continuum of care have access to training that meets state and federal goals and objectives on culturally and linguistically appropriate service delivery; and ensure providers are sensitive to members with cultural, linguist and social differences as they relate to ethnicity, gender, socioeconomics and other areas of diversity.

Performance Targets

2019 AllCare CCO Improvement Target: 70%

APM Challenge Pool

APM funds not paid-out to providers will become the "challenge" pool- these funds will be distributed to providers who meet the goal on the challenge pool measures listed below.

- **Increased Dental Sealants in Children 6-14**
- **Dental Exam for DHS Children**

APM BONUS POOL

Percentage retained by AllCare for Operations Support	Bonus paid out based on achievement
	Challenge pool paid out based on specific measures

AllCare Health
Behavioral Health
Alternative Payment Model
2019

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2019 AllCare CCO PCP Alternative Payment Model

2019 Updated Measures for AllCare CCO's Alternative Payment Model
Behavioral Health

New Measures for 2019:

- Mental Health Assessment within 60 Days for Children in DHS Custody

Modified Measures for 2019:

- Follow up w/in 30 Days of Residential Rehab – (By discharging agency instead of county)

Behavioral Health Quality Compensation Report
January - December 2019

BH AGENCY XYZ

Behavioral Health Measures					
Measures	**Goal**	**Rolling 12 Month**	**YTD**	**Possible Points**	**Points Earned**
Avg. Wait Time from Referral to Appt.	<20 Days	18	22	2	2
Appt w/in 30 days of assessment	63%	62%	58%	3	3
3 Treatment Episodes w/in 90 days of assessment	61%	64%	62%	1	1
Increased Visits	1892	2012	1758	3	3
Level 1 & 2 ER Visits/1000	≤ 304	218	289	2	2
Peer Services	TBD	33%	36%	3	3
Survey Results	80%	86%	86%	1	1
Integrated Care in the Community	Y/N	Y	Y	1	1
Resources for Warm Handoffs	Y/N	Y	Y	1	1
Health Equity	Y/N	Y	Y	5	5
Alcohol & Drug Measures					
Follow up w/in 30 Days of A&D Rehab	69%	64%	60%	3	3
Mental Health Measures					
Follow up w/in 7 Days of MH Discharge	80%	82%	76%	3	3
Follow up w/in 30 Days of MH Discharge	66%	68%	62%	3	3
MH Assessment for DHS Children	73%	75%	75%	3	3
Assertive Community Treatment	Y/N	Y	Y	2	2
Wraparound Program	Y/N	Y	Y	2	2
					38
Tier 1 (65%)	*15-21 points*				
Tier 2 (80%)	*22-29 points*				
Tier 3 (100%)	*30+ points*				

Time from Referral to First Appointment

Measure Definition

Measure Definition: Average wait time from referral date to first appointment. Combined average # of days from referral date to patient being seen by referred agency

Unit of Measurement: # of Days

Results Grouped By: Behavioral Health Agency

Measure Formula: Behavioral Health Agency performs audit and attests to average # of days from referral date to patient being seen by their agency

> *Exclusions:* Patients with referrals to see agency but had no corresponding claim from referred agency

First Appointment within 30 Days of Assessment/Evaluation Date

Measure Definition

Measure Definition: Percentage of qualifying services received within 30 days of assessment/evaluation date

Unit of Measurement: %

Results Grouped By: Behavioral Health Agency
Measure Formula:

Numerator: Number of qualifying services performed within 30 days of assessment/evaluation date

Qualifying Services Include:

Code	Service	Code	Service
90785	PSYTX COMPLEX INTERACTIVE	H0001	ASSESSMENT/ADA
90791	MH AS ADT	H0002	BEHAVIORAL HEALTH SCREENING
90792	PSYCH ASSESSMENT	H0003	ALCOHOL AND/OR DRUG SCREEN
90806	PSYTX OFF 45-50 MIN	H0004	ALCOHOL AND/OR DRUG INDIV SERVICES
90832	PSYTX PT&/FAMILY 30 MINUTES	H0005	ALCOHOL AND/OR DRUG GRP SERVICES
90833	PSYTX PT&/FAM W/E&M 30 MIN	H0006	ALCOHOL AND/OR DRUG CASE MGMT
90834	PSYTX PT&/FAMILY 45 MINUTES	H0012	ALCOHOL AND/OR DRUG SERVICES
90836	PSYTX PT&/FAM W/E&M 45 MIN	H0015	ALCOHOL AND/OR DRUG GRP SERVICES
90837	PSYTX PT&/FAMILY 60 MINUTES	H0017	ALCOHOL AND/OR DRUG SERVICES
90839	PSYTX CRISIS 60 MINUTES	H0018	ALCOHOL AND/OR DRUG SERVICES
90846	FAMILY PSYTX W/O PATIENT	H0019	ALCOHOL AND/OR DRUG SERVICES
90847	FAMILY PSYTX W/PATIENT	H0023	ALCOHOL AND/OR DRUG OUTREACH
90849	MULTIPLE FAMILY GROUP PSYTX	H0031	MH ASSESSMENT ADT OR CLD
90853	GROUP PSYCHOTHERAPY	H0036	COMM PSY FACE-FACE PER 15MIN
90887	CONSULTATION WITH FAMILY	H0037	COMM PSY SUP TX PGM PER DIEM
98966	T/C FOR PSYCHOTHERAPY	H0038	SELF-HELP/PEER SVC PER 15MIN
99202	OFFICE/OUTPATIENT VISIT NEW	H0039	ASSER COM TX FACE-FACE/15MIN
99203	OFFICE/OUTPATIENT VISIT NEW	H2000	CANS ASSESSMENT
99204	OFFICE/OUTPATIENT VISIT NEW	H2014	SKILLS TRAIN AND DEV, 15 MIN
99205	OFFICE/OUTPATIENT VISIT NEW	H2021	COM WRAP-AROUND SV, 15 MIN
99211	OFFICE/OUTPATIENT VISIT EST	H2022	COM WRAP-AROUND SV, PER DIEM
99212	OFFICE/OUTPATIENT VISIT EST	H2032	ACTIVITY THERAPY, PER 15 MIN
99213	OFFICE/OUTPATIENT VISIT EST	Q3014	TELEHEALTH FAC FEE
99214	OFFICE/OUTPATIENT VISIT EST	T1006	FAMILY/COUPLE COUNSELING
99215	OFFICE/OUTPATIENT VISIT EST	T1015	CLINIC SERVICE
G0176	OPPS/PHP;ACTIVITY THERAPY	T1016	CASE MANAGEMENT
G0177	OPPS/PHP; TRAIN & EDUC SERV	T1023	PROGRAM INTAKE ASSESSMENT
G0396	ALCOHOL/SUBS INTERV 15-30MN		

First Appointment within 30 Days of Assessment/Evaluation Date Cont.

Denominator: Number of qualifying assessment/evaluation codes during the measurement period

Qualifying codes include:

90791	PSYCH DIAGNOSTIC EVALUATION
90792	PSYCH DIAG EVAL W/MED SRVCS
H0001	ALCOHOL AND/OR DRUG ASSESS
H0002	ALCOHOL AND/OR DRUG SCREENIN
H0031	MH HEALTH ASSESS BY NON-MD
H2000	COMP MULTIDISIPLN EVALUATION
T1023	PROGRAM INTAKE ASSESSMENT

Exclusions: Assessment/evaluation dates within 30 days of end of measurement period are excluded

Eligibility Criteria: Member to remain enrolled on plan through 30 days after the assessment/evaluation date

Three Treatment Episodes within 90 Days of Initial Assessment/Evaluation

Measure Definition

Measure Definition: Percentage three or more qualifying services received within 90 days of initial assessment/evaluation date

Unit of Measurement: %

Results Grouped By: Behavioral Health Agency
Measure Formula:

Numerator: Number of third qualifying service provided within 90 days of initial assessment/evaluation date during the measurement period

Qualifying Services Include:

Code	Service	Code	Service
90785	PSYTX COMPLEX INTERACTIVE	H0001	ASSESSMENT/ADA
90791	MH AS ADT	H0002	BEHAVIORAL HEALTH SCREENING
90792	PSYCH ASSESSMENT	H0003	ALCOHOL AND/OR DRUG SCREEN
90806	PSYTX OFF 45-50 MIN	H0004	ALCOHOL AND/OR DRUG INDIV SERVICES
90832	PSYTX PT&/FAMILY 30 MINUTES	H0005	ALCOHOL AND/OR DRUG GRP SERVICES
90833	PSYTX PT&/FAM W/E&M 30 MIN	H0006	ALCOHOL AND/OR DRUG CASE MGMT
90834	PSYTX PT&/FAMILY 45 MINUTES	H0012	ALCOHOL AND/OR DRUG SERVICES
90836	PSYTX PT&/FAM W/E&M 45 MIN	H0015	ALCOHOL AND/OR DRUG GRP SERVICES
90837	PSYTX PT&/FAMILY 60 MINUTES	H0017	ALCOHOL AND/OR DRUG SERVICES
90839	PSYTX CRISIS 60 MINUTES	H0018	ALCOHOL AND/OR DRUG SERVICES
90846	FAMILY PSYTX W/O PATIENT	H0019	ALCOHOL AND/OR DRUG SERVICES
90847	FAMILY PSYTX W/PATIENT	H0023	ALCOHOL AND/OR DRUG OUTREACH
90849	MULTIPLE FAMILY GROUP PSYTX	H0031	MH ASSESSMENT ADT OR CLD
90853	GROUP PSYCHOTHERAPY	H0036	COMM PSY FACE-FACE PER 15MIN
90887	CONSULTATION WITH FAMILY	H0037	COMM PSY SUP TX PGM PER DIEM
98966	T/C FOR PSYCHOTHERAPY	H0038	SELF-HELP/PEER SVC PER 15MIN
99202	OFFICE/OUTPATIENT VISIT NEW	H0039	ASSER COM TX FACE-FACE/15MIN
99203	OFFICE/OUTPATIENT VISIT NEW	H2000	CANS ASSESSMENT
99204	OFFICE/OUTPATIENT VISIT NEW	H2014	SKILLS TRAIN AND DEV, 15 MIN
99205	OFFICE/OUTPATIENT VISIT NEW	H2021	COM WRAP-AROUND SV, 15 MIN
99211	OFFICE/OUTPATIENT VISIT EST	H2022	COM WRAP-AROUND SV, PER DIEM
99212	OFFICE/OUTPATIENT VISIT EST	H2032	ACTIVITY THERAPY, PER 15 MIN
99213	OFFICE/OUTPATIENT VISIT EST	Q3014	TELEHEALTH FAC FEE
99214	OFFICE/OUTPATIENT VISIT EST	T1006	FAMILY/COUPLE COUNSELING
99215	OFFICE/OUTPATIENT VISIT EST	T1015	CLINIC SERVICE
G0176	OPPS/PHP;ACTIVITY THERAPY	T1016	CASE MANAGEMENT
G0177	OPPS/PHP; TRAIN & EDUC SERV	T1023	PROGRAM INTAKE ASSESSMENT
G0396	ALCOHOL/SUBS INTERV 15-30MN		

Three Treatment Episodes within 90 Days of Initial Assessment/Evaluation

Denominator: Number of qualifying assessment/evaluation codes during the measurement period

Qualifying codes include:

90791	PSYCH DIAGNOSTIC EVALUATION
90792	PSYCH DIAG EVAL W/MED SRVCS
H0001	ALCOHOL AND/OR DRUG ASSESS
H0002	ALCOHOL AND/OR DRUG SCREENIN
H0031	MH HEALTH ASSESS BY NON-MD
H2000	COMP MULTIDISIPLN EVALUATION
T1023	PROGRAM INTAKE ASSESSMENT

Exclusions: Assessment/evaluation dates within 90 days of end of measurement period are excluded

Eligibility Criteria: Member to remain enrolled on plan through 90 days after the assessment/evaluation date

Assertive Community Treatment

Measure Definition

Measure Definition: Does the Community Mental Health Program (CMHP) have an Assertive Community Treatment (ACT) program in place? If so, is the most recent Fidelity score higher than 115?

Unit of Measurement: Y/N & Most Recent Fidelity Score

Results Grouped By: CMHP

Measure Formula: CMHP attests that they have an ACT program in place and provides the score from their most recent fidelity review

Wraparound Services

Measure Definition

Measure Definition: Does the Community Mental Health Program (CMHP) have a Wraparound program in place for children?

Unit of Measurement: Y/N

Results Grouped By: CMHP

Measure Formula: CMHP attests that they have a Wraparound program in place for qualifying members

7 Day Follow Up after Mental Health Hospitalization

Measure Definition: The percentage of inpatient discharges for members age 6 years and older who receive follow up services within 7 days after discharge for a mental health hospitalization

Unit of Measurement: %

Results Grouped By: County

Measure Formula:

Numerator: Number of discharges in the denominator who received a qualifying follow up service within 7 days of discharge for a mental health hospitalization

Qualifying follow up services include the following CPT codes: 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510, 90846, 90791, 90792, 90832-90834, 90836-90838

90839, 90840, 90845, 90847, 90849, 90853, 90867-90870, 90875, 90876 with Place of Service Codes: 03,05,07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71 or 72

99221-99223, 99231-99233, 99238, 99239, 99251-99255 with Place of Service Codes: 52 or 53

Or the following HCPCS Codes: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0006, H0031, H0034-H0037, H0039, H0040, H2000, H2001,H2010-H2020, H2021, M0064, S0201, S9480, S9484, S9485, T1015, T1016

Denominator: Number of members 6 years or older who were hospitalized for a qualifying mental illness during the measurement period

   Mental Illness diagnoses include the following ICD-9 codes: 295-299, 300.3, 300.4, 301,308,309, 311-314

7 Day Follow Up after Mental Health Hospitalization

Exclusions: Discharges followed by an inpatient readmission within 30 days for principal mental health diagnosis will exclude the original discharge but the subsequent discharge will count. Discharges followed by an inpatient readmission within 30 days for non-mental health diagnoses and those who are admitted to step down facilities are excluded from the measure.

Hospitalizations outside the CCO service area are excluded from the measure.

30 Day Follow Up after Mental Health Hospitalization

Measure Definition

Measure Definition: The percentage of members age 6 years and older who receive two qualifying services within 30 days of discharge for a mental health hospitalization

Unit of Measurement: %

Results Grouped By: County

Measure Formula:

Numerator: Sum of members in the denominator who received two qualifying follow up services within 30 days of discharge for a mental health hospitalization

Qualifying Services Include:

Code	Service	Code	Service
90785	PSYTX COMPLEX INTERACTIVE	G0176	OPPS/PHP;ACTIVITY THERAPY
90791	MH AS ADT	G0177	OPPS/PHP; TRAIN & EDUC SERV
90792	PSYCH ASSESSMENT	H0001	ASSESSMENT/ADA
90806	PSYTX OFF 45-50 MIN	H0002	BEHAVIORAL HEALTH SCREENING
90832	PSYTX PT&/FAMILY 30 MINUTES	H0004	BEHAVIORAL HEALTH COUNSELING
90833	PSYTX PT&/FAM W/E&M 30 MIN	H0031	MH ASSESSMENT ADT OR CLD
90834	PSYTX PT&/FAMILY 45 MINUTES	H0036	COMM PSY FACE-FACE PER 15MIN
90836	PSYTX PT&/FAM W/E&M 45 MIN	H0037	COMM PSY SUP TX PGM PER DIEM
90837	PSYTX PT&/FAMILY 60 MINUTES	H0038	SELF-HELP/PEER SVC PER 15MIN
90839	PSYTX CRISIS 60 MINUTES	H0039	ASSER COM TX FACE-FACE/15MIN
90846	FAMILY PSYTX W/O PATIENT	H2000	CANS ASSESSMENT
90847	FAMILY PSYTX W/PATIENT	H2014	SKILLS TRAIN AND DEV, 15 MIN
90849	MULTIPLE FAMILY GROUP PSYTX	H2021	COM WRAP-AROUND SV, 15 MIN
90853	GROUP PSYCHOTHERAPY	H2022	COM WRAP-AROUND SV, PER DIEM
90887	CONSULTATION WITH FAMILY	H2032	ACTIVITY THERAPY, PER 15 MIN
98966	T/C FOR PSYCHOTHERAPY	Q3014	TELEHEALTH FAC FEE
99202	OFFICE/OUTPATIENT VISIT NEW	T1006	FAMILY/COUPLE COUNSELING
99203	OFFICE/OUTPATIENT VISIT NEW	T1015	CLINIC SERVICE
99204	OFFICE/OUTPATIENT VISIT NEW	T1016	CASE MANAGEMENT
99205	OFFICE/OUTPATIENT VISIT NEW	T1023	PROGRAM INTAKE ASSESSMENT
99211	OFFICE/OUTPATIENT VISIT EST		
99212	OFFICE/OUTPATIENT VISIT EST		
99213	OFFICE/OUTPATIENT VISIT EST		
99214	OFFICE/OUTPATIENT VISIT EST		
99215	OFFICE/OUTPATIENT VISIT EST		

30 Day Follow Up after Mental Health Hospitalization Cont.

Denominator: Sum of members 6 years or older who were hospitalized for a qualifying mental illness during the measurement period

Mental Illness diagnoses include the following ICD-9 codes: 295-299, 300.3, 300.4, 301,308,309, 311-314

Eligibility Criteria: Member to remain enrolled on plan through 90 days after the hospital discharge

Exclusions: Hospitalizations outside the CCO service area are excluded from the measure.

30 Day Follow up after Rehab Discharge

Measure Definition

Measure Definition: The percentage of follow up services within 30 days after discharge from agency's residential alcohol/drug rehab

Unit of Measurement: %

Results Grouped By: Behavioral Health Agency

Measure Formula:

> *Numerator:* Number of qualifying services received within 30 days of discharge from agency's residential rehab
>
> Qualifying Services Include:

Code	Service
G0396	ALCOHOL/SUBS INTERV 15-30MN
H0001	ASSESSMENT/ADA
H0002	ALCOHOL AND/OR DRUG SCREENING
H0003	ALCOHOL AND/OR DRUG SCREEN
H0004	ALCOHOL AND/OR DRUG INDIV SERVICES
H0005	ALCOHOL AND/OR DRUG GRP SERVICES
H0006	ALCOHOL AND/OR DRUG CASE MGMT
H0012	ALCOHOL AND/OR DRUG SERVICES
H0015	ALCOHOL AND/OR DRUG GRP SERVICES
H0017	ALCOHOL AND/OR DRUG SERVICES
H0018	ALCOHOL AND/OR DRUG SERVICES
H0019	ALCOHOL AND/OR DRUG SERVICES
H0023	ALCOHOL AND/OR DRUG OUTREACH
H0038	SELF-HELP/PEER SVC PER 15MIN
H2000	COMP MULTI DISCIPLINE EVAL

> *Denominator:* Number of residential rehab stays of at least 30 days with no more than a break of 2 days between rehab claims from one of the Agencies
>
> Residential Rehab procedure codes include: H0018 or H0019
>
> *Eligibility Criteria:* Members must have continued enrollment for at least 30 days post discharge from Rehab

Peer Services

Measure Definition

Measure Definition: The percentage of members who receive Peer Services during the measurement period

Unit of Measurement: %

Results Grouped By: Behavioral Health Agency

Measure Formula:

Numerator: The number of members in the denominator who receive Peer delivered services during the measurement year

    Qualifying codes: H0038 – Self-help/peer service per 15 min
                                  H2014 – Skills training and development, 15 min

Denominator: Number of patients with qualifying assessment/evaluation codes during the measurement period

Qualifying codes include:

90791	PSYCH DIAGNOSTIC EVALUATION
90792	PSYCH DIAG EVAL W/MED SRVCS
H0001	ALCOHOL AND/OR DRUG ASSESS
H0002	ALCOHOL AND/OR DRUG SCREENIN
H0031	MH HEALTH ASSESS BY NON-MD
H2000	COMP MULTIDISIPLN EVALUATION
T1023	PROGRAM INTAKE ASSESSMENT

Level 1 & 2 ED Visits/1000

Measure Definition

Measure Definition: # of level 1 or 2 (low acuity) ER visits of those receiving services from the BH agency/1000

Unit of Measurement: #/1000

Results Grouped By: Behavioral Health Agency

Measure Formula: # of level 1 or 2 ER visits/member months of those receiving services X 12 (months) X 1000

> *Numerator:* Number of Level 1 or 2 ER Visits
> Codes: 99281, 99282
>
> *Denominator:* Member months of members receiving services

Increased Visits

Measure Definition

Measure Definition: Increase in # of qualifying member visits

Unit of Measurement: %

Results Grouped By: Behavioral Health Agency

Measure Formula: For Capitated Agencies: (# of qualifying visits/# of capitated member months) X 12 (months) X 1000   For Non-Capitated Agencies: Count of Qualifying Visits

Code	Service	Code	Service	Code	Service
80100	DRUG SCREEN QUALITATE/MULTI	99202	OFFICE/OUTPATIENT VISIT NEW	H0017	ALCOHOL AND/OR DRUG SERVICES
80101	DRUG SCREEN SINGLE	99203	OFFICE/OUTPATIENT VISIT NEW	H0018	ALCOHOL AND/OR DRUG SERVICES
80102	DRUG CONFIRMATION	99204	OFFICE/OUTPATIENT VISIT NEW	H0019	ALCOHOL AND/OR DRUG SERVICES
80104	DRUG SCRN 1+ CLASS NONCHROMO	99205	OFFICE/OUTPATIENT VISIT NEW	H0023	ALCOHOL AND/OR DRUG OUTREACH
81002	URINALYSIS NONAUTO W/O SCOPE	99211	OFFICE/OUTPATIENT VISIT EST	H0031	MH HEALTH ASSESS BY NON-MD
90785	PSYTX COMPLEX INTERACTIVE	99212	OFFICE/OUTPATIENT VISIT EST	H0032	MH SVC PLAN DEV BY NON-MD
90791	PSYCH DIAGNOSTIC EVALUATION	99213	OFFICE/OUTPATIENT VISIT EST	H0034	MED TRNG & SUPPORT PER 15MIN
90792	PSYCH DIAG EVAL W/MED SRVCS	99214	OFFICE/OUTPATIENT VISIT EST	H0035	MH PARTIAL HOSP TX UNDER 24H
90806	PSYTX OFF 45-50 MIN	99215	OFFICE/OUTPATIENT VISIT EST	H0036	COMM PSY FACE-FACE PER 15MIN
90832	PSYTX PT&/FAMILY 30 MINUTES	99408	AUDIT/DAST 15-30 MIN	H0037	COMM PSY SUP TX PGM PER DIEM
90833	PSYTX PT&/FAM W/E&M 30 MIN	99409	AUDIT/DAST OVER 30 MIN	H0038	SELF-HELP/PEER SVC PER 15MIN
90834	PSYTX PT&/FAMILY 45 MINUTES	99420	HEALTH RISK ASSESSMENT TEST	H0039	ASSER COM TX FACE-FACE/15MIN
90836	PSYTX PT&/FAM W/E&M 45 MIN	G0176	OPPS/PHP;ACTIVITY THERAPY	H0045	RESPITE NOT-IN-HOME PER DIEM
90837	PSYTX PT&/FAMILY 60 MINUTES	G0177	OPPS/PHP; TRAIN & EDUC SERV	H0048	SPEC COLL NON-BLOOD:A/D TEST
90838	PSYTX PT&/FAM W/E&M 60 MIN	G0396	ALCOHOL/SUBS INTERV 15-30MN	H2000	COMP MULTIDISIPLN EVALUATION
90846	FAMILY PSYTX W/O PATIENT	G0431	DRUG SCREEN MULTIPLE CLASS	H2010	COMPREHENSIVE MED SVC 15 MIN
90847	FAMILY PSYTX W/PATIENT	G0442	ANNUAL ALCOHOL SCREEN 15 MIN	H2011	CRISIS INTERVEN SVC, 15 MIN
90849	MULTIPLE FAMILY GROUP PSYTX	H0001	ALCOHOL AND/OR DRUG ASSESS	H2012	BEHAV HLTH DAY TREAT, PER HR
90853	GROUP PSYCHOTHERAPY	H0002	ALCOHOL AND/OR DRUG SCREENIN	H2013	PSYCH HLTH FAC SVC, PER DIEM
90882	ENVIRONMENTAL MANIPULATION	H0004	ALCOHOL AND/OR DRUG SERVICES	H2014	SKILLS TRAIN AND DEV, 15 MIN
90887	CONSULTATION WITH FAMILY	H0005	ALCOHOL AND/OR DRUG SERVICES	H2021	COM WRAP-AROUND SV, 15 MIN
96101	PSYCHO TESTING BY PSYCH/PHYS	H0006	ALCOHOL AND/OR DRUG SERVICES	H2022	COM WRAP-AROUND SV, PER DIEM
Q3014	TELEHEALTH FACILITY FEE	H0012	ALCOHOL AND/OR DRUG SERVICES	H2023	SUPPORTED EMPLOY, PER 15 MIN
S5151	UNSKILLED RESPITECARE /DIEM	H0015	ALCOHOL AND/OR DRUG SERVICES	H2032	ACTIVITY THERAPY, PER 15 MIN
S9125	RESPITE CARE, IN THE HOME, P	T1015	CLINIC SERVICE	T1006	FAMILY/COUPLE COUNSELING
S9484	CRISIS INTERVENTION PER HOUR	T1016	CASE MANAGEMENT		
T1005	RESPITE CARE SERVICE 15 MIN	T1023	PROGRAM INTAKE ASSESSMENT		

Integrated Care

Measure Definition

Measure Definition: Does Behavioral Health agency contribute to integrated care in the community?

Unit of Measurement: Y/N

Results Grouped By: Behavioral Health Agency

Measure Formula: Agency attests that they contribute to integrated care in the community, so that a patient's needs are able to be addressed regardless of the setting in which they present.

Examples of integrated care would be Qualified Mental Health Providers (QMHPs) or Licensed Providers who provide services in settings such as Child Welfare, Correctional Facilities, ER, Dental Clinic, OB Clinic, Medical Clinic, Schools

Resources for Warm Handoffs

Measure Definition

Measure Definition: Does the Behavioral Health agency provide resources in the community for 'warm handoffs'?

Unit of Measurement: Y/N

Results Grouped By: Behavioral Health Agency

Measure Formula: Agency attests that they provide resources in the community to engage new patients in non-billable handoff services with the agency.

Examples include: Community partner meetings, Engaging the Community meetings, Child Welfare, School Meetings, ER or Provider Meetings, etc.

Mental Health Evaluation for DHS Children within 60 Days

Measure Definition

Measure Definition: Percentage of children 4 years or older who receive a qualifying mental health assessment within 60 days of OHA/DHS providing notification that the child has entered DHS custody.

Unit of Measurement: %

Measure Formula:

Numerator: Total number of children 4 years or older in DHS custody who received a qualifying mental health assessment within 60 days

Codes:
- Psychological assessment and intervention codes: 90791 – 90792, 96101 – 96102, H0031, H1011.
- Mental health assessment, by non-physician with CANS assessment: H2000-TG (modifier must be included).
- Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days): H00192
- Psychiatric health facility service, per diem: H2013
- Community psychiatric supportive treatment program, per diem: H0037

Denominator: Total number of eligible members

Performance Targets

TBD

Patient Satisfaction Survey (Bonus Measure)

Measure Definition

Measure Definition: BH agency provides results from patient satisfaction survey.

Unit of Measurement: %

Measure Formula:

> *Numerator:* # of survey respondents who marked "Satisfied" for the specified question

> *Denominator:* Total number of surveys completed for the agency

Health Equity (Bonus Measure)
Attestation

Measure Definition

Provider attests that they, and at least 70% of office staff, completed training from the suggested list during the measurement year or have an *OHA Qualified* or *Certified* medical interpreter on staff at their location.

Unit of Measurement: Y/N

Measure Formula:

Provider attests that they and at least 70% of office staff have completed one of the trainings located at the link below:

https://www.allcarehealth.com/doctors-providers/resources/health-equity

*If the practice completes courses that are similar in content to the suggested list, this may also qualify for the measure if approved by AllCare.

OR

Provider attests that they have an *OHA Qualified* or *Certified* Medical Interpreter on staff (For more information, contact Stick Crosby: stick.crosby@allcarehealth.com

Measure Intent & Purpose

To ensure that contracted providers across the continuum of care have access to training that meets state and federal goals and objectives on culturally and linguistically appropriate service delivery; and ensure providers are sensitive to members with cultural, linguist and social differences as they relate to ethnicity, gender, socioeconomics and other areas of diversity.

Performance Targets

2019 AllCare CCO Improvement Target: 70%

Challenge Pool

APM funds not paid-out to providers will become the "challenge" pool- these funds will be distributed to providers who meet the goal on the challenge pool measures listed below.

Percentage retained by AllCare for Operations Support	Bonus paid out based on achievement
	Challenge pool paid out based on specific measures

The challenge pool measures are:

- **Appointment within 30 Days of Assessment**
- **Level 1 & 2 ED Visits**

Attachment 8 – Value-Based Payment Requirements

A. **Value-Based Payment (VBP) Requirements**

<u>**VBP Minimum Threshold**</u>

CCOs must begin CCO 1.0 – January 2020- with at least 20% of their projected annual payments to Providers in contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" Pay for Performance category 2C or higher. OHA will assess adherence retrospectively. The denominator in this calculation is the total dollars paid (claims and non-claims-based payments) for medical, behavioral, oral, prescription drugs and other health services. Administrative expenses, profit margin, and other non-service-related expenditures are excluded from the calculation.

AllCare implemented Value Based Payments beginning in 2014 for Primary Care, Pediatrics, and Non-Emergent Medical Transportation followed by Surgical Specialty, Medical Specialty, Maternal Health, Behavioral Health and Oral Health in 2015 and Hospitals and Skilled Nursing in 2016. Currently each VBP meets or exceeds the January 2020 requirement of 20% of projected annual payments to Providers involved in Value Based Payments based on quality, access, and patient satisfaction measures.

AllCare intends to monitor its VBP models over the next CCO contract cycle to measure their effectiveness in achieving the goals of better individual health, better community health, at lower costs. Over the course of the monitoring period, AllCare may refine the measures, add or delete measures or modify benchmarks/targets to meet emerging needs over time.

<u>**Expanding VBP Beyond Primary Care to Other Care Delivery Areas**</u>

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

Currently, 80% of AllCare's contracted physical health providers, including primary care, pediatrics, specialty care, hospitals, and skilled nursing facilities participate in our VBP models, 90% of our contracted behavioral health providers participate in our behavioral health VBP, and 100% of our contracted Dental Care Organizations (DCO) participate in

our oral health VBP. However, the downstream provider network within our DCO contractors includes some dental providers who elect not to participate.

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

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

- **By 2021, CCO shall implement two new or expanded VBPs. The two new or expended VBPS must be in two of the listed care delivery areas, and one of the areas must be Hospital Care or maternity care. A CCO may design new VBPs in both Hospital care and maternity care. A VBP may encompass two care delivery areas: e.g. a hospital maternity care VBP that meet specifications for both care delivery areas could count for both hospital care and maternity care delivery areas.**

  AllCare currently offers VBP to all five care delivery areas to be required within the CCO 2.0 contract. This includes a wide array of provider types. Among others, this includes organizations across the continuum of care:
  o PCPCH Providers by Tier
  o Integrated Behavioral Health PCPCH Providers
  o Family Medicine
  o General Practice
  o Pediatrics
  o Maternal Health/OB-Gyn Specialists
  o Alcohol and Drug Treatment Programs
  o Mental Health Organizations
  o Methadone Treatment Centers
  o Surgery Centers
  o Skilled Nursing Facilities
  o Dental Care Facilities
  o Non Emergent Medical Transport Service

- **By 2022, CCO shall implement a new VBP in one more care delivery area. By the end of 2022, new CBPs in both Hospital and maternity care must be in place.** AllCare currently offers VBP in both Hospital and maternity care.

- **By 2023 and 2024, CCO shall implement one new VBP each year in each of the remaining care delivery areas. By the end of 2024, new or expanded VBPs in all five delivery areas must be implemented.** AllCare currently meets this requirement.

CCO VBP Targets that Achieve 70% VBP by 2024

AllCare will ensure that all five VBP models meet the 70% target by 2024 and all intermediate milestones leading to that goal. Overall, we are currently at 65% for provider participation.

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

- **For services provided in 2021, no less than 35% of the CCO's payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance or higher.** AllCare currently meets this threshold in all of its VBP models.

- **For services provided in 2022, no less than 50% of the CCOs payments to Providers must be the form of a VBP and fall within LAN category 2C (Pay for Performance) or higher.** AllCare CCO currently meets this threshold in all of its VBP models.

- **For services provided in 2023, no less than 60% of the CCO payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher; and it is expected that beginning in 2023, no less than 20% of the CCO's payments to Providers must fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. Payments that fall within LAN Category 3B or higher will qualify for the overall VBP target of 60% because Lan Category 3B is higher than LAN Category 2C.** AllCare currently meets or exceeds this threshold in all of its VBP models.

- **For services provided in 2024, no less than 70% of the CCO's payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher and it is expected that beginning 2024, no less than 25% of the CCOs payments to Providers fall within LAN Category 3B (Shared Savings and Downside Risk) or higher, also qualifying for the overall VBP target of 70% per statement above.** AllCare has currently achieved 65% of its payments to Providers in our VBP models for Category 2C and will ensure that the target of 70% will be achieved by 2024.

Patient-Centered Primary Care Home (PCPCH) VBP Requirements

CCOs must provide per-Member-per-month (PMPM) payments to their PCPCH clinics as a supplement to any other payments made to PCPCHs, such as fee-for-service or VBPs. CCOs must also vary the PMPMs such that higher-tier PCHCHs receive higher payments than lower-tier PCHCHs. The PMPMs must be

appropriate, increase each year over the five-year contract and, although is not defining a specific minimum dollar amount, the payments should be sufficient to aid in the development of infrastructure and operations needed to maintain or advance PCPCH tier level.

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

AllCare currently pays its primary care providers on a PMPM basis in addition to our VBP that rewards Providers who meet quality, access, and effectiveness metrics. This includes both Pay for Performance and Shared Risk. AllCare PCPCH VBP model currently meets the requirements for Category 2C.

Payments vary by PCPCH Tier based on each provider's performance on their tier level achievement. Our VBP incentives are designed to encourage participating providers to engage patients and their families to collaborate with their provider to ensure that care treatments plans are aligned with patient goals, values and preferences in a manner that reflects shared decision-making across the continuum of care. Our PCPCH VBP model focuses on payment incentives to reward providers who improve patient outcomes, experience of care and health equity as well as use of lower cost health care resources where quality is equal or better relative to other options.

<u>**Risk adjustment within VBP arrangements**</u>

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

B. **VBP Reporting**

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

<u>**CCO Data Reporting: 2020**</u>

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

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

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

Table 1: AllCare Quality Measures by VBP Model & Benchmarks
(* signifies consistency with 2019 HPQMC Measures)

Metric	Primary Care Adult	Primary Care Peds	Maternal Health	Medical Specialty	Surgical Specialty	Behavioral Health	Oral Health	Facilities
Patient Portal Use	Y/N	Y/N						
SBIRT*	Y/N	Y/N						
Depression Screening*	Y/N	55%						
Days to Third Next Appointment	Y/N	Y/N	Y/N	Y/N	Y/N			
Cigarette Smoking Prevalence*	<29%	29%	Y/N					
Colorectal Cancer Screening*	51%							
Controlling Hypertension*	67%							
HbA1c Poor Control*								
Weight Assessment & Counseling *	30%	29%						
Effective Contraceptive Use*	48%	48%						
Adolescent Well Care*	43%	43%						
ED Utilization for Mental Illness*	<1115/1000							
PCPCH*	0-5	Y/N						
Health Equity	Y/N	Y/N	Y/N	Y/N	Y/N	X	Y/N	
Patient Satisfaction*	85%	85%	85%	85%	X	80%	85%	X
Childhood Immunization Status*		71%						
Developmental Screening*		67%						
Lower Severity ER Visits		123/1000				<304 visits / 1000		
Documentation of Current Meds			Y/N	Y/N	Y/N			
Prescribing Generic Meds			85%	85%	85%			
Wait Time to See a Specialist			30 days	30 days	30 days			
Tobacco Use: Screening and Cessation Intervention*			Y/N	Y/N	Y/N			
Timely Post-Partum Care*			50%					
Closing the Referral Loop				Y/N				
Reduction of Severe Adverse Events					TBD			X
Opioid MME dosing					TBD			
Use of Lower Cost Settings					Varies by Specialty			

Metric	Primary Care Adult	Primary Care Peds	Maternal Health	Medical Specialty	Surgical Specialty	Behavioral Health	Oral Health	Facilities
Time from Referral to First Appointment						<20 Days		
First Appointment within 30 Days of Assessment						63%		
3 Treatment Episodes within 90 Days of Assessment						61%		
Assertive Community Treatment						Y/N		
Wraparound Services						Y/N		
7 Day FU after MH Hospital Stay*						80%		
30 Day FU after MH Hospital Stay*						66%		
30 Day FU after MH Rehab Stay						69%		
Peer Services						TBD		
Increased Visits						1892/ 1000		
Integrated Care						Y/N		
Resources for Warm Handoffs						Y/N		
Eval for DHS Children within 60 Days*						73%	65%	
Dental Sealants ages 6-14*							23%	
Increased Diagnostic & Preventive Services*							40%	
Oral Eval for Diabetic Pts*							45%	
% of Pregnant Members who had a dental visit							47%	
Documentation of Caries Risk							25%	
Increase PCP Follow up within 14 days post discharge								Varies by Facility
Discharge Instructions								85%
Central Line Assoc. Bloodstream Infections (Hospital)								<1
Catheter Associated Urinary Tract Infections (Hospital)								<1
Hospital Transfers (Surgery Centers)								Varies by Facility
Infection Rates (Surgery Centers)								Varies by Facility
Moderate to Severe Pain for Short Stay Residents (SNF)								17.1%
New/Worse Pressure Ulcers for Short Stay Residents (SNF)								1.3%

b. **Should OHA contract with one or more other CCOs serving in the same geographical area, the CCO shall participate in workgroups to select performance measures to be incorporated into each CCO's value-based purchasing Provider contracts for common provider types and specialties. CCOs will be informed in advance of the Provider types and specialties under consideration for performance measures. Each CCO shall incorporate all selected measures into its Participating Provider contracts.** There are currently two CCOs in each of the three counties served by AllCare and each of those CCOs is administered by a different legal entity. AllCare collaborates with our counterparts in each county and would welcome sharing our experience with VBPs and working together to establish a common set of performance measures for each of our respective VBPs.

2. **By September 30, 2020, CCOs must submit payment arrangement data via APAC's Appendices G and H. Please see APAC Reporting Guide for additional information.** AllCare will commit to reporting payment data via APAC's Reporting Guide.

3. **Report PCPCH VBP details including:**

   a. **Payment differential and/or range across the <u>PCPCH tier</u> levels during CY 1 (2020).** AllCare will commit to reporting payment differentials across PCPCH tier levels by 2020.

   b. **Payment differential and/or range by PCPCH tier levels over CY2 (2021) through CY5 (2024).** AllCare will commit to reporting payment differentials by PCPCH tier levels for CY 2 through CY5.

   c. **Rationale for approach (including factors used to determine the rate as Rural/Urban, social complexity).** AllCare will commit to reporting the rationale for our approach for payment differentials by PCPCH tier levels as requested by the OHA beginning in 2020. Currently, AllCare considers panel size and the urban/rural split to determine PCPCH rates by Tier.

4. **By Spring/Summer, CCOs executive leadership team must engage in interviews with OHA to:**
   a. **Describe how the first year of activities and VBP arrangements compare to that which was reported in the Application, including detailed information about VBP arrangements and LAN categories.**

   b. **Discuss the outcome of the CCO's plan for mitigating adverse effects of VBPs and compare/describe any modifications to that which was reported in in the Application.**

c. **Report implementation plans for the two care delivery areas that will start in 2021.**

d. **Any additional requested information on VBP development and implementation.**

AllCare will commit to interviews with OHA staff to address the above discussion points.

Data Reporting: 2021

1. **In the first quarter of 2021, CCOs must submit Year 1 VBP Data Template, which includes summary data stratified by LAN categories that describes 2020 payment arrangements. Although the CCO will likely be unable to report exactly all adjudicated payments for 2020, OHA will require the reporting of fee-for-service payments that are associated with a VBP in order to assess the CCO's preliminary progress towards meeting VBP targets. This will function as a rolled-up version of APACs Appendix G (before Appendix G data are available) and will show for more timely monitoring of the CCO's progress towards achieving the VBP targets. This report will serve as a comparison for what the Applicant initially submitted. Note: Data submitted to Appendix G and H, which allows for a nine-month lag after the reported time period, will be the official assessment of a CCO's VBP target achievement.** AllCare CCO will commit to submit Year 1 results in requested Data Template.

2. **By September 30, CCOs must submit VBP data via APAC's Appendix G and H for the previous calendar year.** AllCare will commit to submit Year 2-5 results in requested Data Template by September 30 of each year.

3. **Report PCPCH VBP details including:**

   a. **Payment differential and/or range across the PCPCH tier levels during CY 2020.** AllCare will commit to reporting payment differentials across PCPCH tier levels for 2020 by September 30, 2021. Please refer to Table 2 below for our 2019 payment differentials.

   b. **Payment differential and/or range by PCPCH tier levels over CY2 (2021) through CY5 (2024).** AllCare will commit to reporting payment differentials by PCPCH tier levels for CY 2 through CY5 by September 30 of each year for the preceding year.

   c. **Rationale for approach (including factors used to determine the rate as Rural/Urban, social complexity).** AllCare will commit to reporting the rationale

for our approach for payment differentials by PCPCH tier levels as requested by the OHA in its September 30th report for the preceding year. Currently, AllCare considers panel size and the urban/rural split to determine PCPCH rates by Tier.

4. **By May 2021, CCOs executive leadership team must meet formally with OHA to:**

    a. **Describe the second year of VBP arrangements;**

    b. **Discuss the outcome of the CCO's plan for mitigating adverse effects of VBPs on populations with complex care needs or at risk for health disparities, and compare and describe any modifications to the plan;**

    c. **Report outcomes of the two care delivery areas implemented in January of 2021; and**

    d. **Report implementation plans for the new care delivery area/s in January, 2022.**

    AllCare will commit to interviews with OHA staff to address the above discussion points.

Data Reporting: 2022-2024

1. **By September 30, CCOs must submit VBP data via APAC's Appendix G and H for the previous calendar year.** AllCare will commit to submit requested data in the requested format/template.

2. **Report PCPCH VBP details including:**

    a. **Payment differential and/or range across the <u>PCPCH tier</u> levels during year CY 1 2020**

Table 2
PCPCH Recommendation for 2019-2024

Tier Level	2019 pmpm	2020 pmpm	2021 pmpm	2022 pmpm	2023 pmpm	2024 pmpm
Tier 1	$0	$0.25	$0.25	$0.25	$0.25	$0.25
Tier 2	$0	$0.50	$0.50	$0.50	$0.50	$0.50
Tier 3	$3.00	$2.75	$2.50	$2.25	$2.00	$1.75
Tier 3 with > 500 members	$3.00	$3.25	$3.25	$3.50	$3.50	$3.50
Tier 4	$4.00	$3.75	$3.50	$3.50	$3.50	$3.50
Tier 4 with > 500 members	$4.00	$4.50	$4.75	$5.00	$5.25	$5.50
Tier 5	$5.00	$4.75	$4.50	$4.50	$4.50	$4.50
Tier 5 with > 500 members	$5.00	$5.50	$5.75	$6.00	$6.25	$6.50
Clinics > than 10 miles from a city center	$0.50	$0.50	$0.85	$0.95	$1.00	$1.10

     b. Payment differential and/or range by PCPCH tier levels over CY 2 (2021) through CY 5 (2024). Please refer to the table above.

     c. Rationale for approach (including factors used to determine the rate such as Rural, Urban, or social complexity). AllCare will commit to submit requested data in the requested format/template. Currently, AllCare considers panel size and the urban/rural split to determine PCPCH rates by Tier.

3. **By May of each year, CCO's executive leadership team must met formally with OHA to:**

     a. Describe the previous year of VBP arrangements.
     By May 2021, AllCare's executive leadership team will meet with OHA to describe the second year of VBP arrangements.

     b. Discuss the outcome of the CCO's plan for mitigating adverse effects of VBPs on populations with complex care needs and/or at risk for health disparities and compare and describe any modifications to the plan.
     By May 2021, AllCare's executive leadership team will meet with OHA to discuss the outcome of the CCO's plan for mitigating the adverse effects of VBPs on populations with complex care needs or at risk for health disparities, and compare and describe any modifications to the plan.

     c. Report outcomes of the care deliver areas implemented in the previous year.
     By May 2021, AllCare's executive leadership team will meet with OHA to report outcomes of the two care delivery areas implemented in January of 2021.

     d. Report implementation plans for the upcoming new care delivery areas.
     By May 2021, AllCare's executive leadership team will meet with OHA to report report implementation plans for the new care delivery area/s in January 2022.

4. **Report complete Encounter Data with contract amounts and additional detail for VBP arrangements.** AllCare will commit to interviews with OHA staff to address the above discussion points.

C. VBP Questions

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

1. **Submit two variations of the information in the supplement baseline RFA VBP Template: a detailed estimate of the percent of VBP spending that uses the Applicant's lowest Enrollment viability threshold, and a second set of detailed and historical data-driven estimate of VBP spending that uses the Applicant's self-**

reported highest Enrollment threshold that their network can absorb. Please refer to *EXHIBIT 8.8-VBP Template LAN Categories*.

2. **Provide a detailed estimate of the percent of the Applicants PMPM Lan category 2A investments in PCPCHs and the plan to grow those investments.**

   Applicants must submit the following details:

   a. **Payment differential across <u>PCPCH tier</u> levels and estimated annual increases to the payments.**

Table 3
AllCare PCPCH Recommended Payments Annual Increases 2019 -2024

Tier Level	2019 pmpm	2024 pmpm	2019 – 2024 Percent Change	Average Annual Percent Change
Tier 1	$0	$0.25	0	0
Tier 2	$0	$0.50	0	0
Tier 3	$3.00	$1.75	(99.4%)	(19.9%)
Tier 3 with > 500 members	$3.00	$3.50	16.7%	3.3%
Tier 4	$4.00	$3.50	(12.5%)	(2.5%)
Tier 4 with > 500 members	$4.00	$5.50	37.5%	7.5%
Tier 5	$5.00	$4.50	(10.0%)	(2.0%)
Tier 5 with > 500 members	$5.00	$6.50	30.0%	6.0%
Clinics > than 10 miles from a city center	$0.50	$1.50	120.0%	20.0%

   b. **Rationale for approach (including factors used to determine the rate such as Rural, Urban, or social complexity).** AllCare takes into consideration panel size and urban/rural split when setting its PCPCH Payment Rates by Tier.

3. **Describe in detail the Applicant's plan for mitigating any adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; lesbian, gay, bisexual, transgender and queer (LBGTQ) people persons with disabilities; people with limited English proficiency; immigrants or refugees and Members with complex health care needs as well a populations at the intersections of these groups. Mitigation plans could include, but shall not be limited to:**

   a. **Measuring contracted Provider performance against their own historical performance rather than national benchmarks when patient mix is more complex.** In 2018, AllCare incorporated an additional VBP question into its patient satisfaction survey related to health equity. The question is "Do you feel that you were treated differently from other patients because of any of the following? (check all that apply: Insurance type, race, gender, age, LGBTQ+, disabled, language,

other) This question is in addition to patient satisfaction ratings related to access to care and outcomes of care. This information applies to each provider's VBP model.

In 2018 AllCare created a Health Equity Data Work Group whose purpose is to identify areas of disparities between subgroups (racial and ethnic) in health outcomes, utilization, and spending. The focus areas include 1) produce a quarterly Health Equity report that helps identify disparities that exist in our region; 2) identify ways to incorporate regional Census Data into dashboards; and 3) use data to inform policy decisions and to target populations and geographies for potential intervention.

AllCare, in coordination with the Oregon Health Authority and So-Health-E, brought two Medically Certified Spanish Language Interpreter training sessions to our region. After the overwhelming demand of these trainings, AllCare became a Bridging the Gap training site. This is a 64-hour medical interpreter training. This effort led to the addition of 91 Certified Medical Interpreters to our service area.

AllCare is now one of three CCHI Certified Medical Interpreter Testing Site in Oregon whose purpose is to ensure that providers and patients are able to communicate in order to accurately diagnose and treat medical conditions by removing language barriers. AllCare is also an accredited CCHI training site.

b. **Use of risk-adjustment models that consider social and medical complexity within the VBP.** AllCare's current VBP models do not incorporate any risk adjustment factors. However, they do reward Providers whose performance exceeds expectations on metrics that are high priorities for the CCO. For example, providers who have achieved a higher tier level for PCPCH will receive extra points on that measure compared to those with lower tier levels. The more points each provider receives, the higher his/her VBP for that year.

c. **Monitoring number of patients that are "fired" from Providers.** Our current VBP models do not incorporate this particular measure. Instead, providers are rewarded based on member satisfaction surveys related satisfaction with experience of care and timely access to care which are part of our VBPs. Providers are compared to their peers on satisfaction measures and if a particular Provider continually scores low on member satisfaction, our provider relations team reaches out to implement performance improvement measures for the Provider and his/her staff.

4. **Describe in detail the new or expanded, as previously defined, care delivery area VBPs the Applicant will develop in year one and implement in year two. The two new VBPs must be in two of the following care delivery areas: Hospital care, maternity care, children's health care, Behavioral Healthcare, and oral health care; noting which payment arrangement is either with a Hospital or focuses on maternity care as required in 2021. The description will include the VBP Lan**

category 2C or higher, with which the arrangement aligns; details about what quality metrics the Applicant will use; and payment information such as the size of the performance incentive, withhold, and/or risk as a share of the total projected payment.

AllCare offers all of its seven VBP models to its network of contracted providers in our three county service area which includes Jackson, Josephine, and Curry counties. This is the same service delivery area we are requesting for CCO 2.0 plus two adjacent zip codes in Douglas County. The seven VBPs that are already in place, some since 2013, include: Primary Care, Pediatrics, some Surgical and Medical Specialties, Maternity care, Behavioral Health, Oral Health, Hospitals, and Skilled Nursing Facilities.

Our VBPs for PCPCH meets the definition of LAN 2C or higher at this time and the metrics for all seven VBPs are listed in response to item B - VBP Reporting Requirements above. Payments have varied each year but, for 2017, AllCare paid out an average per PCP of $21,200 for primary care, $13,500 per specialist for specialty care, $136,200 for behavioral health (4 agencies) and $64,200 for dental care (5 organizations). Our total distribution for 2017 was $4,589,080. Our total spend for PCPCH was $1,979,231.

For more detail about each of our VBP models, please refer to following:

- *EXHIBIT 8.1-APM 2019 Primary Care Handbook*
- *EXHIBIT 8.2-APM 2019 Peds Handbook*
- *EXHIBIT 8.3-APM 2019 OB Handbook*
- *EXHIBIT 8.4-APM 2019 Medical Specialties Handbook.pdf*
- *EXHIBIT 8.5-APM 2019 Surgical Specialies Handbook.pdf*
- *EXHIBIT 8.6-APM 2019 Oral Health Handbook*
- *EXHIBIT 8.7-APM 2019 Behavioral Health Handbook*

5. **Provide a detailed plan for how the Applicant will achieve 70% VBP by the end of 2024, taking into consideration the Applicant's current VBP agreements. The plan must include at a minimum information about:**

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

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

AllCare's VBP models in all five service delivery areas are well on their way to achieve 70% VBP by the end of 2024. Currently, we are achieving 67% of our total medical

spend in a VBP. Because we are so close to the 70% mark, we feel that with very few changes in contracting, we will be successful in meeting this expectation well in advance of the 2024 timeframe. As we examine our opportunities, we still have ample room in:

- Durable Medical Equipment
- Pharmacy
- Home Health
- Radiology
- Physical Therapy
- Etc.

D. VBP Reference Documents

- **OHA's Value-Based Payment Roadmap for Coordination Care Organizations**
- **OHA's Value-Based Payment Categorization Guidance for Coordinated Care Organizations**
- **Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017"**
- **LAN-APM Framework**
- **RFA VBP Data Template**
- **APAC Reporting Guide**
- **Health Plan Quality Metrics Committee 2019 Aligned Measures Set**
- **Oregon Health Authority Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide**

HIT Roadmap

AllCare CCO: DRAFT

Goal	Initiative	Use Case	Responsible Party	Start Date	Completion Date
Increase rates of EHR adoption among Providers	Increase rates of EHR adoption across all categories of providers (physical, mental, oral) to support current and future HIT and HIE activities.	Supporting CCO contract operational and reporting requirements. EHR utilization will promote provider achieving higher VBP scores.	COO, CIO	Q2, 2019	Q4, 2024
Increase rates of HIE access among Providers	Proliferate the adoption of regional HIE(s) (e.g. Reliance, Collective) across all categories of providers	HIEs could act as a 'clearing house' for VBP/APM payment models paid on clinical data as opposed to traditional 837 claims flow	COO, CIO	Q2, 2019	Q4, 2024
Increase access to timely hospital event notifications for Providers	Use partnership with Reliance and CMT to provide access to all providers of all categories	HIEs make hospital ADT triggers nearly real time for providers to better manage their patients.	COO, CIO	Q2, 2019	Q4, 2024
Access and use timely hospital ADT event notifications within Organization	Consume HIE ADT records and integrate with Population Management and Case Management Software	HIE HL7 ADT messages could be integrated with population management, care and case management software so care coordinators get immediate notification of hospitalizations of members	VP of Population Health, CIO	Q2, 2019	Q4, 2024

		under case management			
Use HIT for VBP	Explore EHR templates for providers that map to CCDs	If supported, EHRs could templatize VBP measures thereby exporting via CDA/CCD, transferring via HIE, to be scored at CCOs	COO, CIO	Q2, 2019	Q4, 2024
Educate and train providers on how to use HIT tools and data received from CCO	Make technical assistance available to providers of all categories	HIT educated providers will be better able to capture VBPs. HIT increases data immediacy, efficiency, and minimize duplication.	COO, CIO	Q2, 2019	Q4, 2024
Provide risk stratification reports to providers	AllCare benefits from risk stratification and predictive modeling algorithms that are traditionally unaffordable for providers and is in position to distribute that data to providers based on their patient panel.	Providers are better able to prevent avoidable ED visits and costly hospitalizations.	VP of Population Health, COO, CIO	Q2, 2019	Q4, 2024
Streamline Data Transfer for Member Transition Process	Partner with CCOs to develop data interfaces that automate member transition into care coordination	Explore HL7 solutions inclusive of all Member Transition data including UM, Care Plans, Claims History, Diagnosis, predecessor	VP of Population Health, HIT team	Q3, 2019	Q4, 2024

		CCO, Services, Behavioral Health Services, Active Prescriptions, etc.			
Enhance staff ability to coordinate care and manage populations through HIT solutions	Expand current Care Management Software with Population Management Module	Population health software will allow us to prospectively correspond with members. HRS process will have more stratification capabilities. Represents a transition from individual care to predefined populations. This is inclusive of defined Transition of Care groups.	VP of Population Health, HIT team	Q1, 2020	Q4, 2024

Babe Store helps connect mothers and children with appropriate care

AllCare Health offers pregnant women and children under age 3 vouchers for the Babe Store if they attend medical and wellbeing appointments like prenatal care or diabetes education. Vouchers are worth $5 and may be redeemed at the Babe Store for baby supplies like clothes or diapers.

An evaluation of the Jackson County Babe Store in 2016 found that:

Pre-delivery, mothers who used the Babe Store were significantly more likely to have doctor's visits than mothers who didn't.

Average # of outpatient visits per member per year

5.94
4.44
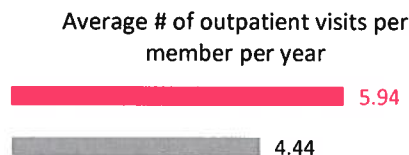
Children who used the Babe Store had significantly more well-child visits than children who didn't.

Average # of well-child visits per member per year

4.38
3.22

Usually when you see an increase in health care utilization, you see a corresponding increase in cost. However, no significant differences in total cost of care were seen between mothers who used the Babe Store and those who didn't.

This may be due to increased preventive services and healthier families.

In summer 2017, AllCare Health rebranded and expanded the Babe Store to Josephine County. Another location in Curry County is in development. Evaluation results do not reflect these changes.

More information at www.allcarehealth.com/medicaid/services/babe-store

Investment in First Tooth Training Program Improved Oral Health

To improve oral health in children in the region, AllCare Health trained more than 300 healthcare providers between 2014 and 2017 to conduct oral health assessments, apply fluoride varnish, and refer children to dental homes.

An evaluation of AllCare Health's efforts found that:

Oral health assessments increased in young children (ages 0-6) after AllCare Health began promoting First Tooth trainings.

Younger children who saw a First Tooth-trained medical provider were significantly more likely to receive fluoride varnish than children who saw other providers.

Fluoride Varnish

	2014	2015	2016
(pink line)	35%	47%	55%
(gray line)		30%	32%
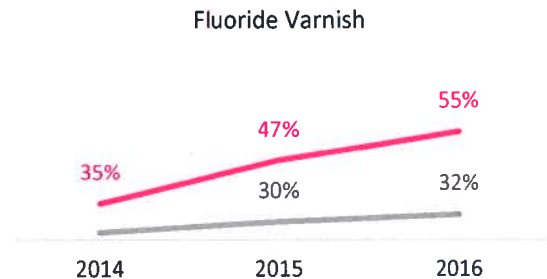
Older children who saw a First Tooth-trained medical provider were significantly more likely to have received any dental service (from a dentist) than children who saw other providers.

Any Dental Service

	2014	2015	2016
(pink line)	55%	62%	63%
(gray line)	47%	55%	57%
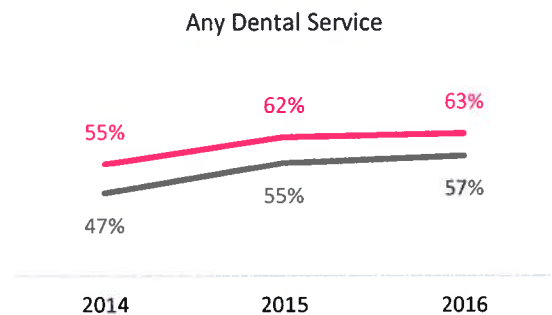
AllCare Health efforts to train medical providers in the First Tooth program resulted in more children receiving preventive oral health services from a medical provider, and children receiving more services from dentists.

AllCare has continued to train medical providers since the evaluation period. These results do not reflect the additional trainings or oral health services provided in 2017 and 2018.

First Tooth Evaluation conducted by Center for Outcomes Research & Education (CORE), June 2018.
Dentist icons by Made, corpus delicti; protection teeth icon by vectoriconset10 from the Noun Project

![allcare health logo]

In an effort to change healthcare to work for our communities, we have changed the way we view health.

We believe that healthcare goes beyond direct medical care and that an individual's health is impacted by social and economic factors in the community surrounding them. That's why — along with our Board of Governors and our three Community Advisory Councils — we're proud to be an active part of improving the resources available in our communities that impact overall health.

Certified B Corporation

AllCareHealth.com/BCorp

Our Service Area

DOUGLAS

CURRY JOSEPHINE JACKSON
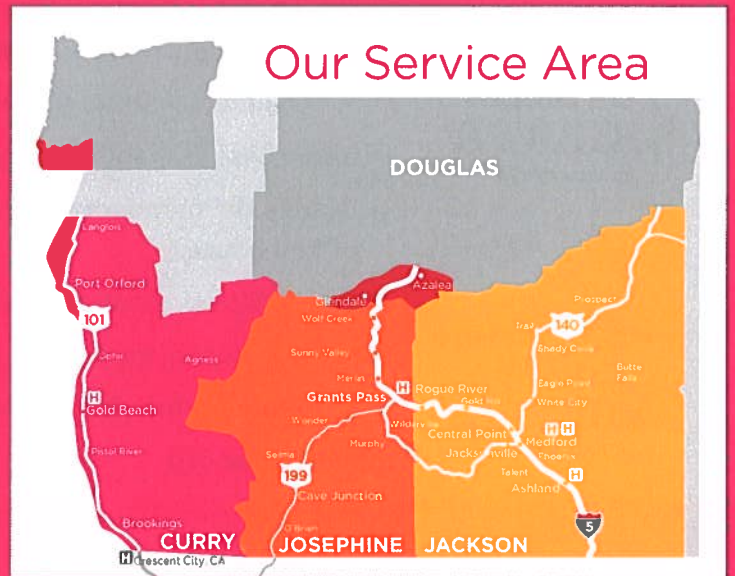
AllCare Health serves more than **50,000 children, adults, and families** in southern Oregon.

Babe allcare health

Since opening in July of 2017, AllCare Health's Babe Stores offer new and pregnant mothers with vouchers for attending medical wellbeing appointments, like prenatal care, tobacco cessation, or diabetes education. The vouchers can be redeemed at the Babe Store for baby supplies and clothes.

2,268 Families in Josephine and Jackson Counties have been helped!

632,163 rides
provided to CCO members since 2014

ReadyRide does more than just Non Emergency Medical Transport (NEMT) rides for AllCare members. They provide flex fund rides, care coordination support, interactive human support, local jobs, and economic development. ReadyRide services have shown an overall reduction in health risk scores for our members.
ReadyRideService.com

94%
SATISFACTION RATE!

1-800-479-7920

ReadyRide Moving People Touching Hearts

1701 NE 7th Street, Grants Pass, OR 97526   (541) 471-4106   **AllCareHealth.com**
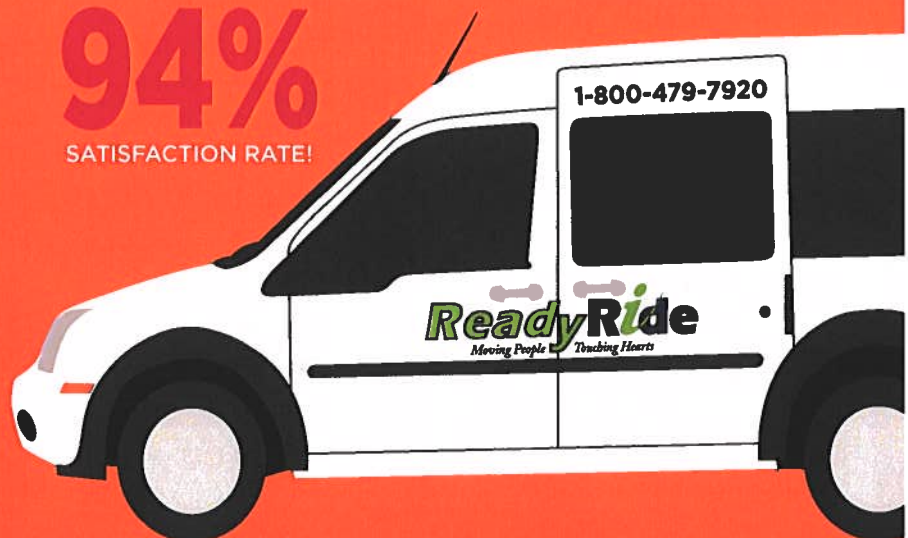
ROGUE RETREAT
Restoring Lives

THE KELLY SHELTER
by Rogue Retreat

HOPE VILLAGE
ROGUE RETREAT

Rogue Retreats services are designed for homeless individuals with a history of Substance Use Disorder (SUD). While services vary across their multiple residences, Rogue Retreat typically accepts individuals who are homeless, have 60 to 90 days of sobriety, and would otherwise be discharged to the street.

AllCare Health supports their efforts because we saw **more than a 60% reduction** in member's monthly healthcare costs!

Since partnering with Rogue Retreat, we've been able to help them:

- Begin case management in The Kelly Shelter.
- Double the number of homes in Hope Village, a transitional housing complex of tiny houses.
- Create 5 new, medically-assisted homes for pregnant women or new moms.
- Provide access for AllCare Health's members to all units.
- Facilitate partnership with an additional CCO to increase funding.

RogueRetreat.org

First Tooth

The First Tooth program offers training for dental and medical organizations. AllCare Health supports this effort to provide training at no cost to our providers. It has resulted in more children receiving preventive oral health services from both medical and dental providers.

Between **2014** & **2017**
300+
healthcare providers trained to give oral health assessments!

orohc.org/first-tooth

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pax
Good Behavior Game

Visit www.GoodBehavior.Game.org

AllCare Health has been instrumental in bringing the PAX Good Behavior Game to schools in Southern Oregon. The game teaches students self-regulation, self-control, and self-management while collaborating with others for peace, productivity, health, and happiness.

By reaching Southern Oregon students in this year's 1st grade cohort, the estimated results (based on previous research findings) are listed below:

Special Education Services
4,029 fewer young people will need them.

Graduate from High School
2,607 more boys and 4,157 more girls will likely graduate.

College Attendance
3,129 more boys, and 3,249 more girls will likely attend college.

Violent Crime
455 fewer young people will commit and be convicted of serious violent crimes.

Substance Use Disorders
4,503 fewer young people will develop serious drug addictions; 3,081 fewer will become regular smokers; and 1,659 fewer will develop serious alcohol addictions.

Suicide
2,272 fewer young women and 3,081 fewer young men will contemplate suicide.

Over **400** staff within our schools and early childhood education programs have joined the PAX movement.

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allcare health·   1701 NE 7th Street, Grants Pass, OR 97526   (541) 471-4106   **AllCareHealth.com**

Attachment 9 — Health Information Technology

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response.

Page limit for this Health Information Technology Questionnaire is 36 pages, items that are excluded from the page limit will be noted in that requirement.

Introduction

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

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

o **Attest that they have or will have certain HIT capabilities as described in this document.**

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

o **Certify or attest that they will meet monitoring and reporting requirements.**

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

Please refer to *EXHIBIT 9.1-DRAFT HIT Roadmap*.

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

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

o **An annual attestation that the CCO made progress on their roadmap, and provide supporting information on progress made, including any changes to the HIT Roadmap.**

o **Discuss the CCO's annual HIT Roadmap update.**

Discussion of the HIT Roadmap update also be part of the annual VBP interview in addition to the annual HIT Roadmap interview. Each annual HIT Roadmap update must be approved by OHA.

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

Other HIT-related deliverables under the Contract:

o **Annual attestation and reporting on progress on activities in the HIT Roadmap.**

o **Annual reporting on EHR adoption and HIE access and use information for CCO's physical, behavioral, and oral health Providers. Information will be reported to OHA in the form of:**

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

- **proportion of contracted physical, behavioral and oral health Providers who have adopted EHRs (including those with any EHR, Certified EHR, and 2015 Certified EHR);**
- **proportion of contracted physical, behavioral and oral health Providers who have access to HIE and proportion using HIE for Care Coordination; and**

- **proportion of contracted physical, behavioral and oral health Providers' who have access to, and proportion using, Hospital event notification; and**

- **EHR product and HIE tool(s) in use by each contracted Provider, in a format agreed to by OHA and the CCO during the draft HIT Roadmap review process.**

o **Signed HIT Commons Memorandum of Understanding (MOU) and annual payment of HIT Commons assessments.**

o **Transformation Quality Strategy (TQS) – OHA encourages CCOs to reflect the HIT components of the transformation and quality initiatives in their TQS work plan and**

reporting (see Appendix B, Sample Contract, Exhibit B). HIT components will not be stand-alone requirements for TQS, but OHA would like to understand where HIT plays an important role in the transformation and quality work underway.

OHA's requirements are not intended to cause a proliferation of HIT systems. CCOs should have a good understanding of the HIT in place in their communities – with their network Providers and Hospitals – and incorporate Community partners in their HIT efforts. CCOs are encouraged to collaborate and leverage regional or statewide initiatives, where appropriate, as part of their HIT strategies. Further, OHA is supporting statewide HIT efforts that CCOs should consider leveraging. OHA can provide technical assistance related to HIT available to CCOs.

A. HIT Partnership

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

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

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

1. Informational Question (recommended page limit 1 page)

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

AllCare has had a representative on the Health Information Technology Group (HITAG) since February, 2014. Through that participation AllCare has monitored the development of HITOC, HIT Commons, and the HIT Transformation projects and spend. AllCare does not expect any challenges in signing the 2020 HIT Commons MOU and fulfilling the terms or paying annual assessment dues.

AllCare understands a successful full statewide adoption of EDIE by hospital systems has been completed. EDIE's sister platform designed for CCOs, Collective Medical Technologies' (CMT) Collective Platform, formerly PreManage, has been adopted by AllCare and a portion of its provider network. AllCare will work to expand adoption of Collective Platform across its network.

AllCare utilizes PDMP data as a part of the patient's clinical record as provided by clinician PDMP users with access as permissible by current law. AllCare intends to encourage and educate practitioners, Medical Directors, and Pharmacy Directors in clinical settings to gain access to and utilize PDMP as provisioned by HB4124. AllCare intends to gain access to and utilize PDMP in a CCO setting for coordinated care as provisioned by HB2257 Section 15, should it pass.

B. Support for EHR Adoption

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

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

- **Medicaid EHR Incentive Program:
  https://www.oregon.gov/oha/HPA/OHIT/Pages/Programs.aspx.**

1. Evaluation Questions (recommended page limit 5 pages)

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

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

AllCare has supported contracted physical health Providers EHR adoption through a (since removed) EHR Adoption Measure from CCO Incentive Metrics, resource support for attaining PCPCH status and meaningful use, Value Based Payments, and subsidies. These programs are much easier to operationalize and monitor for a provider through the use of EHR as opposed to paper charting. AllCare's primary care provider network currently has approximately a 95% penetration rate of EHR adoption. The few providers that have opted out of EHR systems have chosen to do so for philosophical, geographical or internal business reasons as opposed to any technical, resource, or other barriers.

AllCare partners with AllCare eHealth Services, LLC to provide a regionally available, affordable, fully supported EHR product as a Value Added Reseller (VAR) of Greenway's PrimeSuite. AllCare fully staffs a support and training team available to provider offices as well as a Provider Office Development and Optimization consultant.

Value Based Payments are met in part by clinical data provided by reporting directly from EHR systems.

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

AllCare has supported contracted behavior health Providers EHR adoption through a (since removed) EHR Adoption Measure from CCO Incentive Metrics, resource support, Value Based Payments, and subsidies. These programs are much easier to operationalize and monitor in a practice through the use of EHR as opposed to paper charting. AllCare contracts with Community Mental Health Organizations that contract directly with behavioral health providers. Currently all CMHPs contracted with AllCare have an EHR its providers utilize. AllCare has approved grant funding for an EHR implementation and upgrade for primary substance use disorder agency in Jackson County.

AllCare partners with AllCare eHealth Services LLC to provide a regionally available, affordable, fully supported EHR product as a Value Added Reseller

(VAR) of Greenway's PrimeSuite. AllCare fully staffs a support and training team available to provider offices as well as a Provider Office Development and Optimization consultant. Resources are also available for EHR evaluation, education, and adoption. EHR supports the CCBHC (Certified Community Behavioral Health Clinic) program for behavioral health providers.

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

AllCare contracts with Dental Care Organizations (DCO) that contract directly with oral health providers. AllCare currently contracts with 4 DCOs and 1 oral health subcontractor. In 2013 DCOs received a grant of $20,000 per office for EHR which considerably expanded the adoption rate. AllCare will work to model its VBP or Alternative Payment Methodology (APM) for DCOs to incentivize increased oral health provider EHR adoption rates. Contracted DCOs currently have plans in place to promote and set improvement targets to incrementally increase EHR adoption rates to 100%. AllCare will continuously explore grant opportunities for Oral Health Providers to help offset the expense of EHR adoption.

d. **What barriers does Applicant expect that physical health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?**

AllCare's primary care provider network currently has approximately a 95% rate of adoption. AllCare remains available as a resource to help willing providers either adopt an EHR solution or to navigate the EHR vendor landscape through product selection and implementation. The barriers for any physical health provider that does not already utilize an EHR is largely philosophical or an internal business decision.

e. **What barriers does Applicant expect that Behavioral Health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?**

AllCare's behavioral health provider network already maintains a complete rate of adoption. In the event a future Community Mental Health Provider (CMHP) contractor with AllCare does not have an EHR, AllCare remains available as a resource to help willing providers either adopt a solution or offers as a VAR for, or to navigate the EHR vendor landscape through product selection and implementation. The barriers for any future CMHP that did not have an EHR would have to be evaluated at that time.

  f. What barriers does Applicant expect that oral health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?

   AllCare expects expense to be a barrier for Oral Health Providers. Given the expense and process of evaluating Oral Health EHR systems, purchasing, and implementing. The Oral Health office also must retrofit their office with digital X-Ray machines, incurring that additional expense. AllCare will work with Dental Care Organizations to identify grant and subsidies opportunities for Oral Health Providers.

 2. Informational Questions (recommended page limit 2 pages)

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

   AllCare is confident it can collect and report EHR use through its Provider Network Participation Application, provider portal, CMHP and DCO reporting, and surveys.

   AllCare recognizes that the Oregon Health Authority is in a unique position to collect EHR utilization data at the point of enrolled Medicaid provider application and updating, and transmit that data to CCOs.

   AllCare would hope that a future Common Credentialing, State Provider Directory or similar programs would include EHR utilization information that was available to CCOs.

   Without mandated targets, AllCare's network has already organically achieved a high utilization and possibly a saturation rate for EHR adoption.

  b. Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted physical health Providers. Include data sources or data collection methods.

   AllCare will continue to collect data on EHR use through its Provider Network Participation Application, quarterly Provider Directory Outreach, surveys, and on the AllCare Provider Portal.

   AllCare will continue to reach out and provide educational resources for physical health providers on options and benefits of EHR systems.

c. **Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted Behavioral Health Providers. Include data sources or data collection methods.**

AllCare contracts with CMHP providers. All CMHPs currently utilize EHR systems. AllCare will collect data on CMHP EHR use through surveys and conduct routine scheduled annual audits of CMHPs.

d. **Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted oral health Providers. Include data sources or data collection methods.**

AllCare contracts with 4 DCOs and a single oral health subcontractor. AllCare will survey them quarterly for their EHR adoption rates. All data on adoption rates must be surveyed, reported, or audited. The Oral Health Provider audit tool will include EHR adoption questions.

C. **Support for Health Information Exchange (HIE)**

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

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

In addition, CCOs must ensure their contracted Providers have access to timely Hospital event notifications. Hospital event notifications are electronic messages that notify a Provider or CCO that their patient or Member has been admitted to, discharged from, or transferred within a Hospital or Emergency Department. Unlike claims data, admit, discharge, and transfer data can be made available in near-real time. "Timeliness" refers to near-real time availability. CCOs must also use Hospital event notification tool(s) to inform their own Care Coordination and population health management activities. CCOs have the option to use, and provide Providers access to, Hospital event notifications via the subscription to the statewide EDIE/PreManage tool, or any other tool or resource that ensures contracted Providers have access to timely Hospital event notifications.

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

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

- **EDIE/PreManage: http://www.orhealthleadershipcouncil.org/edie/, https://www.oregon.gov/oha/HPA/OHIT/Pages/Programs.aspx**

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

1. **Evaluation Questions (recommended page limit 8 pages)**

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

   a. **How will Applicant support increased access to HIE for Care Coordination among contracted physical health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.**

   AllCare was foundational in the formation and growth of Reliance, formerly Jefferson Health Information Exchange (JHIE). Through AllCare paying CCO fees, Reliance is available to all of our contracted physical health providers. AllCare will educate providers through managers meetings and announcements of the use cases

for HIE and ensure that they are encouraged to utilize HIE. Some Value Based Payments are calculated through data submitted by Providers to the HIE, a provider not submitting to HIE may miss out on VBP numerators. A provider utilizing an HIE will be able to view hospital admissions for their patient panel. AllCare may further encourage adoption by making certain data exclusively available through the HIE.

b. **How will Applicant support increased access to HIE for Care Coordination among contracted Behavioral Health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.**

Access to PreManage and Reliance is available to all behavioral health providers. We provide contacts for and encourage access, training, and resources. An existing use case is an AllCare Behavioral Health Care Coordination Supervisor creating Care Plans and submitting them on PreManage for SPMI populations. These care plans are reviewed when SPMI members present in ED and Primary Care settings while receiving physical services, and tucks them back in under Behavioral Health Care Coordination.

Additionally, HIE is useful to Behavioral Health Providers to see and monitor ADT notifications such as ED admissions.

There is a community agreement through the Southern Oregon PreManage Workgroup that care plans should only be created by regional CCOs that are delivered via PreManage.

c. **How will Applicant support increased access to HIE for Care Coordination among contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.**

All DCOs that currently contract with AllCare have access to PreManage and monitor ED admission and usage. The DCO case management team reaches out to members who present in ED with dental issues and contacts the member to facilitate scheduling with the Member's Oral Health Provider for needed care.

    d. **How will Applicant ensure access to timely Hospital event notifications for contracted physical health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.**

All hospitals in the state of Oregon participate in EDIE which submits ADT data to PreManage. ADT data on PreManage provides timely hospital event notifications. PreManage is currently expanding availability to providers. PreManage data is integrated with Reliance and ADT data is also available through that HIE.

AllCare will work to expand the regional PreManage adoption rate so providers can view timely event notifications.

    e. **How will Applicant ensure access to timely Hospital event notifications for contracted Behavioral Health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.**

AllCare contracts directly with CMHPs, who employ and contract providers. AllCare becomes aware of daily ED admissions/ADT via PreManage (HIE). AllCare contacts the PCP or CMHP to write ED care plan and ask for outreach. Options and Curry Community Health are actively gaining access to PreManage. The PreManage Cohorts Currently most regularly used are "5 ED visits in 6 months" and "ED disparity measure".

AllCare participates in a Southern Oregon PreManage Workgroup consisting of Asante, Providence, Jackson Care Connect, LaClinica de Valle, Rogue Community Health, Options for Southern Oregon, Columbia Care, Mercy Flights, ARC, and Jackson County Mental Health. The Workgroup focuses on how each entity participates in the use of PreManage for SPMI care plans.

    f. **How will Applicant ensure access to timely Hospital event notifications for contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.**

All DCOs that AllCare currently contract with have access to PreManage and monitor ED admission and utilization. The DCO case management team reaches out to educate members on ED dental protocol. They attempt to get the member to schedule with their Oral Health Providers office. If they cannot reach the member directly they follow up with a letter.

g. **How will Applicant access and use timely Hospital event notifications within your organization? Please describe your strategy, including any focus areas and methods for use, which HIE tool(s), and any actions you plan.**

Local hospitals provide AllCare a census report each day for admissions.

AllCare is working to adopt PreManage into its Utilization Management workflow to improve admission notification. The ADT admission notification will automate the beginning of the authorization process whereby the UM team can follow up with admission reason and discharge planning.

AllCare receives ADT data from Reliance HIE and is working to automate and import data into our Care and Case Management system to notify Care Coordinators of admissions.

2. **Informational Questions (recommended page limit 2 pages)**

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

AllCare would find a report sufficient from the OHA or CMT on which provider offices are currently actively using PreManage, Reliance, or other state HIEs.

b. **Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted physical health Providers. Include data sources or data collection methods.**

AllCare will continue to collect data on contracted physical health providers HIE use through its Provider Network Participation Application, quarterly Provider Directory Outreach, surveys, and questionnaires on the "AllCare Health Provider Portal".

c. **Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted Behavioral Health Providers. Include data sources or data collection methods.**

AllCare will continue to collect data on contracted Behavioral Health Providers HIE use through its CMHPs outreach, surveys, annual audits and questionnaires.

d. **Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted oral health Providers. Include data sources or data collection methods.**

AllCare will continue to collect data on contracted Oral Health Providers HIE use through its DCO's outreach, surveys, annual audits and questionnaires.

D. **Health IT For VBP and Population Health Management**

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

1. **Information Questions: (recommended page limit 3 pages)**

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

AllCare has been very successful with VBP and utilizing HIT for gathering Measures and Metrics data. AllCare's Chief Operating Officer is currently chair of the Metrics and Scoring Committee for the OHA.

One gap is assisting clinics in their development of Quality Reporting Data Architecture (QRDA) 1 data. OHA can assist CCOs in understanding the collection of QRDA1 so we can assist our providers.

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

AllCare outreaches to members to conduct a Health Risk Survey including physical, mental, oral, substance abuse, and other specific Social Determinants of Health questions. Through the survey we discover issues also related to Health Equity. In many instances we have programs that are triggered based on the survey results as they relate to certain SDOH issues.

AllCare utilizes a population health system within its care coordination team to work with members through care pathways to coordinate access to services through individualized care plans.

Within the AllCare provider network, some offices have an EHR system that can capture SDoH data discretely. AllCare hopes to design SDoH programs and assist offices in EHR template configuration to capture that data discretely and report it through CCDs or other EDI to an HIE or AllCare directly to obtain outcomes related to specific factors.

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

AllCare partnered with Center for Outcomes Research and Education (CORE), an independent third party data research group to examine the benefits of our member-focused SDoH-HE programs. In their in-depth and validated analyses, CORE found the following results:

- AllCare has experienced a lower PMPM cost for a population of homeless members who have been inducted into Rogue Retreat program which is a private non-profit organization that transitions homeless into permanent housing and specializes in a populations with substance use disorders, with peer support.
- Please refer to *EXHIBIT 9.2-CORE and Internal Data Related to SDoH-HE Programs*.

2. **Evaluation Questions (recommended page limit 15 pages)**

a. **Describe how Applicant will use HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models). Include in your description how Applicant will implement HIT to administer its initial VBP arrangements and how Applicant will ensure that it has the necessary HIT as it scales its VBP arrangements rapidly over the course of 5 years and spreads VBP arrangements to different care settings. Include in your description, plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements over the 5-year contract, including activities, milestones, and timelines.**

AllCare has seven Value Based Payment (VBP) models in place dating back to 2016. We currently have the HIT infrastructure built to report on all of the measures in our VBP arrangements that are based on administrative and claims data. Data is pulled from our data warehouse using both SAS and SQL queries. The code is written to pull member level data for each measure. The data from the export files

are then transferred to a template that is configured in Excel with macros that were built to parse the data into provider level performance reports. The member level detail includes the attributed provider for each member and are used in compiling gap list reports that are sent out with the quarterly provider level performance reports.

Moving ahead we anticipate developing enhancements to the reporting process that will decrease the manual intervention that is required currently. The enhancements are also anticipated to increase the timeliness and accessibility of the reporting information for our participating providers. The enhancements on our radar include:

- Build capability in our web-based Provider Portal to allow providers to view and download performance reports and gap lists. A pilot clinic will be engaged for testing by 1/1/2020. We target developing production functionality by 7/1/2020.
- Build capability to further automate the actual build of the performance reports so they can be updated and reported out via the Provider Portal. This functionality will increase the timeliness and accuracy of the reporting. A pilot clinic will be engaged for testing by 1/1/2021. We target developing production functionality by 7/1/2021.

b. Describe how Applicant will support contracted Providers with VBP arrangements with actionable data, attribution, and information on performance. Include in your description, plans for start of Year 1 as well as plans over the 5 year contract, including activities, milestones, and timelines. Include an explanation of how, by the start of Year 1, the Applicant will provide contracted Providers with VBP arrangements with each of the following:

(1) Timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers;

Since 2016 AllCare has provided and plans to continue providing provider level performance reporting and gap lists on a quarterly basis. As mentioned in (a) above we plan on building the functionality to increase the frequency of reporting to monthly over the next two years.

(2) Accurate and consistent information on patient attribution; and

AllCare uses an attribution methodology that is based on attributing a member to the provider for which the member is assigned for 51% or more of the measurement period. For VBPs that don't involve assignment of members (i.e. Specialty, Facilities, Behavioral Health) the attribution is based on a member's

engagement with the provider/entity for services specific to that measure. All data used in the VBP reporting is peer reviewed for accuracy. Additional QA queries are analyzed independently from the production data that is used in the VBP reporting to validate accuracy and integrity of the data.

(3) Identification of specific patients who need intervention through the year, so the Providers can take action before the year end.

AllCare produces and provides gap lists to providers identifying members attributed to that provider that have not had qualifying services for specific measures on a quarterly basis. The identified gaps are the interventions required before period end.

We target release of an initial gap list each year by April that is a partial YTD experience report of pre runout data, so that providers can get more timely information than would be available if we waited for the traditional 3-month lag to get a Q1 report out in the July timeframe.

c. **Describe other ways the Applicant plans to provide actionable data to your Provider Network. Include information on what you currently do, what you plan to do by the start of the Contract (Jan. 1, 2020), and what you intend to do in the future. Please include a narrative as well as a roadmap that includes activities, milestones and timelines.**

The Primary Care Provider Network has approximately a 95% EHR adoption rate. AllCare working closely with its Provider Network enables us to customize templates and train offices on how to capture VBP related data discretely. AllCare currently provides VBP reporting to its Contracted Provider Network on a quarterly basis. Included in this reporting package is a summary report, at a physician or organization level, which provides year-to-date performance status at the measure level against targets. Also included in the reporting package with the summary report are gap lists that provide member level detail on measure compliance status for their attributed membership.

We expect to produce the same reporting package described above going into the new contract, while benefiting from additional emerging data systems from regional and state HIEs. We have received feedback from our provider community asking for more frequent and timely data than they currently receive. In response to that feedback we have two enhancements to the reporting process planned:

- Build capability in our web-based Provider Portal to allow providers to view and download performance reports and gap lists. The purpose of the gap lists is to encourage providers to attain higher rates of patient evaluations for prevention and wellness services, preventing avoidable unnecessary

downstream medical care. A pilot clinic will be engaged for testing by 1/1/2020. We target developing production functionality by 7/1/2020.

- Build capability to further automate the actual build of the performance reports so they can be updated and reported out via the Provider Portal application. This functionality will increase the timeliness and accuracy of the reporting. A pilot clinic will be engaged for testing by 1/1/2021. We target developing production functionality by 7/1/2021.

d. Describe how you will help educate and train Providers on how to use the HIT tools and data that they will receive from the CCOs.

AllCare employs Provider Services staff that spend the majority of their time engaged with provider offices. Included in their responsibilities are education of office staff on our VBP programs. This includes developing understanding of the performance reports and assistance in working the gap lists efficiently. If more technical support is needed for a meeting then the Provider Services team will bring along appropriate internal staff. AllCare employs a Practice Development Director that works to improve provider office workflow and HIT adoption.

AllCare employs a Provider Programs Coordinator that visits provider offices, assisting them in configuring their EHR and EHR templates specifically for capturing discrete VBP data.

e. Describe the Applicant's plans for use of HIT for population health management, including supporting Providers with VBP arrangements. Include in the response any plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Describe how Applicant will do the following:

(1) Use HIT to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes? Please include the tools and data sources that will be used (e.g., claims), and how often Applicant will re-stratify the population.

AllCare currently has a case and care management HIT system it uses for creating Health Risk Surveys (HRS), care plans, goals, and interventions. AllCare is investing in expanding its capabilities with an implementation of a more scoped and capable Population Health Management software. In the current system AllCare already interfaces with some regional and state HIE data (e.g. lab) and as the applications capabilities expand AllCare will import all available data (e.g. ADT, microbiology, radiology). This would provide each care coordinator current hospital admissions for their case load, allowing

them to immediately coordinate with providers and discharge planners. Providers would then be able to take action on evaluations and health services defined by VBPs with individualized care plans.

AllCare uses Milliman's MedInsight platform that implements the Milliman Advanced Risk Adjusters (MARA) licensed algorithms for predictive modeling and risk stratification based on experienced and encountered claims, diagnoses, and services. This information ties into the VBP models that incentivize providers to reach out to their high risk patients to minimize avoidable ED utilization.

AllCare's Population Health department uses this information to create and manage individual populations based on member conditions. For example, lab data is used from Reliance, our regional HIE, to prospectively manage disease states and to identify populations for chronic disease management. In another case, we establish an A1c threshold for diabetics and combine that information with ED or inpatient visit data and compare that to MARA score trends. This helps us to identify potential risk for adverse health conditions in the future.

f. **What are your plans to provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in those arrangement(s)?**

Contracted Providers receive copies of AllCare Care Plans that are a result of identifying the member through risk stratification. These care plans include all known member characteristics. AllCare's stratified populations entirely overlap our VBP categories so that the Care Plans inform our providers of their patients' risk stratification and member characteristics that can be used to prepare individualized treatment plans.

g. **Please describe any other ways that the Applicant will gather information on, and measure population health status and outcomes (e.g., claims, clinical metrics, etc.). Describe Applicant's HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Include information about the following items:**

(1) **Data sources: What data sources do you draw on – for example, if you incorporate clinical quality metrics, what data do you collect and how? How often do you update the data? How are new data sources added? How do you address data quality?**

Data sources used in the production of VBP reports are primarily claims sourced. Claims data is either processed by AllCare staff (Physical and Behavioral Health), or by outside vendors (Dental and Pharmacy) and then imported into our data warehouse. Our claims department has peer review quality assurance processes in place for the source data, including multiple monitoring reports through each phase of claims processing. We include several clinical quality measures in the VBP programs for which the clinics report data to AllCare. We also have 3 member survey questions that address health equity, access to care, and experience of care. This data informs our population health management team of potential gaps in timeliness to care as perceived by members and cultural appropriateness across our provider network.

AllCare currently produces quarterly reports for all of our VBP programs.

If new data sources are added the data to be used is validated for accuracy. We are currently working on a new access measure for physicians called Third Next Available Appointment. The clinics self-report this data out of their appointment scheduling tool to AllCare on a standardized data template. We began receiving data in 2018 for the measure but found several inconsistencies in the data being reported. We re-set the reporting criteria for 2019 and will review Q1 data in 2019 to see if the data is tracking more consistently.

As data integrity is key, AllCare uses a rigorous quality review process to assure accuracy of the data being reported. Below are steps in the QA process:

- For initial programming of measures the results are vetted against independent queries. The same process occurs when there are changes in a measure. The vetting of data is done down to the member level for this step with discrepancy reports.
- Independent data sources are used to compare results derived from our internal reporting. For example, we'll compare member level results from our reporting against data in the OHA_CCO monthly dashboard from the OHA Actuarial Services Unit (ASU).
- Results are reviewed for consistency from period to period. Unexpected swings in data are researched to assure accuracy and/or develop understanding of any dynamics causing the variation.
- Data from clinical quality metrics is reviewed for accuracy with the primary focus on consistency. Other key factors reviewed are condition/disease prevalence thresholds and general data credibility issues (e.g. accurate calculated measure results).
- AllCare also does a quality review of the provider reports that are to be released to VBP participants. This process reviews the data feeds and linkages to assure accuracy at this level prior to release.

(2) Data storage: Where do you store data (e.g., enterprise data warehouse)?

AllCare hosts its own applications locally. All data is stored either:
a) In the run time database system for the application;
b) In the data warehouse and reporting environments; or
c) The source files if sourced externally; Electronic Data Interchange (EDI) or any combination thereof.

Data files used in the VBP reporting are stored on a server that is shared by the analytical staff that are involved in the production of the reports.

(3) Tools:

(a) What HIT tool(s) do you use to manage the data and assess performance?

The primary source of data used in our VBPs is claims based. The data is housed in our data warehouse and is accessed via SAS and SQL. Exported files from the query tools are imported into Excel for production of VBP reports and gap lists.

(b) What analytics tool(s) do you use? What types of reports do you generate routinely (e.g., daily, weekly, monthly, quarterly)?

AllCare uses multiple data analytical tools including but not limited to SQL Server Management Studio (SSMS), SQL Server Reporting Services (SSRS), Crystal Reports, Tableau, ArcGIS, and Excel. Many of AllCare systems and applications also include internal or application specific analytic and reporting tools.

Provider level reports for the VBPs are currently produced and sent out on a quarterly basis. Internally we produce summary reports twice a year to assess performance levels by provider and clinic and to review for potential disparities.

(4) Workforce: Do you have staff (in-house, contractors or a combination) who can write and run reports and who can help other staff understand the data? What is your staffing model, including contracted staffing?

AllCare employs in-house Developers, Report writers, Population Health Data Analysts, Business Analysts, Actuarial Analysts, and other Subject Matter Experts (SMEs) all who write and run reports in support of staff. AllCare also contracts with Health Care Analytics, an actuarial firm, to identify cost and

utilization trends, member level risk scores, rate setting methodologies, and other financial data.

(5) Dissemination: After reports are run, how do you disseminate analysis to Providers or Care Coordinators in your network? How do you disseminate analysis within your organization?

Data analysis within the organization is in partnership with SME staff. They can request reports and analysis through IT ticketing, and have an ad hoc report delivered, an automated report scheduled, or a reoccurring report with enterable criteria available on Crystal Reports Info View. The Business Analysts work directly with any staff member seeking data or analysis of data.

(6) Effectiveness: How will you monitor progress on your roadmap and the effectiveness of the HIT supports implemented or to be implemented?

AllCare has a continuous improvement process in place for our VBP programs. Internal staff is continually receiving feedback from plan participants on the merits of the program. Requested changes that entail process improvements might be acted on immediately while measure changes are considered when going through an annual review and update process. Staff is also focused on potential measure changes throughout the year with an eye on adding new measures, or for eliminating measures where performance levels have capped out or are underperforming. We meet at least annually with provider committees for all of the respective VBPs to get their input and to present and decide upon program changes for the succeeding year.

AllCare VBPs track and overlap to every extent possible with measures and metrics developed by the OHA Metrics and Scoring Committee.

(7) Addressing challenges: What challenges do you anticipate related to HIT to support VBP arrangements with contracted Providers, including provider-side challenges? How do you plan to mitigate these challenges? Do you have any planned projects or IT upgrades or transitions that would affect your ability to have the appropriate HIT for VBP?

The biggest issue we hear from our provider community is the "ask" to deliver VBP reporting on a more frequent and automated basis than our current quarterly updates. We have taken this feedback into account in beginning work on using our Provider Portal in a more dynamic way for VBP reporting in the future. Our plans are to roll out two enhancements over the next two years as follows:

- Initially we plan to provide gap list type reports to providers that will be available on the Portal.
- Stage 2 is a plan to upgrade VBP report production to a more automated and streamlined process with accessibility again on the Portal. With this change we would move to a monthly update as opposed to our current quarterly reporting.

E. Reference Documents

- **2020 HIT Commons MOU**

AllCare Community Engagement Plan 2013-current

The health of individuals and our community is a very large topic. Measuring health and effectively addressing health problems is complex. Improving the health of a community requires resources, efforts, innovation and community engagement. The CHIP is a plan that is based on the CHA data and prioritizes issues that CCOs in the three county region of Jackson, Josephine and Curry counties feel are important to address. In order to tackle such a large undertaking, several Coordinated Care Organizations (CCOs) came together in 2013 to collaborate on a single, collective community health assessment for Jackson and Josephine Counties. Jackson Care Connect, AllCare, and Primary Health of Josephine County and their Community Advisory Councils (CACs) collaborated to create a single health assessment for Jackson and Josephine Counties. The AllCare Community Health Assessment in Curry County was based on the Curry County Public Health Community Health Assessment.

Community Health Improvement Plan (CHIP)
The next step, to create a Community Health Improvement Plan (CHIP), began in January 2014. Focus areas were chosen collectively for all three CCOs, continuing the spirit of collaboration set with the previous CHA. CAC members from all three CCOs, Jackson, Josephine and Curry Counties reviewed CHA data and chose three general focus areas.

They are: **Healthy Beginnings, Healthy Living** and **Health Equity.**
The next collaborative step involved the collection of extensive community input about possible strategies to address the health priority areas. Surveys, public meetings and focus groups captured over 1300 unique comments and survey data from 751 community participants, both community members and service providers in Jackson, Josephine and Curry Counties. All three CCOs shared in the cost and data analysis of the community input part of the process for Jackson and Josephine Counties. AllCare sponsored focus groups and surveys in Curry County.

Strategies were then chosen from the community input. Each CCO chose strategies based on their guiding philosophies, organization resources and priorities and their individual CAC input. Each CCO drafted their own CHIP but continued to have shared health priority focus areas, format and design. The CHIP includes strategies for members of AllCare Health Plan and some strategies for the community at large. Progress on the CHIP will be reviewed annually by each of AllCare's three CACs (Jackson, Josephine and Curry CACs). The 2013 Community Health Assessment and the 2014 Community Health Improvement Plan draws attention to many health challenges and many opportunities for change. The documents and processes are designed to complement one another, not stand on their own. These efforts mark the first step in an ongoing process of community health assessment, planning and improvement. The process and the documents will remain dynamic and will be added to and changed over the next several

years as community health and perceptions of health change. Engagement of the CAC members will continue to be instrumental in the process, as will listening to community members priorities and concerns.

Addressing Health Equity with the community

Health equity is defined as all people and communities having the opportunity to attain their full potential and highest level of health.

Achieving health equity requires valuing everyone equally while focusing on eliminating inequities experienced by groups that have encountered obstacles to health. Some of these obstacles may be based on their racial or ethnic group, income, gender identity, sexual orientation, neighborhood, disability, language, religion, insurance status, political affiliation or other characteristics historically linked to discrimination or exclusion. Health equity requires looking for solutions inside and outside of the health care system. This includes addressing social, economic and environmental conditions (such as housing, employment, public safety, education, bias and discrimination) that create unjust differences in health status and opportunities. It must address policies and systemic structures that create barriers to equitable outcomes for all.

Steering Committee

Establish a cross departmental Health Equity Steering Committee to advance policy, systems, and environmental changes that promote equity and address social determinants of health. The Committee shall prioritize health disparities for underrepresented populations; including racially and ethnically diverse communities, people with disabilities, age, gender, protected classes, mental illness, LGBT communities, and low income individuals. The Steering Committee maintains AllCare Health's health equity strategic plan and provides oversight for the implementation of initiatives to staff, First-Tier, Downstream, and Related Entities.

The Steering Committee shall consist of 12-14 Stakeholders. The Committee shall strive to include at least 51% representation from the following priority populations: persons of color, persons of non-dominant sexual orientation or gender identity, persons with disabilities, and persons from disadvantaged socio-economic backgrounds. The Steering Committee will consist of one member from each county that represents the Community Advisory Council in that county and a decision makers from internal AllCare Health departments.

Work Groups

The Health Equity team has five work groups Community Engagement, Culturally Specific Materials, Health Equity Dates, Language Access, Policy Work Group, and Training and Education with the following goals.

Community Engagement
The Community Engagement Workgroup is an ad-hoc group of the Health Equity Steering Committee. All workgroups have the expectation to work with the community directly impacted by the policies and processes being developed. For larger Community Forums, the Steering Committee will hold a Multicultural Storytelling Listening Session. These sessions follow the model developed by the Minneapolis Multicultural Health Storytelling Project.

Multicultural communities often convey health information and knowledge qualitatively through sharing stories. Professionals tend to rely more upon quantitative methods to gather information such as data collection. Storytelling and other qualitative methods can help professionals understand and determine the meaning behind the numbers. This relationship is key to effective policy and program development. In addition, sharing a personal story can empower the storyteller and aid with his/her healing process. This is especially true when heard by those in leadership positions who can influence positive changes to address elements shared within the story.

Culturally Specific Materials Workgroup
The Culturally Specific Materials Workgroup is a sub-group of the Health Equity Steering Committee. The workgroup's purpose is to provide effective, equitable, understandable, and respectful materials that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
Focus Areas: This group will focus on the three (3) following priorities:
1. Collaborate with the community to design, implement, and evaluate policies, practices, and services that ensure cultural and linguistic appropriateness.
2. Establish culturally and linguistically appropriate goals and accountability to be infused throughout AllCare Health's planning and operations.
3. Collect and maintain accurate, reliable demographic data used to monitor and evaluate the impact of Culturally Specific Materials Workgroup on health equity and outcomes. Data will also help to inform service delivery.

Health Equity Data Workgroup
The Health Equity Data Workgroup is a sub-group of the Health Equity Steering Committee. The workgroup's purpose is to identify disparities between subgroups of Medicare and Medicaid beneficiaries (e.g., racial and ethnic groups). The group will focus primarily on the areas of health outcomes, utilization, and spending.
Focus Areas: This group will focus on the three (3) following priorities:
1. Create and produce a quarterly Health Equity Report to identify health disparities in our region.
2. Identify methods to incorporate regional Census Data into data dashboards.
3. Utilize data to inform policy decisions and to target populations and geographies for potential interventions.

Language Access Workgroup
The Language Access Workgroup is a sub-group of the Health Equity Steering Committee. The workgroup's purpose is to address the specific language needs of the Limited English Proficient (LEP) beneficiaries, in a method consistent with the core objectives of the federally assisted programs or activities. The group must identify and evaluate the specific language needs for both oral and written information. These needs may operate as artificial barriers to full and meaningful participation in AllCare Health, Inc. programs, activities, or services.
Focus Areas: This group will focus on the three (3) following priorities:
1. Create a yearly Language Access Assessment and Work plan for AllCare Health.
2. Assess quality of AllCare Health's Language Access Services including:
   a. Interpreters
   b. Translations
   c. Training on interpreter use for First Tier, Downstream, and Related entities.
   d. Internal staff trainings
3. Create and maintain AllCare Health's Language Access Policy

Policy Workgroup
The Policy Workgroup is a sub-group of the Health Equity Steering Committee. The workgroup's purpose is to provide resources and support for reviewing AllCare Health, First Tier, Downstream, and Related Entities policies with an "Equity Lens."
Focus Areas: This group will focus on the three (3) following priorities:
1. Create a policy evaluation process that aligns with the Culturally Appropriate Standards in Health and Healthcare.
2. Engage First Tier, Downstream, and Related Entities to advocate policies that support the social determinants of health and health equity.
3. Review, refine, and implement equitable hiring practice policies in coordination with Human Resources.

Training and Education
The Training and Education Workgroup is a sub-group of the Health Equity Steering Committee. The workgroup's purpose is to provide resources and support for improving the cultural competence of AllCare Health staff and First Tier, Downstream, and Related Entities within AllCare Health's service area.
Focus Areas: This group will focus on the three (3) following priorities:
1. Develop training and education with community input.
2. Train-the-trainers within AllCare Health's service area to broaden the reach of available trainings.
3. Develop and update criteria for approving external cultural competence continuing education opportunities.

AllCare CCO – Community Advisory Council Title: CAC Temporary funding process	Policy Number: CAC 006 - Temporary	
Department: CCO Administration	Last Reviewed:	Next Review Date:
Date of Origin: 11/01/18		

Purpose: To ensure timely and accurate processing and filing of funding requests from the community to the CACs. To ensure timely response of award or denial of award to community partners.

Policy:
1. Application for CAC funding will be efficiently shared among lead staff, CACs, and contractor
2. Funding decisions will be made by CACs
3. Funding decisions will be communicated to applicants in a timely manner
     a. This includes the issuance of checks, as applicable

Procedure:

- Applications received by staff, CAC members, or contractor. (original recipient)
- Application is shared by **original recipient** with, contractor, content-lead staff (see below) and CAC chairs.
- CAC reviews application and determines whether to fund, deny, or request additional information
- The **contractor** will communicate this decision to the **lead staff** who will respond in one of the three following ways:
    o If application is funded: prepare check request and award letter (templates in U: drive)
    o If denied: Communicate by phone and email to the applicant
    o If more information is required: Work with CAC chair and applicant to answer CAC's questions before the next CAC meeting.
- If the application is funded, **lead staff** will send the check request and award letter for the SDoH manager to be processed:
    o Signed by CEO
    o Submitted to fiscal for payment
    o Filed in the U: drive
    o Check and award letter mailed to applicant

Content lead staff:
Oral health integration: Laura McKeane
Mental/Behavioral health integration: Lana McGregor
Childhood, parenting, early education: Susan Fischer
Interpersonal/domestic violence: Jennifer Gustafson
All projects in Curry County: Cameron McVay plus other content lead
Housing, Food and Nutrition: Sam Engel

Contractor:
Vanessa Becker

RFA Community Engagement Plan TABLES

Applicants must provide a detailed plan for community engagement according to the required components in the RFA Community Engagement Plan Reference Document, including identified gaps and plans to address gaps. **Applicant's Community Engagement Plan must be no more than 4 pages (according to the RFA spacing and font restrictions), excluding tables. Tables should be completed in the format provided below and submitted with Applicant's Community Engagement Plan (narrative).**

Table 1: Stakeholders to be included in the engagement process			
All applicants must complete this full table. Applicants may add rows as needed.			
Part 1a. List stakeholder types to be included in the engagement process. Applicants must include, at a minimum, plans to engage the following stakeholder types: OHP consumers, community-based organizations that address disparities and the social determinants of health ("SDOH-HE"), providers, including culturally specific providers as available (includes physical, oral, behavioral, providers of long term services and supports, traditional health workers and health care interpreters), Regional Health Equity Coalitions (if present in the service area), early learning hubs, local public health authorities, local mental health authorities, other local government, and tribes. Add additional rows as needed.	**Part 1b.** List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1.a, with which the applicant will engage. Add additional rows under the stakeholder type as needed.	**Part 1b.** Describe why each listed agency, organization and individual was included.	**Part 1b.** Describe how Applicant plans to develop, maintain or strengthen relationships with each stakeholder and maintain a presence within the community.
OHP consumers (list in first column below)			
OHP consumers	**Jackson County Community Advisory Council**	Desire to be accurately informed by our community and to empower our members to provide direct feedback to AllCare CCO staff and leadership.	Chair of CAC serves on the AllCare CCO Board of Governors, fund CAC-administered community improvement budgets, staff support, leadership and training opportunities. Build accountability and transparency between AllCare CCO and CAC.
OHP consumers	**Josephine County Community Advisory Council**	Desire to be accurately informed by our community and to empower our members to provide direct feedback to AllCare CCO staff and leadership.	Chair of the CAC serves on the AllCare CCO Board of Governors, fund CAC-administered community improvement budgets, staff support, leadership

			and training opportunities. Build accountability and transparency between AllCare CCO and CAC.
OHP consumers	**Curry County Community Advisory Council**	Desire to be accurately informed by our community and to empower our members to provide direct feedback to AllCare CCO staff and leadership.	Chair of CAC serves on the AllCare CCO Board of Governors, fund CAC-administered community improvement budgets, staff support, leadership and training opportunities. Build accountability and transparency between AllCare CCO and CAC.
Community-based organizations that address disparities and SDOH-HE (list in first column below)			
Community-based organizations that address disparities and SDOH-HE	**Maslow Project**	Works to support children and families struggling with homelessness, marginal housing, and related symptoms of poverty, joblessness, and academic achievement.	AllCare works with Maslow Project on collaborative committees and workgroups to align goals and outcomes. AllCare CCO is pursuing a social service contract with Maslow.
Community-based organizations that address disparities and SDOH-HE	**Rogue Retreat / Hope Village**	Works to provide "housing pipeline" services ranging from street outreach and warming shelter services to independent living transitions, with an emphasis on drug and alcohol recovery.	AllCare has a social service contract with Rogue Retreat in Jackson County to provide case management services for our members. We intend to continue this contract and help Rogue Retreat expand services to Josephine County.
Community-based organizations that address disparities and SDOH-HE	**Oasis Shelter Home**	Oasis Shelter Home provides essential forensic services, is an active partner in ACE-Interface work, victims' advocacy, and provides shelter and housing services to victims of domestic violence.	AllCare has a provider contract with Oasis for forensic interviewing with the victims of forensic assault. We will continue to support Oasis in claims processing and to become a "provider."
Community-based organizations that address disparities and SDOH-HE	**Women's Crisis Support Team (WCST)**	WCST provides victims' advocacy, and provides shelter and housing	AllCare will continue to support WCST with a combination of financial and in-kind support to

		services to victims of domestic violence.	help serve the needs of women and children who have been the victims of domestic abuse.
Community-based organizations that address disparities and SDOH-HE	**Grants Pass Sobering Center**	Works to provide a safe and supportive environment for individuals suffering from intoxication in lieu of going to Jail or the Emergency Department. Provides a crucial access point to engage members struggling with Substance Use Disorders to get them connected to needed treatment and mental health services.	AllCare will continue to support GPSC with a combination of financial and in-kind resources to help ensure our community has a resource for intoxication that better meets the needs of our citizens, law enforcement agencies, hospitals and our community as a whole. Grants Pass Sobering Center reflects AllCare's 'no wrong door' to accessing needed services.
Community-based organizations that address disparities and SDOH-HE	**Age Friendly Innovators (DBA Rebuilding Together Rogue Valley)**	Rebuilding will engage qualified professionals, in accordance with applicable state and federal requirements, who will perform in-home safety assessment's and identify the need for bathroom safety devices in a member's home. Rebuilding also identifies other SDOH-HE needs that member may have and informs Care Coordination	As a result of wildfires affecting air quality in southern Oregon, AllCare is piloting a project with Rebuilding where they will perform an in-home air quality assessment and identify the need for air quality interventions in a member's home.
Community-based organizations that address disparities and SDOH-HE	**Growers and Farmers Markets in Josephine and Jackson Counties**	Growers and Farmers Markets in our region are increasingly playing an active role in food security and economic stability by accepting SNAP, offering Double Up food Bucks (SNAP Matching), and donating excess produce to area food banks.	AllCare CCO's CACs have supported the Double Up food Buck program in all three counties that we serve to help address food insecurity and economic stability. CACs will accept and review application for funding renewal. AllCare CCO will offer in-kind support.

Community-based organizations that address disparities and SDOH-HE	**Access Community Action Agency**	In addition to traditional food bank services, Access, the Jackson County community action agency, offers a healthy mobile pantry, focused on nutrition for chronic conditions and limited access populations.	AllCare CAC in Jackson County renewed operational funding for this program in 2019.
Community-based organizations that address disparities and SDOH-HE	**Oregon Coast Community Action (ORCCA)**	ORCCA, the community action agency for Coos and Curry Counties, operates several key services in Curry County: FAST family stability program, homeless and housing services, and economic/financial literacy.	AllCare CAC in Curry County funded ORCCA's FAST program in 2018. We are awaiting their year-end grant report to determine the level of future support.
Community-based organizations that address disparities and SDOH-HE	**Josephine County Food Bank (JCFB)**	JCFB offers on-site agricultural education and operates a small farm in addition to traditional food bank activities. Through their network of kitchens and pantries, they serve over 11,000 people each month. They have been listed as one of the most nutritious emergency food providers in the state.	AllCare CAC in Josephine County renewed funding for JCFB's on-site garden education program for children in 2019. Additionally, AllCare CCO has supported a senior garden at JCFB (Raptor Creek) since 2013. School age children and seniors are able to interact and benefit from one another's knowledge and experience.
Community-based organizations that address disparities and SDOH-HE	**Jackson County Aging and People with Disabilities**	APD is the backbone entity for the Deaf and Hard of Hearing Workgroup. This group is majority Deaf and advancing ASL interpretation in the region.	AllCare is supporting this group in strategic planning and including participants on internal Health Equity committees to inform policy.
Providers, physical health, including culturally specific providers as available (list in first column below)			
Providers, physical health, including culturally specific providers as available	**La Clinica**	La Clinica actively engages AllCare with feedback from community on our services. The CAC chair is on the AllCare CCO board. La Clinica conducts street outreach efforts to the homeless	Continue to actively partner with La Clinica in innovative projects in the communities we serve. Work collaboratively to develop effective community outreach and health improvement.

		populations, participates in the Accountable Health Communities SDoH/HE screening project, has a strong emphasis on multi-lingual and culturally appropriate services, and is a partner in the collaborative CHA/CHP.	
Providers, physical health, including culturally specific providers as available	**Rogue Community Health**	Rogue Community Health is an FQHC Rogue Community Health was one of 5 agencies that participated in our Health Equity 'Train the Trainer' Training. Rogue Community Health is part of the regional "Rogue Challenge" closed –loop referral project, launched an innovative 'health-legal partnership', and is a partner in the collaborative CHA/CHP.	Continue to actively engage RCH in innovation and community feedback. Work collaboratively to develop effective community outreach and health improvement.
Providers, physical health, including culturally specific providers as available	**Siskiyou Community Health Center**	Siskiyou Community Health Center was one of 5 agencies that participated in our Health Equity 'Train the Trainer' Training. SCHC is a partner in Blue Zones; operates 2 school-based health centers; operates "Project Baby Check, an innovative and effective home visiting program; and participates in the collaborative CHA/CHP.	Continue to actively engage SCHC in innovation and community feedback. Work collaboratively to develop effective community outreach and health improvement.
Providers, physical health, including culturally specific providers as available	**Siskiyou Pediatrics**	AllCare funds a Care Coordinator at Siskiyou Pediatrics (pediatric clinic with 6 health care providers) that works with families to address the complex SDOH-HE needs of our young members and their families.	AllCare will continue to work with Siskiyou Pediatrics to address workflow inefficiencies and support their effort in addressing the SDoH-HE needs for their patients and families.

Providers, physical health, including culturally specific providers as available	Josephine and Jackson County Justice System	AllCare employs THWs to provide peer support for members recently released form the justice system. They offer side-by-side support during probation meetings as well as coordination with community based programs and services needed to re-enter society such as housing, employment and transportation. Family Partners is a program for those living with children who have behavioral health issues, interaction with the criminal or juvenile justice systems or intellectual developmental disabilities. Peers who have navigated the system offer wrap-around services for families.	AllCare will continue to work with the justice and public safety system to avoid costly and unnecessary future arrests and mitigate barriers to prevent relapse.
Providers, behavioral health, including culturally specific providers as available (list in first column below)			
Providers, behavioral health, including culturally specific providers as available	ARC – Addictions Recovery Center	In addition to providing an array of outpatient Substance Use Disorder (SUD) treatment services to our members, ARC works towards addressing the health disparities of our community members that struggle with severe behavioral health challenges. They are collaborating with the other local SUD providers to build competencies in their workforce. They are also investing in many integration efforts to support their consumers with all of their	Continue to support ARC as a large provider of SUD services for our members and support them as they work with other community SUD providers to improve and strengthen the competencies of our local SUD workforce. This includes a focus and investment on HE trainings to ensure the workforce is delivering Culturally and Linguistically appropriate services. Also, we will continue to provide assistance to further

		healthcare needs. They have added mental health services and have a strong partnership with a co-located a Specialty and Primary Care clinic. They are currently developing Oral Health services that will be available in their programs.	build and improve their integration efforts.
Providers, behavioral health, including culturally specific providers as available	**OnTrack Rogue Valley**	In addition to providing an array of Substance Use Disorder (SUD) treatment services to our members, OnTrack RV works towards addressing the health disparities of our community members that struggle with severe behavioral health challenges. OnTrack has a large focus on housing and supporting their consumers in transitional housing while they are in treatment. They are also collaborating with the other local SUD providers to build competencies in their workforce. OnTrack RV is improving integration efforts to support their consumers with all of their healthcare needs by strengthening their relationships with local mental health, primary care and MAT providers. They are currently developing Oral Health services that will be available in their programs.	AllCare will continue to support OnTrack RV as a large provider of SUD services for our members and support them as they work with other community SUD providers to improve and strengthen the competencies of our local SUD workforce. This includes a focus and investment on Health Equity trainings to ensure the workforce is delivering Culturally and Linguistically appropriate services. Also, we will continue to provide assistance to further build and improve their integration efforts.

Providers, behavioral health, including culturally specific providers as available	**Phoenix Counseling Center**	Phoenix Counseling currently provides outpatient SUD services to AllCare members. They have been a leader in ensuring Spanish Speaking counselors are available for members seeking SUD treatment.	AllCare will continue to support Phoenix Counseling as a provider and to assist them with their work of providing services/resources to Spanish speaking members and their families on their roads to recovery. Also AllCare will support their work with the other community SUD providers to improve and strengthen the competencies of our local SUD workforce. This includes a focus and investment on Health Equity trainings to ensure the workforce is delivering Culturally and Linguistically appropriate services.
Providers, behavioral health, including culturally specific providers as available	**Options of Southern Oregon**	Options is our largest provider of Mental Health services. They provide a full array of Mental health, primary care and SUD treatment services. Their primary focus is reducing health disparities for our community members with Severe and Persistent Mental Illnesses (SPMI). They continuously work on the SDOH of all of their consumers to help them fully recover from behavioral health challenges. Options has followed AllCare's lead and committed to train all their staff in Health Equity and CLAS standards. Options has sent	AllCare will continue to partner and support Options with their full continuum of Behavioral Health services and their efforts to greatly improve the health for our community members with SPMI and other behavioral health challenges. AllCare will continue to support and increase resources for Options to provide community trainings and engagement around behavioral health promotion, prevention, treatment and recovery.

		many staff to AllCare's HE trainings and now has their own staff member who has completed our Train the Trainer series.	
Providers, behavioral health, including culturally specific providers as available	**Curry Community Health**	Curry Community Health (CCH) is an AllCare provider of Mental Health services. They provide a full array of Mental health, primary care and SUD treatment services. They have a strong focus on reducing health disparities for our community members with Severe and Persistent Mental Illnesses (SPMI) and other behavioral health issues. They continuously work on the SDOH of all of their consumers to help them fully recover from behavioral health challenges. CCH has risen to AllCare's challenge of investing in Health Equity by sending their Mental Health Director to participate in the DELTA program.	AllCare will continue to support CCH in their provision of integrated services and assist them in their Health Equity investments. Continue to support and increase resources for CCH to provide community trainings and engagement around behavioral health promotion, prevention, treatment and recovery.
Providers, behavioral health, including culturally specific providers as available	**Jackson County Mental Health**	JCMH has made significant efforts and investments in Suicide Prevention throughout Jackson County. They have provided countless suicide prevention trainings to professionals, schools and community members. They have forged fruitful partnerships with their local School Districts to ensure access to an array of Suicide Prevention education and resources. They convened a local,	AllCare will continue to participate and support Jackson County's Suicide Prevention efforts.

		multidisciplinary Suicide Prevention coalition that has been involved in promoting community awareness and education efforts.	

Providers, oral health, including culturally specific providers as available (list in first column below)			
Providers, oral health, including culturally specific providers as available	Advantage Dental	Advantage Dental's outreach is focused on helping the professionals who work with pregnant women and parents with infants and toddlers to teach them about preventative care. AD have been engaged partners with AllCare in promoting 'First Tooth' trainings; with 'Train the Trainer' for this important outreach program. Advantage Dental's internal leadership sponsored 'Poverty Simulations' and 'Bridge Out of Poverty' training to all their staff and providers in order to raise the awareness of oral health disparities in those individuals who are poor and impoverished. Advantage Dental was one of 5 agencies that participated in our Health Equity 'Train the Trainer' Training and conducts regular training for their employees.	AllCare and Advantage Dental share common oral health goals for children and families of southern Oregon. AllCare will continue to actively engage and support Advantage Dental in innovative outreach programs and preventative health (fluoride treatment, dental sealants) and promotion of routine oral health care for children and families.
Providers, oral health, including culturally specific providers as available	Capitol Dental	Capitol Dental is committed to preventing dental disease and improving the oral and systemic health of children and low income patients. They have been interested partners in providing care in non-traditional venues	AllCare and Capitol Dental share common oral health goals for children and families of southern Oregon. AllCare will continue to actively engage and support Capitol Dental in innovative outreach programs, preventative

		(schools, medical offices and community settings). Capitol Dental has a robust Head Start and school dental screening, fluoride treatment and sealant placement effort. Innovative pilot projects with tele-dentistry show promise in being expanded to other locations which will help mitigate access issues in rural settings. Capitol Dental was one of 5 agencies that participated in our Health Equity 'Train the Trainer' Training and conducts regular training for their employees.	health (fluoride treatment, dental sealants) and promotion of routine oral health care for children and families. AllCare is supportive in expanding tele-dentistry to other areas such as Curry County to improve access to oral health services.
Providers, oral health, including culturally specific providers as available	**ODS**	ODS cultural competency training is available to all MODA employees. The online program consists of three modules: working in an inclusive environment, implicit bias and cultural competency. ODS is also a will partner in community programs to further develop cultural competency skills.	Though our membership with ODS is small, AllCare will continue to actively engage and support ODS Dental in innovative outreach programs, preventative health (fluoride treatment, dental sealants), promotion of routine oral health care for children and families and ensuring a caring culturally sensitive environment to our members.
Providers, oral health, including culturally specific providers as available	**Willamette Dental**	Willamette Dental has embedded care coordinators (Care Advocates) in every office to assist OHP members with their care needs. The Care Advocates place special attention to ensure that our members understand their treatment plans which in turn improves patient-motivation and compliance with their treatment	Though our membership with Willamette is small, AllCare will continue to actively engage and support Willamette Dental in innovative outreach programs, preventative health (fluoride treatment, dental sealants), promotion of routine oral health care for children and families and ensuring a caring, culturally

		plans. The main goal being to reduce oral health disparities among their members.	sensitive environment for our members.
Providers, long term services and supports, including culturally specific providers as available (list in first column below)			
Providers, long term services and supports, including culturally specific providers as available	**Grants Pass Treatment Center (GPTC)**	GPTC is an outpatient addiction treatment center focusing on treating those suffering from an addiction opioids (pain-pills, heroin, morphine) through a combination of Medication Assisted Treatment (MAT) with either methadone or buprenorphine/Suboxone, detoxification, and intensive one-on-one and group counseling. GPTC has been a willing partner to address the needs of the under-served population of Southern Oregon. The location in Grants Pass has provided access to individuals in Josephine and Curry County; making it unnecessary to travel to Medford for their treatment.	AllCare will continue to partner with GPTC and support their mission to focus on recovery, relapse prevention and utilize the holistic needs of the patient.
Providers, long term services and supports, including culturally specific providers as available	**Allied Health Services**	Allied Health Services in Medford (Jackson County) provides medication assisted treatment (MAT) services for adults aged 18 or older who are addicted to opioids (morphine, heroin, and prescription painkillers).	AllCare will continue to partner with Allied Health Services.
Providers, traditional health workers, including culturally specific providers as available (list in first column below)			
Providers, traditional health workers, including culturally specific providers as available	**Compass House**	Compass House is a Peer Run Clubhouse that provides an array of supportive services and resources to Adults living with	AllCare will continue to support Compass House and their efforts to educate our community and engage members with mental

		mental illness. They have an engagement coordinator that AllCare initially funded that goes to our local Psychiatric Unit and other places where members may need assistance engaging in supports. Compass House provides many community awareness and education opportunities for our community.	illness. We will ensure that our contracted mental health agencies continue to provide support and resources to Compass House so they in turn can continue to provide the level of peer support to our members.
Providers, traditional health workers, including culturally specific providers as available	**Siskiyou Community Health Center**	Siskiyou Community Health Center sponsors Project Baby Check and Health Start – Healthy Families of Southern Oregon. AllCare has funded positions for this worthwhile evidence-based program since 2010. Outreach workers are certified through 'Parents as Teachers' which supports a parent's role in promoting school readiness and the healthy development of their children. The program offers a relationship-based approach that embraces learning experiences that are relevant and customized to the individual families.	AllCare will continue to support the programs that focus on healthy families getting upstream of avoidable negative outcomes for children and their readiness for school.
Providers, traditional health workers, including culturally specific providers as available	**Head Start Curry County THW**	This position is funded by AllCare and works directly with teachers, aides and others while children are in the Head Start setting. Issues are problem-solved such as clothing, adequate food, inadequate transportation; factors that directly impact a child's ability to start school and successfully attain educational and	AllCare will continue to partner with the Curry County School District and fund the THW position.

		social milestones. Curry County has limited resources and the Curry County CAC funds projects brought to their attention.	
Providers, traditional health workers, including culturally specific providers as available	**Head Start Josephine County Three Rivers School District THW**	Similar to the Curry County position, the THW is funded by AllCare and works directly with teachers, aides and others while children are in the Head Start setting. Issues are problem-solved such as clothing, adequate food, inadequate transportation; factors that directly impact a child's ability to start school and successfully attain educational and social milestones.	AllCare will continue to partner with the Three Rivers School District in Josephine County and fund the THW position.
Providers, health care interpreters (list in first column below)			
Providers, health care interpreters	**Sylvia Roxanna-Zapata**	Ms. Zapata is engaged with our internal Language Access workgroup to provide feedback on our internal interpreter services.	AllCare will continue to engage interpreters locally to inform us on improvements to language access service.
Providers, health care interpreters	**Iram Nunes**	Mr. Nunes is our Internal trainer for the 64 hour Bridging the Gap (BTG) medical Interpretation Training. Mr. Nunes brings feedback from these interpreters back to our internal leadership to address policy.	AllCare will continue in supporting the Bridging the Gap training and becoming a recognized site by CCHI for Continuing Education Training outside of BTG.
Providers, health care interpreters	**Ila Sachs**	Ms. Sachs provides interpretation for the Deaf and Hard of Hearing Workgroup. She is critical for advising AllCare on American Sign Language interpretation	AllCare will continue to support Ms. Sachs as a leader in the community.
Early learning hubs (list in first column below)			

Early learning hubs	**South Coast Regional Early Learning Hub (SCREL) (Coos/Curry)**	SCREL promotes the alignment of programs and resources for child 0-6 and was established in May 2015 as one of the 16 regional Early Learning Hubs of Oregon. SCREL works with families, schools, businesses, CCOs, healthcare providers to develop a shared vision and goals.	AllCare will continue to be involved in the governance, collaborate in the priorities outlined in the 2018 collaborative CHA (Coos/Curry) and invest in local initiatives.
Early learning hubs	**Southern Oregon Early Learning Services (SOELs) (Josephine/Jackson)**	SOELs makes resources and support more effective for children and families that have been historically under-represented in services. They work to ensure that needed programs and services reach those most in need. Their efforts have been dedicated on building outcomes–focused collaborations across K-12 schools, early education, health/human services and business.	AllCare will continue to be involved in the governance, collaborate in the priorities outlined in the 2018 collaborative CHA (Josephine/Jackson) and invest in local initiatives.
Local public health authorities (list in first column below)			
Local public health authorities	**Josephine County Public Health**	JCPH provides many safety net services to our county residents and members including: WIC, treatment of STIs, childhood immunizations, CaCoon program and family planning. JCPH engages and collaborates with many community partners to improve the health of Josephine County. Such partnerships include: providing training to local Law Enforcement on the use of Narcan and participation in our Local Public Safety Coordinating	AllCare will continue to provide funding for 3 clinical positions (RN, RD and WHNP) and support to JCPH to ensure their services and community engagement efforts continue in our community.

		Councils. JCPH representatives are active members of AllCare's CAC and participate in the collaborative CHA/CHIP processes.	
Local public health authorities	**Jackson County Public Health**	AllCare and public health departments share the common goals of prevention and access to services.	AllCare will continue to support Jackson County's robust Syringe Exchange program and harm reduction approach to promote the safety of IV drug users and the safety of the larger community.
Local public health authorities	**Curry County Public Health**	Curry County Public Health/Community Health representatives are active members of AllCare's CAC and participates in the collaborative CHA/CHIP processes.	AllCare will continue our relationship with CCPH to ensure their voice is represented at our CAC.
Local mental health authorities (list in first column below)			
Local mental health authorities	**Options of Southern Oregon**	Options provides safety net crisis services for our members and communities as a whole. Options provide Mobile Crisis Services, Jail Diversion programs and support for our Mental Health Court.	AllCare will continue to support these functions to ensure our members have access to these services when needed.
Local mental health authorities	**Curry Community Health (CCH)**	CCH provides safety net crisis services for our members and community as a whole. CCH provides Mobile Crisis Services, Jail Diversion programs and support for our Mental Health Court.	AllCare will continue to support these functions to ensure our members have access to these services when needed.
Local mental health authorities	**Jackson County Mental Health (JCMH)**	JCMH provides safety net crisis services for our members and community as a whole. They also	Continue to support these functions to ensure our members

		provide Mobile Crisis Services, Jail Diversion programs and support for our Mental Health Court.	have access to these services when needed.
Other local government (list in first column below)			
Tribes, if present in the service area (list in first column below)			
Regional Health Equity Coalitions, if present in the service area (list in first column below)			
Regional Health Equity Coalitions	**Southern Oregon Health Equity Coalition (SO Health-E)**	A cross-jurisdictional Regional Health Equity Coalition to advance policy, systems, and environmental changes that promote equity and address social determinants of health. The Coalition prioritizes health disparities for under-represented populations, with the strongest and most particular focus on racially and ethnically diverse communities, and how this intersects with people with disabilities, gender and sexual minorities (GSM), and low income levels. So Health-E has 5 workgroups that AllCare participates with and guides Health Equity decision making internally.	AllCare will continue to access the wealth of community input that So Health-E provides and engage with the coalition in a transparent way that provides local accountability.
Add additional stakeholder types here (list in first column below)			
Data sharing collaboration	**Reliance (formerly Jefferson Regional Health Information Exchange)**	Reliance eHealth Collaborative is a community collaboration of health care providers, hospitals, health	AllCare is part of the governing board and will continue to participate in upcoming projects

		plans, CCOs, public health agencies, clinics and others interested in harnessing technology to improve the cost, quality, and efficiency of health care. Reliance started in the Rogue Valley in 2011 with the start-up costs and continued funding being shared by AllCare, Asante and Providence Health Systems.	helping to create efficiencies and improve the quality of care while affecting the cost of care in our region. We will build on the successes experienced in other areas that will promote care management across physical, behavioral and oral health pathways via a web-based application or through the delivery of clinical results for use within an existing care management system.
Regional achievement collaborative	**Southern Oregon Success**	Southern Oregon Success is a collaboration of talent, expertise and resources of the communities in southern Oregon. The focus is to promote the health, academic and life success of our children, youth and families. Among noted projects underway in Josephine and Jackson counties: 'ACES and Self-Healing Communities Initiative', 'College and Career for All', 'Early Childhood Education', 'Youth Development' and 'Systems of Care'.	AllCare has supported one of the primary positions at SORS – ensuring there would be dedicated personnel to complete ACES training across all sectors (Public Education: teachers, bus drivers, cafeteria staff, principles), law enforcement, health care providers. Southern Oregon is now known as a Trauma Informed Region. AllCare will continue to be involved with SORS in order to promote the shared goals for children and families.
Regional health collaborative	**Jefferson Regional Health Alliance**	JRHA is a consortium of regional community leaders from all sectors learning and working together to improve the health and healthcare resources of Southern Oregon. JRHA was the 'convener' to oversee the development of the collaborative CHA and CHIP that involves	AllCare has 2 staff that chair the collaborative CHIP steering committees (Housing and Parenting/Life Skills). AllCare is involved in the governance (executive committee and board) and funding of JRHA and will continue to participate in the

		hospital systems, public health departments, FQHCs, CCOs in Josephine and Jackson counties. The goal is to leverage relationships and resources so that there is a greater collective impact on the communities' health concerns.	collaborative projects that result from the CHIP.
Add additional stakeholder types here (list in first column below)			
Add additional stakeholder types here (list in first column below)			
Add additional stakeholder types here (list in first column below)			

Table 2: Major activities and deliverables for which the CCO will engage the community	
All applicants must complete this full table.	
Part 2a. List and describe the five to eight major projects, programs and decisions for which the CCO will engage the community.	**Part 2b.** Identify the level of community engagement for each project, program and decision. Answers* must be 1) inform/communicate, 2) consult, 3) involve, 4) collaborate, or 5) shared decision-making. Applicant may include more than one level of engagement for each project, program or decision to account for differences among stakeholder groups.
Housing: Increase the supply of affordable, safe, and appropriate housing and improve housing security – Solicit grant proposals from low-income, and transitional housing agencies such as Rogue Retreat and Maslow Project. Collaborate on local workgroups and steering committees to identify and remove barriers to housing and housing creation.	1) inform/communicate, 2) consult, 3) involve, 4) collaborate, 5) shared decision-making
Substance abuse: Focus on school based clinics & school based education on drug use. Address expanded alternatives and treatment, grow ARC, address prescription drug monitoring and Increase education.	1) inform/communicate, 2) consult, 3) involve, 4) collaborate, 5) shared decision-making
Mental Health and Well-being: Through programs, partnerships, and community engagement, work to reduce stigma, improve access to treatment, and create bi-partisan support across our service area.	1) inform/communicate, 2) consult, 3) involve, 4) collaborate, 5) shared decision-making
Parenting and life skills: Poverty and Employment: Improve job opportunities and increase wage opportunities for low-income residents. Connect social service sector to economic development planning. Improve and expand vocational training programs.	1) inform/communicate, 2) consult, 3) involve, 4) collaborate, 5) shared decision-making
Increased use of PrEP (Pre-exposure prophylaxis treatment for HIV): Increase the availability and use of PrEP in a culturally appropriate way among partners of HIV positive individuals.	1) inform/communicate, 2) consult, 3) involve, 4) collaborate, 5) shared decision-making
Native American and SPMI Listening sessions: Through the use of demographic and claims data, AllCare Health CCO has identified that a disparity exists for two populations in regard to Emergency Room utilization for physical health reasons. The data shows that in Jackson and Josephine counties, members who identify as Native American and members diagnosed with a Severe and Persistent Mental Illness (SPMI) have a significantly higher rate of ER utilization in comparison to the rest of the AllCare Health CCO population. Our goal is to determine the reasons these members access the Emergency Room and to assist them in engaging or re-engaging with their primary care provider.	1) inform/communicate, 2) consult, 3) involve, 4) collaborate, 5) shared decision-making

The model used for these sessions was Multicultural Listening Sessions. Multicultural communities often convey health information and knowledge qualitatively – through sharing stories – while professionals tend to rely more upon quantitative methods – such as data collection – to gather information. Storytelling and other qualitative methods can help professionals understand and determine the meaning behind the numbers, which is key to effective policy and program development. In addition, sharing a personal story has the added benefit of empowering the storyteller and, if applicable, can also help with his/her healing process. This is especially true when the story is heard by those in leadership positions who can influence positive changes to address elements shared within the story.	
LGBTQIA Listening Sessions: Provider offices that participate in AllCare Health's Alternative Payment Models (APM) are surveyed annually to determine patient satisfaction with access to care and their provider. In an effort to make the program more equitable the following question was added to the survey: Do you feel that you were treated differently from other patients because of any of the following? (Check all that apply) Insurance Type, Race, Gender, Age, LGBTQ, Disabled, Language, Other LGBTQ continues to be checked as one of the most common reasons that members feel they are treated differently. Through AllCare's Community Advisory Council in each county those that identify as transgender continue to voice concerns of discrimination, as well as, verbal and physical abuse, according to feedback from AllCare's Community Advisory Councils in Josephine, Jackson and Curry counties. The model used for these sessions was Multicultural Listening Sessions. Multicultural communities often convey health information and knowledge qualitatively – through sharing stories – while professionals tend to rely more upon quantitative methods – such as data collection – to gather information. Storytelling and other qualitative methods can help professionals understand and determine the meaning behind the numbers, which is key to effective policy and program development. In addition, sharing a personal story has the added benefit of empowering the storyteller and, if applicable, can also help	1) inform/communicate, 2) consult, 3) involve, 4) collaborate, or 5) shared decision-making

with his/her healing process. This is especially true when the story is heard by those in leadership positions who can influence positive changes to address elements shared within the story. https://www.youtube.com/watch?v=2lR_HVIjagE&feature=youtu.be	

*
1. **Inform**: Provide the community with information to assist in their understanding of the issue, opportunities, and solutions. Tools include fact sheets, published reports, media releases, education programs, social media, email, radio, information posted on websites, and informational meetings.
2. **Consult**: Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions.
3. **Involve**: Work directly with the community throughout the process to ensure that community concerns and aspirations are understood and considered. Applicant provides feedback to the community describing how the community input influenced the decision. Tools include meetings with key stakeholders, workshops, subject matter expert and stakeholder roundtables, conferences, and task forces.
4. **Collaborate**: Partner with the community in each aspect of the process, including decision points, the development of alternatives and the identification of a solution. Tools include advisory committees, consensus building, and participatory decision making.
5. **Shared decision-making**: To place the decision-making in the hands of the community (delegate) or support the actions of community initiated, driven and/or led processes (community driven/led). Tools include delegated decisions to members of the communities impacted through steering committees, policy councils, strategy groups, Community supported processes, advisory bodies, and roles and funding for community organizations.

RFA COMMUNITY ENGAGEMENT PLAN TABLES

Table 3: Engagement with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans					
All applicants must complete this full table. Applicants may add rows as needed.					
Part 1. Applicants with an existing CCO CHA and CHP will submit their most recent CHA and CHP with the community engagement plan.					
Part 2. List of all local public health authorities, non-profit hospitals, other CCOs that share a portion of the service area, and any federally recognized tribe in the service area that is developing or has a CHA/CHP. Add additional rows as needed.	**Part 3.** The extent to which each organization was involved in the development of the Applicant's current CHA and CHP. Answers***** must be a) competition and cooperation, b) coordination, c) collaboration, or d) not applicable (NA).******	**Part 4.** For any organization that is a <u>collaborator</u> for a shared CHA and shared CHP priorities and strategies, the applicant will list the shared priorities and strategies.******	**Part 5.** For any organization that is <u>not a collaborator</u> for a shared CHA and shared CHP priorities and strategies, the applicant will describe the current state of the relationship between the applicant and the organization(s), including gaps.	**Part 6.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the steps the applicant will take to address gaps prior to developing the next CHA and CHP, and the dates by which the applicant will complete key tasks.*******	**Part 7.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed CHAs and CHPs developed by these other organizations. List the health priorities from existing plans.
Local public health authorities (list in this column below)					
Josephine County Public Health	Collaboration	Developing a collaborative CHA from which a collaborative CHIP is being developed. Priorities: Housing, Behavioral Health, Parenting and Life Skills.	N/A	N/A	N/A
Jackson County Public Health	Collaboration	Developing a collaborative CHA from which a collaborative CHIP is being developed.	N/A	N/A	N/A

		Priorities: Housing, Behavioral Health, Parenting and Life Skills.			
Curry County Public Health	Collaboration	Developing a collaborative CHA from which a collaborative CHIP is being developed. Priorities: Health Systems and Capacity, Health Equity, Communities and Families.	N/A	N/A	N/A
Non-profit hospitals (list in this column below)					
Asante: Rogue Regional Medical Center	Collaboration	Developing a collaborative CHA from which a collaborative CHIP is being developed. Priorities: Housing, Behavioral Health, Parenting and Life Skills.	N/A	N/A	N/A
Asante: Three Rivers Community Hospital	Collaboration	Developing a collaborative CHA from which a collaborative CHIP is being developed. Priorities: Housing, Behavioral Health, Parenting and Life Skills.	N/A	N/A	N/A
Asante: Ashland Community Hospital	Collaboration	Developing a collaborative CHA from which a collaborative CHIP is being developed.	N/A	N/A	N/A

		Priorities: Housing, Behavioral Health, Parenting and Life Skills.			
Providence Medford Medical Center	Collaboration	Developing a collaborative CHA from which a collaborative CHIP is being developed. Priorities: Housing, Behavioral Health, Parenting and Life Skills.	N/A	N/A	N/A
Curry General Hospital	Collaborator	Developing a collaborative CHA from which a collaborative CHIP is being developed. Priorities: Health Systems and Capacity, Health Equity, Communities and Families.	N/A	N/A	N/A
Sutter Coast Hospital	Coordinator	N/A	Neighboring state hospital system; provides access to ED, MAT, and other services. Not engaged in the CHA process. We are looking to engage them as a critical partner in the CHIP process.	By September 30th, 2019: Sutter will be engaged as a collaborator in the Curry Collaborative CHIP process.	N/A
Current coordinated care organizations, as of 2019 (list in this column below)					
Jackson Care Connect / Care Oregon	Collaborator	Developing a collaborative CHA from	N/A	N/A	N/A

		which a collaborative CHIP is being developed. Priorities: Housing, Behavioral Health, Parenting and Life Skills.			
Primary Health	Collaborator	Developing a collaborative CHA from which a collaborative CHIP is being developed. Priorities: Housing, Behavioral Health, Parenting and Life Skills.	N/A	N/A	N/A
Advanced Health	Collaborator	Developing a collaborative CHA from which a collaborative CHIP is being developed. Priorities: Health Systems and Capacity, Health Equity, Communities and Families.	N/A	N/A	N/A
Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)					
Tolowa Dee-ni' Nation	Collaborator	Developing a collaborative CHA from which a collaborative CHIP is being developed. Priorities: Health Systems and Capacity, Health Equity,	N/A	N/A	N/A

		Communities and Families.			
* a) Competition and Cooperation: Loose connections and low trust; tacit information sharing; ad hoc communication flows; independent goals; adapting to each other or accommodating others' actions and goals; power remains with each organization; resources remain with each organization; commitment and accountability only to own organization; relational time frame short; low risk and reward. b) Coordination: Medium connections and work-based trust; structured communication flows and formalized project-based information sharing; joint policies, programs and aligned resources; semi-interdependent goals; power remains with parent organizations; commitment and accountability to parent organization and project; relational time frame medium and based on prior projects; medium risk and reward. c) Collaboration: Dense interdependent connections and high trust; frequent communication; tactical information sharing; systems change; pooled and collective resources; negotiated shared goals; power is shared between organizations; commitment and accountability to network first, community and parent organization; relation time frame long (3 years or more); high risk and reward. d) Not applicable					
**If the applicant does not have a current CHA and CHP, the applicant will enter not applicable (NA).					
***Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.					

Table 4: Engagement with social determinants of health and health equity (SDOH-HE) partners for CHA and CHPs Applicants may add rows as needed.					
All applicants must complete Part 1.	**Applicants <u>with an existing CHA and CHP</u> must complete Parts 2, 3 and 4.** **Applicants <u>that intend to change their service area </u>must also complete Parts 2, 3, and 4.**			**Applicants <u>without an existing CHA and CHP or</u> <u>that intend to change their service area</u> must complete Parts 2a and 4a.**	
Part 1. List of organizations that address the social determinants of health and health equity in the applicant's service area. Add additional rows as needed.	**Part 2.** Applicants **with an existing CHA and CHP** will describe existing partnerships with each identified organization, including whether the organization contributed to the applicant's current CHA and CHP.	**Part 3.** Applicants **with an existing CHA and CHP** will describe gaps in existing relationships with identified organizations.	**Part 4.** Applicants **with an existing CHA and CHP** will describe the steps the applicant will take to address the identified gaps prior to developing the next CHA and CHP and the dates by which the applicant will complete key tasks for engagement.**	**Part 2a.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area. For each organization listed in Part 1, the applicant will document the organization's level of involvement in developing any other CHAs or CHPs by entering one of these responses: a) The organization was explicitly involved in developing one or more CHAs or CHPs; b) The organization was not explicitly involved in developing a CHA or CHP; c) unknown.	**Part 4a.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area by describing the steps the applicant will take to form relationships and secure participation by each organization prior to developing the first or next CHA and CHP, and the dates by which the applicant will complete key tasks for engagement.**

All tribes that are present in the service area (list in this column below). If no tribe is present in the service area, note there are none.					
Tolowa Dee-ni' Nation	Provided input for the collaborative CHA	Gap: we do not have a formal relationship with the tribe. However, we will establish a formal relationship by September 2019.	We will work through the collaborative CHIP process to engage the Tolowa Dee-ni' Nation to develop a health improvement plan and engage the indigenous members we serve throughout the region.	N/A	N/A
All regional health equity coalitions (RHECs) that are present in the service area (list in this column below). If no RHEC is present in the service area, note there are none.					
Southern Oregon Health Equity Coalition	Provided input for the collaborative CHA, providing input for the collaborative CHIP.	N/A	N/A	N/A	N/A
Local government, including counties					

City of Medford	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
City of Ashland	Active role in collaborative CHIP	N/A	N/A	N/A	N/A
Representative Pam Marsh	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Josephine County	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Curry County	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Rogue Valley Council of Governments	Provided input for the collaborative CHA				
Jackson County	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Organizations that address the four key domains of social determinants of health* (list in this column below).					
Southern Oregon ESD Migrant Education	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Medford School District 549c	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Southern Oregon Head Start	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A

Southern Oregon University	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Grants Pass School District 7	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
OSU Extension	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
OHSU School of Nursing	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Rogue Valley YMCA	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Rogue Valley Transportation District	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Gordon Elwood Foundation	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Housing Authority of Jackson County	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Grants Pass YMCA	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Maslow Project	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Rogue Workforce Partnership	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Southern OR Veterans Rehabilitation Services and Clinics	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Rogue Action Center	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
OnTrack Rogue Valley	Provided input for the collaborative CHA,	N/A	N/A	N/A	N/A

	active role in collaborative CHIP				
Grants Pass Blue Zones	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Unete Center for Farmworker Advocacy	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Kairos	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Family Nurturing Center	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Options for Southern Oregon	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Jefferson Regional Health Alliance	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
United Community Action Network	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
ACCESS	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Oregon Coast Community Action Network	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
The Family Connection	Active role in collaborative CHIP	N/A	N/A	N/A	N/A

Illinois Valley Community Development Organization	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
United Way of Jackson County	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).					
La Clinica	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Rogue Community Health	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Siskiyou Community Health Center	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Oregon Coast Community Action Network	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Primary Health CCO Staff	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
AllCare CCO Staff	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
Curry Community Health	Provided input for the collaborative CHA,	N/A	N/A	N/A	N/A

	active role in collaborative CHIP				
Culturally specific organizations and organizations that work with underserved or at-risk populations (list in this column below).					
Unete	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Unite Oregon	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Hearts with a Mission	Active role in collaborative CHIP	N/A	N/A	N/A	N/A
HIV Alliance	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Maslow Project	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Tolowa Dee-ni' Nation	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Women's Crisis Support Team	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
CASA of Jackson County	Provided input for the collaborative CHA, active role in collaborative CHIP	N/A	N/A	N/A	N/A
LISTO	Provided input for the collaborative CHA	N/A	N/A	N/A	N/A
Other organizations (list in this column below).					
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A

*The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health.
Engagement activities **must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.

Table 5: Assessment of existing social determinants of health priorities and process to select Year 1 social determinants of health priorities		
All applicants must complete this full table to describe how the applicant will identify social determinants of health ("SDOH-HE") priorities to meet the CCO SDOH-HE spending requirements. <u>Housing must be included as one of the SDOH-HE spending priorities.</u>		
Part 1. List of existing SDOH-HE CHP priorities* in applicant's proposed service area from its own CHP or other existing CCO, local hospital, local public health authority and/or tribal CHPs, if applicable. Add additional rows as needed.	**Part 1a.** Source for priority (i.e. which CHP it came from).	**Part 1b.** Whether priority describes a <u>health outcome goal</u> (i.e. addressing food insecurity to address obesity as a health issue) **or** <u>priority populations</u> (i.e. addressing early childhood education for children as a priority population) **or** <u>other</u>.
1. Increase supply of affordable and safe housing across our three county service area	Jackson/Josephine 2019 Collaborative Community Health Assessment	The goal is to address a priority population: Homeless children and adults
2. SUD: Reduce trauma and crime among youth and young adults	Jackson/Josephine 2019 Collaborative Community Health Assessment	The goal is to address a priority population: Youth and young adults with substance use disorders
3. Mental Health: Improve access to treatment	Jackson/Josephine 2019 Collaborative Community Health Assessment	The goal is to address a health need within the communities we serve
4. Increase System Capacity	Coos/Curry 2019 Collaborative Community Health Assessment	The goal is to improve Member access to care through workforce capacity development
5. Promote Health Equity	Coos/Curry 2019 Collaborative Community Health Assessment	The goal is to improve outcomes by addressing the SDoH in housing, transportation, food, & education
6. Improve Community Health and Families	Coos/Curry 2019 Collaborative Community Health Assessment	The goal is to improve population health by reducing poverty, job & economic development, stable families, better services for veterans and seniors

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Part 2. Description of process through which the applicant will identify and vet SDOH-HE priorities** in line with CHP priorities for submission to OHA by March 15, 2020. This must include, timelines, milestones, methods for vetting selected priorities with community partners (such as those described in Table B, Part 1) and CAC, and planned actions to clarify and define CCO housing priority in line with statewide priority.
- Process may also include planned actions to identify additional community-based SDOH-HE priorities from CHP priorities.
- If housing has not been identified as a priority in existing CHPs, note that housing must still be selected as an SDOH-HE priority. Consider adding the housing priority in alignment with either a health outcome goal or priority population identified in Part 1b.

County	Priorities	SDoH Domain	Health Outcome Goal	Process/Methodology	Timelines/Milestones
Jackson Josephine	Availability of Safe and Affordable Housing	Economic Stability	Increase Supply of Affordable and Safe Housing	Solicit proposals and/or funding requests from low-income and transitional housing agencies such as Rogue Retreat and Maslow Project.	1. Prepare and release Request for Proposals or Request for Funding Application by Summer 2020 2. Review Proposals for Funding in Fall 2020 3. CACs Select Proposals for Funding in Fall 2020 4. Launch Projects January, 2021
Jackson Josephine	Improve Mental Health & Well Being with specific focus on Substance Use Among Youth and Young Adults	Social & Community Health	Reduce Trauma and Crime; Improve Health	Focus on school based clinics and school based education on drug use Expand alternatives for treatment; Grow ARC; Address prescription drug monitoring and increase education Promote community and school collaboration	1. Engage school administrators, teachers, and children's advocates to create evidence based curriculum on drug use by Spring 2020 2. Launch programs in Fall 2020 & establish Baseline measures 3. Monitor predetermined metrics/measures of drug use among youth and young adults over time
Jackson Josephine	Improve Parenting and Life Skills	Education	Increase Parenting skills and Improve childhood behavior and self-regulation	Expand use of Good Behavior Game for Children; Develop and Implement Parenting Classes	1. Continue to support Good Behavior Game in elementary schools across the service area 2. Collaborate with the Babe Stores in each county to develop and implement parenting classes in 2020
Curry	Health System Capacity	Social & Community Health	Improve Access to Care	Establish a consortium of local public and private healthcare partners to evaluate options to	1. Establish public and private collaborative workgroups by health sector

				increase workforce capacity across the continuum of care (PH, BH, OH Maternity, Pediatrics)	2. Prepare project charter and timelines for each sector by February 2020 3. Establish process and methodology & work plans by February 2020 4. Identify and evaluate options by Summer 2020 5. Select initiatives to increase health system capacity Summer 2020 6. CAC to release RFP or RFA from local agencies to fund development of selected Initiatives	
Curry	Health Equity	Social & Community Health	Promote Cultural and Ethnic Equality	Establish a consortium of local public and private community partners to evaluate options to promote health equity around SDoH, housing, transportation, food and education	1. Establish process and methodology & work plans by February 2020 2. Identify and evaluate options by Summer 2020 3. Select initiatives to increase health equity by Summer 2020 4. CAC to release RFP or RFA from local agencies to fund development of selected Initiatives	
Curry	Communities & Families	Social & Community Health	Economic Stability	Establish a consortium of local public and private community partners to evaluate options to address poverty, jobs, lifestyles, stable families, veterans & seniors	1. Establish process, methodology & work plans by February 2020 2. Identify and evaluate options by Summer 2020 3. Select initiatives to promote economic stability by Fall 2020 4. CAC to release RFP or RFA from local agencies to fund development of selected Initiatives by Fall 2020	

*Applicants must include description of housing priority if already identified in CHPs. (e.g. housing overall, housing for targeted populations).
**The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health. Refer to the Social Determinants of Health and Health Equity Glossary reference document.

Exhibit 10.2 - THW/CHW Integration and Utilization Plan

- Integrating THWs and CHWs into the Delivery of Services

AllCare CCO currently employs five certified Community Health Workers (CHWs) and one certified Traditional Health Worker (THW). Additional staff work in care coordination as member advocates like our CHW/THW but have bachelor degrees in health related fields. They currently focus on the following services:

- o Initial Health Risk Assessments
  - ➢ Behavioral Health
  - ➢ Oral Health
  - ➢ Physical Health
- o Social Determinants of Health Assessments and Referral
  - ➢ Domestic Violence Shelters
  - ➢ Family Support Specialists
- o Peer Support for Care Coordination Programs, including:
  - ➢ Health & Wellness programs
  - ➢ Tobacco Cessation
  - ➢ Chronic Disease Management
  - ➢ The Babe Store
  - ➢ Maternal & Child Health
    - ▪ Maternal Health Advocate
    - ▪ Certified Lactation Educator
    - ▪ Infant Massage Trainer

This program benefits from an approach that embraces continuous performance improvement. Our CHW/THW staff engage with community peers biweekly for skill development training sessions in self-care, defining boundaries, nutrition, and community events. They also debrief on peer-to-peer experiences and gather feedback on best practices related to:

- o Member engagement
- o Home visits
- o PCP engagement and integration
- o Health literacy
- o Housing insecurity
- o Tobacco cessation
- o Food access and delivery
- o Warm hand-offs to behavioral health through co-meetings with the Member for assessment as well as linkage to community based services
- o Bi-lingual staff attend medical appointments as interpreters
- o Coordination with
  - ➢ organizational Health Equity staff, in-house utilization management staff, in-house care coordination and transitions of care staff
  - ➢ criminal justice system for pending releases (Welcome Home Program)
  - ➢ youth programs and foster care for care coordination
  - ➢ developmental disabilities and AAA for long term care coordination, transitions of care, and care integration

In the area of behavioral health, the THWs provide Peer Support Services for Members involved in Substance Use Disorder treatment programs and Mental Health treatment programs, especially members in ACT and other intensive services. EASA and Wraparound services also include participation of Peers and Family Partners in their evidenced-based models. These Peers and Family Partners provide members and their families' assistance with navigation of services, coordination of their identified supports and advocate for member's preferences.

In the area of early childhood development, AllCare CCO has funded a Community Health Workers within the Siskiyou Pediatric Health Center who is an integral member of their care coordination team of pediatricians and offers support services for those in need of housing and other social determinants of health. AllCare has also supported CHWs in a Head Start program and within Curry County Health Department.

- Member Communication – Available Benefits

  Members are introduced to our staff including Community and Traditional Health Workers during the screening and assessment phase of care coordination plan development. When our care coordinators and/or intensive case managers identify a need for peer interfaces, they contact our THWs/CHWs and enlist their services as part of the care planning process. The Member and their caregiver/family is introduced via an initial phone call or in-person visit by the THW/CHW for intensive assessment of current needs and issues. This may include in home visits. This information is communicated to the care coordinator for inclusion within the individual care plan. Where indicated, the THW/CHW continues to provide peer-to-peer support throughout plan implementation. This level of member communication assures that screening and assessment information is accurate for care planning purposes and also promotes increased numbers of successful transitions to a healthier lifestyle among Members.

- Increase THW/CHW Utilization

  Looking forward, increased use of Traditional Health Workers will occur within our integrated physical/behavioral/and oral clinics as well as Community Health Workers in the area of the Social Determinants of Health, with a focus on housing and early childhood development. Our success over the last six years demonstrates that THWs/CHWs have an important role in improving individual health and community health at lower cost.

  AllCare CCO plans to increase its community outreach programs by coordinating with local partners that share our vision and who already support these services through their community outreach efforts. Working together, we will braid community services, public health services, mental health services and clinical health services to better meet the needs of our most vulnerable OHP Members through face to face and peer to peer supports across the continuum of social and health services.

- **Best Practices**: Peer support from a person who has successfully overcome barriers to good health similar to those currently experienced by Members is a powerful incentive for change. Through motivational interviewing techniques, THW/CHWs are able to address the goals of each Member's care plan. AllCare sees value in the common "experience" which connects THW/CHWs with Members in need. Programs that offer best practices include:

- o "Welcome Home Oregon" which is a program that provides peer support for Members recently released from the justice system. Our THWs offer side-by-side support during probation meetings as well as coordination with community based programs and services needed to re-enter society such as housing, employment, and transportation.
- o AllCare CCO's contract with Options of Southern Oregon affords our Members with behavioral health needs access to a Tier 5 PCPCH that fully integrates behavioral health with physical health and includes on-site pharmacy services.

- **Performance Improvement Plan**: THW/CHWs will increasingly assist in developing and implementing our 2020-2024 Collaborative Community Health Improvement Plan. Our 2019 Community Health Assessment identified substance use disorders as a key area of focus for improving health across the communities we serve. AllCare CCO plans to improve our efforts to combat SUD over the next five years by building sustainable partnerships with community based organizations and through integration of peer support for Members impacted by substance abuse and/or mental health issues. This will require enhanced recruitment, retention and training of our THW/CHW team as well as development of alternative payment models that reward increased Member adoption of sustainable prevention and wellness into their activities of daily living.

- **Member Access Improvement Plan**: Member access to THW/CHW peer supports occurs during the care management and care planning assessment process performed by our case managers and care coordination team. If the case manager identifies a need for THW/CHW services, the case manager adds those services to the care coordination plan. Improving member access will require additional THW staff through new hires by AllCare and/or through partnership with other community based services who also deploy peer support programs.

- **THW Recruitment Plan**: AllCare's recruitment plan for all personnel occurs through a variety of programs, including direct recruitment for specific skills to expand the workforce or to fill a current vacancy.

- **THW Retention Plan:** AllCare CCO currently enhances THW/CHW skills sets through its biweekly training sessions that focus on OHA objectives, including skills around self-care, defining boundaries, nutrition, motivational interviewing, home visits, debriefing on peer to peer best practices, and meeting Members "where they are".

2018 Community Health Assessment of Jackson and Josephine Counties

Jefferson Regional
Health Alliance

Health Resources in Action
Advancing Public Health and Medical Research

Acknowledgements

Table of Contents

Acronym List

Adverse Childhood Experiences	(ACEs)
Asset Limited, Income Constrained, Employed	(ALICE)
Behavioral Risk Factor Surveillance System	(BRFSS)
Biennial Implementation Plan	(BIP)
Community Advisory Councils	(CAC)
Community Health Assessment	(CHA)
Community Health Improvement Plan	(CHIP)
Community Mental Health Programs	(CMHP)
Coordinated Care Organizations	(CCO)
Federally Qualified Health Centers	(FQHC)
Forces of Change Assessment	(FOCA)
Health Resources and Services Administration	(HRSA)
Health Resources in Action	(HRiA)
Jefferson Regional Health Alliance	(JRHA)
Local Public Health System Assessment	(LPHSA)
Mobilizing for Action through Planning and Partnerships	(MAPP)
National Association of County and City Health Officials	(NACCHO)
Public Health Accreditation Board	(PHAB)
Supplemental Nutrition Assistance Program	(SNAP)
Years of Potential Life Lost	(YPLL)

EXECUTIVE SUMMARY

INTRODUCTION

Jefferson Regional Health Alliance is a collaboration of regional community leaders from all sectors learning and working together to improve the health and health care resources of Southern Oregonians. The vision of JRHA is a) that the organizations and individuals responsible for the health of the community are interconnected, promoting health and health care transformation together, b) current systems are transformed, reducing economic, cultural and system barriers to health and health care access while reducing the costs of health care services, and c) relationships and resources are leveraged through collaboration to implement best practices and ensure a sustainable health care system.

To advance the vision of JRHA and create a healthy community for Jackson and Josephine Counties, in 2018 JRHA undertook a collaborative community health assessment (CHA). Many of JRHA's partners have state, federal, or accreditation requirements as stated below:

- The Public Health Accreditation Board (PHAB) sets the standards that public health departments need to meet in order to achieve and maintain accredited status. Included in these standards are requirements to work collaboratively with community partners to produce both a CHA and a community health improvement plan (CHIP) every 5 years.
- Section 501(r) of the Internal Revenue Service Code was added in 2012 by the 2010 enactment of the Affordable Care Act and requires tax-exempt 501(c)(3) organizations that operate one or more hospital facility to conduct a community health needs assessment (CHNA) at least once every 3 years.
- The Oregon Health Authority requires Coordinated Care Organizations (CCO) to create a CHIP every 5 years. The CHIP is derived from the most recent CHA.
- Community Mental Health Programs (CMHP) are required to have a Biennial Implementation Plan (BIP) informed by this CHA
- Department of Health and Human Services – Health Resources and Services Administration (HRSA) requires Federally Qualified Health Centers (FQHC) to complete Form 9: Need for Assistance Worksheet every 3 years which makes use of the most recent CHA.

This 2018 community health assessment for Jackson and Josephine Counties aims to meet the requirements of partners as well as develop a shared understanding of community health in order to guide collaborative community health improvement efforts.

In January 2018, JRHA hired Health Resources in Action (HRiA), a non-profit public health organization, as a consultant to provide strategic guidance and technical assistance for the community health assessment process, and to collect, analyze, and report the data for the final CHA deliverables.

APPROACH AND METHODS

This CHA aims to identify the health-related needs and strengths of Jackson and Josephine Counties through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors—from employment to housing to access to care—that have an impact on the community's health. Social, economic, and health data were drawn from existing data sources, such as the U.S. Census, Oregon Health Authority, and both Jackson and Josephine County Public Health, among others. In addition to an online and paper community survey that engaged over 1,100 residents, approximately 170 individuals from multi-sector organizations, residents, and community stakeholders

participated in community forums, focus groups and interviews to gather feedback on community strengths, challenges and priority health concerns.

Through the process of compiling, analyzing and synthesizing quantitative and qualitative data, a list of fifteen key themes emerged. This list was then prioritized by key stakeholders, resulting in the following six priority key themes:

- Substance use
- Affordable housing
- Mental health and well-being
- Poverty and employment
- Parenting and life skills
- Education and workforce development

KEY FINDINGS

DEMOGRAPHICS AND HEALTH STATUS

Jackson and Josephine Counties are experiencing population growth, especially among the Hispanic/Latino population. Compared to Oregon overall, the region has a higher proportion of residents who identify as White and those who are aged 65 and over.

According to the BRFSS, a nation-wide survey that asks residents about their health-related risk behaviors, health conditions, and use of preventive services, over 80% of adults reported their general health status to be good, very good, or excellent across all geographies, with adults slightly less likely to report as such in Josephine County (Figure 5). While self-reported health status is high, more local data from the community survey indicated that only 46.5% of respondents felt that the general health status of the community within which they live was good, very good or excellent.

Age Distribution, by State and County, 2012-2016
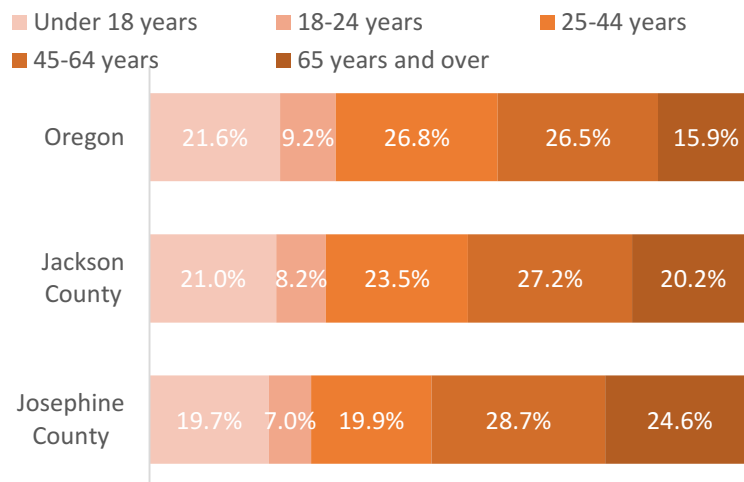
Legend: Under 18 years | 18-24 years | 25-44 years | 45-64 years | 65 years and over

Geography	Under 18	18-24	25-44	45-64	65+
Oregon	21.6%	9.2%	26.8%	26.5%	15.9%
Jackson County	21.0%	8.2%	23.5%	27.2%	20.2%
Josephine County	19.7%	7.0%	19.9%	28.7%	24.6%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Years of Potential Life Lost Before Age 75 per 100,000 Population, 2014-2016
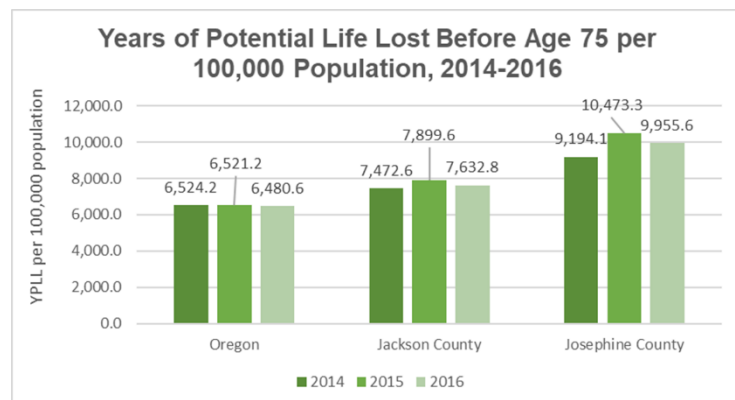
Mortality statistics help us understand health and how it can be improved. In 2017, the mortality rates for Josephine and Jackson Counties (847.4 deaths per 100,000 population and 756.4 deaths per 100,000 population, respectively) were higher than that for Oregon (717.5 deaths per 100,000 population). Years of potential life lost (YPLL) is an estimate of the average years a person would have lived if he or she had not died prematurely. It is, therefore, a measure of premature mortality. As an alternative to death rates, it is a method that gives more weight to deaths that occur among younger people. According to the Oregon Health Authority, the YPLL before age 75 was higher in both Josephine (9,706.2 per 100,000 population) and Jackson Counties (7,486.9 per 100,000 population) compared to the statewide rate (6,432.7 per 100,000 population).

SUBSTANCE USE

Substance use and abuse is a critical public health issue that affects not only the individual, but also has serious direct and indirect impacts on families, communities and society as whole. The causes of substance use disorders are multi-faceted and include biological, social and environmental factors.[1]

Substance use is prevalent among youth and adults in Jackson and Josephine, resulting in trauma and crime. As seen across all the data sources for this assessment, substance use emerged as a top issue. Looking at the community survey conducted as part of this assessment, substance use was the third most frequently selected health issue having the largest impact on the community (59.6%). Respondents were most concerned about meth use, opioid abuse, and drug use among youth. Current alcohol and marijuana use among Jackson County 11th graders as well as current cigarette use among Josephine County adults stand out. Additionally, opioid overdose hospitalization rates are higher in the two counties compared to the state.

> *"Opioids are what we're seeing. The amount of heroin that runs through here – it affects so much of the population"*

Percent 11th Grade Students Reported Current Alcohol Consumption, by State and County, 2012, 2014, and 2016

■ Oregon ■ Jackson County ■ Josephine County

	2012	2014	2016
Oregon	35.9%	33.5%	29.8%
Jackson County	39.3%	37.6%	34.3%
Josephine County	36.9%	29.5%	29.6%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

AFFORDABLE HOUSING

Affordability, quality and stability are important characteristics that directly impact an individual's ability to access safe and healthy housing.[2] Unstable housing and homelessness can lead to stress, isolation, chronic disease, substance use, mental health issues and violence.[3] While housing itself is an important factor in an individual's health, it can also be a cost burden and result in compromises to health in other areas – i.e. foregoing prescription medications – due to cost. The supply of affordable housing does not meet the demand among residents, particularly renters, within Jackson and Josephine counties, resulting in housing insecurity, homelessness and stress, among other health issues.

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[1] US Department of Health and Human Services, Office of the Surgeon General. Facing Addiction in America The Surgeon General's Report on Alcohol, Drugs, and Health. 2016.
[2] Shaw M. Housing and Public Health. Annual Review of Public Health. 2004; 25: 397-418.
[3] Shaw M. Housing and Public Health. Annual Review of Public Health. 2004; 25: 397-418.

Affordable housing was the top issue that emerged from focus group and interview discussions. Renters in the region are particularly burdened by the high cost of housing and the high percentage of income spent on housing. Housing is a regional issue that is also connected to workforce shortages in some professions, such as health care, which has implications not only for providers but also community members needing care.

Percent Households where Housing Costs are 30% or More of Income, by U.S., State, and County, 2012-2016

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
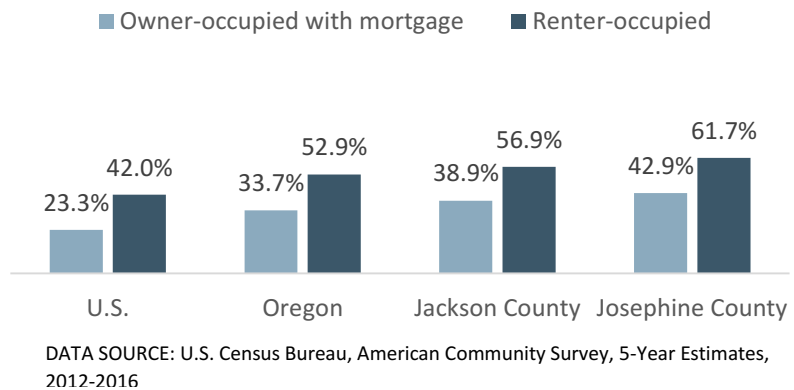
MENTAL HEALTH AND WELL-BEING

Mental health is essential to overall well-being and is closely connected to physical health. Mental health issues, such as anxiety and depression, can arise from genetic factors and/or from a number of individual and societal factors – incidence of trauma, poor nutrition and poverty. [4] Mental illness affects people's ability participate in health-promoting behaviors, and thus affects their ability to maintain good physical health. Mental illness can also impact other areas of life including attending and focusing at school, obtaining and maintaining a job, finding and keeping housing, and having relationships with friends and family.[5]

Depression and anxiety were noted as prevalent across the lifespan in Jackson and Josephine Counties. Mental health of youth was especially concerning to assessment participants, who explained that trauma at home and peer pressure were primary issues facing youth. For working age adults, mental health was discussed in the context of experiencing stress related to high cost of living and raising a family. Social isolation was the most commonly cited stressor for seniors.

Age-adjusted Suicide Rate per 100,000 Population, 2015-2017
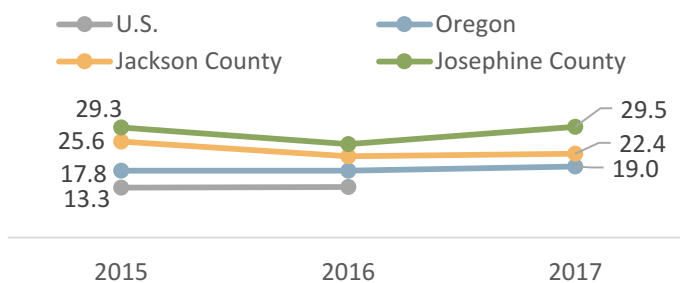
DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017
NOTE: 2017 data not publicly available for the U.S.

Many mental illnesses can lead to an increased risk of suicide. Between 2015 and 2017, the suicide rate in Jackson and Josephine Counties was consistently higher than Oregon and the U.S.

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[4] Tulchinsky TH, et al. Editorial: Mental Health as a Public Health Issue. Public Health Reviews. 2012; 34, 2.
[5] Mental health and mental disorders. Healthy People 2020. Available at:
https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed on: October 30, 2018

POVERTY AND EMPLOYMENT

Poverty and employment are linked to health[6] – an individual's employment and income level directly impacts their ability to afford access to health care, healthy food, and housing, all of which influence myriad health outcomes. Individuals who are unemployed or underemployed experience higher rates of depression, stress and stress-related conditions, such as stroke, heart attack, heart disease, arthritis.[7]

Despite declining and low unemployment, assessment participants indicated that it is a challenge for community members to make a living in the area, given the limited jobs available and the low pay for those opportunities that do exist. Median household income is lower and rates of poverty are higher in Jackson and Josephine Counties, especially among communities of color, compared to Oregon and the U.S. The effects of poverty and under/unemployment are far-reaching. Focus group and interview participants shared that the regional economic environment hinders community members' ability to pay for housing, food, transportation, medications, and child care.

"Young people here who are beginning their work life or family life… they're distressed because there are not enough jobs with sufficient pay."

Median Household Income, by U.S., State, and County, 2007-2011 and 2012-2016
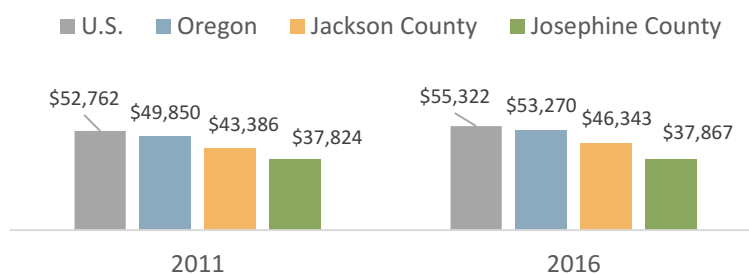
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Approximately half of survey respondents indicated that cost of living is a primary issue facing them and their community and perceived a lack of support in the community for low-income families and individuals.

PARENTING AND LIFE SKILLS

Adverse childhood experiences (ACEs) are instances of child abuse and neglect - physical abuse, sexual abuse, emotional abuse, and living with a household member experiencing substance use, mental illness, and domestic violence that are captured to create a score. The presence of these traumatic experiences not only has immediate impacts, but also increases a child's risk for poor health outcomes as an adult – chronic disease, substance use, depression, suicide, violence and crime.[8] Children raised in

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[6] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: What the patterns tell us. American Journal of Public Health. 2010; 100: S186-S196.

[7] Robert Wood Johnson Foundation. How Does Employment – or Unemployment – Affect Health? Health Policy Snapshot Issue Brief. Available at: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360 Accessed: October 30, 2018.

[8] Felitti VJ, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine. 1998; 14(4): 245-258.

safe and nurturing families and communities, free from maltreatment and other adverse childhood experiences, are more likely to have better outcomes as adults.[9]

While child abuse and neglect did not surface extensively in qualitative data for this assessment, quantitative data on a variety of other childhood exposures indicate that the family environment in Jackson and Josephine Counties is not always conducive to good health. When looking across indicators among 11th graders, ACEs in Josephine County appears to be increasing compared to stable or decreasing in Jackson County and Oregon overall.

Percent 11th Grade Students Reported ACEs, by State and County, 2016
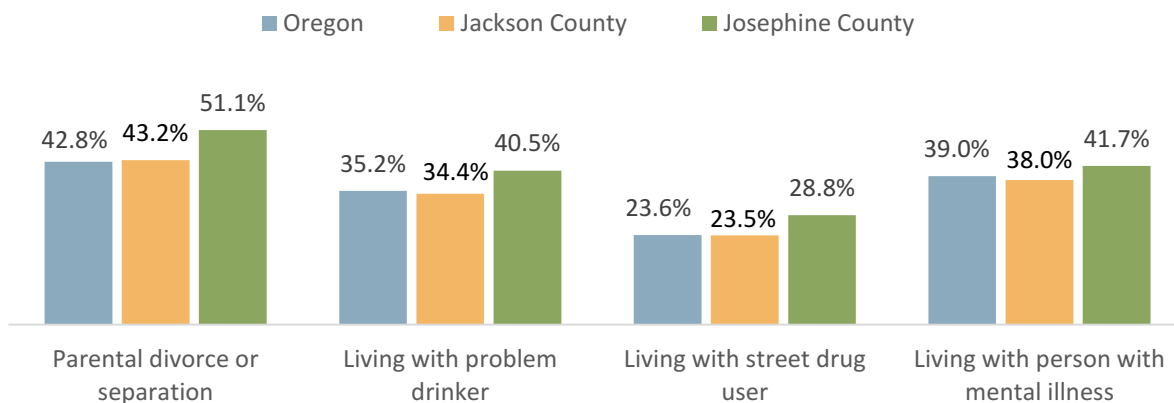
DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2016

Focus group and interview participants broadly discussed the challenges facing parents as they raise children in Jackson and Josephine Counties, including parents' limited knowledge of and skills for parenting, and stigma associated with asking for help. Assessment participants shared the perception that parents do not have the understanding, skills, and time to devote to parenting given the demands on them to financially provide for their families.

EDUCATION AND WORKFORCE DEVELOPMENT

Education influences health outcomes at many levels – from the individual to population level. As one of the strongest predictors of health, the more education an individual has the more likely they are to live a longer and healthier life.[10] While education beyond high school continues to improve health outcomes, having a credential and skill set that opens the door to benefits, i.e. a job, shows the role education plays in many factors that impact health outcomes. Adults continue to be impacted by their educational attainment, as more education is associated with access to more, and better paying, job opportunities. This link between education, employment and income drives much of an individual's

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[9] Anda RF, Felitti VJ, Walker J, et al. The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. Eur Arch Psychiatry Clin Neurosci. 2006 Apr;256(3):174–86.

[10] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us. American Journal of Public Health. 2010; 100: S186-S196.

ability to achieve economic stability and the positive health outcomes that result from access to housing, food and health care.[11]

Educational attainment is the highest level of education that an individual has completed. Based on 2012-2016 data, there was a smaller percentage of individuals 25 years and older who received a bachelor's degree or more in Josephine County (17.2%) and Jackson County (26.1%) compared to Oregon (31.5%). People of color in the two counties are even less likely to have a bachelor's degree or more.

Educational Attainment for Population 25 Years and Over, by U.S., State, and County, 2012-2016
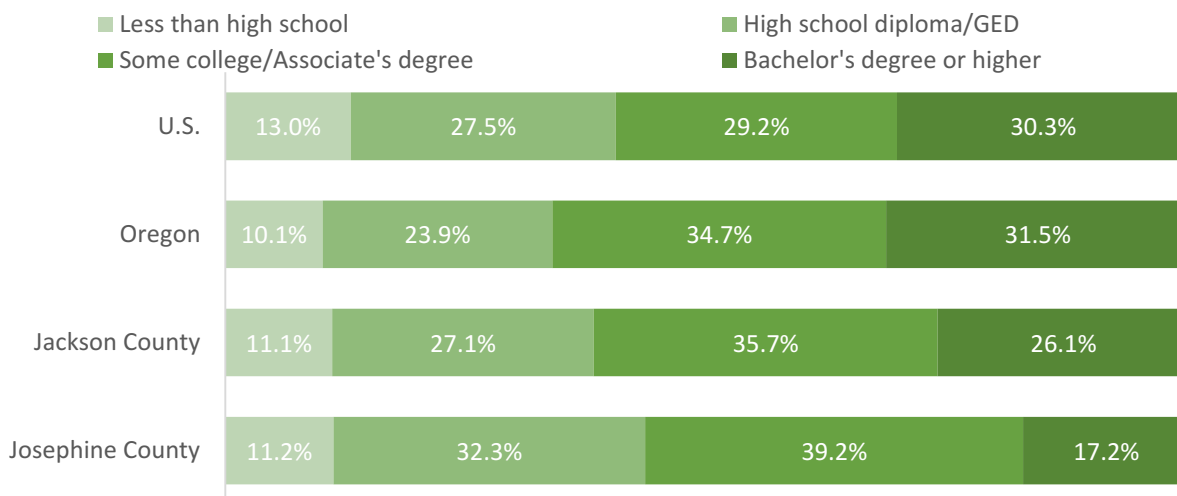
Legend	
Less than high school	High school diploma/GED
Some college/Associate's degree	Bachelor's degree or higher

Region	Less than high school	High school diploma/GED	Some college/Associate's degree	Bachelor's degree or higher
U.S.	13.0%	27.5%	29.2%	30.3%
Oregon	10.1%	23.9%	34.7%	31.5%
Jackson County	11.1%	27.1%	35.7%	26.1%
Josephine County	11.2%	32.3%	39.2%	17.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

The connections between education and employment are strong. Assessment participants explained that low average educational attainment levels among community members in Jackson and Josephine Counties do not meet minimum requirements for many professional workforce needs, and recruitment challenges exist due to limited affordable housing.

NEXT STEPS

The 2018 community health assessment of Jackson and Josephine Counties serves multiple purposes for a variety of audiences. Among these purposes, the assessment enables JRHA and its partners to

- Explore current health status and determinants of health, health priorities, and new and emerging concerns among Jackson and Josephine County community members and service providers
- Hear individual and group voices to provide a deeper understanding of the "why" and "how" of current and emerging health issues
- Understand the shifting patterns of these health issues over time in Jackson and Josephine Counties

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[11] Zimmerman EB, Woolf SH, and Haley A. Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. Content last reviewed September 2015. Agency for Health care Research and Quality, Rockville, MD.
http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html

- Identify assets and resources as well as gaps and needs in services in order to help partners set funding and programming priorities
- Fulfill the community health needs assessment requirements for Asante and Providence Hospitals, regional federally qualified health centers, Jackson and Josephine County Public Health, Community Mental Health Programs, and Coordinated Care Organizations
- Use the data gathered to engage JRHA members, partners and the community in the community health improvement process

This assessment lays the foundation for a regional Community Health Improvement Plan (CHIP) effort to begin in early 2019. The quantitative and qualitative data presented in this report and the six priority key themes identified can guide the development of goals, objectives, strategies and performance measures. While JRHA is the convener for community health improvement planning in Jackson and Josephine Counties, objectives and strategies developed for the CHIP must be owned by a local organization or collaborative for meaningful progress to occur. The priorities identified in this assessment represent complex community issues, and effective action will require infrastructure and community capacity to support collective impact.

INTRODUCTION

Background

Overview of JRHA

Jefferson Regional Health Alliance is a collaboration of regional community leaders from all sectors learning and working together to improve the health and health care resources of Southern Oregonians. The vision of JRHA is a) that the organizations and individuals responsible for the health of the community are interconnected, promoting health and health care transformation together, b) current systems are transformed, reducing economic, cultural and system barriers to health and health care access while reducing the costs of health care services, and c) relationships and resources are leveraged through collaboration to implement best practices and ensure a sustainable health care system.

Purpose and Scope of 2018 Assessment

To create a healthy community for Jackson and Josephine Counties, in 2018 JRHA undertook a collaborative community health assessment (CHA). Many of JRHA's partners have state, federal, or accreditation requirements as stated below:

- The Public Health Accreditation Board (PHAB) sets the standards that public health departments need to meet in order to achieve and maintain accredited status. Included in these standards are requirements to work collaboratively with community partners to produce both a CHA and a community health improvement plan (CHIP) every 5 years.
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- Department of Health and Human Services – Health Resources and Services Administration (HRSA) requires Federally Qualified Health Centers (FQHC) to complete Form 9: Need for Assistance Worksheet every 3 years which makes use of the most recent CHA.

This 2018 community health assessment for Jackson and Josephine Counties aims to meet the requirements of partners as well as develop a shared understanding of community health in order to guide collaborative community health improvement efforts.

In January 2018, JRHA hired Health Resources in Action (HRiA), a non-profit public health organization, as a consultant to provide strategic guidance and technical assistance for the community health assessment process, and to collect, analyze, and report the data for the final CHA deliverables.

Approach and Methods

The following section describes the frameworks used to guide the assessment process, as well as how data for the assessment were collected.

Social Determinants of Health Framework

It is important to recognize that multiple factors have an impact on health, and that there is a dynamic relationship between community members and their lived environments. The following diagram provides a visual representation of this relationship, demonstrating how individual lifestyle factors are influenced by more upstream factors, such as employment opportunities and housing. The World Health Organization further defines the social determinants of health as "the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources." Social determinants of health can affect individual and community health directly and indirectly, including influence on health promoting behaviors. Policies and other interventions influence the availability of these determinants and how they are distributed among different social groups, including those groups defined by socioeconomic status, race and ethnicity, sex, sexual orientation, disability status, and geographic location. Inequitable distribution of social determinants contributes to health inequities. A stronger understanding of how local societal conditions, health behaviors, and access to health care affect health outcomes in the community can increase awareness and understanding of what is needed to move toward health equity.
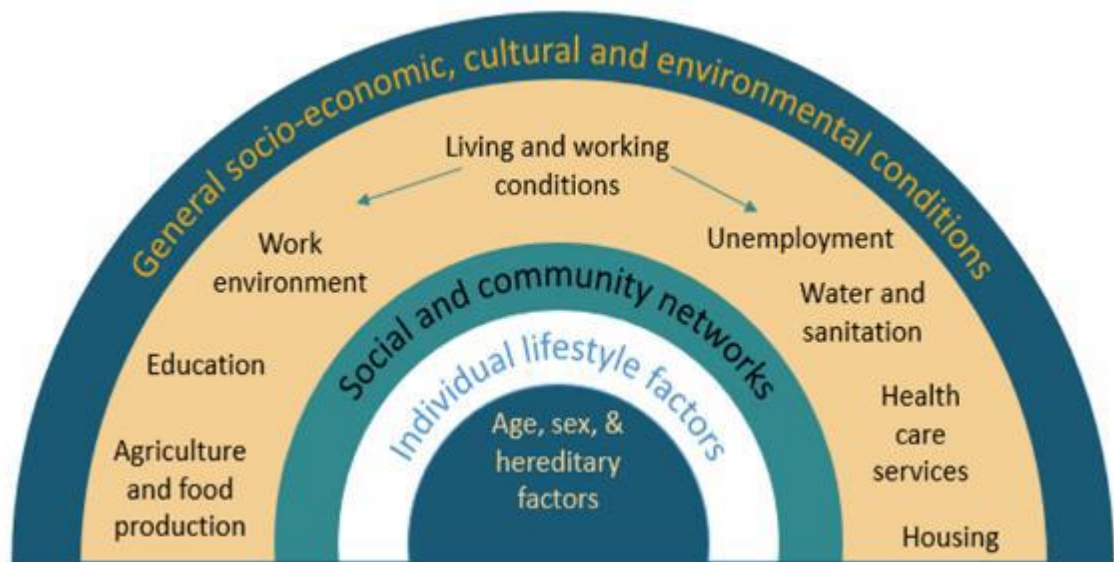
DATA SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

Health Equity Framework

Health equity means that every person has a fair and just opportunity to achieve optimal health regardless of:

- The color of their skin
- Level of education

- Gender identity
- Sexual orientation
- The job they have
- The neighborhood they live in
- Whether or not they have a disability[12]

Health equity is fundamental to having a healthy community. Unfortunately, many communities and populations have experienced historical isolation from opportunities that continue today. Where possible, this report incorporates data that highlight disparities in opportunities and their impacts on the health of populations.

> **Health Equity** – "The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." – Healthy People 2020, Office of Disease Prevention and Health Promotion

Mobilizing for Action through Partnerships and Planning

JRHA selected the Mobilizing for Action through Planning and Partnerships (MAPP) model as a framework to guide the community health improvement process in Jackson and Josephine Counties. MAPP is a community-based strategic planning process that relies on collaborative partnership and includes four assessment components to inform planning:

a. Community Health Status Assessment
b. Community Themes and Strengths Assessment
c. Forces of Change Assessment
d. Local Public Health System Assessment

SOURCE: https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

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[12] Braveman PA, Kumanyika S, Fielding J, et al. Health disparities and health equity: the issue is justice. Am J Public Health. 2011;101(suppl 1):S149-S155.

CHA Oversight

JRHA assembled a CHA Steering Committee in 2016 to explore the development of a single regional community health assessment. The Steering Committee provided strategic oversight of the CHA process and worked closely with HRiA to provide community context and engagement. The Steering Committee is comprised of members representing hospitals and health systems, Coordinated Care Organizations, community health centers, local public health authorities, Community Mental Health Programs, addiction treatment organizations, and other health and human service organizations. The committee provided guidance on each component of the assessment, including the CHA methodology, recommendation of secondary data sources, identification of key informants and focus group segments, dissemination of the community survey, and communication and dissemination throughout the CHA process.

Data Collection and Analysis Methods

In order to better understand the health of Jackson and Josephine Counties, the following data collection methods were used.

Review of secondary data

This assessment incorporated data on social determinants of health as well as health behavior and outcome data from various sources at national, state, regional, county and local levels. These data sources included but were not limited to the U.S. Census, Oregon Health Authority, and both Jackson and Josephine County Public Health. Data included self-report of demographics, health behaviors and outcomes from large, population-based surveys such as the Behavioral Risk Factor Surveillance System (BRFSS). The data work group of the CHA Steering Committee participated in the selection of quantitative data sources and indicators for the assessment. A full list of data indicators and sources can be found in Appendix B – List of data sources and indicators.

Focus groups

In May 2018, HRiA conducted ten focus groups with 95 individuals from across Jackson and Josephine Counties. Focus groups were conducted with representatives of priority populations or sectors, including communities of color, homeless youth, seniors, parents, individuals with disabilities, and rural communities. Focus group discussions explored participants' perceptions of the community, priority health concerns, and suggestions for future programming and services to address these issues. A semi-structured moderator's guide was used across all focus groups to ensure consistency in the topics covered (see Appendix D - Focus Group Discussion Guide). The moderator's guide was translated to Spanish for one focus group. Each focus group was facilitated by a trained moderator, and detailed notes were taken during each discussion. On average, focus groups lasted 90 minutes and included 5-10 participants. As an incentive, focus group participants received a $20 stipend to compensate them for their time.

Interviews

In April through June 2018, HRiA conducted 20 interviews with community stakeholders to gauge their perceptions of the community, health concerns, and what programming, services, or initiatives are most

needed to address these concerns. Interviews were conducted by phone with twenty individuals representing a range of sectors including education, social services, and health care, among others. A semi-structured interview guide was used across all discussions to ensure consistency in the topics covered (see Appendix E - Key informant interview guide). Each interview was facilitated by a trained moderator, and detailed notes were taken during conversations. On average, interviews lasted approximately 45 minutes.

Community forums

On May 7 and 8, 2018 HRiA facilitated two community forums, one in Medford and one in Grants Pass. The purpose of the community forums was to gather additional feedback from community members on priority health concerns, needs and assets. Each forum began with a presentation of the assessment process and preliminary quantitative data. Participants had a chance to reflect and ask questions about the data in small and large group discussions. Detailed notes were taken and incorporated into the qualitative data for this report. A total of 55 community members attended the two community forums.

Community survey

In May through July 2018, a community survey was developed and distributed in both paper and electronic formats across Jackson and Josephine Counties to broadly capture and quantify the perspective of stakeholders. The survey focused on community members' and providers' perceptions of the community, top health concerns, and barriers to accessing health and social services. The survey was developed by HRiA in collaboration with the JRHA CHA Steering Committee, and used both Likert-type scales and closed-ended response categories. Skip patterns were embedded within the electronic survey so that questions could be tailored to the respondent (i.e. provider or community member). English and Spanish versions of the survey were made available to all respondents. In total, 1,116 people completed the survey. The survey instrument can be found in Appendix F - Survey instrument.

Table 1. Community Survey Respondent Characteristics (N=1116), 2018

	N	Percent
County	1116	
Jackson	833	74.6%
Josephine	283	25.4%
Provider	440	39.4%
Community Member	676	60.6%
Gender	983	
Male	276	28.1%
Female	705	71.7%
Other	2	0.2%
Age	989	
18-24 years old	36	3.6%
25-34 years old	183	18.5%
35-44 years old	225	22.8%
45-64 years old	429	43.4%

65+ years old	116	11.7%
Race/Ethnicity	**970**	
Hispanic/Latino(a), any race	81	8.4%
African American or Black, non-Hispanic	8	0.8%
American Indian or Alaskan Native, non-Hispanic	14	1.4%
Asian, non-Hispanic	4	0.4%
Native Hawaiian or Other Pacific Islander, non-Hispanic	5	0.5%
White, non-Hispanic	825	85.1%
Other, non-Hispanic	4	0.4%
Multiple races	29	3.0%
Educational Attainment	**980**	
Less than high school	44	4.5%
High school graduate or GED	143	14.6%
Some college	185	18.9%
Associate or technical degree/certification	118	12.0%
College graduate	244	24.9%
Graduate or professional degree	246	25.1%
Household Income	**958**	
Less than $25,000	210	21.9%
$25,000 to $49,999	225	23.5%
$50,000 to 74,999	193	20.1%
$75,000 to $99,999	145	15.1%
$100,000 or more	185	19.3%
Disability (respondents were able to select multiple responses)	**266**	
Hearing	106	39.8%
Vision (blindness, severe vision impairment)	73	27.4%
Mobility (walking, climbing stairs)	87	32.7%
Cognitive functioning (concentrating, remembering, making decisions)	83	31.2%
Independent Living (dressing, bathing)	12	4.5%

Forces of Change Assessment (FOCA)

As part of the assessment, on July 12, 2018, HRiA facilitated a working meeting with 27 stakeholders, comprised of CHA Steering Committee members, Community Advisory Councils (CAC), and a select group of external stakeholders, to determine what factors (e.g. trends, events) are occurring or might occur that affect the health of the community or the public health system. This discussion helped to identify specific threats and opportunities that could be generated by these forces. Forces of change factors identified included issues related to political will, economic factors, trends in legislation, funding shifts, health care, workforce, population changes, health disparities and priorities, and other emerging organizational trends in Jackson and Josephine Counties.

This event explored via small and large group discussions the macro issues that have an impact on health. The discussion focused on generating a list of external factors that were most critical to the region and identifying opportunities and threats for each force. This event served as a brainstorming session for CHA Steering Committee members and other leaders of community-based organizations, health care institutions and hospitals, and health and social service agencies to identify these external

factors, how they might impact—for better or worse—the population's health, and ways to capitalize on opportunities they provide for future initiative planning. On July 30th, the CACs conducted a similar FOCA conversation, the results of which were incorporated into this report. HRiA captured detailed notes from these FOCA discussions, which can be found in Appendix C - Additional findings.

Local Public Health System Assessment (LPHSA)

A group of 35 organizational stakeholders participated in a half-day working meeting on July 12, 2018 to conduct the Local Public Health System Assessment (LPHSA). This process looked at the local public health system activities that are ongoing, identified whether they carry out essential services in the community, and captured this information using the National Public Health Performance Standards Local Public Health System Assessment Instrument which is recommended by the National Association of County and City Health Officials (NACCHO) for use in the LPHSA part of the MAPP process, and is a nationally-recognized gold-standard instrument for the LPHSA. HRiA provided strategic guidance on this effort, facilitated discussion groups and their electronic completion of the LPHSA tool. The results of the LPHSA can be found in Appendix C - Additional findings

Data analysis

The secondary data, qualitative data from interviews, focus groups and community forums, survey data, and Forces of Change and Local Public Health System Assessment data were synthesized and integrated into this community health assessment report. The collected qualitative information was manually coded and then analyzed thematically for main categories and sub-themes. Data analysts identified key themes that emerged across all discussions as well as the unique issues that were noted for specific populations. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While county differences are noted where appropriate, analyses emphasized findings common across the region. Selected paraphrased quotes – without personal identifying information – are presented in the narrative of this report to further illustrate points within topic areas.

For the survey data, frequencies and cross-tabulations by demographic characteristics were conducted using SPSS statistical software, Version 21. In most instances, response options from the survey were collapsed for ease of interpretation.

Four MAPP Assessments Flowchart

SOURCE: https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp
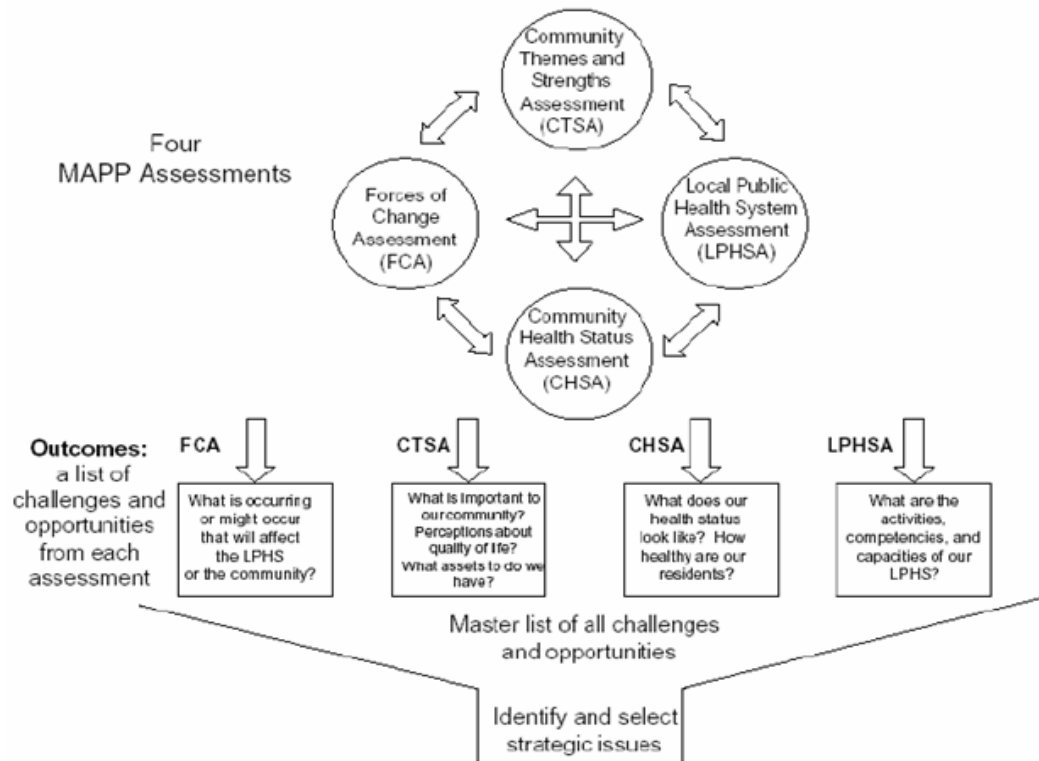
Prioritization

Stakeholders convened for a three-hour meeting on October 2, 2018 to review and discuss the preliminary results of the CHA and identify priorities, what the MAPP process calls strategic issues, for the CHIP. Forty-one community members and leaders representing diverse perspectives and multiple sectors from both Jackson and Josephine Counties attended this session.

Participants received an overview of 15 key themes that emerged in the collection of qualitative and quantitative data. While all of the key strategic issues identified through the CHA are important and many have initiatives already underway in many communities, the issues selected for health improvement planning will represent a more focused set of goals, objectives and strategies for collaborative implementation. The prioritization process used a method of rating the key issues against established criteria to then select those health issues that are most appropriate for health improvement planning. The table below represents the criteria presented to the group. Participants rated each key strategic issue based on how well they felt it met each criteria category and then voted on their top highest rated issues.

RELEVANCE	APPROPRIATENESS	IMPACT	FEASIBILITY
How Important Is It?	Should We Do It?	What Will We Get Out of It?	Can We Do It?

- Burden (magnitude and severity; economic cost; urgency) of the problem - Community concern - Focus on equity and accessibility	- Ethical and moral issues - Human rights issues - Legal aspects - Political and social acceptability - Public attitudes and values	- Effectiveness - Coverage - Builds on or enhances current work - Can move the needle and demonstrate measurable outcomes - Proven strategies to address multiple wins	- Community capacity - Technical capacity - Economic capacity - Political capacity/will - Socio-cultural aspects - Ethical aspects - Can identify easy short-term wins - FOC alignment

The 15 key themes are presented below, with the top six priorities **bolded**.

- **Affordable housing**
- **Substance use**
- **Poverty and employment**
- **Mental health and wellbeing**
- Transportation
- Health care access
- Fragmentation of services
- **Education and workforce development**

- Aging
- Environmental health
- Community safety
- Oral health
- Food insecurity
- Communicable diseases
- **Parenting and life skills**

Limitations

As with all assessment efforts, there are some information gaps related to the assessment methods that should be acknowledged. First, for quantitative (secondary) data sources, most data could not be provided at geographic levels smaller than county due to the small population size in the region. Similarly, there were limited data available stratified by subgroup (age, race/ethnicity) for the area. It should be noted that while comparisons are made between geographies and demographic groups, these do not reflect tests of statistical significance.

While examining data across multiple time points provides important information about health patterns over time, there were some indicators for which data may not have been available for the same geographic unit across multiple time points. There were also a few indicators that changed slightly since previous assessments. Accordingly, direct comparisons across time points should be interpreted conservatively or with caution. For example, the indicator of poor mental health for adults shifted from 15+ days of poor mental health in the past month to 14+ days of poor mental health.

Data based on self-reports should be interpreted with particular caution. In some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk

factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHA benefit from large sample sizes and repeated administrations, enabling comparison over time.

Additionally, while the focus groups and interviews conducted for this CHA provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. Recruitment for focus groups was conducted by community organizations and participants were those individuals who were able to connect to these community organizations. Because of this, it is possible that the responses received only provide one perspective of the issues discussed. Lastly, it is important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

How This Assessment Can Be Used

The 2018 Community Health Assessment of Jackson and Josephine Counties serves multiple purposes for a variety of audiences. Among these purposes, the assessment enables JRHA and its partners to:

- Explore current health status and determinants of health, health priorities, and new and emerging concerns among Jackson and Josephine County community members and service providers
- Hear individual and group voices to provide a deeper understanding of the "why" and "how" of current and emerging health issues
- Understand the shifting patterns of these health issues over time in Jackson and Josephine Counties
- Identify assets and resources as well as gaps and needs in services in order to help partners set funding and programming priorities
- Fulfill the community health needs assessment requirements for Asante and Providence Hospitals, regional federally qualified health centers, Jackson and Josephine County Public Health Departments, Community Mental Health Programs, and Coordinated Care Organizations
- Use the data gathered to engage JRHA members, partners and the community in the community health improvement process

REGIONAL SNAPSHOT – DEMOGRAPHICS AND HEALTH STATUS

The primary and secondary data collected for this assessment covered a large range of epidemiological, social and economic data. The following section provides a brief quantitative overview of the population demographics and health status of Jackson and Josephine Counties. Additional data related to each of the top six priorities that emerged from the prioritization process can be found in the key themes section and a full range of demographic and health indicators is included in Appendix C - Additional findings.

Demographic Profile

Oregon, Jackson County, and Josephine County all experienced growth in population between 2011 and 2016, with a 4.3% increase in Jackson County and a 1.9% increase in Josephine County (Table 2).

Table 2. Total Population and Percent Change, by State and County, 2007-2011 and 2012-2016

	2011	2016	% change
Oregon	3,801,991	3,982,267	4.7% ↑
Jackson County	202,178	210,916	4.3% ↑
Josephine County	82,456	84,063	1.9% ↑

Based on 2012-2016 American Community Survey 5-year estimates, Josephine County and Jackson County (24.6% and 20.2%, respectively) had higher proportions of community members aged 65 and over than Oregon as a whole (15.9%) (Figure 1). The topic of aging emerged as a theme in qualitative conversations, which highlighted the inadequate resources that exist to support the needs of the disproportionately large number of older community members in the two counties.

Figure 1. Age Distribution, by State and County, 2012-2016
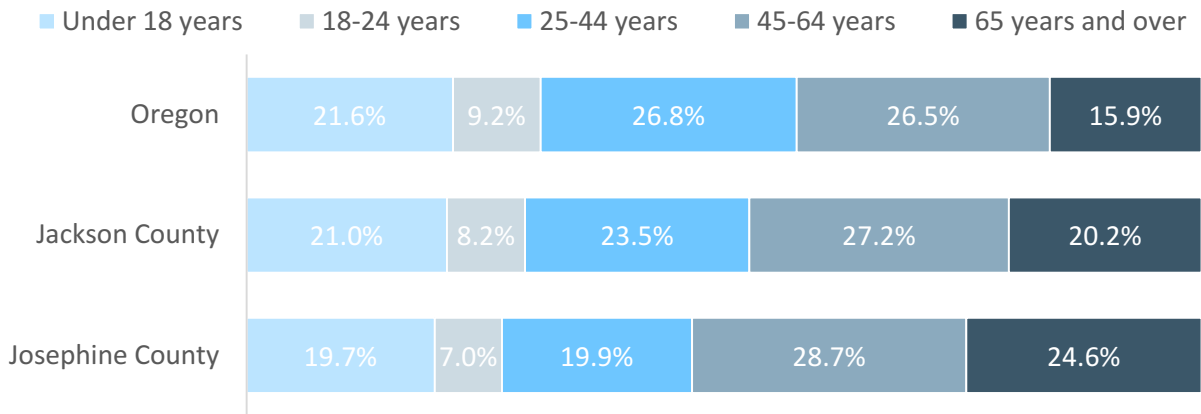
As seen in Figure 2, the majority of community members in the three geographies identified as White, non-Hispanic, with Josephine County having a higher proportion of community members identifying as White, non-Hispanic (87.7%). Jackson and Josephine counties reported to have smaller proportions of community members identifying as non-White compared to the state.

Figure 2. Racial and Ethnic Distribution, by State and County, 2012-2016
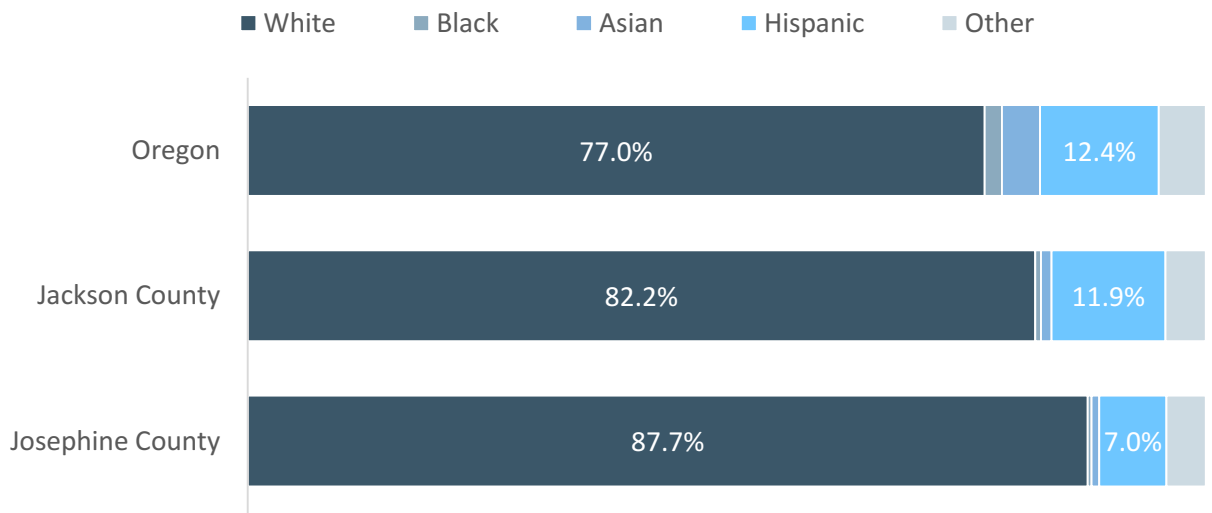
NOTE: White, Black, Asian, and Other include only individuals that identify as one race; Hispanic/Latino include individuals of any race; Other includes American Indian and Alaska Native, Native Hawaiian and other Pacific Islander, other race alone, or two or more races

Jackson County saw the largest percent increase in Hispanic or Latino population (18.7%) between 2007-2011 and 2012-2016 compared to Oregon (13.1%) and Josephine County (13.1%) (Table 3). Qualitatively, focus group and interview participants observed growth in the Latino population across both counties and discussed implications for providing culturally-competent services. Participants in several focus groups shared that the community has good intentions to help meet the needs of the growing Latino population regionally. However, interviewees expressed that the community can do a better job both engaging the Latino population and providing leadership opportunities so that "our organizations reflect the diversity of our community members."

Table 3. Change in Hispanic or Latino Population, by State and County, 2007-2011 and 2012-2016

	2011	2016	% change
Oregon	436,806	494,806	13.3% ⬆
Jackson County	21,109	25,058	18.7% ⬆
Josephine County	5,171	5,850	13.1% ⬆

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Smaller proportions of community members in Jackson and Josephine counties were foreign-born (6.3% and 3.9%, respectively) when compared to Oregon overall (10.3%) (Figure 3).

Figure 3. Percent Population 5 Years and Over Foreign-Born, by State and County, 2007-2011 and 2012-2016
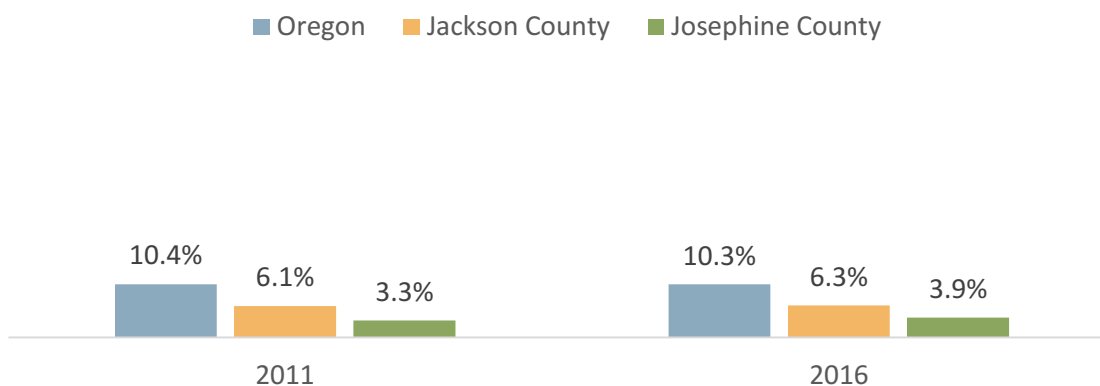
■ Oregon   ■ Jackson County   ■ Josephine County

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

As depicted in Table 4, across Oregon, Jackson County, and Josephine County, the largest proportions of foreign-born community members were from Central America (41.7%, 57.9%, and 39.8%, respectively).

Table 4. Top Five Places of Birth for Foreign-Born Population, by State and County, 2012-2016

	Oregon	Jackson County	Josephine County
1	Central America 41.7%	Central America 57.9%	Central America 39.8%
2	China 6.2%	United Kingdom 5.6%	Germany 10.0%

3	Vietnam 5.2%		Canada 5.3%		United Kingdom 9.4%
4	Canada 3.9%		China 4.4%		Canada 8.3%
5	India 3.6%		Germany 3.4%		Philippines 5.3%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTE: Central America includes Mexico, Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and Other Central America; United Kingdom includes England, Scotland, and Crown Dependencies

As shown in Figure 4, approximately one in ten community members in Jackson County (9.6%) and one in twenty community members (4.8%) in Josephine County spoke a language other than English at home, which was lower than the percentage of community members in Oregon (15.1%).

Figure 4. Percent Population 5 Years and Over Speak a Language Other than English at Home, by State and County, 2007-2011 and 2012-2016
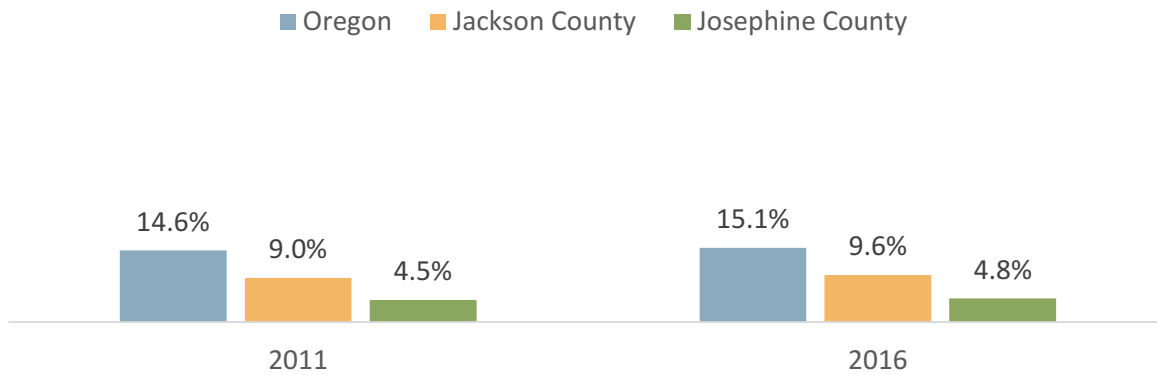
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

General Health Status and Mortality

According to the BRFSS, a nation-wide survey that asks community members about their health-related risk behaviors, health conditions, and use of preventive services, over 80% of adults reported their general health status to be good, very good, or excellent across all geographies, with adults slightly less likely to report as such in Josephine County (Figure 5). While self-reported health status is high, more local data from the community survey indicated that only 46.5% of respondents felt that the general health status of the community within which they live was good, very good or excellent.

Figure 5. Age-Adjusted Percent Adults Reported General Health Status as Good or Very Good or Excellent, by State and County, 2012-2015

| U.S. | Oregon | Jackson County | Josephine County |
| 83.6% | 82.1% | 81.6% | 80.9% |

Mortality statistics help us understand health and how it can be improved. In 2017, the mortality rates for Josephine and Jackson Counties (847.4 deaths per 100,000 population and 756.4 deaths per 100,000 population, respectively) were higher than that for Oregon (717.5 deaths per 100,000 population) (Figure 6). Across the three time points there is some fluctuation in mortality rates but small overall decreases in both counties between 2015 and 2017.

Figure 6. Age-Adjusted Overall Mortality Rate per 100,000 Population, by State and County, 2015-2017
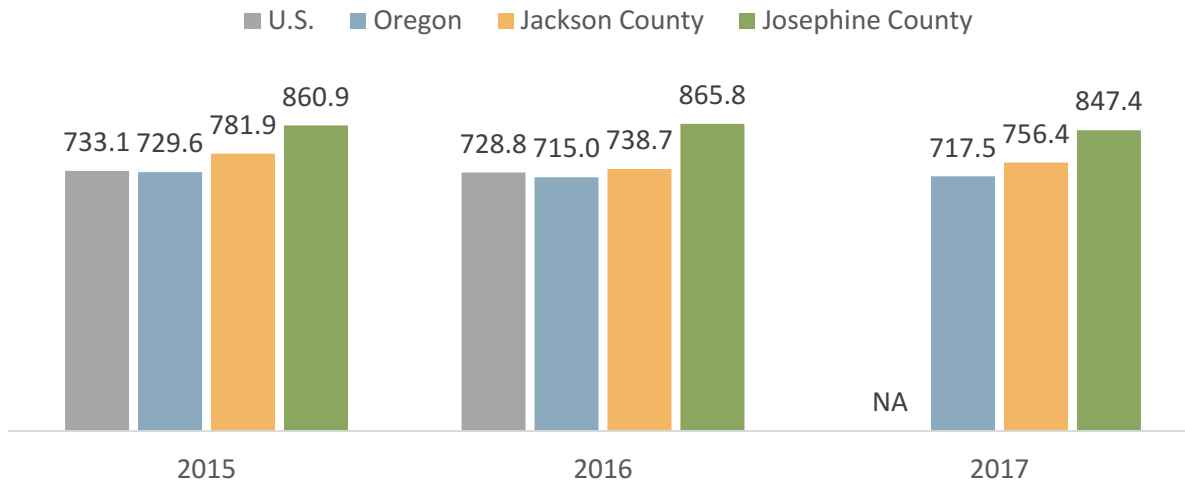
The leading causes of mortality were similar across Oregon and Jackson and Josephine Counties, with the highest mortality rates due to cancer and heart disease (Table 5). The mortality rate due to accidents (unintentional injuries) was higher for Josephine County (72.4 deaths per 100,000) when compared to Oregon

(44.7 deaths per 100,000 population) and Jackson County (40.2 deaths per 100,000 population). Both counties experience high mortality rates due to chronic lower respiratory disease compared to the state overall.

Table 5. Top Five Leading Causes of Mortality, Age-Adjusted Rates per 100,000 Population, 2017

Rank	Oregon	Jackson County	Josephine County
1	Cancer 154.2	Cancer 154.8	Cancer 165.8
2	Heart Disease 134.0	Heart Disease 122.0	Heart Disease 146.6
3	Accidents 44.7	Chronic lower respiratory disease 47.8	Accidents 72.4
4	Cerebrovascular disease 39.9	Accidents 40.2	Chronic lower respiratory disease 47.7
5	Chronic lower respiratory disease 39.7	Cerebrovascular disease 37.4	Cerebrovascular disease 43.6

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2017

Years of Potential Life Lost (YPLL) is an estimate of the average years a person would live if they had not died prematurely. A larger number indicates greater loss. For the period of 2012-2016, according to the Oregon Health Authority, the YPLL before age 75 was higher in both Josephine (9,706.2 per 100,000 population) and Jackson Counties (7,486.9 per 100,000 population) compared to the statewide rate (6,432.7 per 100,000 population).

Life expectancy is a summary mortality measure often used to describe the overall health status of a population. Life expectancy is defined as the average number of years a population of a certain age would be expected to live, given a set of age-specific death rates in a given year, in other words how long a person can expect to live. Examining life expectancy at birth across Jackson and Josephine Counties, there are vast differences by census tract, indicating that where people are born and live influences how long they live. Within Jackson County, the range is nearly 20 years (66.2 years to 85.6 years),

> "Affordable, high-quality health care is essential to our health. But where we live can have an even great impact. Improving health and longevity in communities starts with ensuring access to healthy food, good schools, affordable housing, and jobs that provide us the resources necessary to care for ourselves and our families – in essence, the types of conditions that can help keep us from getting sick in the first place." – Robert Wood Johnson Foundation

according to data from the U.S. Small-area Life Expectancy Estimate Project. Overall, the 2014 life expectancy at birth for Jackson County was 79 years, which was the same as Oregon as a whole. Life expectancy at birth was 74 years in Josephine County.

KEY THEMES

As detailed in the methods section, this community health assessment covered a broad range of economic, social, and epidemiological quantitative data as well as extensive qualitative data. From these data, and as a

result of the prioritization process previously described, several priority key themes emerged. This section of the report provides background on each of the top six priorities, supporting data from the assessment, existing assets and resources in Jackson and Josephine Counties, and future explorations.

Substance Use

Importance and connection to other health issues

Substance use and abuse is a critical public health issue that affects not only the individual, but also has serious direct and indirect impacts on families, communities and society as whole. The causes of substance use disorders are multi-faceted and include biological, social and environmental factors.[13] Trauma and adverse childhood experiences increase the chances of substance use and addiction.[14] Individuals with substance use disorders can experience negative health and social outcomes including higher rates of infectious disease (HIV, hepatitis), cancer, mental illness, domestic violence, crime, financial hardship, housing instability and homelessness, child-abuse and overdose.[15] Illicit drug use, along with existing and emerging alcohol and marijuana use, strains resources from law enforcement to social and health services.

Key Findings

As seen across all the data sources for this assessment, substance use emerged as a top issue. Looking at the community survey conducted as part of this assessment, substance use was the third most frequently selected health issue having the largest impact on the community (59.6%) and the fourth most frequently selected health issue having the largest impact on themselves/their family/their patients (

Figure *7*). Middle-income households (those making $50,000-$99,999) were more likely to view substance use as a top health issue in the community (65.3%). In general, respondents were more likely to report substance use as a top issue impacting the community compared to as an issue impacting themselves/their family/their patients.

Figure 7. Percent Survey Respondents Reported Substance Use (Alcohol, Marijuana, Heroin, Meth, etc.) as a Top Health Issue Having the Largest Impact on You/Your Family* and Your Community, by Respondent Type, 2018

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[13] US Department of Health and Human Services, Office of the Surgeon General. Facing Addiction in America The Surgeon General's Report on Alcohol, Drugs, and Health. 2016.

[14] Felitti VJ, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study. American Journal of Preventative Medicine. 1998; 14(4): 245-258.

[15] US Department of Health and Human Services, Office of the Surgeon General. Facing Addiction in America The Surgeon General's Report on Alcohol, Drugs, and Health. 2016.
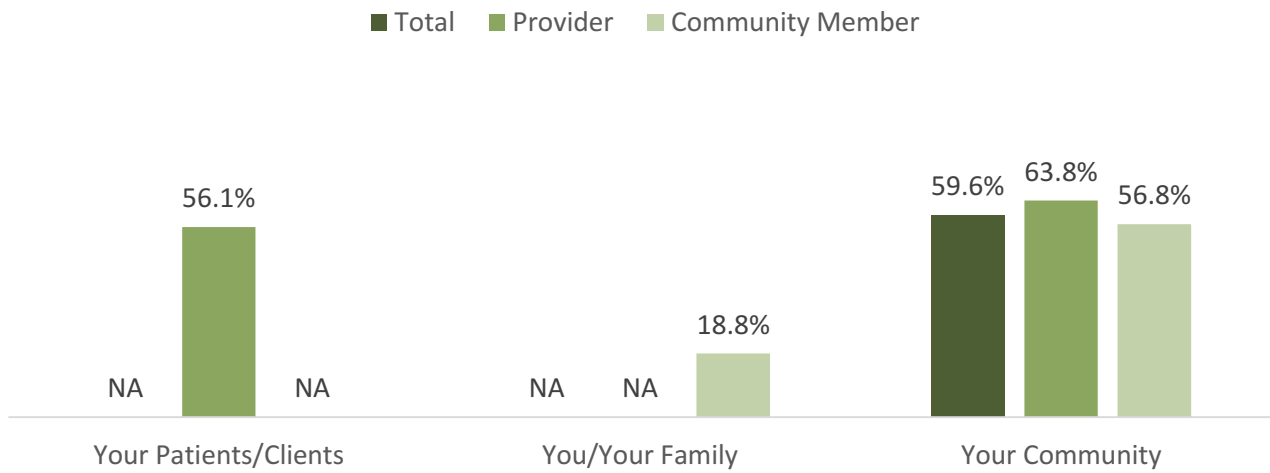
Respondents were asked to rate their level of concern for specific community issues.

Figure *8* lists specific issues related to substance abuse. Over 70% of survey respondents overall reported methamphetamine use (76.7%), opioid use (72.3%), and drug use among youth (71.4%) were of "high concern." Alcohol and marijuana use were also high concerns, particularly among the Hispanic/Latino population.

Figure 8. Survey Respondents Perceived Level of Concern for Issues Related to Substance Abuse, 2018
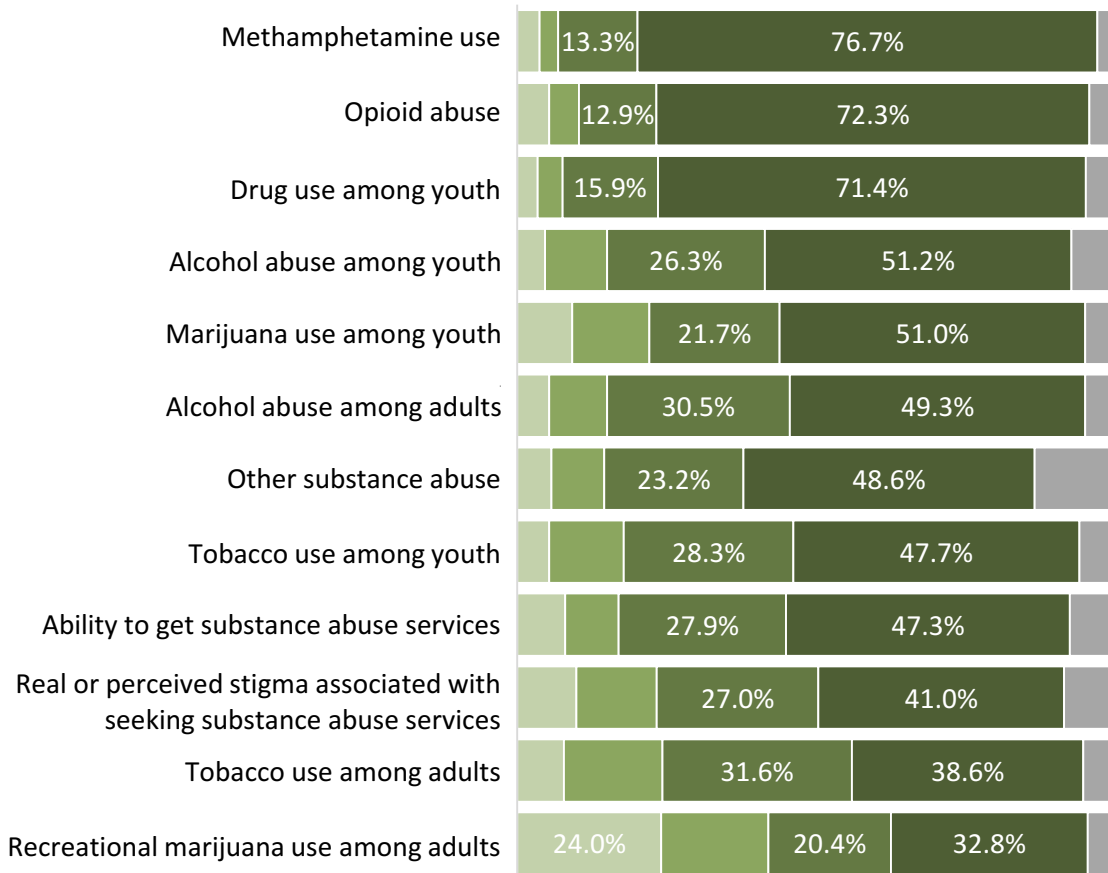
Legend: Not a concern · Slight concern · Moderate concern · High concern · I don't know

Category	Slight/Moderate %	High concern %
Methamphetamine use	13.3%	76.7%
Opioid abuse	12.9%	72.3%
Drug use among youth	15.9%	71.4%
Alcohol abuse among youth	26.3%	51.2%
Marijuana use among youth	21.7%	51.0%
Alcohol abuse among adults	30.5%	49.3%
Other substance abuse	23.2%	48.6%
Tobacco use among youth	28.3%	47.7%
Ability to get substance abuse services	27.9%	47.3%
Real or perceived stigma associated with seeking substance abuse services	27.0%	41.0%
Tobacco use among adults	31.6%	38.6%
Recreational marijuana use among adults	24.0% / 20.4%	32.8%

DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Data are organized in descending order by "high concern"

These concerns were echoed among focus group and interview participants, who most frequently mentioned substance use as the top community health concern, highlighting opioids, meth, and the co-occurrence of substance use and mental illness.

"There's generational use of meth. We've got 60+ year olds, their kids, and then their teenage grandkids all using."

While harder drugs, such as opioids and meth, were of primary concern to both survey respondents and focus group participants, data are limited as to the prevalence of use among adults. Alcohol use is most commonly and reliably measured among adults. As seen in Figure 9, adults were more likely to report current binge drinking statewide (17.9%) and in Jackson County (17.6%) compared to Josephine County (16.3%) and adults nationwide (16.3%).

Figure 9. Age-Adjusted Percent Adults Reported Current Binge Drinking, by U.S., State, and County, 2012-2015
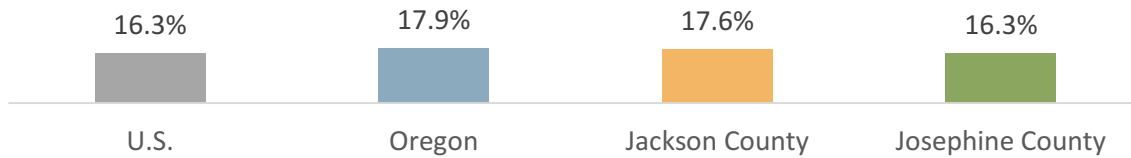
16.3%	17.9%	17.6%	16.3%
U.S.	Oregon	Jackson County	Josephine County

DATA SOURCE: (for U.S. data) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence Data and Analysis Tools, BRFSS Prevalence & Trends Data, 2015; (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

NOTE: Data for U.S. are crude percentages; Current binge drinking is defined as consuming five or more (men)/four or more (women) alcoholic beverages on one occasion in past 30 days

A higher percentage of adults in Josephine County reported current heavy drinking (10.4%) compared to Jackson County (8.0%), Oregon (7.3%), and the U.S. (5.9%) (Figure 10).

Figure 10. Age-Adjusted Percent Adults Reported Current Heavy Drinking, by U.S., State, and County, 2012-2015

5.9%	7.3%	8.0%	10.4%
U.S.	Oregon	Jackson County	Josephine County

DATA SOURCE: (for U.S. data) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence Data and Analysis Tools, BRFSS Prevalence & Trends Data, 2015; (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

NOTE: Data for U.S. are crude percentages; Current heavy drinking is defined as consuming two or more (men)/one or more (women) alcoholic beverages per day in past 30 days

As noted above, substance use among youth was highlighted as a major concern among survey respondents. Over a third of 11th grade students in Jackson County reported current alcohol consumption (34.3%) in 2016, which was higher than the percentage of 11th graders in Oregon as a whole (29.8%) and Josephine County (29.6%) (Figure 11).

Figure 11. Percent 11th Grade Students Reported Current Alcohol Consumption, by State and County, 2012, 2014, and 2016
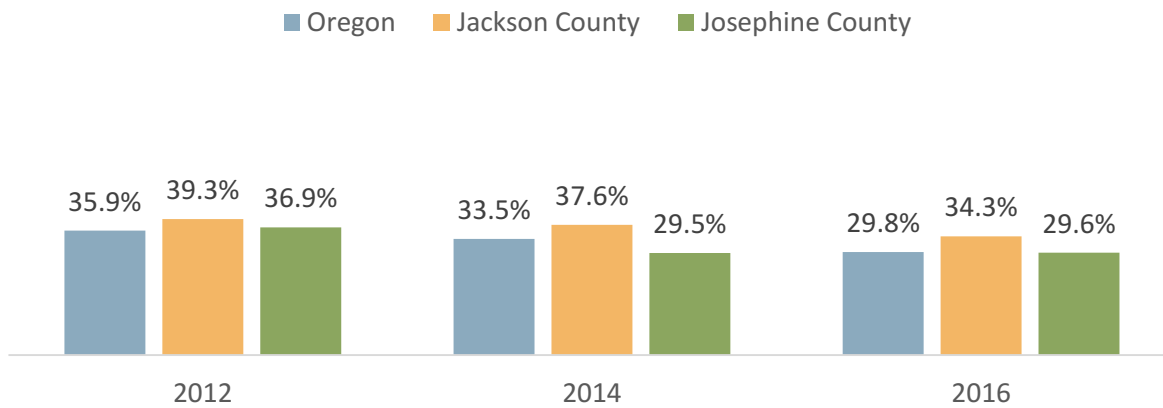
DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Current alcohol consumption is defined as "had at least one drink on at least one day in past 30 days"

Compared to 2012, 11th grade students were less likely to report current binge drinking across all geographies in 2016 (Figure 12). Slightly higher percentages of 11th grade students reported current binge drinking in Jackson and Josephine counties than in Oregon overall.

Figure 12. Percent 11th Grade Students Reported Current Binge Drinking, by State and County, 2012, 2014, and 2016
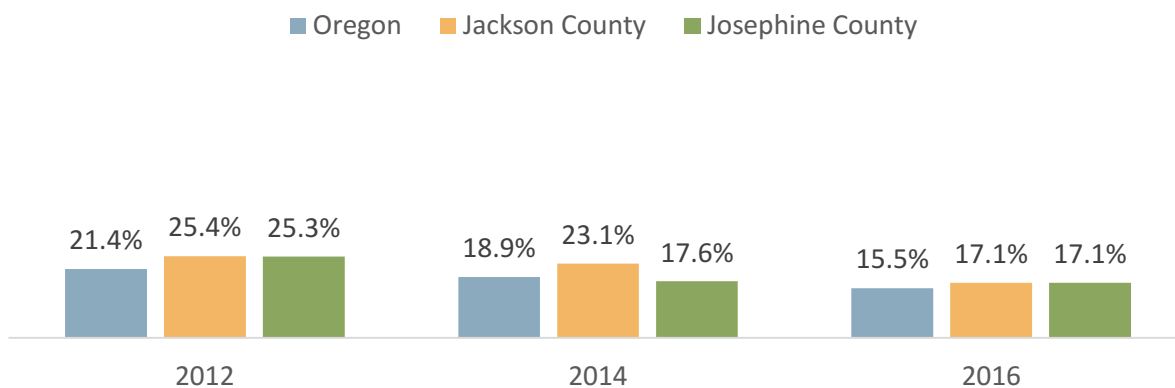
■ Oregon   ■ Jackson County   ■ Josephine County

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Current binge drinking is defined as "had five or more drinks in a row (within a couple of hours) on at least one day in past 30 days"

As shown in Figure 13, in 2015, adults in Josephine County were more likely to report current cigarette smoking (24.7%) than adults in Jackson County (19.6%) and Oregon as a whole (17.7%). It is important to note that Josephine County also experiences higher lung cancer incidence and mortality rates, which can be seen in Appendix C - Additional findings.

Figure 13. Age-Adjusted Percent Adults Reported Current Cigarette Smoking, by U.S., State, and County, 2012-2015
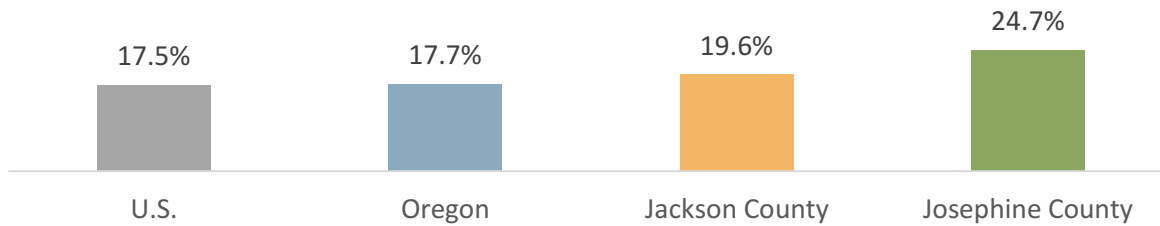
Bar chart showing: U.S. 17.5%, Oregon 17.7%, Jackson County 19.6%, Josephine County 24.7%

DATA SOURCE: (for U.S. data) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence Data and Analysis Tools, BRFSS Prevalence & Trends Data, 2015; (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015
NOTE: Data for U.S. are crude percentages

The percentage of 11th grade students reporting current cigarette use decreased between 2012 and 2016 for all geographies (Figure 14). In 2016, 11th grade students in Jackson and Josephine counties were slightly more likely to report current cigarette use (8.3% and 8.2%, respectively) than in Oregon overall (7.7%).

Figure 14. Percent 11th Grade Students Reported Current Cigarette Use, by State and County, 2012, 2014, and 2016
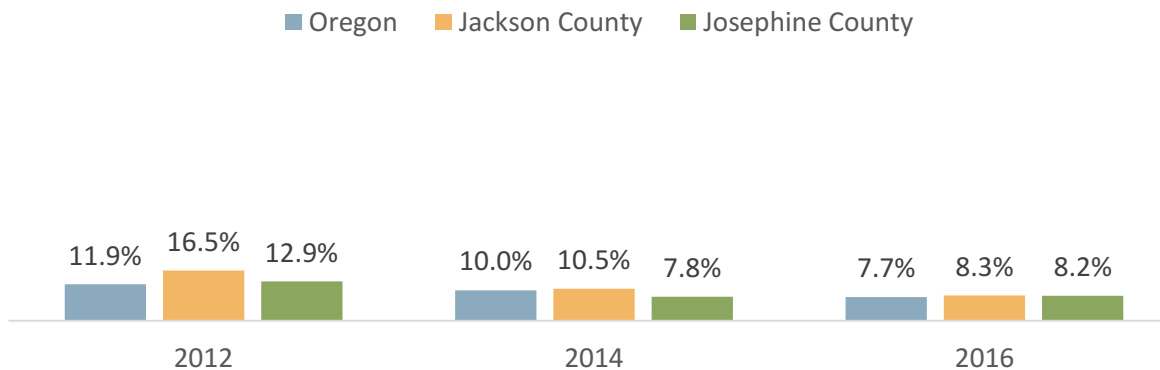
Legend: ■ Oregon ■ Jackson County ■ Josephine County

Bar chart showing:
2012: Oregon 11.9%, Jackson County 16.5%, Josephine County 12.9%
2014: Oregon 10.0%, Jackson County 10.5%, Josephine County 7.8%
2016: Oregon 7.7%, Jackson County 8.3%, Josephine County 8.2%

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Current cigarette use is defined as "smoked cigarettes at least one day in past 30 days"

Figure 15. Percent Survey Respondents Reported Smoking as a Top Health Issue Having the Largest Impact on You/Your Family* and Your Community, by Respondent Type, 2018
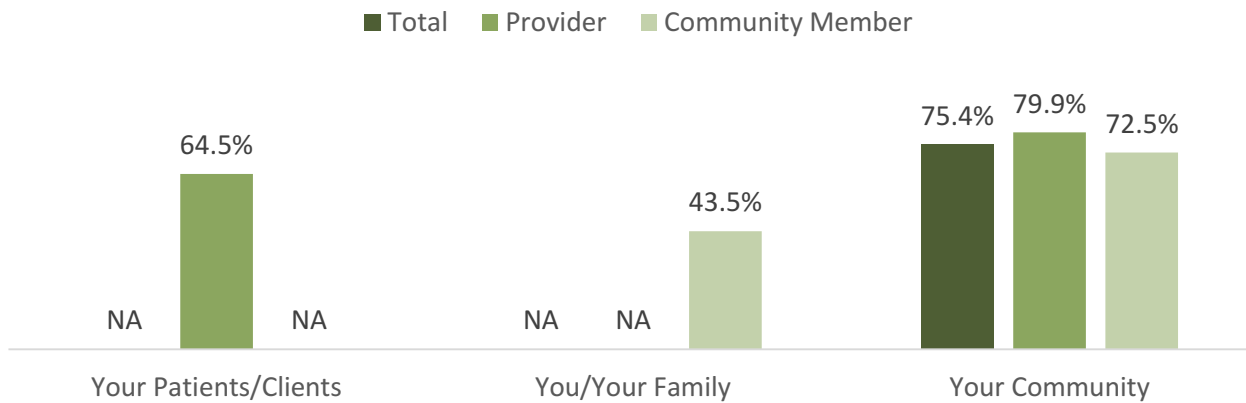
Total   Provider   Community Member

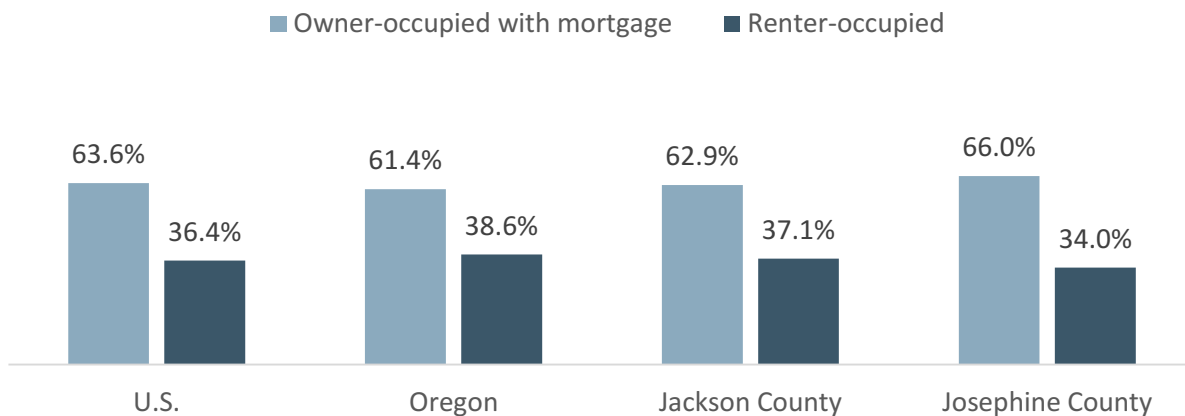|	Your Patients/Clients	You/Your Family	Your Community
17.6%			
	NA / 17.6% / NA	NA / NA / 14.4%	18.3% / 14.9% / 20.6%
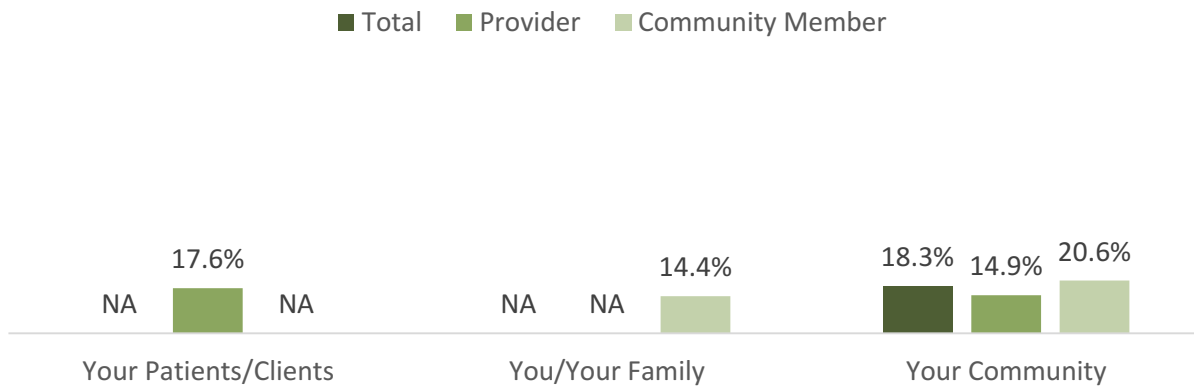
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTES: Asterisk denotes "You/Your Family" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated or applicable due to the difference in wording in the survey versions

Compared to other substances, few community members viewed tobacco use as a top health concern. Community members who responded to the community survey were slightly more likely to select smoking as a top issue impacting their community (20.6%) compared to providers (14.9%) (Figure 15). However, there are disparities by income, with low-income households (those making less than $25,000 per year) more likely to report smoking as a top concern (26.1%).

In 2016, 11th grade students in Jackson and Josephine counties were more likely to report current marijuana use (26.3% and 24.3%, respectively) than in Oregon overall (21.6%) (Figure 16).

Figure 16. Percent 11th Grade Students Reported Current Marijuana Use, by State and County, 2012, 2014, and 2016
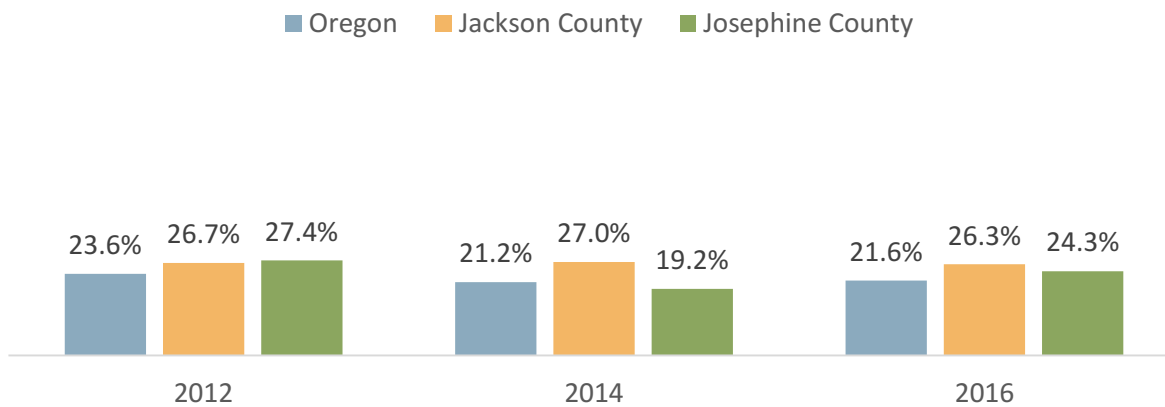
Oregon   Jackson County   Josephine County

	2012	2014	2016
Oregon	23.6%	21.2%	21.6%
Jackson County	26.7%	27.0%	26.3%
Josephine County	27.4%	19.2%	24.3%

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Current marijuana use is defined as "used marijuana at least one time in past 30 days"

Focus group and interview participants widely discussed the marijuana industry and use of marijuana in the region. Participants spoke positively of the economic growth that the industry has brought to the region; however, the long-term social, environmental, and physical health impacts on the community were raised as concerns.

Survey respondents as well as focus group and interview participants were troubled about the perceived prevalence of prescription drug use among youth. However, the quantitative data are limited to support this perception. The percentage of 11th grade students reporting current prescription drug use without a prescription decreased between 2012 and 2016 (Figure 17). In 2016, 11th grade students were less likely to report current prescription drug use in Josephine County (4.0%) compared to Jackson County and Oregon as a whole (5.9% and 6.2%, respectively).

Figure 17. Percent 11th Grade Students Reported Current Prescription Drug Use Without Doctor's Prescription, by State and County, 2012, 2014, and 2016
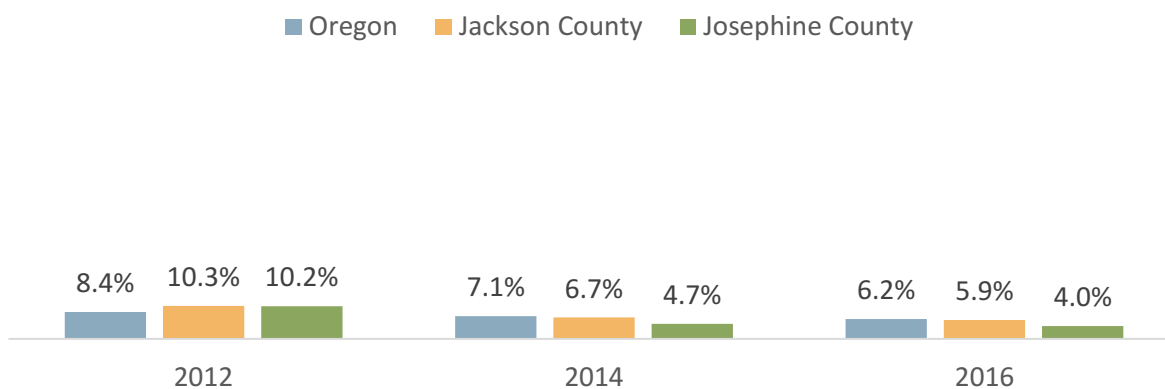
DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Current prescription drug use is defined as "used a prescription drug (e.g., OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's orders at least one day in past 30 days"

Figure 8 indicated that opioid use was of particular concern to community survey respondents. As seen in Figure 18, the opioid overdose hospitalization rates were higher for Jackson and Josephine counties (14.5 hospitalizations per 100,000 population and 12.8 hospitalizations per 100,000 population) compared to Oregon overall.

Figure 18. Opioid Overdose Hospitalization Rate per 100,000 Population, by State and County, 2010-2014
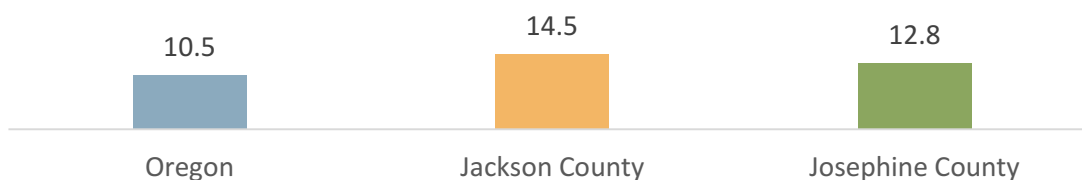
DATA SOURCE: Oregon Health Authority, Center for Health Statistics, Public Health Division, Oregon Hospital Discharge Data as cited by Opioid Data Dashboard, 2010-2014

"Opioids are what we're seeing. The amount of heroin that runs through here – it affects so much of the population."

According to 2012-2016 estimates, the mortality rate due to opioid overdose was higher in Jackson County (7.5 deaths per 100,000 population) compared to Josephine County and the state (6.0 deaths per 100,000 population and 6.6 deaths per 100,000 population, respectively) (Figure 19).

Figure 19. Age-Adjusted Opioid Overdose Mortality Rate per 100,000 Population, by State and County, 2002-2006, 2007-2011, and 2012-2016
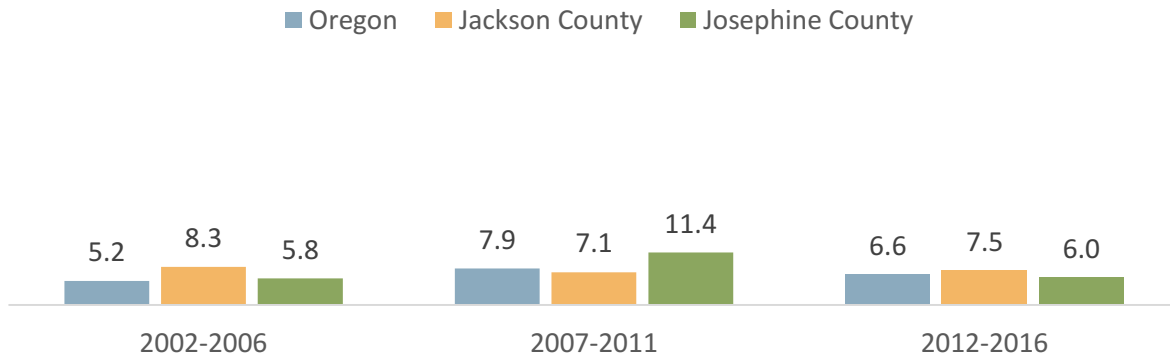
■ Oregon   ■ Jackson County   ■ Josephine County

	2002-2006	2007-2011	2012-2016
Oregon	5.2	7.9	6.6
Jackson County	8.3	7.1	7.5
Josephine County	5.8	11.4	6.0

DATA SOURCE: Oregon Health Authority, Center for Health Statistics, Public Health Division, Death Certificates as cited by Opioid Data Dashboard, 2002-2006, 2007-2011, and 2012-2016
NOTE: Includes any opioid

Future Exploration

Future exploration should include developing a better understanding of the risk and protective factors of substance use, and how to best engage in community dialogue about these factors. Additionally, there were many questions raised among interview and focus group participants regarding marijuana production and use in Jackson and Josephine Counties. Assessment participants expressed concerns about the impact of marijuana on land and housing prices, and environmental health concerns related to air and water quality. Further inquiry is needed to understand the impact of legalization and the associated health outcomes.

Existing Assets and Resources

Assessment participants were asked about the assets in their communities related to substance use and shared the following list of resources:

- Adapt
- Addictions Recovery Center
- Allied Health Services
- Choices Counseling Center
- Community Works
- County Alcohol and Drug Prevention and Education Programs (ADPEP)
- County LADPCs (Local Alcohol and Drug Planning Committees)

- County Tobacco Prevention and Education Programs (TPEP)
- Grants Pass Sobering Center
- Grants Pass Treatment Center
- HIV Alliance in Josephine County
- Jackson County Syringe Exchange
- Kolpia Counseling
- La Clinica
- Max's Mission
- OnTrack Rogue Valley
- Options for Southern Oregon
- Oregon Pain Guidance (OPG)
- Oregon Prescription Drug Monitoring Program
- Phoenix Counseling Center
- Rogue Community Health
- Southern Oregon Veterans Rehabilitation Center & Clinics

NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

Despite the existence of several local resources to address substance use disorders, as seen in Figure 20, over half of providers selected substance abuse services as a health and social service currently lacking in the community, which was higher than survey respondents overall (40.4%) and community members (32.4%). It should be noted that female survey respondents (44.6%) and those with household incomes of $75,000-$99,999 (51.7%) were more likely to report substance abuse services as lacking in the community.

Figure 20. Percent Survey Respondents Reported Substance Abuse Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018
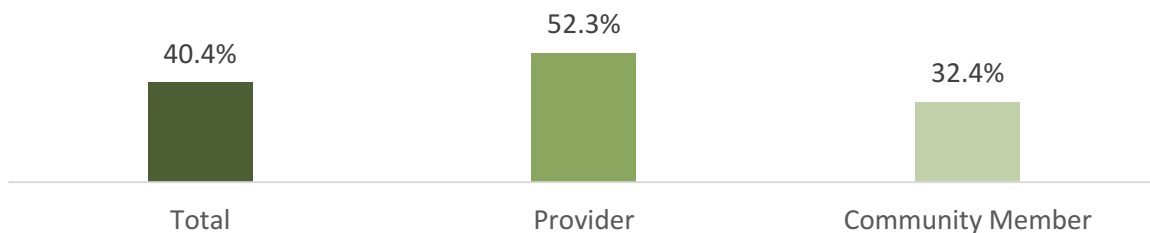
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Tension between the range of factors affecting substance use disorders can create a challenging environment for open dialogue and may prevent individuals from seeking help from the resources that exist. Nationally, 95% of people with substance use disorders are considered unaware of their issue and many are unaware of the far-

reaching effects on children and families.[16] The co-occurrence of substance use disorders and mental illness, and the limited resources to address them, further complicates these issues.

Affordable Housing

Importance and connection to other health issues

Affordability, quality and stability are important characteristics that directly impact an individual's ability to access safe and healthy housing.[17] Unstable housing and homelessness can lead to stress, isolation, chronic disease (e.g., asthma), substance use, mental health issues and violence.[18] For those with housing, the affordability and quality of housing impact health and well-being. Housing is often a household's single greatest expense. The cost of housing directly impacts an individual's ability to afford housing, as well as how much money they can use towards health care, food, childcare and transportation.[19] While housing itself is an important factor in an individual's health, it can also be a cost burden and result in compromises to health in other areas – i.e. foregoing prescription medications – due to cost. High housing-related costs place a disproportionate economic burden on low-income families in particular, as demonstrated by one study which found that low-income people with difficulty paying rent, mortgage or utility bills were less likely to have a usual source of medical care, and were more likely to postpone treatment and use the emergency room for treatment.[20] Additionally, research has shown that children who live in areas with greater housing instability are more likely to have worse health outcomes, more behavioral problems, and lower school performance.[21]

The quality of housing includes everything from the structure of the housing unit itself to the built environment around it. Indoor exposure to lead paint, secondhand smoke and mold are all pollutants that can cause negative health outcomes. The location of housing also has broad health implications – from access to employment that provides health insurance, green spaces for physical activity, healthy food, and accessible transportation.

Key Findings

Affordable housing was the top issue that emerged from focus group and interview discussions. Similarly, among overall survey respondents, affordable housing was the most frequently selected issue having an impact on themselves/their family/their patients (64.5% of providers, 43.5% of community members) and their community (75.4%) (Figure 21). Approximately 80% of providers reported affordable housing as a top issue. When looking at these data by race, non-White survey respondents were more likely to select affordable housing as a top health concern for themselves/their family (61.7%) as were respondents who reported household income less than $25,000 (63.1%).

Figure 21. Percent Survey Respondents Reported Affordable Housing as a Top Health Issue Having the Largest Impact on You/Your Family* and Your Community, by Respondent Type, 2018

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[16] Healthy People 2020

[17] Shaw M. Housing and Public Health. Annual Review of Public Health. 2004; 25: 397-418.

[18] Shaw M. Housing and Public Health. Annual Review of Public Health. 2004; 25: 397-418.

[19] Maqbool N, Viveiros J, and Ault M. The Impacts of Affordable Housing on Health: A Research Summary. Center for Housing Policy. 2015.

[20] Jelleyman T. and Spencer N. Residential Mobility in Childhood and Health Outcomes: A Systemic Review, J Epidemiol Community Health, 62(7): 584-92, 2008.

[21] Jelleyman T. and Spencer N. Residential Mobility in Childhood and Health Outcomes: A Systemic Review, J Epidemiol Community Health, 62(7): 584-92, 2008.

Legend: Total, Provider, Community Member

Your Patients/Clients: Total: NA, Provider: 64.5%, Community Member: NA

You/Your Family: Total: NA, Provider: NA, Community Member: 43.5%

Your Community: Total: 75.4%, Provider: 79.9%, Community Member: 72.5%
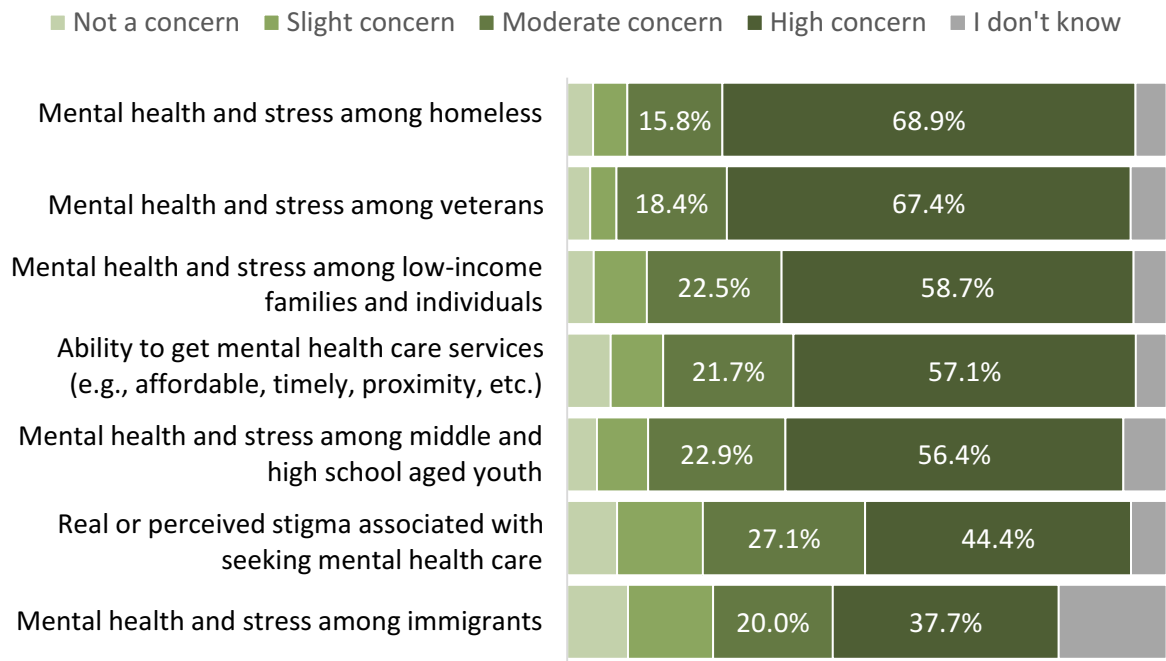
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTES: Asterisk denotes "You/Your Family" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated or applicable due to the difference in wording in the survey versions

It is important to look at how many households are owners compared to renters. Across all geographies, higher proportions of housing units were occupied by owners with mortgages than by renters (Figure 22). Josephine County had the highest proportion of owner-occupied housing units (66.0%) compared to the U.S., Oregon, and Jackson County.

Figure 22. Percent Owner- and Renter-Occupied Housing Units, by U.S., State, and County, 2012-2016

Legend: Owner-occupied with mortgage, Renter-occupied

	Owner-occupied with mortgage	Renter-occupied
U.S.	63.6%	36.4%
Oregon	61.4%	38.6%
Jackson County	62.9%	37.1%
Josephine County	66.0%	34.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

As shown in Figure 23, the median monthly housing costs for owners with a mortgage were lower in Jackson County ($1,441/month) and Josephine County ($1,325/month) compared to Oregon ($1,563/month) and the U.S. ($1,491/month). Similar trends were seen for renter-occupied housing units.

Figure 23. Median Monthly Housing Costs by Owner- and Renter-Occupied Housing Units, by U.S., State, and County, 2012-2016
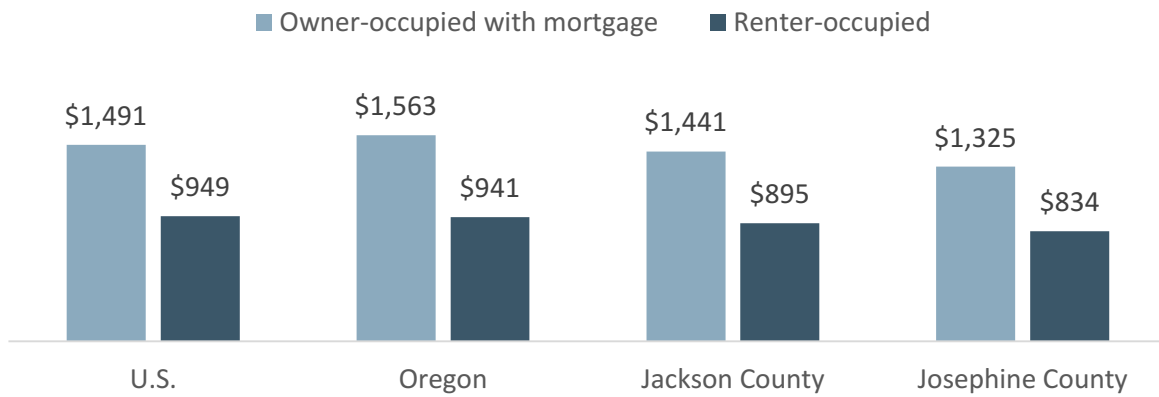
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Higher percentages of both owner-occupied and renter-occupied households in both counties reported to spend at least 30% of their income on housing costs, compared to Oregon and the U.S. (Figure 24). It is important to consider these data in conjunction with income data found in the priority related to poverty and employment. Based on 2012-2016 data, median monthly income is approximately $3,156 in Josephine County and $3,862 in Jackson County. Renters in the region are particularly burdened by the high cost of housing and the high percentage of income spent on housing.

Figure 24. Percent Households where Housing Costs are 30% or More of Income, by U.S., State, and County, 2012-2016
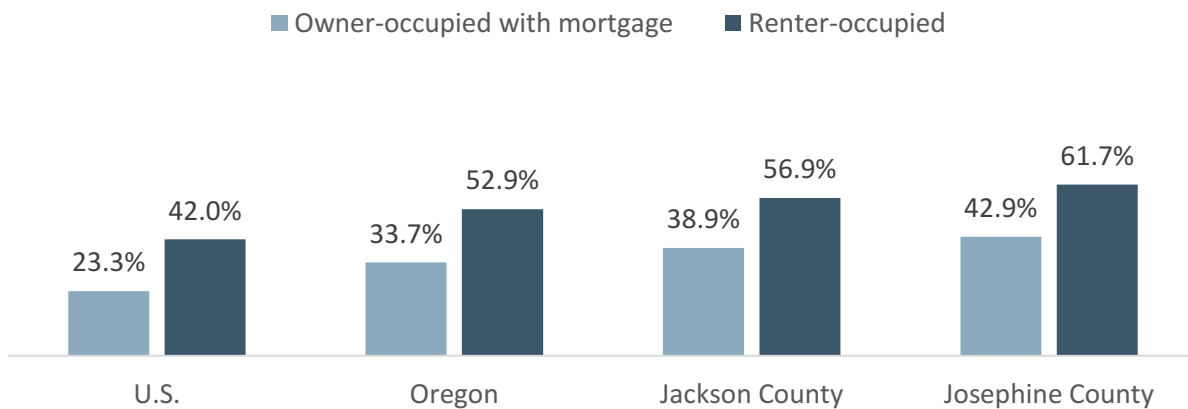
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Housing is a regional issue that is also connected to workforce shortages in some professions, such as health care, which has implications not only for providers but also community members needing care.

"Recruitment of doctors is really hard. Housing is a big part of that. It's hard to bring professionals in for schools and hospitals, since we don't have housing. They essentially have to commute from another city."

Approximately 80% of survey respondents reported housing costs and issues associated with renting to be of high concern and over 60% of survey respondents reported housing costs and issues associated with home ownership to be of high concern (Figure 25).

Figure 25. Survey Respondents Perceived Level of Concern for Issues Related to Housing Costs, 2018
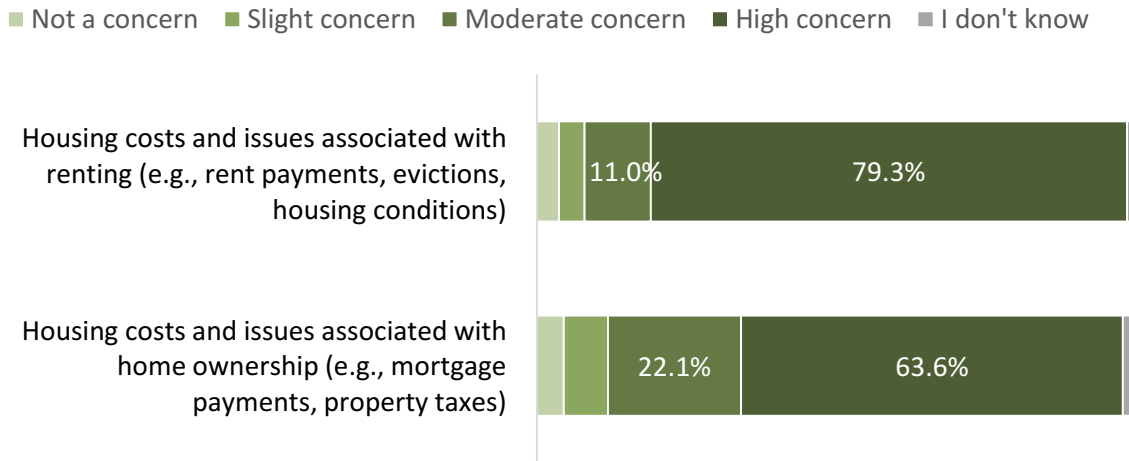
Legend: ■ Not a concern ■ Slight concern ■ Moderate concern ■ High concern ■ I don't know

Housing costs and issues associated with renting (e.g., rent payments, evictions, housing conditions): 11.0% | 79.3%

Housing costs and issues associated with home ownership (e.g., mortgage payments, property taxes): 22.1% | 63.6%

DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Data are organized in descending order by "high concern"

"The rent is astronomical. You can't even ask a landlord to make improvements because someone else is willing to pay double."

Housing safety and quality, particularly in relation to rental properties, was also extensively discussed during focus groups and interviews. As seen in Figure 26, a larger proportion of households were reported to have at least one severe housing problem (incomplete kitchen facilities, incomplete plumbing facilities, more than 1.5 people per room, or cost burden greater than 50%) in Josephine County (22.7%) and Jackson County (23.0%) compared to Oregon (20.0%), and the U.S. (18.6%).

Figure 26. Percent Households with Severe Housing Problems, by U.S., State, and County, 2011-2015

U.S.	Oregon	Jackson County	Josephine County
18.6%	20.0%	23.0%	22.7%
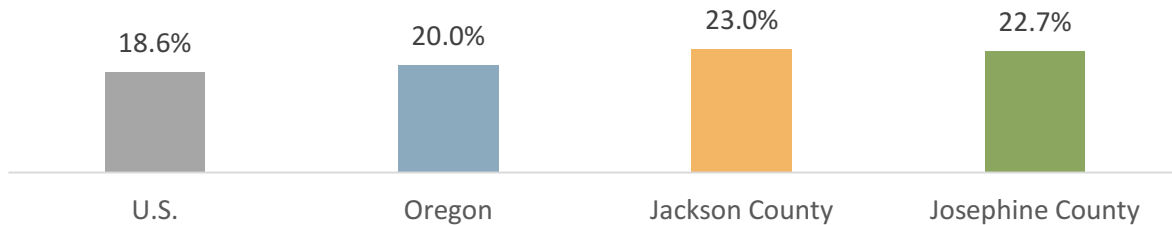
DATA SOURCE: U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy, using U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2011-2015
NOTE: Severe housing problems is defined as having at least one of four severe housing problems (incomplete kitchen facilities, incomplete plumbing facilities, more than 1.5 persons per room, and cost burden greater than 50%)

Poor health – illness, injury and/or disability – can lead to homelessness when people have insufficient income to afford housing. Further, homelessness can exacerbate existing health issues as well as cause new ones.

Chronic diseases, such as hypertension, asthma, diabetes and mental illness, are difficult to manage under the stressful conditions of homelessness.[22]

There was a decrease in the number of homeless individuals in Jackson and Josephine counties between 2015 and 2017, compared to an increase in Oregon (5.9% increase), according to the Oregon point-in-time homeless counts (Table 6). There was a greater decrease seen in Josephine County (26.4% decrease) than in Jackson County (6.8% decrease). It should be noted, however, that 2017 presented a challenge in obtaining an accurate point-in-time count due to extreme winter weather. Because of this challenge, as well as the transience of the population, this "snapshot" of homelessness does not provide the whole picture.

Table 6. Point in Time Homeless Population Count and Percent Change, by State and County, 2015 and 2017

	2015	2017	% change
Oregon	13,176	13,953	5.9% ⬆
Jackson County	679	633	-6.8% ⬇
Josephine County	883	650	-26.4% ⬇

DATA SOURCE: Oregon Housing and Community Services, Oregon Point-in-Time Homeless Counts, 2015 and 2017

Although data to quantify the issue are limited, homelessness among veterans, individuals with mental illness and young people was highlighted among assessment participants. In 2017, higher proportions of students were reported to be homeless in Josephine and Jackson counties (9.0% and 8.0%, respectively) than Oregon as a whole (3.9%) (Figure 27). While the percentage of homeless students increased between 2016 and 2017 for all geographies, there was a greater increase in percentages seen in Josephine County.

Figure 27. Percent Students (Grades K-12) who are Homeless, by State and County, 2014-2015, 2015-2016, and 2016-2017
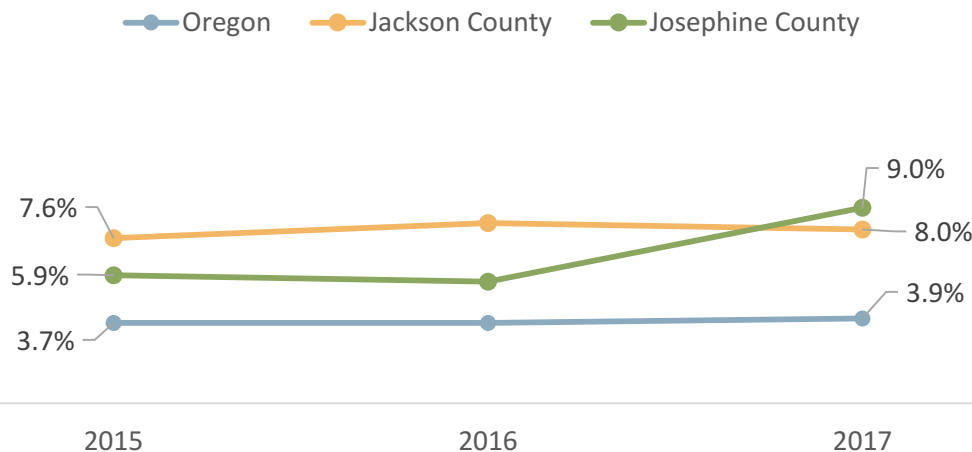
DATA SOURCE: Oregon Department of Education, as reported by Children First for Oregon, Oregon County Data Book, 2016 and 2017

Across school districts within Jackson and Josephine counties, Butte Falls and Rogue River school districts had the highest percentages of homeless students (29.6% and 13.1%, respectively) in 2017 (Figure 28).

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[22] What is the relationship between health, housing and homelessness? National Health Care for the Homeless Council. Available at: https://www.nhchc.org/faq/relationship-health-housing-homelessness/ Accessed on: November 6, 2018

Figure 28. Percent Students (Grades K-12) who are Homeless, by School Districts, 2014-2015, 2015-2016, and 2016-2017

Jackson County
- Ashland: 2.9%
- Butte Falls: 29.6%
- Central Point: 9.2%
- Eagle Point: 3.0%
- Medford: 9.9%
- Phoenix/Talent: 6.5%
- Prospect: 6.4%
- Rogue River: 13.1%

Josephine County
- Grants Pass: 8.5%
- Three Rivers: 9.8%
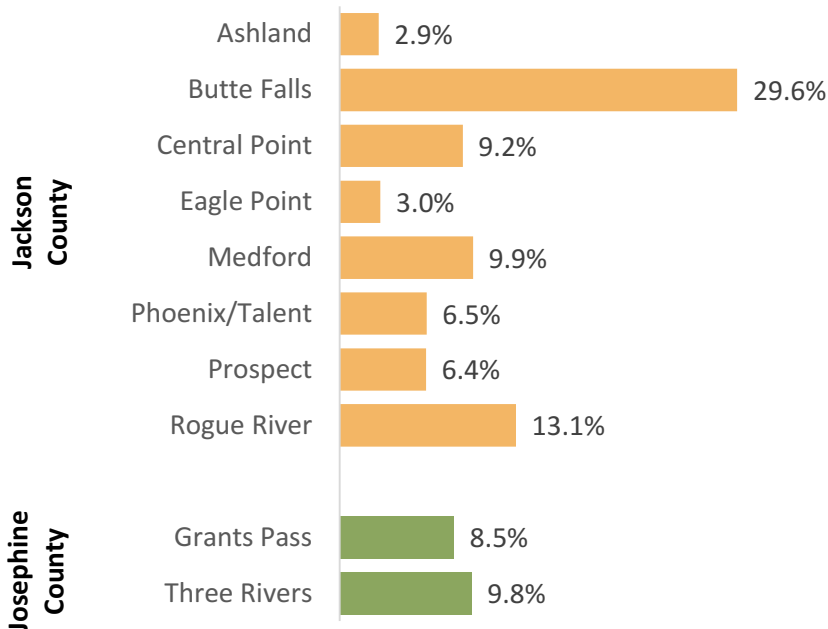
DATA SOURCE: Oregon Department of Education, McKinney-Vento Act, Homeless Student Data, 2014-2015, 2015-2016, and 2016-2017

Future Exploration

While collaborative discussions are occurring in the region related to affordable housing, further inquiry into supply-side barriers and strategies should be explored in both urban and rural contexts of Jackson and Josephine Counties.

Existing Assets and Resources

Assessment participants were asked about the assets in their communities related to housing and shared the following list of resources:

- ACCESS
- City of Grants Pass Housing Task Force
- Hearts with a Mission
- Hope Village/Rogue Retreat
- Housing Authority of Jackson County
- Jackson County Continuum of Care
- Jackson County Homeless Task Force
- Josephine County Housing and Community Development Council
- Magdalene Home
- Maslow Project
- United Community Action Network (UCAN)

- NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

When asked to identify services that were lacking in the community, affordable housing (80.4%) was the most common service and housing services (60.3%) was the third most common service identified by survey respondents, indicating that existing services are not adequate to meet community needs (Figure 29). Looking at these data by income, middle-income households (making $50,000-$74,999) were most likely to view affordable housing services as lacking (66.8%).

Figure 29. Percent Survey Respondents Reported Affordable Housing and Housing Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018
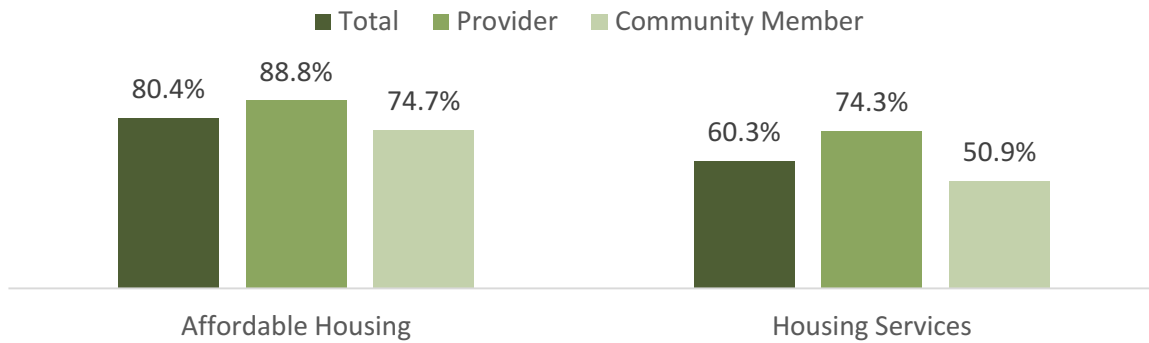
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Housing Services was worded in the survey as "Housing services (including services for the homeless or housing insecure)

Mental Health and Wellbeing

Importance and connection to other health issues

Mental health is essential to overall well-being and is closely connected to physical health. Mental health issues, such as anxiety and depression, can arise from genetic factors and/or from a number of individual and societal factors – incidence of trauma, poor nutrition and poverty. [23] Mental illness affects people's ability participate in health-promoting behaviors, and thus affects their ability to maintain good physical health. Substance use and mental health go hand in hand, as addiction to substances is a form of mental illness. The relationship between mental health and physical health is bidirectional. Issues with physical health, such as chronic diseases, can have serious impacts on mental health and decrease a person's ability to participate in treatment and recovery. [24] Mental illness can also impact other areas of life including attending and focusing at school, obtaining and maintaining a job, finding and keeping housing, and having relationships with friends and family. [25] The complexity of mental health, and its interconnectedness with other priority health issues, necessitates multi-faceted approaches to addressing this issue.

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[23] Tulchinsky TH, et al. Editorial: Mental Health as a Public Health Issue. Public Health Reviews. 2012; 34, 2.
[24] Lando J, Marshall Williams S, Sturgis S, et al. A logic model for the integration of mental health into chronic disease prevention and health promotion. Prev Chronic Dis. 2006 April; 3(2):A61.
[25] Mental health and mental disorders. Healthy People 2020. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed on: October 30, 2018

Over half of overall survey respondents selected mental health and stress as a top health issue impacting their community, compared to 67.7% of providers reporting mental health and stress as an issue impacting their patients/clients (

Figure *30*). Women were more likely than men to report mental health and stress as a top health issue.

Figure 30. Percent Survey Respondents Reported Mental Health and Stress as a Top Health Issue Having the Largest Impact on You/Your Family* and Your Community, by Respondent Type, 2018

■ Total ■ Provider ■ Community Member
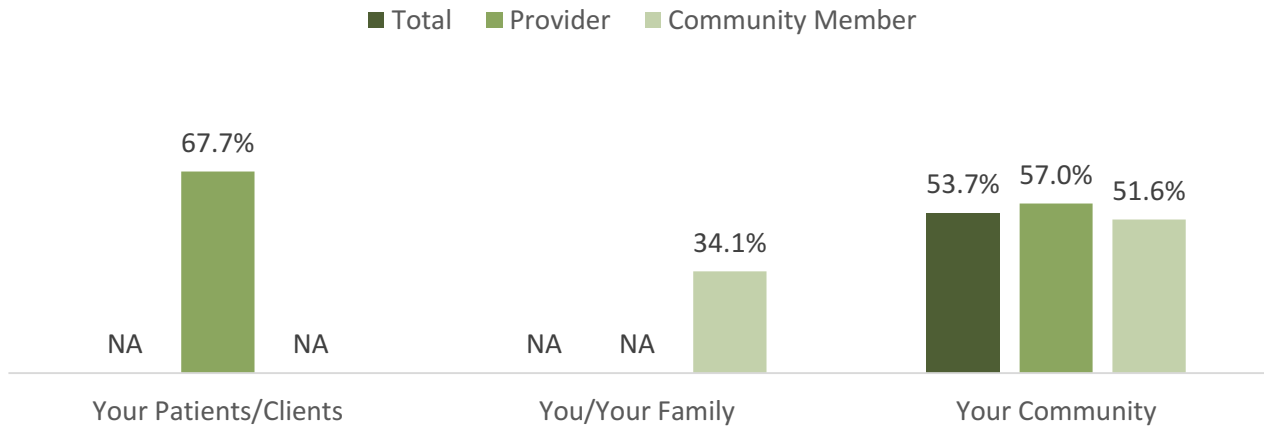
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTES: Asterisk denotes "You/Your Family" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated or applicable due to the difference in wording in the survey versions

"If you were born here and live here and you want to grow up into something, you can't. There's nothing here. There's no hope."

The community survey also asked respondents about specific mental health issues and populations. Approximately 70% of overall survey respondents reported that mental health and stress among homeless (68.9%) and among veterans (67.4%) were of high concern (Figure 31). Further, 51.9% of Hispanic/Latino respondents indicated that mental health and stress among immigrants was a high concern compared to 37.7% of the overall survey sample.

Figure 31. Survey Respondents Perceived Level of Concern for Issues Related to Mental Health and Stress, 2018

Not a concern   **Slight concern**   **Moderate concern**   **High concern**   **I don't know**

Mental health and stress among homeless	15.8%	68.9%
Mental health and stress among veterans	18.4%	67.4%
Mental health and stress among low-income families and individuals	22.5%	58.7%
Ability to get mental health care services (e.g., affordable, timely, proximity, etc.)	21.7%	57.1%
Mental health and stress among middle and high school aged youth	22.9%	56.4%
Real or perceived stigma associated with seeking mental health care	27.1%	44.4%
Mental health and stress among immigrants	20.0%	37.7%

DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Data are organized in descending order by "high concern"

Mental health was one of the two most frequently mentioned health issues among focus group and interview participants. Depression and anxiety were noted as prevalent across the lifespan. For working age adults, mental health was discussed in the context of experiencing stress related to high cost of living and raising a family. Social isolation was the most commonly cited stressor for seniors. Compared to the U.S., adults were more likely to report a depression diagnosis in Jackson County (27.9%), Josephine County (26.7%), and Oregon (25.4%) (Figure 32).

Figure 32. Age-Adjusted Percent Adults Reported Depression Diagnosis, by U.S., State, and County, 2012-2015
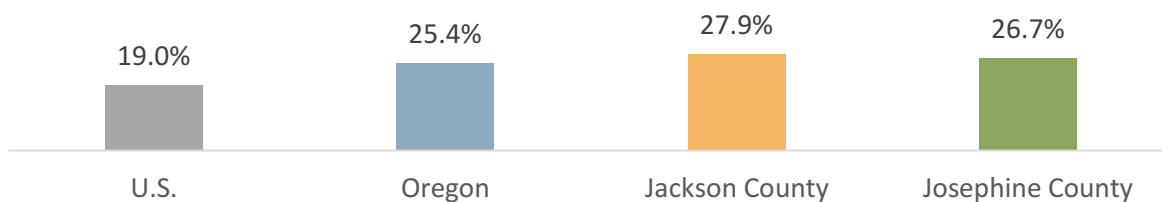
U.S.	Oregon	Jackson County	Josephine County
19.0%	25.4%	27.9%	26.7%

DATA SOURCE: (for U.S. data) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence Data and Analysis Tools, BRFSS Prevalence & Trends Data, 2015; (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015
NOTE: Data for U.S. are crude percentages

Mental health of youth was especially concerning to assessment participants, who noted that trauma at home and peer pressure were primary issues facing youth. Female survey respondents in particular viewed mental health and stress among youth to be of high concern.

"Mental health among kids is a real concern. Kids are mean to each other. The amount of cruelty, bullying, violence. I see it consistently."

As seen in Figure 33, in 2016, a higher proportion of 11th grade students in Josephine County reported signs of depression (38.9%) compared to 11th grade students in Oregon as a whole (31.9%) and Jackson County (31.2%). Josephine County 11th grade students experienced a marked increase in signs of depression over time between 2012 and 2016.

Figure 33. Percent 11th Grade Students Reported Signs of Depression, by State and County, 2012, 2014, and 2016

■ Oregon   ■ Jackson County   ■ Josephine County
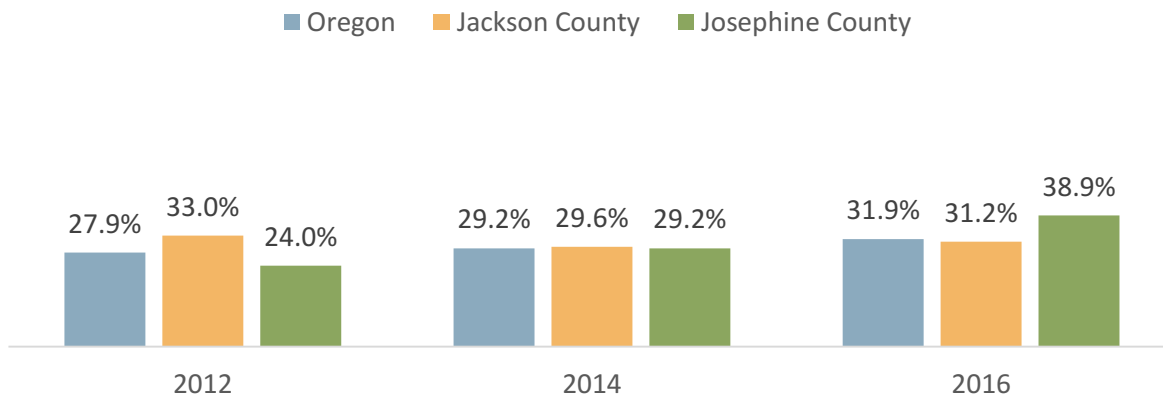
DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Signs of depression is defined as "felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities"

Many mental illnesses can lead to an increased risk of suicide. In 2016, 11th grade students in Josephine County were more likely to report seriously considering attempting suicide (21.9%), compared to 18.1% in Oregon and 16.9% in Jackson County (Figure 34).

Figure 34. Percent 11th Grade Students Reported Seriously Considering Attempting Suicide, by State and County, 2012, 2014, and 2016

■ Oregon   ■ Jackson County   ■ Josephine County
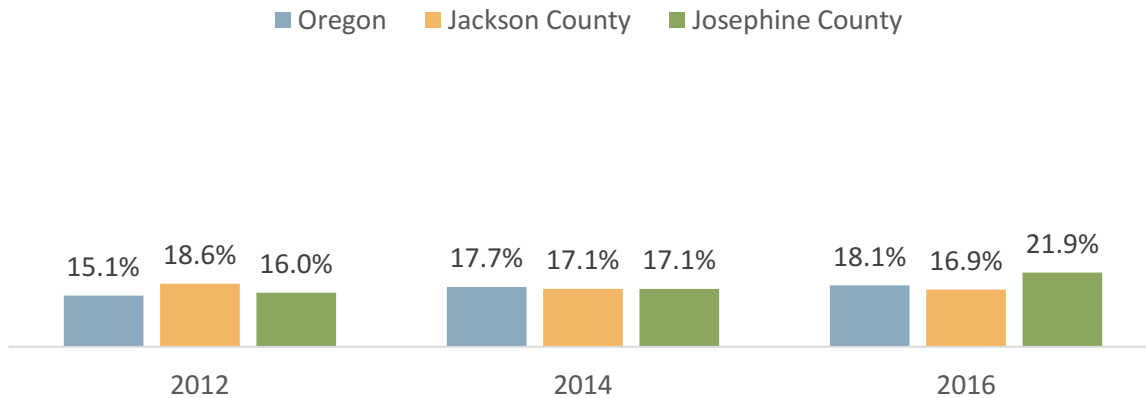
DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016

Approximately one in ten 11th grade students in Jackson County (9.6%) reported to have attempted suicide, which was more than 11th grade students in Oregon (7.8%) and Josephine County (7.5%) (Figure 35).

Figure 35. Percent 11th Grade Students Reported Attempting Suicide, by State and County, 2012, 2014, and 2016
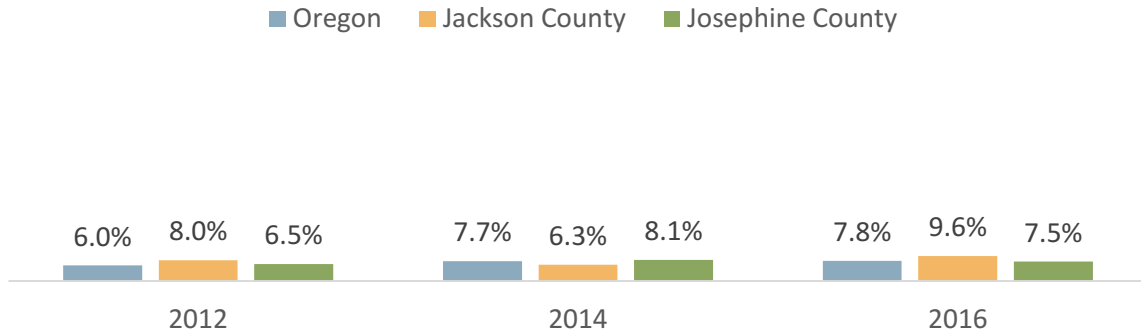
DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016

Between 2015 and 2016, the suicide rates in Oregon, Jackson County, and Josephine County were consistently higher than that of the U.S. (Figure 36). In 2017, the suicide rate for Josephine County was 29.5 deaths per 100,000 population, which was higher than that for Jackson County (22.4 deaths per 100,000 population) and Oregon (19.0 deaths per 100,000 population).

Figure 36. Age-Adjusted Suicide Rate per 100,000 Population, by U.S, State, and County, 2015-2017
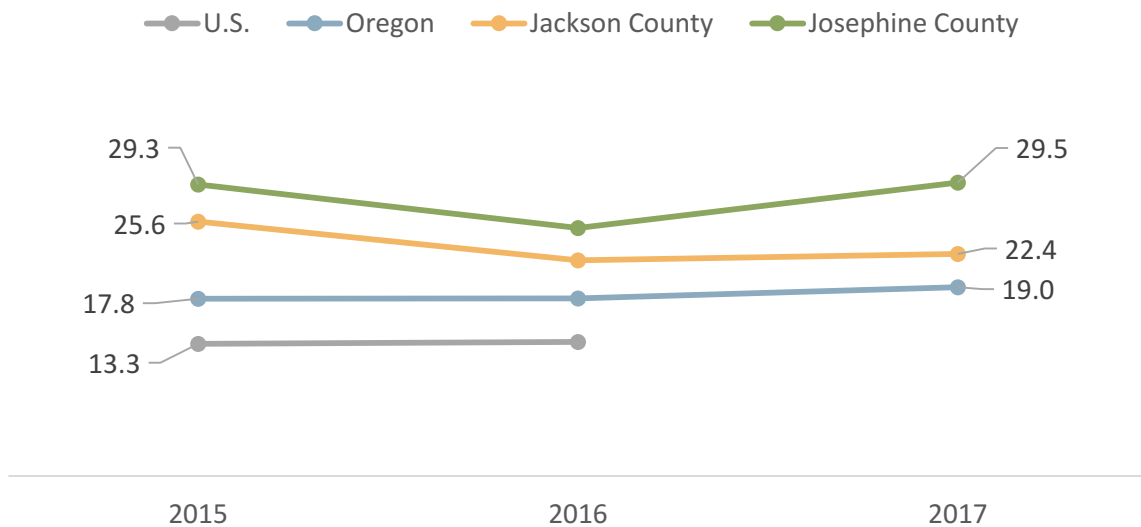
DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017
NOTE: 2017 data not publicly available for the U.S.

Future exploration

Mental health can be difficult to address due to the lack of availability of mental health services, specifically integrated behavioral health services, as well as the stigma attached to mental illness. These issues around

access are relevant at both individual and institutional levels. As noted, quantitative data on the prevalence of mental illness is limited. Further inquiry is needed to explore and describe the extent of mental illness among youth and adults in general, as well as specific subpopulations such as LGBTQ. Also, given the other priorities highlighted in this report, additional data correlating mental health with these issues could help focus future strategic action.

Existing assets and resources

Assessment participants were asked about the assets in their communities related to mental health and shared the following list of resources:

- Adapt
- Addictions Recovery Center
- Asante Rogue Regional Medical Center Behavioral Health Services
- ColumbiaCare Services
- Compass House
- Crisis Resolution Center
- Family Solutions
- Hope Village
- Integrative Health Center at Rogue Community Health
- Jackson County Health & Human Services Crisis Hotline
- Jackson County Mental Health
- Kairos
- La Clinica
- Options for Southern Oregon
- Rogue Community Health
- Rogue Retreat
- Southern Oregon Veterans Rehabilitation Center & Clinics

NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

The ratio of the population to one mental health provider decreased between 2015 and 2017 across Oregon and Jackson and Josephine counties (Figure 37), indicating an increase in availability of mental health providers. In 2017, the ratio was greatest for Jackson County (signifying higher need), with 290 people to one mental health provider, compared to Oregon and Josephine County.

Figure 37. Ratio of Population to One Mental Health Provider, by State and County, 2015-2017
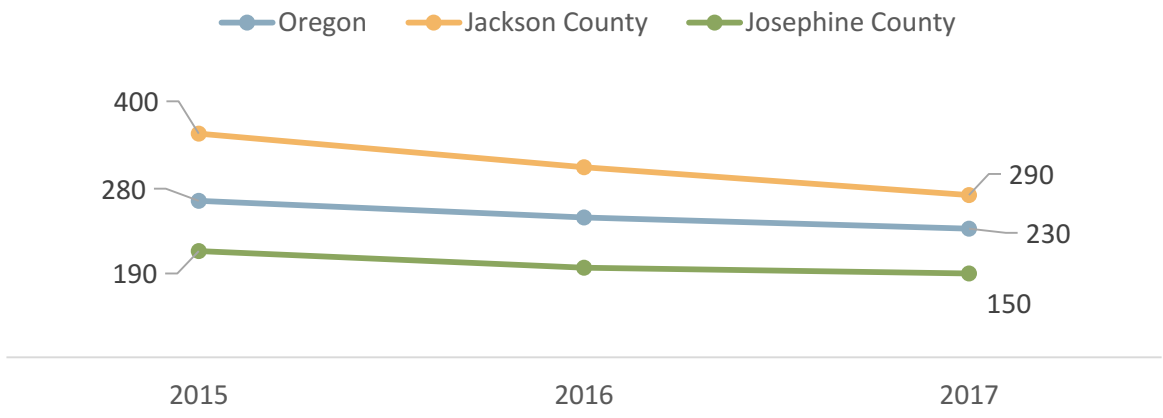
DATA SOURCE: Centers for Medicare and Medicaid Services, National Provider Identification Registry, as cited by Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, County Health Rankings, 2015-2017

However, the limited availability of mental health providers as well as the stigma associated with seeking care were highlighted as barriers to addressing mental health in the region.

"Mental health services are hard to come by. There are huge stigmas around services."

While focus group and interview participants mentioned several resources related to mental health, approximately 56.4% of overall survey respondents selected mental health care services as currently lacking in the community (Figure 38), with notable disparities by gender (46.7% of men compared to 59.9% of women) and income (64.7% of households making $50,000-$74,999). Providers were more likely to report mental health care services as currently missing in the community, when compared to overall survey respondents and community members. Assessment participants specifically highlighted the limited services for youth.

Figure 38. Percent Survey Respondents Reported Mental Health Care Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018
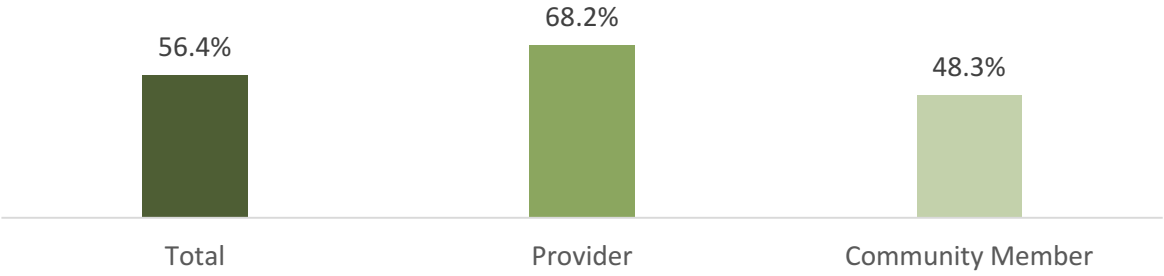
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Poverty and Employment

Importance and connection to other health issues

Poverty and unemployment are linked to health[26] – an individual's employment and income level directly impacts their ability to afford access to health care, healthy food, and housing, all of which influence myriad health outcomes. For individuals that are employed, it is more than just having a job that affects health. The number of hours they work, and the wage they earn impacts the level of economic stability that their job affords. This is especially relevant for individuals who find themselves part of the working poor, individuals who meet the definition of being in the labor force but their income level falls below the poverty line.[27] Individuals who are unemployed or underemployed experience higher rates of depression, stress and stress-related conditions, such as stroke, heart attack, heart disease, arthritis.[28]

Key Findings

While the unemployment rate has been steadily decreasing between 2012 and 2017, in 2017 Jackson and Josephine Counties had a slightly higher percentage of the population unemployed (4.8% and 5.4%, respectively) compared to Oregon overall (4.1%) and the U.S. (4.4%) (Figure 39).

Figure 39. Trend in Unemployment Rate, by U.S., State, and County, 2012-2017
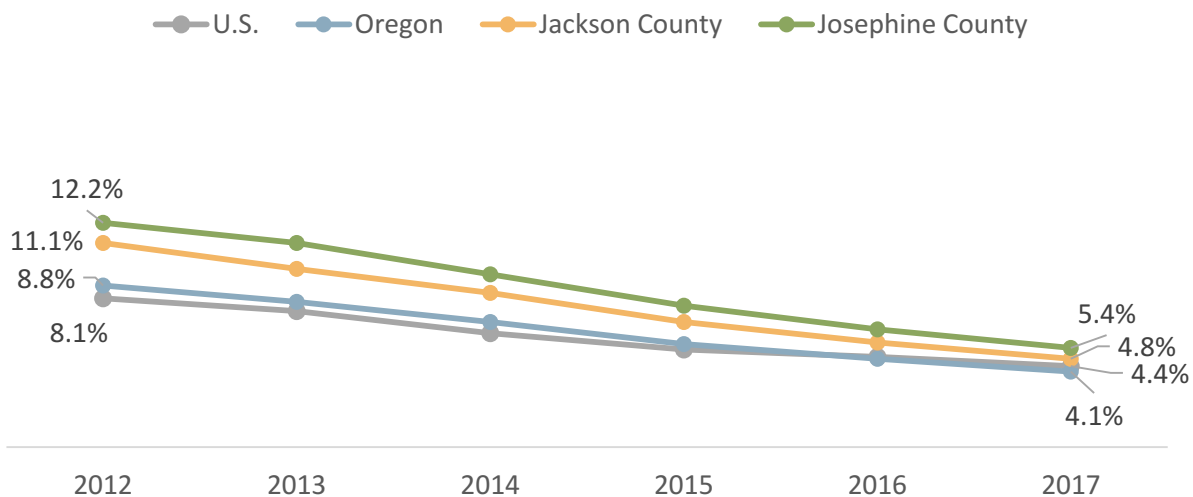
DATA SOURCE: for U.S. data, U.S. Bureau of Labor Statistics, Current Population Survey, 2012-2017 and for state and county data, U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics, 2012-2017
NOTE: Rates shown are a percentage of the labor force; data refer to place of residence.

According to the American Community Survey, lower percentages of the working age population (16-64 years old) worked full-time in Josephine County (42.6%) and Jackson County (50.3%) compared to Oregon (54.4%) (Figure 40). Additionally, over one-third (34.7%) of Josephine County community members aged 16-64 years did not work compared to 25.8% in Jackson County and 23.8% in Oregon.

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[26] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: What the patterns tell us. American Journal of Public Health. 2010; 100: S186-S196.

[27] Bureau of Labor Statistics. A profile of the working poor, 2016. BLS Reports. Available at: https://www.bls.gov/opub/reports/working-poor/2016/home.htm Accessed on: October 30, 2018.

[28] Robert Wood Johnson Foundation. How Does Employment – or Unemployment – Affect Health? Health Policy Snapshot Issue Brief. Available at: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360 Accessed: October 30, 2018.

Figure 40. Percent Individuals (16-64 years) by Work Status, by U.S., State, and County, 2012-2016

■ Full-Time ■ Part-Time ■ Did not work

	U.S.	Oregon	Jackson County	Josephine County
Did not work	24.7%	23.8%	25.8%	34.7%
Part-Time	17.7%	21.8%	23.8%	22.7%
Full-Time	57.6%	54.4%	50.3%	42.6%
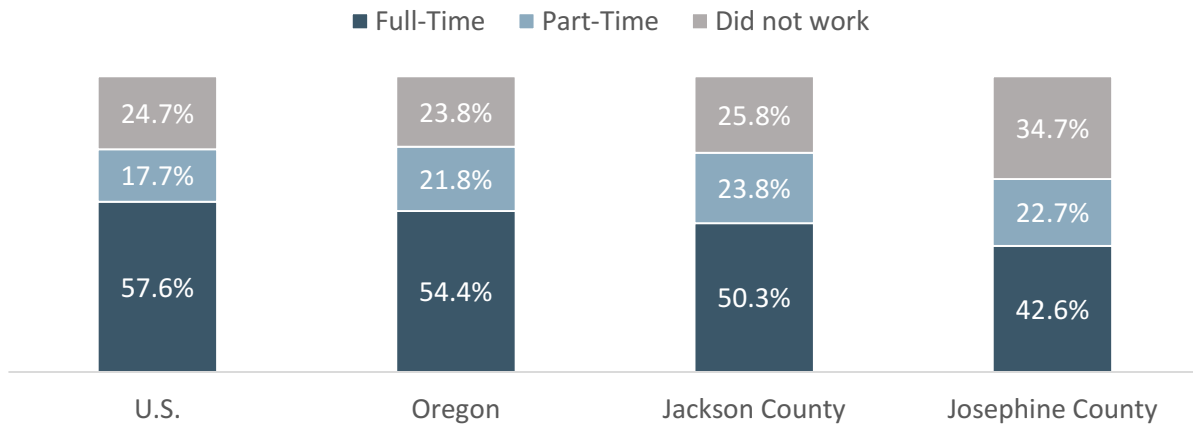
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTES: The respondent was to report the number of hours worked per week in the majority of the weeks he or she worked in the past 12 months. If the hours worked per week varied considerably during the past 12 months, the respondent was asked to report an approximate average of the hours worked per week. People 16 years old and over who reported that they usually worked 35 or more hours each week during the weeks they worked are classified as "Usually worked full time"; people who reported that they usually worked 1 to 34 hours are classified as "Usually worked part time."

Despite relatively low unemployment, assessment participants indicated that it is a challenge for community members to make a living in the area, given the limited jobs available and the low pay for those opportunities that do exist.

"Young people here who are beginning their work life or family life… they're distressed because there are not enough jobs with sufficient pay."

Household income is an economic measure that is most commonly applied to one household and aggregated across cities, counties or the whole country. It is frequently used to describe a household's economic status. Based on 2012-2016 American Community Survey 5-year estimates, the median household income for Josephine County ($37,867) and Jackson County ($46,343) were lower compared to Oregon ($53,270) (Figure 41).

Figure 41. Median Household Income, by U.S., State, and County, 2007-2011 and 2012-2016
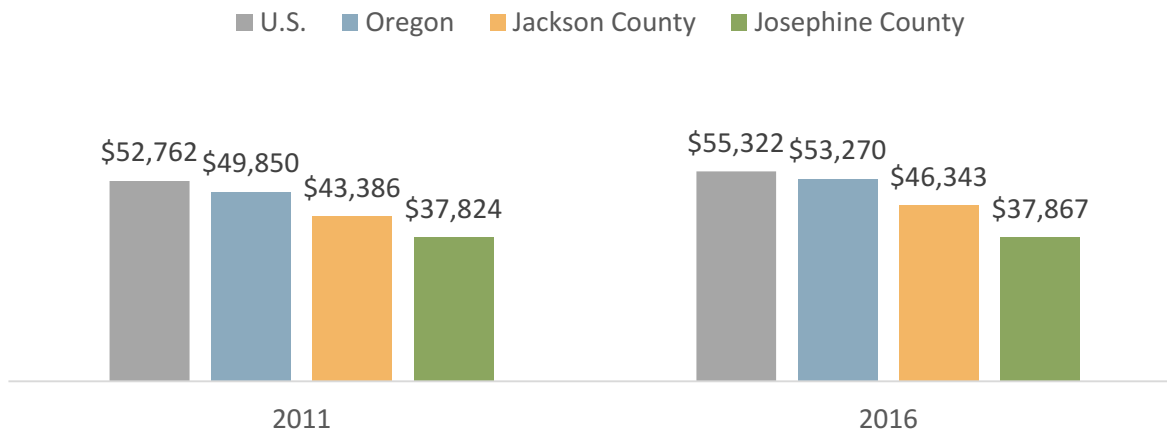
Legend: U.S. | Oregon | Jackson County | Josephine County

2011: $52,762, $49,850, $43,386, $37,824
2016: $55,322, $53,270, $46,343, $37,867

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

The most common measure of poverty in the U.S. is the poverty "threshold" set by the U.S. government. This measure uses a set of dollar value thresholds that vary by family size and composition to determine who is in poverty. Based on 2012-2016 American Community Survey 5-year estimates, higher proportions of individuals living below the federal poverty level were reported for Josephine (19.5%) and Jackson (18.0%) counties than Oregon overall (15.7%) (Figure 42).

Figure 42. Percent Individuals Living Below Poverty Level, by U.S., State, and County, 2007-2011 and 2012-2016

Legend: U.S. | Oregon | Jackson County | Josephine County

2011: 14.3%, 14.8%, 15.8%, 18.8%
2016: 15.1%, 15.7%, 18.0%, 19.5%
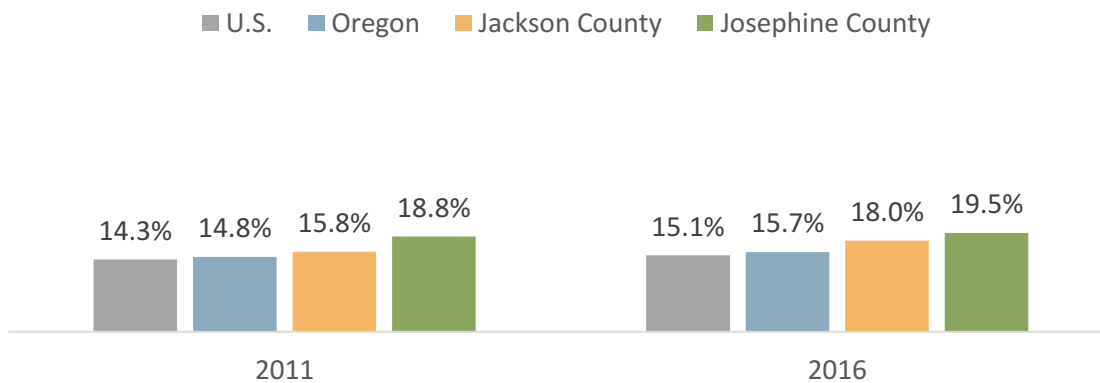
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Examining poverty data by race/ethnicity, in general people of color experience higher rates of poverty in comparison to people who identify as White, non-Hispanic. In particular, people in Jackson County who identify as Black, Hispanic, or American Indian/Alaskan Native and people in Josephine County who identify as Asian or two or more races are more likely to experience poverty (Figure 43).

Figure 43. Percent Individuals Living Below Poverty Level, by Race/Ethnicity, by State and County, 2012-2016

Legend: ■ Jackson County ■ Josephine County

Category	Jackson County	Josephine County
Total	18.0%	19.5%
White, non-Hispanic	15.9%	19.0%
Black	41.1%	21.4%
Hispanic/Latino, any race	30.0%	16.2%
Asian	12.9%	34.0%
American Indian/Alaska Native	29.2%	9.3%
Native Hawaiian/Other Pacific Islander	6.9%	N/A
Other race	22.3%	7.6%
Two or more races	23.9%	36.7%
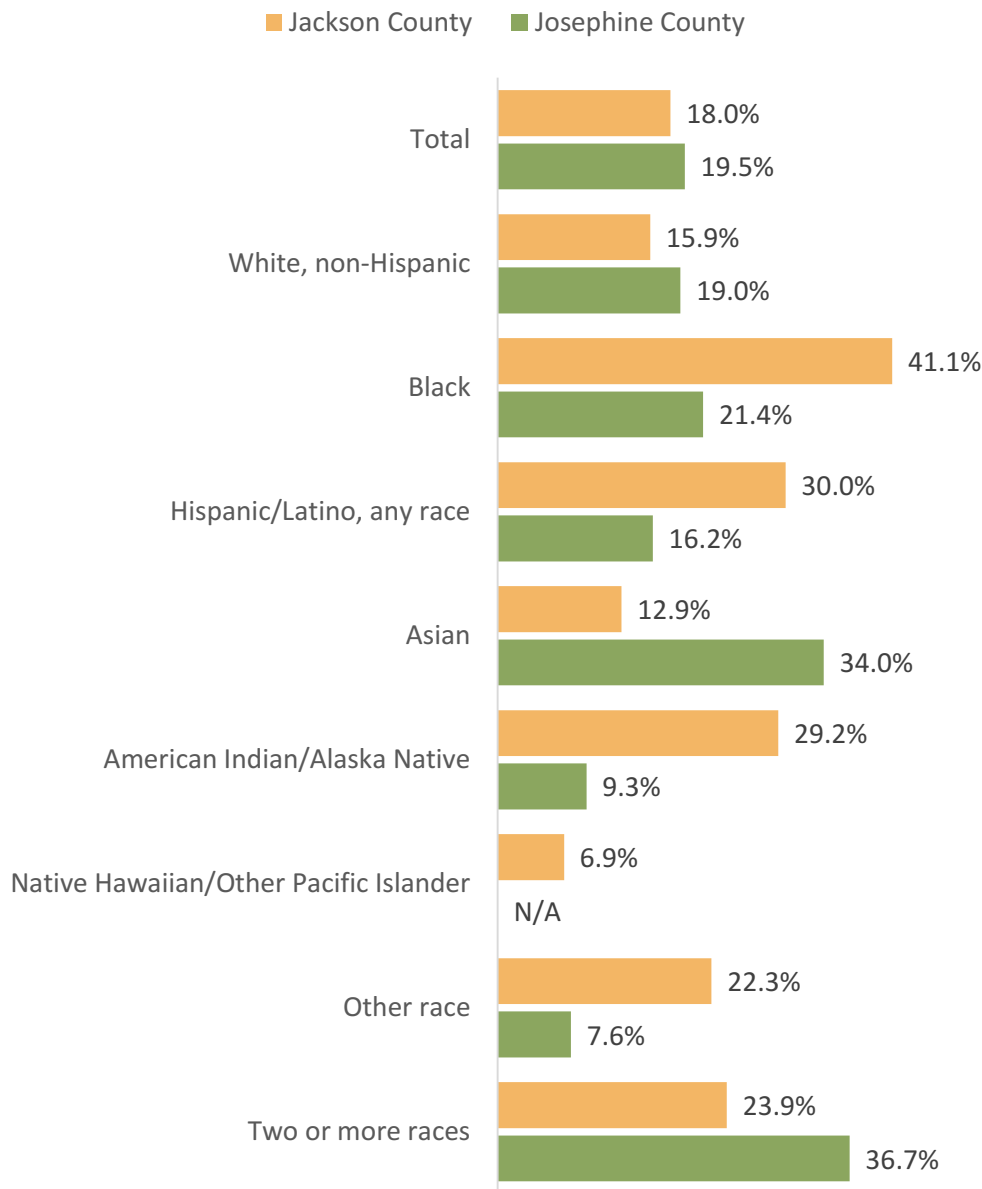
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTE: N/A denotes percentage not calculated due to small numbers

Similarly, higher proportions of families were living below the poverty level in Josephine County (14.2%) in 2016 (Figure 44) than in Jackson County or Oregon. The percentages of families living below the poverty level slightly increased across all geographies between 2011 and 2016.

Figure 44. Percent Families Living Below Poverty Level, by U.S., State, and County, 2007-2011 and 2012-2016
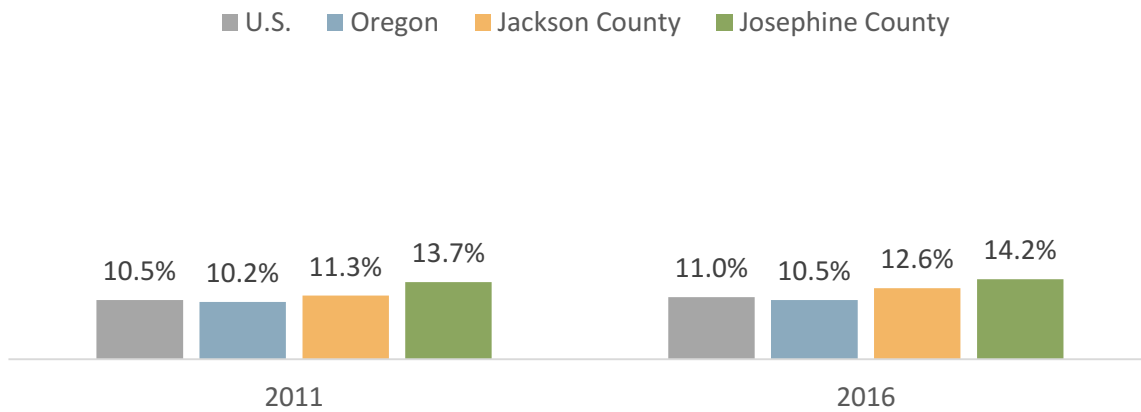
Legend: U.S. ■ Oregon ■ Jackson County ■ Josephine County

2011: 10.5% 10.2% 11.3% 13.7%
2016: 11.0% 10.5% 12.6% 14.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Poverty is particularly detrimental to young people. There were higher proportions of children under 18 years old living below the poverty level in Josephine (27.3%) and Jackson (24.5%) counties than Oregon (20.4%), based on 2012-2016 American Community Survey 5-year estimates (Figure 45).

Figure 45. Percent Individuals Under 18 Years Living Below Poverty Level, by U.S., State, and County, 2012-2016

U.S. 21.2% — Oregon 20.4% — Jackson County 24.5% — Josephine County 27.3%
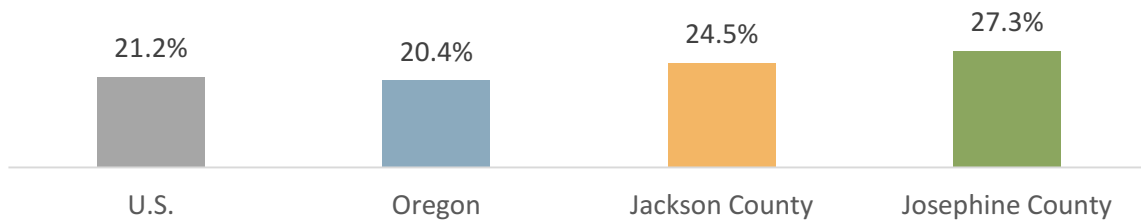
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Additionally, a slightly higher proportion of individuals aged 65 years and over were living below the poverty level in Josephine County (9.3%), compared to Jackson County (8.1%) and Oregon (8.1%).

Many federal, state, and local programs use the federal poverty guidelines to determine eligibility for services such as Head Start, Supplemental Nutrition Assistance Program (SNAP), the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program. Greater than 40% of the region's community members – more than 100,000 people – were living below 200% of the poverty level (46.7% in Josephine County; 40.4% in Jackson County), which was greater than in Oregon (35.2%) and the U.S. (33.6%) (Figure 46).

Figure 46. Percent Individuals Living Below 200% of Poverty Level, by U.S., State, and County, 2012-2016

33.6%	35.2%	40.4%	46.7%
U.S.	Oregon	Jackson County	Josephine County
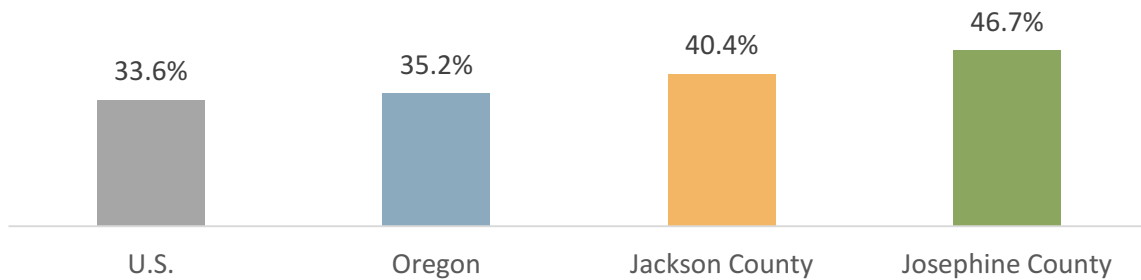
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

The National School Lunch Program is a federally-assisted meal program operating in public and private, nonprofit schools and residential child care; eligibility for this program is also based on the federal poverty guidelines. In 2017, about two-thirds of students in Josephine County were eligible for free and reduced lunch (66.9%), which was higher than the percentage of students eligible in 2015 and 2016 (Figure 47). There were lower proportions of students eligible for free and reduced lunch in Jackson County and Oregon overall.

Figure 47. Percent Students Eligible for Free and Reduced Lunch, by State and County, 2014-2015, 2015-2016, and 2016-2017
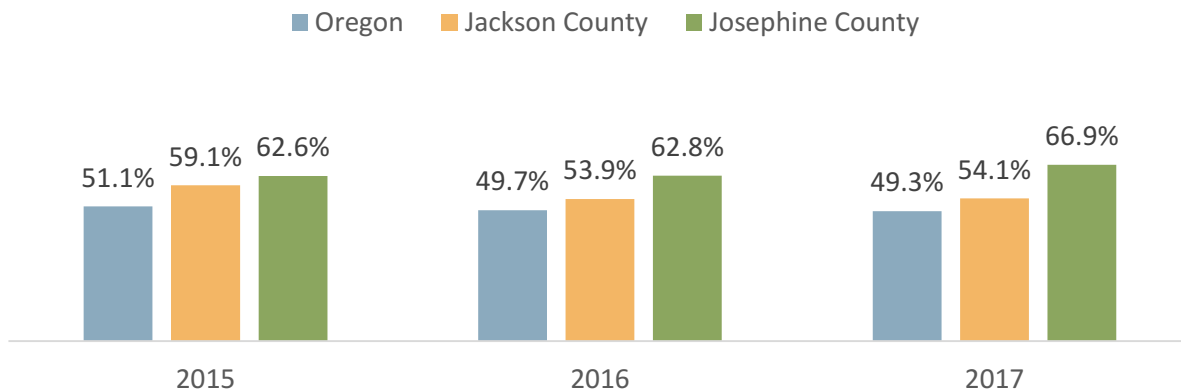
DATA SOURCE: Oregon Department of Education, as reported by Children First for Oregon, Oregon County Data Book, 2016 and 2017

Traditional measures of poverty described above do not fully capture the magnitude of people who are struggling financially. The United Way in a number of states, including Oregon, created the ALICE (Asset Limited, Income Constrained, Employed) Project, which uses standardized measurements to calculate the cost of a basic household budget and to quantify the number of households that cannot afford that budget.[29] According to the United Way report on ALICE, 38% of the population in Josephine County is ALICE compared to 30% in Jackson County. Combined with data on the federal poverty level, over half (57%) of Josephine County community members and 45% of Jackson County community members fall below the ALICE threshold (Figure 48).

Figure 48. Percent Households Below Asset Limited, Income Constrained, Employed (ALICE) Threshold, by State and County, 2016

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[29] United Way ALICE Project. Available at: https://www.unitedwayalice.org/home. Accessed on: November 6, 2018
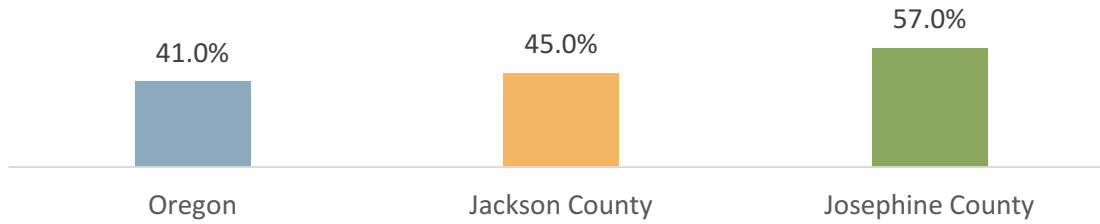
DATA SOURCE: The United Way ALICE Project, Research Center, ALICE: A Study of Financial Hardship in Oregon 2018 Report, County Pages, 2016 (data)

Qualitative data reinforce the statistics above. Assessment participants spoke about the difficulty individuals and families face in breaking out of the cycle of poverty given the low-paying jobs and high cost of living.

"There's intergenerational poverty. There are 80 year olds without running water, and also young families. It's hard to shift because there's no economic base. There is no ability to move up."

Approximately half of survey respondents overall indicated that cost of living is a primary issue facing them (55.1% of providers, 47.7% of community members) and their community (55.1% overall) (Figure 49). Communities of color and low-income households are disproportionately impacted by the high cost of living in the region. Among survey respondents who identify as non-White, 69.0% reported cost of living as a primary concern for themselves/their family as did 60.6% of households with income less than $25,000.

Figure 49. Percent Survey Respondents Reported Cost of Living as a Top Health Issue Having the Largest Impact on You/Your Family* and Your Community, by Respondent Type, 2018
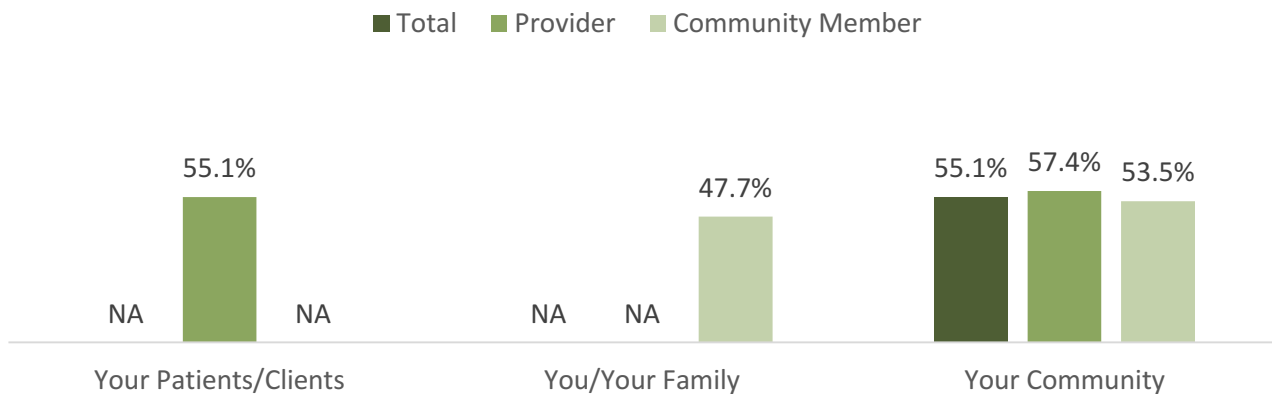
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTES: Asterisk denotes "You/Your Family" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated or applicable due to the difference in wording in the survey versions

The effects of poverty and under/unemployment are far-reaching. Focus group and interview participants shared that the regional economic environment hinders community members' ability to pay for housing, food, transportation, and medications. Slightly under half of survey respondents overall (46.8%) reported that cost of care/co-pays was an issue that made it more difficult for them or their patients to receive health or social services they needed (Figure 50). Examining these data by race and ethnicity, survey respondents who identified

as Hispanic/Latino were more likely to report that cost of care/co-pays were an issue (63.6%). Women were also more likely to report cost of care/co-pays as a barrier (51.0% of women compared to 37.9% of men) as were households making $25,000-$49,999 (58.5%) compared to those making less than $25,000 (33.3%).

Figure 50. Percent Survey Respondents Reported Cost of Care/Co-Pays as an Issue that Made It More Difficult for You* to Get the Health or Social Services You Needed, by Respondent Type, 2018

DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Asterisk denotes "You" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated due to the difference in wording in the survey versions

Further, survey respondents shared their concerns about the implications of high cost of living on the availability of healthy, affordable foods and the cost of utilities (Figure 51).

Figure 51. Survey Respondents Perceived Level of Concern for Issues Related to Cost of Living, 2018
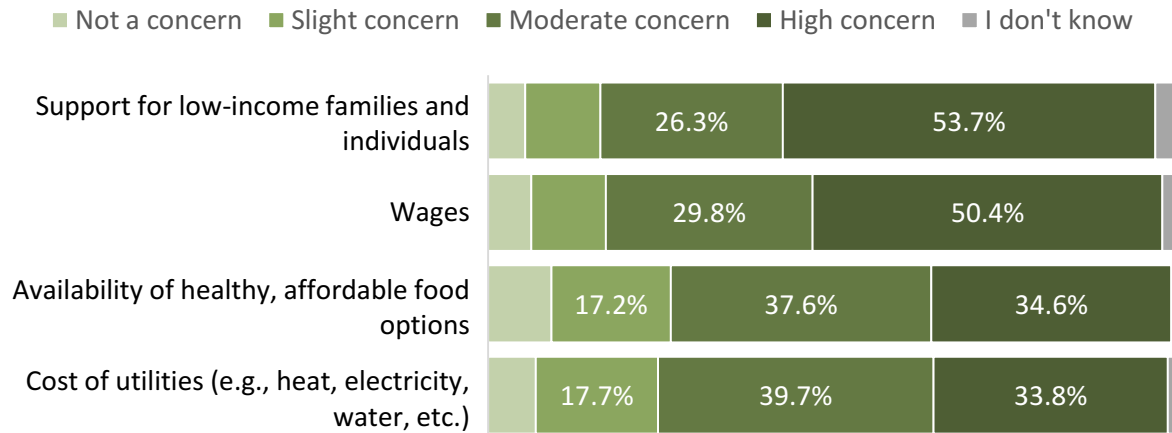
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Data are organized in descending order by "high concern"

Additionally, a lack of childcare providers and high cost of existing providers creates stress for parents and families, and places added financial burden on working parents. According to the Oregon Department of Human Services, in 2018 the median monthly cost of small home-based toddler care is $530 in Jackson County compared to $520 in Josephine County (Figure 52). The median monthly cost of large home-based toddler care is $550 in each county. The median monthly cost for center-based toddler care is $936 in Jackson County and $600 in Josephine County.

Figure 52. Median Toddler Care Monthly Rate, by Type, by State and County, 2018

The image shows a bar chart with legend at top.
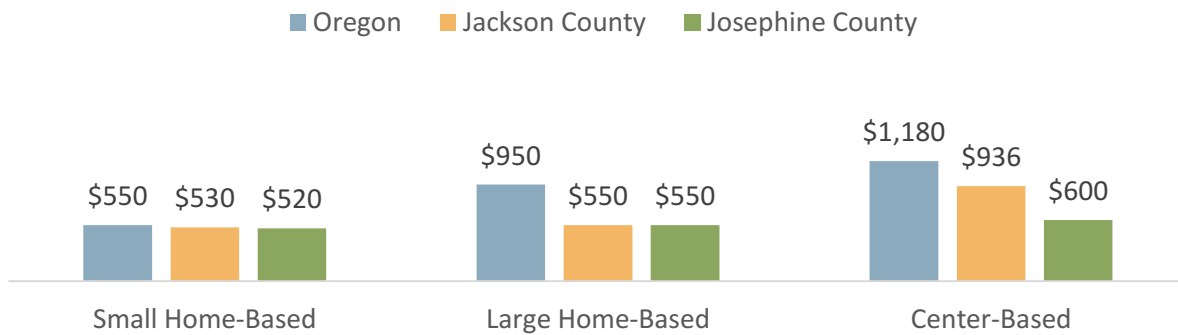
DATA SOURCE: Oregon Department of Human Services; Child Care Data, Publications, Reports; Child Care Market Rate Study; 2018

Approximately 42.8% of survey respondents overall reported that cost of child care was a high concern (Figure 53), and non-White survey respondents were more likely (50.0%) to report cost of child care as a high concern.

Figure 53. Survey Respondents Perceived Level of Concern for Cost of Child Care, 2018
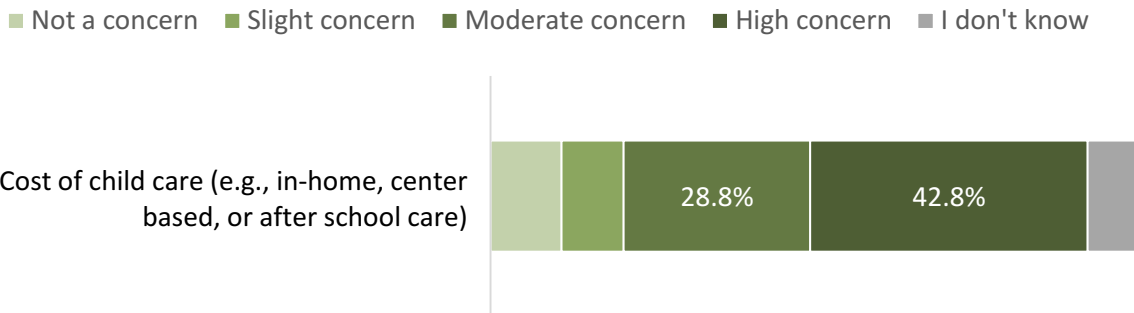
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Slightly under half of survey respondents overall (47.4%) reported affordable child care services to be currently missing in the community, with notable disparities by gender (51.9% of women compared to 38.7% of men) (Figure 54).

Figure 54. Percent Survey Respondents Reported Affordable Child Care Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018
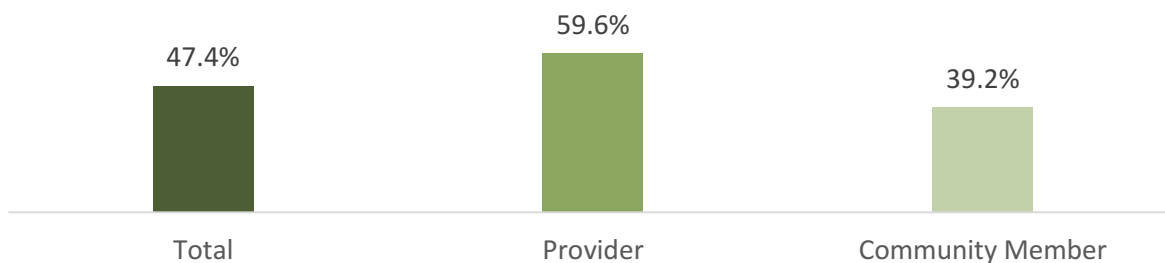
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Future exploration

More inquiry is needed into how minimum wage increases since 2016 have affected income of different subgroups (by age, gender, race/ethnicity), as well as the impact of women leaving the workforce to raise children. Additionally, future exploration is needed regarding what specific factors cause high cost of living in an area where median income is low.

Existing assets and resources

Assessment participants were asked about the assets in their communities related to income and employment and shared the following list of resources:

- ACCESS
- Ashland Resource Center
- Consumer Credit Counseling Services
- Grants Pass Blue Zones Project
- Local Food Banks
- Oregon Department of Human Services
- United Community Action Network (UCAN)
- United Way
- Women Infants and Children (WIC)

NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

Although there are several resources available, approximately one quarter of survey respondents overall reported financial assistance services were currently lacking in the community (Figure 55). Low-income households making less than $25,000 were more likely to report financial service as lacking (35.9%).

Figure 55. Percent Survey Respondents Reported Financial Assistance Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018
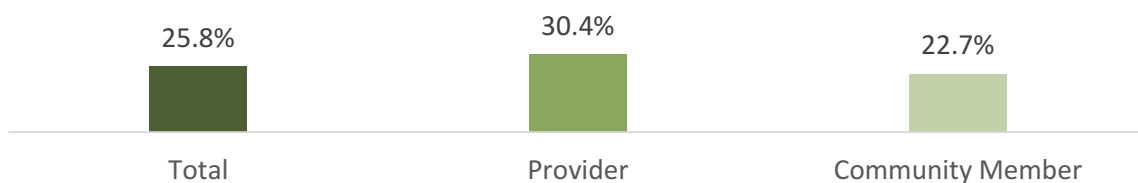
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Parenting and Life Skills

Importance and connection to other health issues

Adverse childhood experiences (ACEs) are instances of child abuse and neglect; physical abuse, sexual abuse, emotional abuse, and living with a household member experiencing substance use, mental illness, and domestic violence that are captured to create a score. The presence of these traumatic experiences has immediate impacts and also increases a child's risk for poor health outcomes as an adult – chronic disease, substance use, depression, suicide, violence and crime.[30] While there is a dose response relationship to the ACE score – the more exposure to adversity the more likely one is to experience negative health outcomes – each of the measures also independently contributes to the increased likelihood of poor health outcomes.[31] Children raised in safe and nurturing families and communities, free from maltreatment and other adverse childhood experiences, are more likely to have better outcomes as adults.[32] Parenting has significant influence on a child's development, impacting their health and well-being. Parenting is not only about preventing abuse, but also being a shield against adversity and building a child's coping and resiliency skills.[33]

Key findings

In 2017, the rate of child abuse/neglect was 19.0 per 1,000 population under 18 years of age in Jackson County, 15.6 per 1,000 population under 18 years of age in Josephine County and 12.8 per 1,000 population under 18 years of age in Oregon overall (Figure 56). Josephine County shows a significant decrease between 2015 and 2017.

Figure 56. Child Abuse/Neglect Victim Rate per 1,000 Population (Under 18), by State and County, FF15-FF17
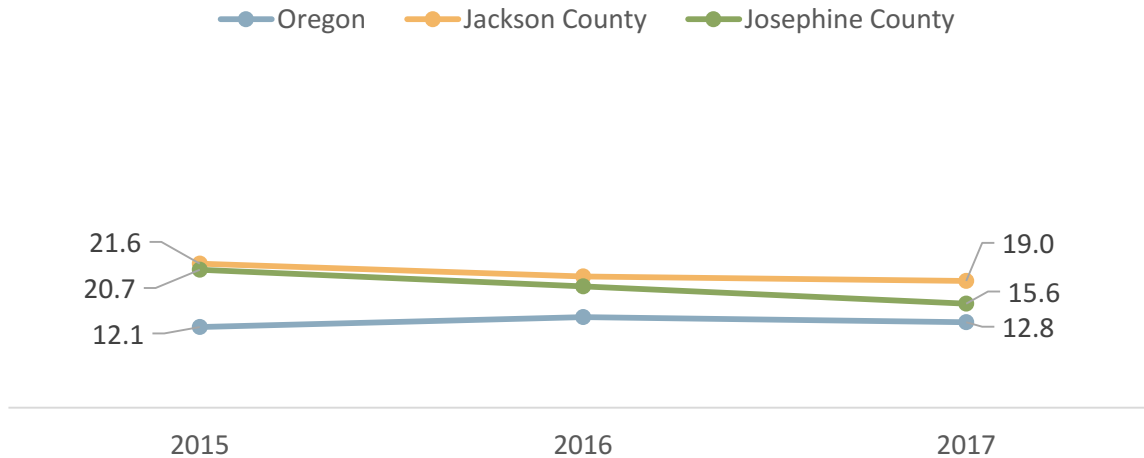
DATA SOURCE: Oregon Department of Human Services, Child Abuse and Neglect Data, Child Welfare Data Book, 2017

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[30] Felitti VJ, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine. 1998; 14(4): 245-258.
[31] Merrick MT, et al. Unpacking the impact of adverse childhood experiences on adult mental health. Child Abuse Neglect. 2017; 69: 10-19.
[32] Anda RF, Felitti VJ, Walker J, et al. The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. Eur Arch Psychiatry Clin Neurosci. 2006 Apr;256(3):174–86.
[33] Hoghughi M. The importance of parenting in child health. British Medical Journal. 1998; 316(7144): 1545-1550.

While child abuse and neglect did not surface extensively in qualitative data for this assessment, quantitative data on a variety of other childhood exposures indicate that the family environment in Jackson and Josephine Counties is not always conducive to good health. When looking across indicators among 11th graders, ACEs in Josephine County appears to be increasing compared to stable or decreasing in Jackson County and Oregon overall.

In 2016, 51.1% of 11th grade students in Josephine County reported that they experienced parental divorce or separation during their lifetime, compared to 43.2% of 11th grade students in Jackson County and 42.8% of 11th grade students across Oregon (Figure 57).

Figure 57. Percent 11th Grade Students Reported Parental Divorce or Separation After They Were Born, by State and County, 2014 and 2016
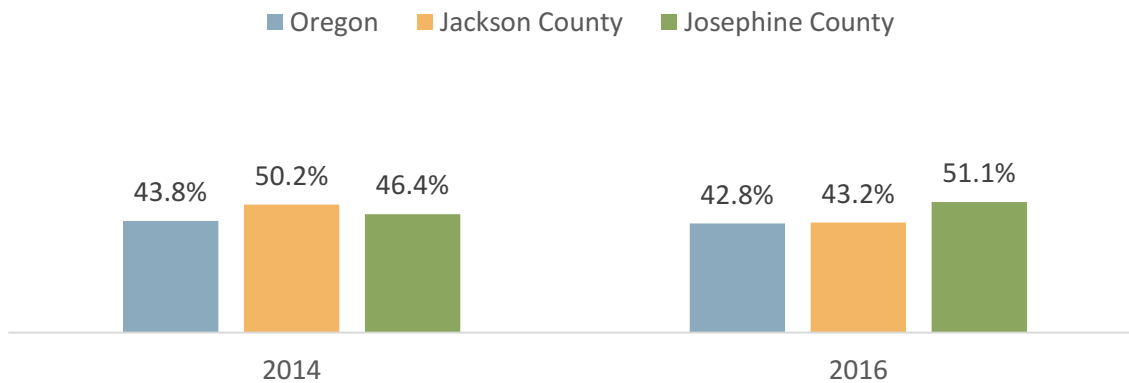
Legend: ■ Oregon ■ Jackson County ■ Josephine County

2014: Oregon 43.8%, Jackson County 50.2%, Josephine County 46.4%
2016: Oregon 42.8%, Jackson County 43.2%, Josephine County 51.1%

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

As seen in Figure 58, in 2016, 40.5% of 11th grade students in Josephine County reported living with someone who was a problem drinker, compared to 34.4% of 11th grade students in Jackson County and 35.2% of 11th grade students in Oregon overall.

Figure 58. Percent 11th Grade Students Reported Living with Someone Who Is/Was a Problem Drinker or Alcoholic, by State and County, 2014 and 2016
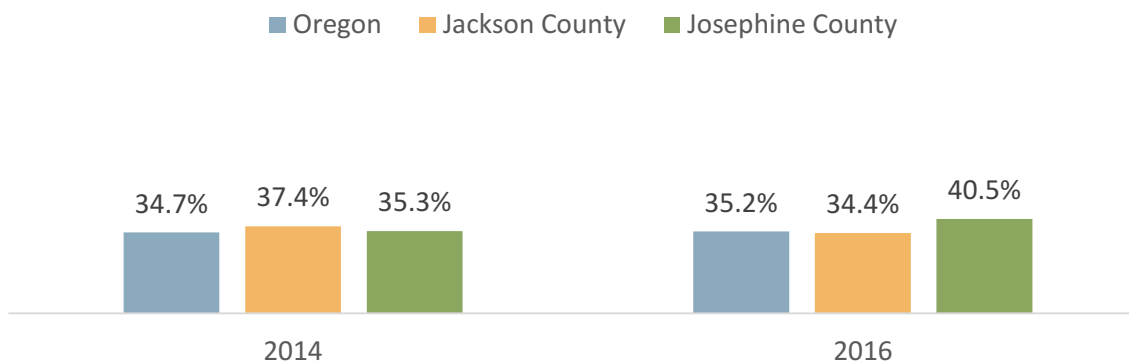
Legend: ■ Oregon ■ Jackson County ■ Josephine County

2014: Oregon 34.7%, Jackson County 37.4%, Josephine County 35.3%
2016: Oregon 35.2%, Jackson County 34.4%, Josephine County 40.5%

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016

Approximately 28.8% of Josephine County 11th grade students reported living with someone who used street drugs in 2016, compared to 23.5% of Jackson County 11th grade students and 23.6% of 11th grade students across Oregon (Figure 59).

Figure 59. Percent 11th Grade Students Reported Living with Someone Who Uses/Used Street Drugs, by State and County, 2014 and 2016
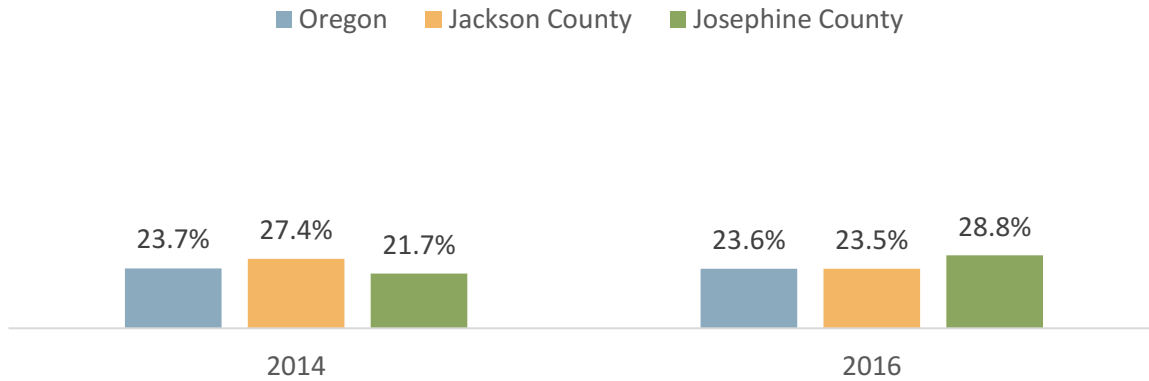
DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

In 2016, 41.7% of Josephine County 11th grade students reported living with someone who was depressed or mentally ill, compared to 38.0% of 11th grade students in Jackson County and 39.0% of 11th grade students across Oregon (Figure 60).

Figure 60. Percent 11th Grade Students Reported Living with a Household Member Who Is/Was Depressed or Mentally Ill, by State and County, 2014 and 2016
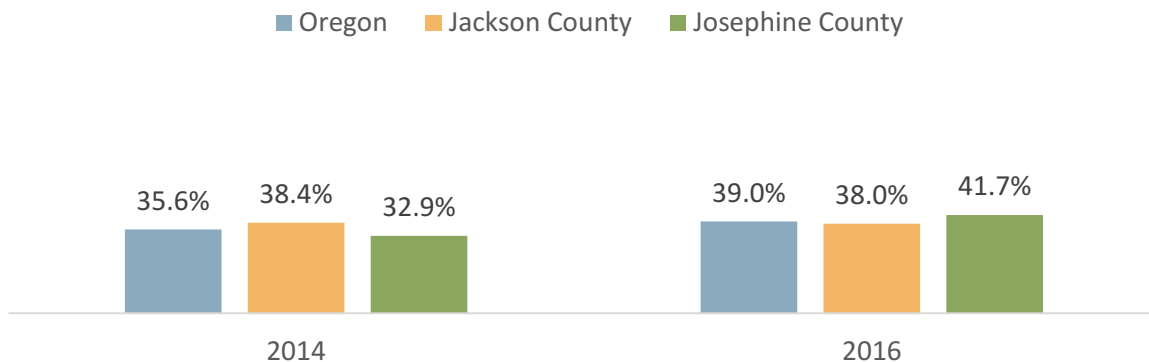
DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

Almost one in five 11th grade students in Josephine County reported they did not have enough to eat (19.0%) in 2016, which was higher than Jackson County (16.5%) and Oregon overall (15.8%) (Figure 61).

Figure 61. Percent 11th Grade Students Reported Ever Feeling They Did Not Have Enough to Eat, by State and County, 2014 and 2016
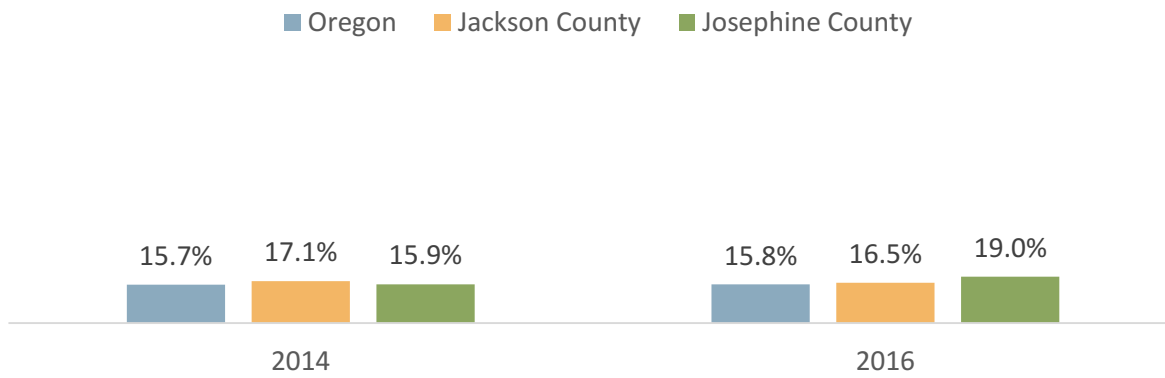
15.7%   17.1%   15.9%   15.8%   16.5%   19.0%

2014   2016

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

In 2016, 12.5% of Josephine County 11th grade students reported feeling that they had to wear dirty clothes, compared to 10.1% of Jackson County 11th grade students and 10.2% of 11th grade students across Oregon (Figure 62).

Figure 62. Percent 11th Grade Students Reported Ever Feeling They Had to Wear Dirty Clothes, by State and County, 2014 and 2016
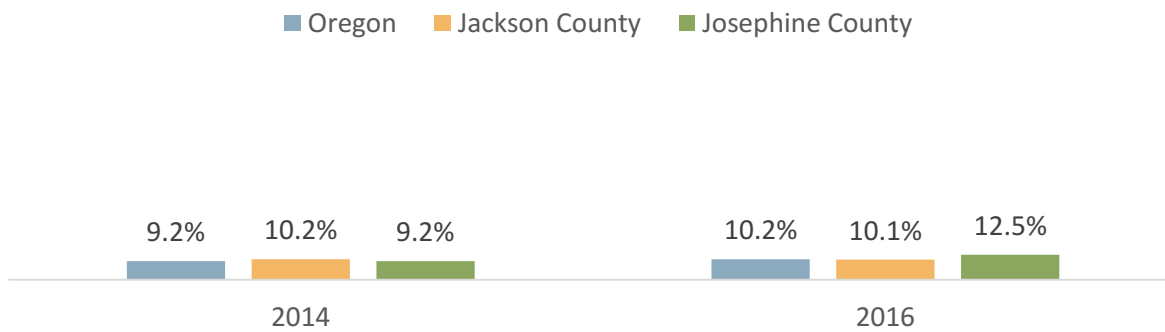
■ Oregon   ■ Jackson County   ■ Josephine County

9.2%   10.2%   9.2%   10.2%   10.1%   12.5%

2014   2016

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

In 2016, 18.7% of Josephine County 11th grade students reported feeling like they had no one to protect them, compared to 12.4% of Jackson County 11th grade students and 14.1% of 11th grade students across Oregon (Figure 63).

Figure 63. Percent 11th Grade Students Reported Ever Feeling They Had No One to Protect Them, by State and County, 2014 and 2016

14.2%   14.0%   15.1%   14.1%   12.4%   18.7%

2014   2016

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

Focus group and interview participants broadly discussed the challenges facing parents as they raise children in Jackson and Josephine Counties, including parents' limited knowledge of and skills for parenting, and stigma associated with asking for help. Assessment participants shared the perception that parents do not have the understanding, skills, and time to devote to parenting given the demands on them to financially provide for their families. The community can play a role in stepping up to support children and families.

"I really want to give my daughter a loving home, but I don't know what that looks like."

Future exploration

Youth-adult connectedness is a key protective factor for adolescent health and can buffer against a range of risky experiences and behaviors. According to assessment participants, families in the region are not as connected with each other or their communities as would be helpful to support parents and children. Further inquiry is needed into how to best connect and support parents and ensure that children have connections to caring adults. Additionally, while late-middle and high school data are available on risk and protective factors, future explorations should include what age-specific experiences younger youth in the region are facing, and how to best build their coping skills at each age.

Existing assets and resources

Assessment participants were asked about the assets in their communities related to parenting and life skills and shared the following list of resources:

- Babies First!
- Birthright of Medford
- Boys and Girls Club
- CaCoon
- Child and Family Welfare Council
- Child Care Resource Network
- Coalition for Kids
- Early Head Start
- Family Connection
- Family Nurturing Center

- Healthy Families America
- Healthy Families programs
- Healthy Start
- Kids Unlimited
- Magdalene House
- Maternity Case Management
- Nurse Family Partnership
- Oregon Child Development Coalition
- Pregnancy Center
- Project Baby Check
- Resolve
- Rose Circle Mentoring
- Project Baby - Siskiyou Community Health Center
- Southern Oregon Early Learning Services
- Southern Oregon Education Service District
- Southern Oregon Head Start
- Southern Oregon Success
- Teresa McCormick Center
- YMCA

NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

Education and Workforce Development

Importance and connection to other health issues

Education influences health outcomes at many levels – from the individual to population level. As one of the strongest predictors of health, the more education an individual has the more likely they are to live a longer and healthier life.[34] During childhood, when a child is engaged in the education system not only are they learning, but they also have access to support systems and resources that can impact health, such as breakfast and lunch programs. Research shows that there are certain levels of education that are defining points, for example increased mortality risk drops at high school graduation.[35] While education beyond high school continues to improve health outcomes, having a credential and skill set that opens the door to benefits, i.e. a job, shows the role education plays in many factors that impact health outcomes. Adults continue to be impacted by their educational attainment, as more education is associated with access to more, and better paying, job opportunities. This link between education, employment and income drives much of an individual's ability to

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[34] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us. American Journal of Public Health. 2010; 100: S186-S196.

[35] Zimmerman EB, Woolf SH, and Haley A. Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. Content last reviewed September 2015. Agency for Health care Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html

achieve economic stability and the positive health outcomes that result from access to housing, food and health care.[36]

Key Findings

Early childhood education has immediate and long-term impacts on child development and adult health.[37] Based on 2012-2016 American Community Survey 5-year estimates, about 34.9% of children aged 3-4 years in Jackson County were enrolled in preschool, compared to 39.4% in Josephine County, 43.4% in Oregon overall, and 47.5% in the U.S. (Figure 64).

Figure 64. Percent Population (3 to 4 Years) Enrolled in School, by U.S., State, and County, 2005-2011 and 2012-2016

■ U.S. ■ Oregon ■ Jackson County ■ Josephine County

	2011				2016		
	48.1%	41.0%	31.7%	42.1%	47.5%	43.4%	34.9%	39.4%
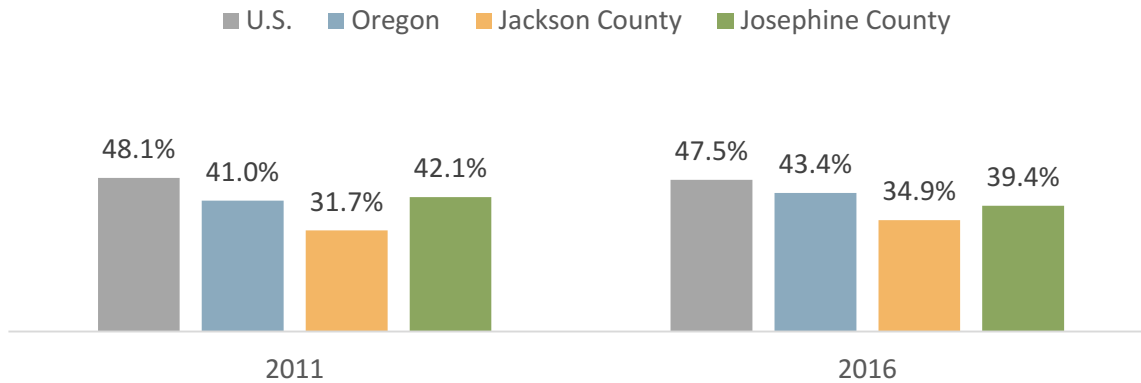
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2005-2011 and 2012-2016

Reading proficiently by 3rd-5th grade is a critical benchmark in a child's educational development. Low achievement has important long-term consequences in terms of individual earning potential, global competitiveness, and general productivity.[38] In 2017, the percentage of students in grades 3-5 meeting English Language Arts (ELA) standards ranged from 30.6% in Prospect school district to 67.0% in Ashland school district (Figure 65). In 2017, 42.2% of 3rd grade students were reading at their grade level in Jackson County, compared to 45.3% in Josephine County.

Figure 65. Percent Students (Grades 3-5) Meeting ELA Standards, by State and School District, 2016-2017

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[36] Zimmerman EB, Woolf SH, and Haley A. Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. Content last reviewed September 2015. Agency for Health care Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html

[37] D'Onise K, McDermott RA, Lynch JW. Does attendance at preschool affect adult health? A systematic review. Public Health. 2010 Sep; 124(9):500-11

[38] Early Warning! Why Reading by the End of 3rd Grade Matters. Annie E. Casey Foundation. 2010
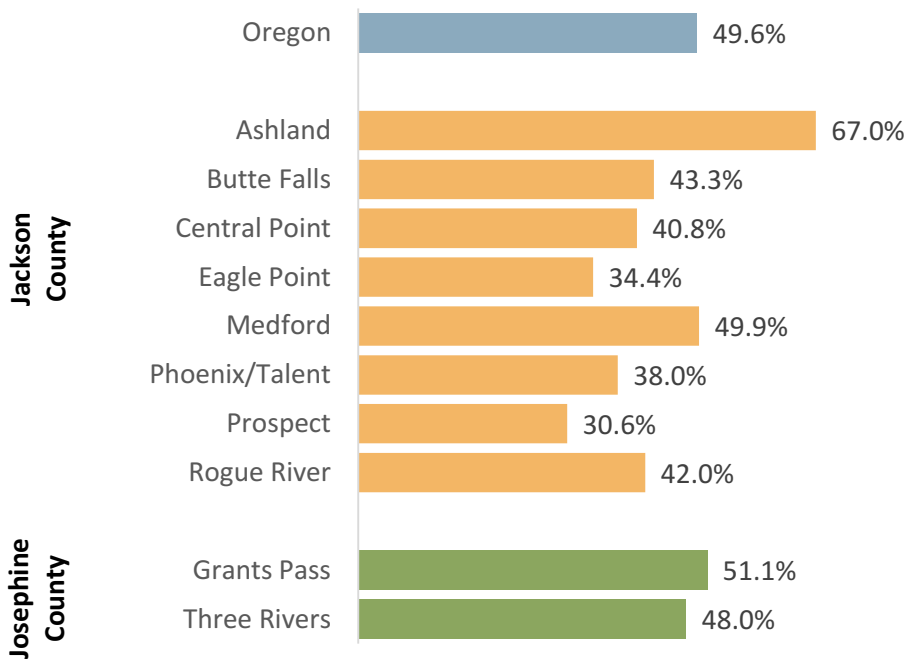
DATA SOURCE: Oregon Department of Education, School and District Report Cards, 2016-2017

Chronic absenteeism ranged from 14.5% in Eagle Point to 30.6% in Butte Falls in 2017 (Figure 66). These have remained consistent over the past 3 school years.

Figure 66. Percent Students Chronically Absent, by State and School District, 2016-2017
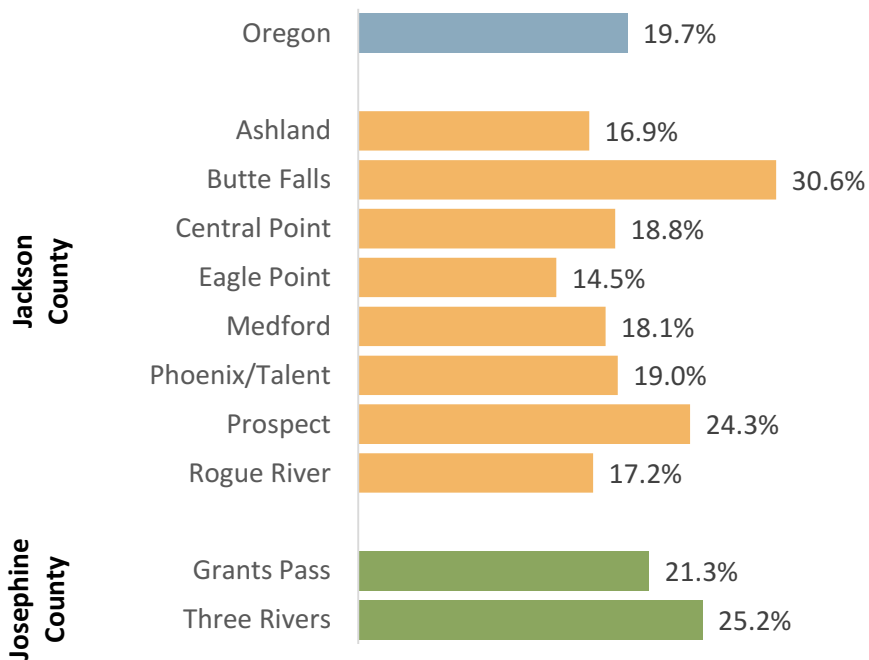
DATA SOURCE: Oregon Department of Education, School and District Report Cards, 2016-2017
NOTE: Chronically absent students are defined as students who attended 90% or fewer of their enrolled days between the start of the school year and the first weekday of May in the school year

About one third of 11th grade students in Jackson County (33.1%) reported skipping school in the past four weeks, which was consistent with 11th grade students in Josephine County (30.9%) and in Oregon (32.1%) (Figure 67).

Figure 67. Percent 11th Grade Students Reported Skipping At Least One Day of School in Past Four Weeks, by State and County, 2012, 2014, and 2016
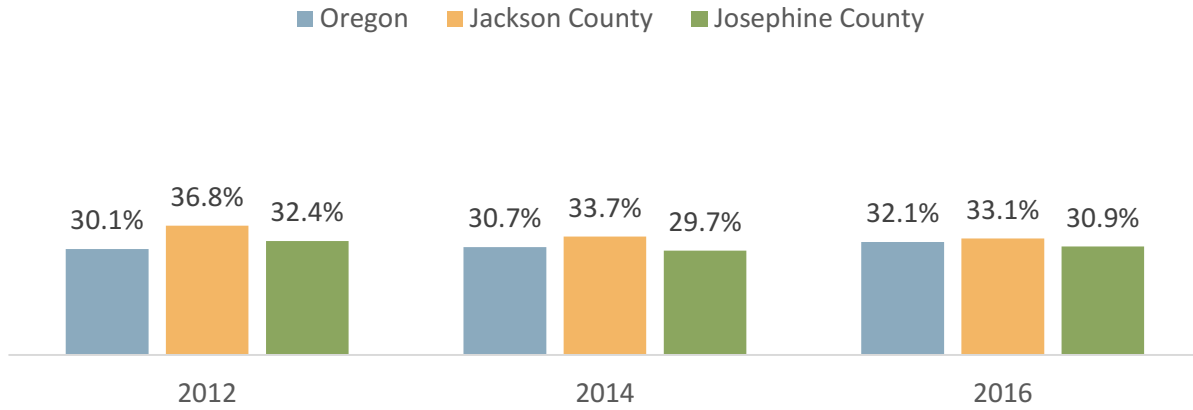
DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016

In 2017, 9th grade attendance was 94.2% in Jackson County and 93.6% in Josephine County, indicating an approximately 1% increase from 2016 (Figure 68).

Figure 68. Percent 9th Grade Students in Attendance Each School Day in Year, by County, 2015-2017
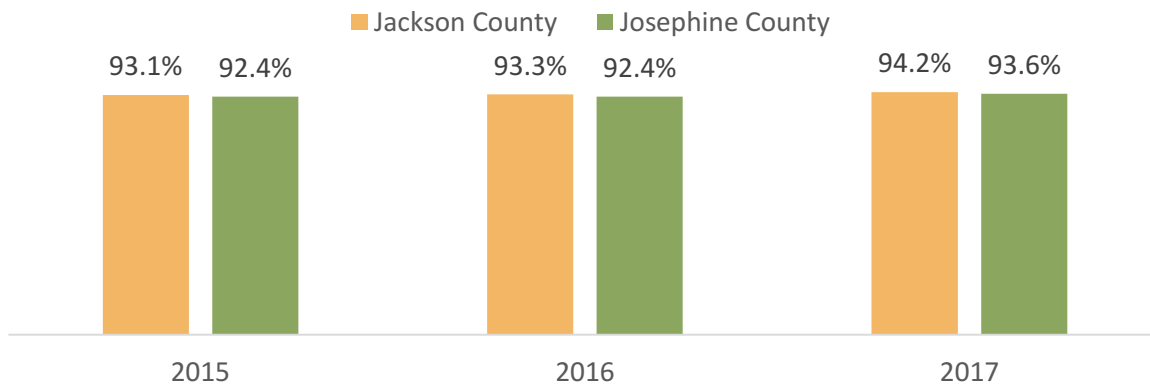
DATA SOURCE: Southern Oregon Education Service District, Southern Oregon Success, 2015-2017

Graduation rates increased between 2014 and 2016 in Oregon, Jackson County, and Josephine County, with 74.8% of students graduating in Oregon in 2016, 75.3% in Jackson County, and 69.7% in Josephine County (Figure 69). The nationwide high school graduation rate was 84% in 2016.

Figure 69. Graduation Rates, by State and County, 2013-2014, 2014-2015, and 2015-2016

High school graduation rates varied across school districts in Jackson and Josephine counties in the 2015-2016 school year. The rate was highest for Ashland school district (88.2%), which is higher than the rate for Oregon overall (74.8%), and lowest for Butte Falls school district (61.9%) (Figure 70).

Figure 70. Graduation Rates, by School Districts, 2015-2016
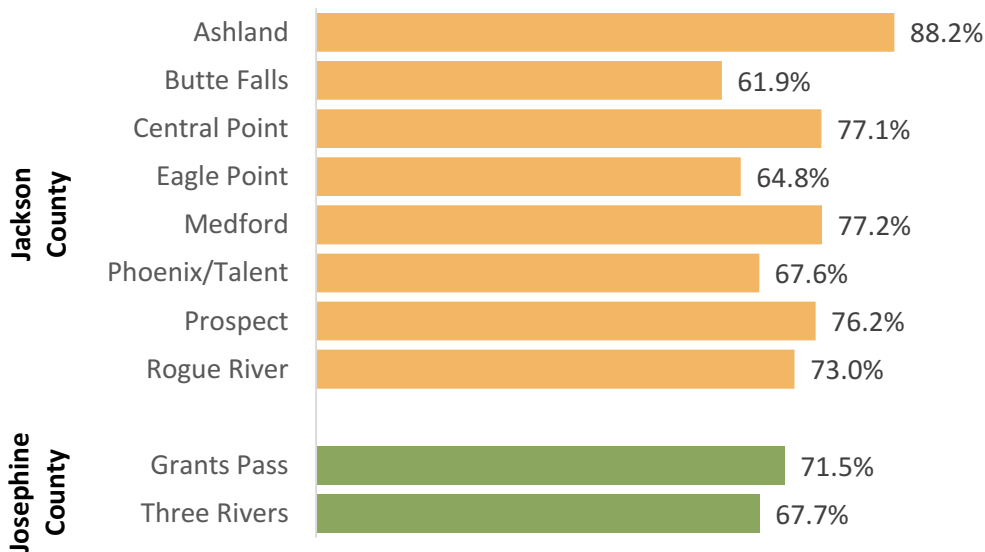
Educational attainment is the highest level of education that an individual has completed. Based on 2012-2016 American Community Survey 5-year estimates, there was a smaller percentage of individuals 25 years old or over who received a bachelor's degree or more in Josephine County (17.2%) compared to Jackson County (26.1%) and Oregon (31.5%) (Figure 71).

Figure 71. Educational Attainment for Population 25 Years and Over, by U.S., State, and County, 2012-2016

	Less than high school	High school diploma/GED	Some college/Associate's degree	Bachelor's degree or higher
U.S.	13.0%	27.5%	29.2%	30.3%
Oregon	10.1%	23.9%	34.7%	31.5%
Jackson County	11.1%	27.1%	35.7%	26.1%
Josephine County	11.2%	32.3%	39.2%	17.2%
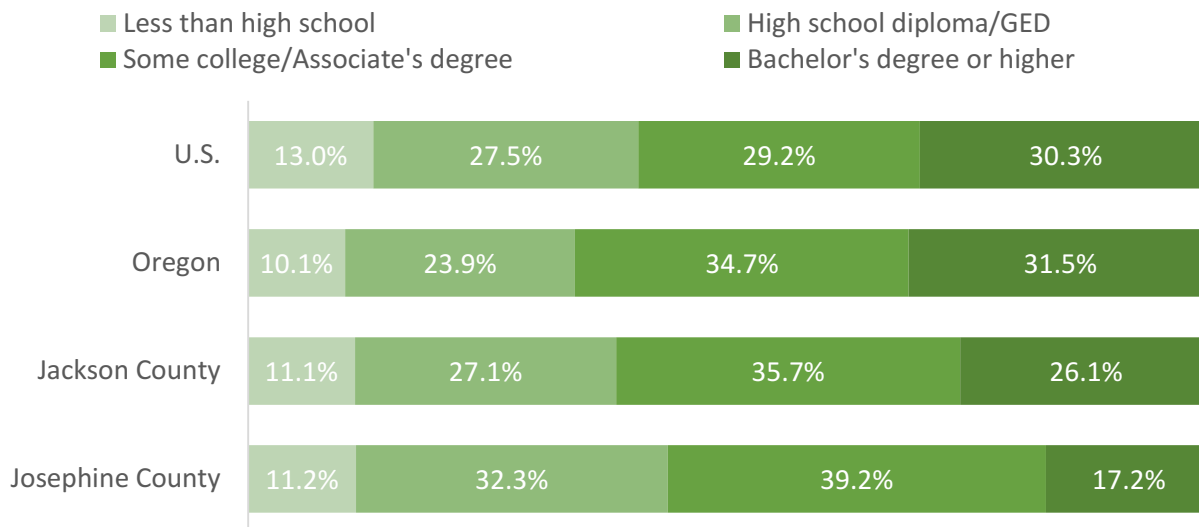
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Examining these data by race and ethnicity, 60.2% of individuals identifying as Hispanic or Latino in Josephine County had a high school degree or less compared to Jackson County (62.4%) and Oregon (62.8%) (Figure 72). In Josephine County, individuals identifying as Asian are much more likely (54.1%) to have only a high school degree or less. This is in contrast to the population overall of which 43.5% of Josephine County, 38.2% in Jackson County, and 34.0% in Oregon overall had a high school degree or less. These education data also mirror data on poverty, which showed that individuals identifying as people of color, especially in Jackson County, are more likely to live below the federal poverty level.

Figure 72. Percent Population 25 Years and Over with a High School Diploma or Less, by Race/Ethnicity, by State and County, 2012-2016
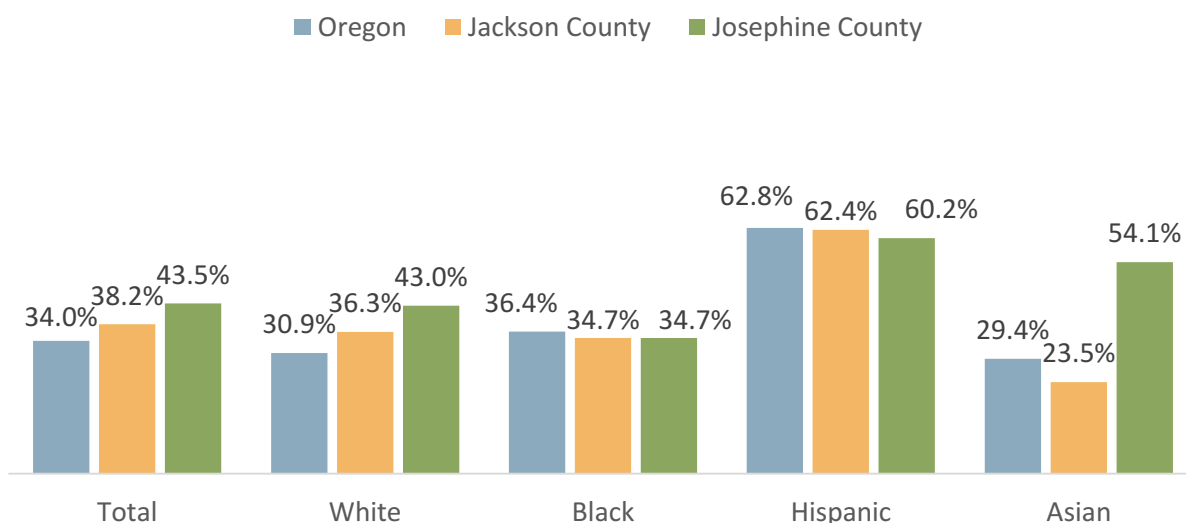
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

The connections between education and employment are strong. The cost of college has increased substantially and many students have difficulty paying for higher education. Further, well-paying jobs for individuals with only a high school degree are limited. Across Jackson and Josephine counties, the leading industries of employment

were educational services, health care and social assistance; retail trade; arts, entertainment and recreation, and accommodation and food services; manufacturing; and professional, scientific and management, and administrative and waste management services (Table 7).

Table 7. Percent Population (16 Years and Over) Employed by Industry, by U.S., State, and County, 2012-2016

	U.S.	Oregon	Jackson County	Josephine County
Agriculture, forestry, fishing and hunting, and mining	1.9%	3.3%	3.4%	2.5%
Arts, entertainment, and recreation, and accommodation and food services	9.7%	10.0%	11.3%	7.7%
Construction	6.3%	5.7%	5.9%	6.3%
Educational services, and health care and social assistance	23.1%	23.0%	24.4%	24.2%
Finance and insurance, and real estate and rental and leasing	6.6%	5.7%	5.0%	5.0%
Information	2.1%	1.9%	1.4%	1.1%
Manufacturing	10.3%	11.4%	9.3%	10.9%
Other services, except public administration	4.9%	4.8%	5.3%	5.9%
Professional, scientific, and management, and administrative and waste management services	11.2%	10.7%	7.9%	10.0%
Public administration	4.7%	4.5%	4.7%	4.4%
Retail trade	11.5%	12.0%	14.2%	14.9%
Transportation and warehousing, and utilities	5.0%	4.2%	4.7%	4.7%
Wholesale trade	2.7%	2.9%	2.4%	2.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

As discussed previously, the region experiences relatively low unemployment; however, jobs are not generally well-paying and median household income is lower than the state and nation. About two-thirds of survey respondents overall reported the availability of jobs was either a moderate concern or high concern (Figure 73).

Figure 73. Survey Respondents Perceived Level of Concern for the Availability of Jobs, 2018
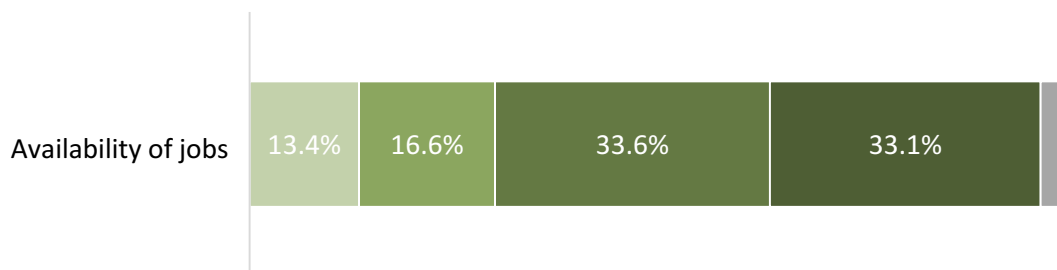
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Future exploration

While there is reported misalignment between the educational attainment and skill level of the current population with the existing job base in the region, assessment participants suggested that there are skill sets that can be gained outside of the traditional education system, such as through workforce development training programs, that can help employers train a workforce with the necessary skills and help individuals who are having difficulty finding employment with their current skill set. This pathway to employment and filling jobs is important to individuals who can benefit from employment, but also to businesses and communities in filling workforce needs from the local population. Further inquiry is needed to better understand the local workforce needs and how they align with the population coming out of regional educational and training institutions.

Existing assets and resources

Assessment participants were asked about the assets in their communities related to education and workforce development, and shared the following list of resources:

- Academia Latina
- College and Career for All (CC4A)
- College Dreams
- Kids Unlimited
- Migrant and English Language Learner (ELL) Education programs
- Migrant Parent Action Committee
- Native American and Alaskan Indian Education programs
- Oregon Community Foundation
- Oregon Health Sciences University School of Nursing (Ashland Campus)
- Rogue Community College
- Rogue Workforce Partnership
- Southern Oregon Education Service District
- Southern Oregon Success
- Southern Oregon University
- United Way of Jackson County

NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

While there are a number of educational and workforce development resources that assessment participants mentioned, one in five survey respondents reported educational support services were currently missing in the community and almost one in four reported employment services were missing (Figure 74). Among Hispanic/Latino survey respondents, nearly one in three (32.9%) indicated that educational support services were lacking. Further, there were notable disparities by gender, with 23.7% of women indicating educational services lacking compared to 12.3% of men.

Figure 74. Percent Survey Respondents Reported Educational Support Services and Employment Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018

Educational support services (including language services) — Total 20.0%, Provider 26.4%, Community Member 15.6%

Employment services (including job training and readiness) — Total 24.1%, Provider 29.0%, Community Member 20.9%

Legend: Total, Provider, Community Member
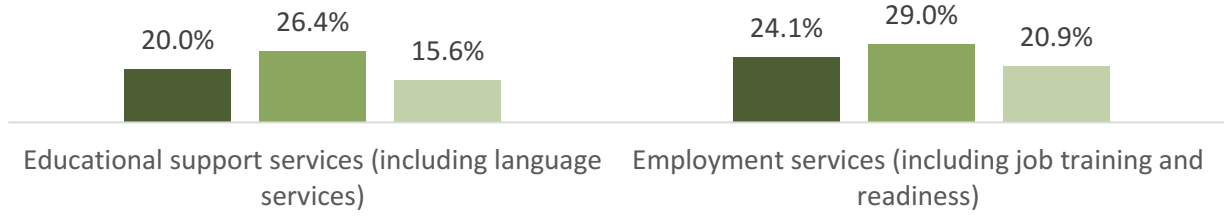
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

NEXT STEPS

The 2018 community health assessment of Jackson and Josephine Counties serves multiple purposes for a variety of audiences. Among these purposes, the assessment enables JRHA and its partners to

- Explore current health status and determinants of health, health priorities, and new and emerging concerns among Jackson and Josephine County community members and service providers
- Hear individual and group voices to provide a deeper understanding of the "why" and "how" of current and emerging health issues
- Understand the shifting patterns of these health issues over time in Jackson and Josephine Counties
- Identify assets and resources as well as gaps and needs in services in order to help partners set funding and programming priorities
- Fulfill the community health needs assessment requirements for Asante and Providence Hospitals, regional federally qualified health centers, Jackson and Josephine County Public Health, Community Mental Health Programs, and Coordinated Care Organizations
- Use the data gathered to engage JRHA members, partners and the community in the community health improvement process

This assessment lays the foundation for a regional Community Health Improvement Plan (CHIP) effort to begin in early 2019. The quantitative and qualitative data presented in this report and the six priority key themes identified can guide the development of goals, objectives, strategies and performance measures. While JRHA is the convener for community health improvement planning in Jackson and Josephine Counties, objectives and strategies developed for the CHIP must be owned by a local organization or collaborative for meaningful progress to occur. The priorities identified in this assessment represent complex community issues, and effective action will require infrastructure and community capacity to support collective impact.

APPENDICES

Appendix A – List of Stakeholders

Cynthia	Ackerman	AllCare Health
Heather	Ackerman	Josephine County Public Health
Anne	Ackles	Jackson County Public Health
Debbie	Ameen	AllCare Health
Hannah	Ancel	Jackson Care Connect
Tina	Anthony	Providence Medford Medical Center
Jean	Atalla	Jackson Care Connect
Charlie	Bauer	Southern Oregon Education Service District
Jackson	Baures	Jackson County Public Health
Jeni	Beck	Rogue Valley YMCA
Vanessa	Becker	AllCare Health
Todd	Bloomquist PhD	Grants Pass School District
Mike	Bond	PrimeCare
Richard	Booth	Siskiyou Community Health Center
Rene	Brandon	Southern Oregon Early Learning Services
Julie	Brown	Rogue Valley Transportation District
Stacy	Brubaker	Jackson County Mental Health
Don	Bruland	AllCare & Jackson Care Connect, Community Advisory Council
Kathy	Bryon	Gordon Elwood Foundation
Peter	Buckley	Southern Oregon Success
Lilia	Caballero	Medford Police Dept
Cara	Carter	Housing Authority of Jackson County
Carolina	Castaneda del Rio	La Clinica
Michael	Cavallaro	Rogue Valley Council of Governments
Kevin	Clark	Grants Pass YMCA
Sheila	Clough	Asante Ashland Community Hospital
Dennie	Conrad	Asante
Spencer	Countiss MD	Grants Pass Clinic
Shannon	Cronin	PrimaryHealth of Josephine County
Terri	Dahl	Medford School District
Beth	DePew	Oregon Health Authority
Karen	Elliott	Rogue Community Health
Jason	Elzy	Housing Authority of Jackson County
Sam	Engel	AllCare Health
DeeAnne	Everson	United Way of Jackson County
Stacy	Ferrell	ColumbiaCare Services
Mary	Ferrell	Maslow Project
Jim	Fong	Rogue Workforce Partnership

Shawn	Furdiga	Southern Oregon Veterans Rehabilitation Center & Clinics
John	Gates	Asante
Cecilia	Giron	LISTO Family Literacy
Michelle	Glass	Rogue Action Center
Lisa	Greif	Jackson County Circuit Court
Brian	Gross MD	Jefferson Regional Health Alliance
Janel	Guretzki	OnTrack Rogue Valley
Bevin	Hansell	Oregon Health Authority
Robin	Hausen	PrimaryHealth of Josephine County
Michelle	Homer-Anderson	Southern Oregon Head Start
Diane	Hoover	Grants Pass Blue Zones
Joseph	Ichter	Providence Health & Services
Brenda	Johnson	La Clinica
Ellen	Johnson	Options for Southern Oregon
Jennifer	Johnstun	PrimaryHealth of Josephine County
Sonya	Kauffman-Smith	Providence Health & Services
Kathy	Keesee	Unete Center for Farm Worker Advocacy
Scott	Kelly	Asante
John	King	Southern Oregon University
Cheryl	Kirk	OSU Extension Services
Jenny	Kowalczyk	Josephine County Public Health
Andrea	Krause	Jackson County Public Health
Kate	Lasky	Josephine County Public Library
Alan	Ledford PhD	OnTrack Rogue Valley
Jennifer	Lind	Jackson Care Connect
Keith	Lundquist	Asante
Harry	Mackin	AllCare Health, Community Advisory Council
Pam	Marsh	Oregon State Representative
Kellyn	Marshall	OnTrack Rogue Valley
Ivonne	Martinez Razo	Jackson County Early Intervention
Christine	Mason	Addictions Recovery Center
Cindy	Mayo	Providence Medford Medical Center
Ruth	McBride	PrimaryHealth of Josephine County
Karla	McCafferty	Options for Southern Oregon
Nancy	McKinnis	Jackson Care Connect
Tony	Mendenhall	PrimaryHealth of Josephine County, Community Advisory Council
Kris	Miller MD	Siskiyou Community Health Center
Michele	Morales	PSU School of Social Work
Emily	Mossberg	Jackson County Public Health
Lee	Murdoch MD	Jefferson Regional Health Alliance
Craig	Newton	Jackson Care Connect, Community Advisory Council

Joanne	Noone	OHSU School of Nursing
Pamela	Norr	Access
William	North	Rogue Community Health
Craig	Norton	Kairos
Laura	O'Bryon	Rogue Valley Council of Governments
Lisa	O'Connor	Family Nurturing Center
Mark	Orndoff	Jackson County Health & Human Services
Lori	Paris	Addictions Recovery Center
Rebecca	Pearson	AllCare Health, Community Advisory Council
Tanya	Phillips	Jackson County Public Health
Bonnie	Pickens	Providence Health & Services
LuAnn	Redding	Josephine County
Sara	Rubrecht	Jackson & Josephine County Emergency Management
Tomi	Ryba	Providence Medford Medical Center
Susan	Sanchez	Providence Medford Medical Center
Dorethy	Schweitzer	AllCare Health, Community Advisory Council
Jim	Shames MD	Jackson County Public Health
Belle	Shepherd	Oregon Health Authority
Becky	Sherman	La Clinica
Amanda	Singh Bans	Health Care Coalition of Southern Oregon
Sarah	Small	Options for Southern Oregon
Ed	Smith-Burns	AllCare Health, Community Advisory Council
Maggie	Sullivan	Health Care Coalition of Southern Oregon
Danni	Swafford	Addictions Recovery Center
Kari	Swoboda	AllCare Health
Brenda	Thomas	PrimaryHealth of Josephine County, Community Advisory Council
Bill	Thorndike Jr	Medford Fabrication
Sue	Thurston	Southern Oregon Veterans Rehabilitation Center & Clinics
Audrey	Tiberio	Josephine County Public Health
Maria	Underwood	La Clinica
Bruce	VanZee MD	Jefferson Regional Health Alliance
Roy	Vinyard	Asante
Heather	Voss	OHSU School of Nursing
Angela	Warren	Jefferson Regional Health Alliance
Michael	Weber	Josephine County Public Health
Kelly	Wessels	United Community Action Network
Caryn	Wheeler	OSU Extension Services
Nicole	Witham	AllCare Health, Community Advisory Council
Thomas K.	Wuest MD	Health Net of Oregon
Jessica	Wynant	Providence Medford Medical Center
Ted	Zuk	Jackson County Development Services

Appendix B – List of data sources and indicators

Topic	Data Indicators	Data Source
Population		
	Population count	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Population change	U.S. Census Bureau, ACS 5-Year Estimates, 2007-2011 v. 2012-2016
	% population in urban v. rural area	U.S. Census Bureau, Decennial Census, as cited by Community Commons, 2010
	% population living with a disability	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
Sex		
	Population by sex	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
Age		
	Under 18 years; 18-24 years; 25-44 years; 45-64 years; 65-74 years; 75-84 years; 85+ years	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
Racial and Ethnic Diversity		
	Racial/ ethnic composition	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Hispanic population change	U.S. Census Bureau, ACS 5-Year Estimates, 2007-2011 v. 2012-2016
	Foreign-born population	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Place of origin (of foreign-born population)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% population who speak language other than English at home	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
Adverse Childhood Experiences		
	% adult Medicaid members reporting 4+ ACEs (by CCO)	MBRFSS, 2014
	% single parent households	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Total number of child abuse/neglect reports to DHS	Oregon DHS, 2018
	Child abuse/neglect victim rate per 1,000 population (under 18)	Oregon DHS, 2018
	Number of DV and sexual assault calls to Oregon Sexual and Domestic Violence Programs	Oregon DHS, 2018
	Number of individuals sheltered in domestic violence programs	Oregon DHS, 2018
	% students reporting parental divorce or separation after birth	Student Wellness Survey, 2016
	% students reporting ever living with someone who is/was a problem drinker or alcoholic	Student Wellness Survey, 2016
	% students reporting ever living with someone who uses/used street drugs	Student Wellness Survey, 2016
	% students reporting ever living with a household member who is/was depressed or mentally ill	Student Wellness Survey, 2016
	% students reporting ever feeling that they had to wear dirty clothes	Student Wellness Survey, 2016

Topic	Data Indicators	Data Source
Economic		
	% individuals below poverty level	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% families below poverty level	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% individuals below 200% poverty level	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% population 65+ living below poverty level	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% population under 18 living below poverty level	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% student population eligible for free/reduced lunch	Oregon Department of Education, as reported by Children First for Oregon, Oregon County Data Book, 2016 and 2017
	Unemployment rate	Bureau of Labor Statistics, Local Area Unemployment Statistics, 2012-2017
	% individuals 16-64 working FT, PT, not working	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Top industries employing population	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Median household income (and by race)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Median family income	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	GINI index of income inequality	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Median cost of childcare - small home-based care, large home-based care, center-based care	Oregon DHS, 2018
	Per capita income or average wage	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
Education		
	Educational attainment of adults 25 years and older (and by race)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	High school graduation rate	Oregon Department of Education, School and District Report Cards, 2015-2016
	% students continuing education within 16 months of high school graduation (by district)	Oregon Department of Education, School and District Report Cards, 2016-2017
	% 3-4 yo enrolled in preschool	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Kindergarten readiness/early learning (by district)	Oregon Department of Education, Statewide Kindergarten Assessment Results, 2017-2018
	% students in grades 3-5 meeting ELA standards	Oregon Department of Education, School and District Report Cards, 2016-2017
	% students chronically absent	Oregon Department of Education, Regular Attenders Report, 2016-2017
	% students reported skipping at least one day of school in past four weeks	Student Wellness Survey, 2016
Food Insecurity		
	% households receiving food stamps/SNAP	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% population food insecure	Map the Meal Gap, Feeding America, 2016
	% population under 18 food insecure	Map the Meal Gap, Feeding America, 2016
	% youth reported eating less because there was not enough money to buy food	Oregon Healthy Teens Survey, 2017

Topic	Data Indicators	Data Source
	% youth reported feeling they did not have enough to eat	Student Wellness Survey, 2016
Housing and Homelessness		
	% households paying 35% or more, 30% or more, 20-29%, and less than 20% of income on housing (by owner occupied and renter occupied)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Median monthly housing costs (by owner occupied and renter occupied)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Housing tenure (owner occupied and renter occupied)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% of households with severe housing problem	County Health Rankings, 2014
	Homeless count	Oregon Housing and Community Services, Oregon Point-in-Time Homeless Counts, 2017
	% homeless students	Oregon Department of Education, McKinney-Vento Act, Homeless Student Data, 2016-2017
Safety/Crime		
	Property crime rate	State of Oregon, Criminal Justice Commission, Oregon Uniform Crime Report, 2016
	Violent crime rate	State of Oregon, Criminal Justice Commission, Oregon Uniform Crime Report, 2016
	% students reporting did not go to school because they did not feel safe at school or on way to/from school	Student Wellness Survey, 2016
	% students reporting bullied at school during past year	Student Wellness Survey, 2016
	% students reporting physical fight on school property past 30 days	Student Wellness Survey, 2016
Social Support		
	% students reporting feeling they had no one to protect them	Student Wellness Survey, 2016
	% youth reporting having friends and family giving positive energy every day (OR and Grants Pass)	Blue Zones Survey, 2016/2017
	% youth reporting having someone encouraging them to be healthy (OR and Grants Pass)	Blue Zones Survey, 2016/2017
	Average social wellbeing score (OR and Grants Pass)	Blue Zones Survey, 2016/2017
Built Environment		
	Means of transportation to work for workers aged 16+	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% housing units built before 1979	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Density of liquor stores (or rate of liquor stores per 100,000 population)	Oregon Liquor Control Commission, 2018

Topic	Data Indicators	Data Source
	Density of marijuana dispensaries (or rate of marijuana dispensaries per 100,000 population)	Oregon Liquor Control Commission, 2018
	Number of active recreational marijuana licenses by type	Oregon Liquor Control Commission, 2018
	% tobacco retailers selling to underage youth	Oregon Health Authority, Synar Inspection Results, 2017
	Rate of recreation and fitness facilities per 100,000 population	U.S. Census Bureau, County Business Patterns, as cited by Community Commons, 2016
	Rate of fast food restaurants per 100,000 population	U.S. Census Bureau, County Business Patterns, as cited by Community Commons, 2016
	Rate of grocery stores per 100,000 population	U.S. Census Bureau, County Business Patterns, as cited by Community Commons, 2016
	Food environment index	County Health Rankings, 2015
	% of population with adequate access to locations for physical activity	County Health Rankings, 2016
Natural Environment		
	% EPA-regulated public water systems with systems score > 11 (meeting standards)	Oregon Public Health Drinking Water Online, 2018
	# confirmed or presumptive cases in children under 18 with elevated childhood blood lead levels	Orpheus, 2017
	Number of extreme heat days	National Oceanic and Atmospheric Administration, 2017
	Annual particulate matter concentration	U.S. Environmental Protection Agency, Outdoor Air Quality Data, Air Quality Statistics Report, 2017
	% days that had good air quality	U.S. Environmental Protection Agency, Outdoor Air Quality Data, Air Quality Statistics Report, 2017
Overall Health		
	% adults reporting at least one day of activity limitations in past month	BRFSS, 2012-2015
	% adults reporting poor physical or mental health limiting daily activities and/or health problems requiring use of special equipment in past month	BRFSS, 2012-2015
	% adults reporting general health status as good, very good, or excellent	BRFSS, 2012-2015
Mortality		
	Overall mortality rate	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Premature mortality (or years of potential life lost)	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Leading causes of death	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016

Topic	Data Indicators	Data Source
	Age-adjusted heart disease mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted cancer mortality rate per 100,000 population (and by cancer type)	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted accidents (unintentional injuries) mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted chronic lower respiratory disease mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted diabetes mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted cerebrovascular disease mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Fall injuries mortality rate per 100,000 population (65+ population)	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted motor vehicle related mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted opioid overdose mortality rate per 100,000 population	Oregon Health Authority, Center for Health Statistics, Public Health Division, Death Certificates as cited by Opioid Data Dashboard, 2012-2016
	Age-adjusted alcohol related mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
Diet and Physical Activity		
	% adults reporting meeting fruits and vegetables consumption recommendations	BRFSS, 2012-2015
	% students reporting consumption of 5+ servings of fruits or vegetables per day	Oregon Healthy Teens Survey, 2017
	% adults reporting meeting aerobic and strengthening physical activity recommendations	BRFSS, 2012-2015
	% students reporting physical activity (for 60+ minutes) per day in past week	Oregon Healthy Teens Survey, 2017
	% adults reporting consumption of 7+ soda beverages per week	BRFSS, 2012-2015
	% students reporting consumption of soda at least one time in past week	Oregon Healthy Teens Survey, 2017
Chronic Diseases		
	Cancer incidence rate per 100,000 population (and by cancer type)	OSCaR, 2014

Topic	Data Indicators	Data Source
	% adults reporting current asthma	BRFSS, 2012-2015
	% adults reporting diabetes diagnosis	BRFSS, 2012-2015
	% adults reporting heart attack	BRFSS, 2012-2015
	% adults reporting stroke	BRFSS, 2012-2015
	% adults reporting high blood cholesterol	BRFSS, 2012-2015
	% adults reporting high blood pressure	BRFSS, 2012-2015
	% female adults reporting pap test in past 3 years	BRFSS, 2012-2015
	% female adults reporting mammogram in past 2 years	BRFSS, 2012-2015
	% adults reporting meeting colorectal cancer screening recommendations	BRFSS, 2012-2015
	% adults reporting overweight or obesity	BRFSS, 2012-2015
	% students reporting overweight or obese	Student Wellness Survey, 2016
Alcohol, Tobacco, and Drugs		
	% students reporting current alcohol consumption	Student Wellness Survey, 2016
	% adults reporting binge drinking	BRFSS, 2012-2015
	% students reporting binge drinking	Student Wellness Survey, 2016
	% adults reporting heavy drinking	BRFSS, 2012-2015
	% adults reporting current marijuana use (data not available by counties)	BRFSS, 2012-2015
	% students reporting current marijuana use	Student Wellness Survey, 2016
	% adults reporting current cigarette smoking	BRFSS, 2012-2015
	% students reporting current cigarette smoking	Student Wellness Survey, 2016
	% students reporting current prescription drug use without prescription	Student Wellness Survey, 2016
	Opioid overdose hospitalization rate per 100,000 population	Oregon Health Authority, Center for Health Statistics, Public Health Division, Oregon Hospital Discharge Data as cited by Opioid Data Dashboard, 2010-2014
	Heroin overdose hospitalization rate per 100,000 population	Oregon Health Authority, Center for Health Statistics, Public Health Division, Oregon Hospital Discharge Data as cited by Opioid Data Dashboard, 2010-2014
	Substance related hospitalization rate per 100,000 population (e.g., alcohol, marijuana, opioids, etc.)	Agency for Health care Research and Quality, HCUPnet, 2014
Mental Health		
	Age-adjusted suicide rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	% adults reporting depression diagnosis	BRFSS, 2012-2015
	% students reporting frequent mental distress	Student Wellness Survey, 2016

Topic	Data Indicators	Data Source
	% students reporting seriously considered suicide in past year	Student Wellness Survey, 2016
	% students reporting attempted suicide in past year	Student Wellness Survey, 2016
Oral Health		
	% adults reporting dental visit in past year	BRFSS, 2012-2015
	% students reporting dental visit in past year	Oregon Healthy Teens Survey, 2017
	% population served with water fluoridation	SDWIS, Oregon Public Health Drinking Water Data, 2018
	% adults reporting all permanent teeth removed due to tooth decay or gum disease (or one or more)	BRFSS, 2012-2015
Maternal, Child, and Infant Health		
	% mothers reporting currently breastfeeding	Oregon Health Authority, Oregon Pregnancy Risk Assessment Monitoring System, 2015
	Infant mortality rate per 1,000 live births	Linked infant births/Death certificates
	% low birth weight births	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2016
	% premature births	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2016
	% births with prenatal care in first trimester	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2016
	% births with no prenatal care	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2016
	Teen (15-17) birth rate per 1,000 population (and by race)	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2016
Hepatitis		
	Hepatitis C (chronic) incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program and Oregon Health Authority, Oregon Public Health Epidemiologists' User System (Orpheus), 2017
	Hepatitis A (viral hepatitis) incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program and Oregon Health Authority, Oregon Public Health Epidemiologists' User System (Orpheus), 2017
HIV/AIDS		
	HIV infection incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program, 2016
STI		

Topic	Data Indicators	Data Source
	Syphilis incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program and Oregon Health Authority, Oregon Public Health Epidemiologists' User System (Orpheus), 2017
	Gonorrhea incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program and Oregon Health Authority, Oregon Public Health Epidemiologists' User System (Orpheus), 2017
	Chlamydia incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program and Oregon Health Authority, Oregon Public Health Epidemiologists' User System (Orpheus), 2017
Immunizations		
	% adults had flu shot in past year	BRFSS, 2012-2015
	% adults 65+ had flu shot in past year	BRFSS, 2012-2015
	% two-year olds up-to-date on vaccines (4:3:1:3:3:1:4)	Oregon Health Authority, Oregon Immunization Program, 2017
	% adolescents 13 to17 years old with Meningococcal vaccination	Oregon Health Authority, Oregon Immunization Program, 2017
	% adolescents 13 to 17 years old with HPV (1+) vaccination	Oregon Health Authority, Oregon Immunization Program, 2017
	% adolescents 13 to 17 years old with up to date HPV vaccination	Oregon Health Authority, Oregon Immunization Program, 2017
	% children K-12 with non-medical exemption for any vaccine	Oregon Health Authority, Oregon Immunization Program, 2018
	% children in Kindergarten with non-medical exemption for any vaccine	Oregon Health Authority, Oregon Immunization Program, 2018
Access		
	% population without insurance	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% population under 65 years uninsured	U.S. Census Bureau, Small Area Health Insurance Estimates: Health Insurance Interactive Data Tool, 2016
	% population under 19 uninsured	U.S. Census Bureau, Small Area Health Insurance Estimates: Health Insurance Interactive Data Tool, 2016
	Medical health care providers per capita - primary care physicians	County Health Rankings, 2015
	Nurse midwives, nurse practitioners, physician assistants per capita	County Health Rankings, 2017
	Behavioral health care providers per capita	County Health Rankings, 2017
	Dentists per capita	County Health Rankings, 2016
	% adults who have a personal doctor or health care provider	BRFSS, 2012-2015
	% adults reporting not seeing health care provider due to cost in past year	BRFSS, 2012-2015
	% students reporting routine checkup in past year	Oregon Healthy Teens, 2017

Topic	Data Indicators	Data Source
	% female adults at risk for unintended pregnancy reporting effective contraceptive use (data not available by counties)	BRFSS, 2012-2015

Appendix C - Additional findings

Community Demographics

Appendix Table 1. Percent Population Living in Urban and Rural Areas, by State and County, 2010

	Urban	Rural
Oregon	81.0%	19.0%
Jackson County	80.0%	20.1%
Josephine County	55.0%	45.0%

DATA SOURCE: U.S. Census Bureau, Decennial Census, as cited by Community Commons, 2010

Appendix Table 2. Percent Population Living with a Disability, by State and County, 2012-2016

	Percent
Oregon	14.7%
Jackson County	17.2%
Josephine County	19.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Appendix Table 3. Percent Population Male and Female, by State and County, 2007-2011 and 2012-2016

	2011		2016	
	Male	Female	Male	Female
Oregon	49.5%	50.5%	49.5%	50.5%
Jackson County	48.8%	51.2%	48.7%	51.3%
Josephine County	48.5%	51.5%	48.9%	51.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Social Determinants of Health

Adverse childhood experiences

Appendix Table 4. Percent Adult Medicaid Members Reported 4+ ACEs, by State and CCO, 2014

	Percent
Oregon	34.7%
AllCare Health Plan	37.6%
Jackson Care Connect	37.6%
Primary Health of Josephine County	35.9%

DATA SOURCE: Oregon Health Authority, Office of Health Analytics, Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) Survey, Report of Results, 2014

Appendix Table 5. Percent Single Parent Households, by U.S., State, and County, 2005-2011 and 2012-2016

	2011	2016
U.S.	26.0%	26.8%
Oregon	22.5%	23.6%
Jackson County	23.5%	24.9%
Josephine County	21.0%	24.9%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Appendix Table 6. Total Number of Child Abuse/Neglect Reports to DHS, by State and County, FF17

	Number
Oregon	80,683
Jackson County	5,489
Josephine County	2,005

DATA SOURCE: Oregon Department of Human Services, Child Abuse and Neglect Data, Child Welfare Data Book, 2017

Appendix Table 7. Number of Domestic Violence and Sexual Assault Calls to Oregon Sexual and Domestic Violence Programs, by State and County, 2016

	Domestic Violence	Sexual Assault
Oregon	93,799	11,483
Jackson County	1,308	59
Josephine County	3,746	410

DATA SOURCE: Oregon Department of Human Services, Domestic Violence Data and Publications, Domestic and Sexual Violence Service Providers Annual Reports, Striving to Meet the Need: Summary of Services Provided by Sexual and Domestic Violence Programs in Oregon, 2016

Appendix Table 8. Number of Individuals Sheltered in Domestic Violence Programs, by State and County, 2016

	Number
Oregon	4,296
Jackson County	303
Josephine County	292

DATA SOURCE: Oregon Department of Human Services, Domestic Violence Data and Publications, Domestic and Sexual Violence Service Providers Annual Reports, Striving to Meet the Need: Summary of Services Provided by Sexual and Domestic Violence Programs in Oregon, 2016

Appendix Table 9. Number of Individuals (Under 18) Sheltered in Domestic Violence Programs, by State and County, 2016

	Number
Oregon	1,926
Jackson County	122
Josephine County	140

DATA SOURCE: Oregon Department of Human Services, Domestic Violence Data and Publications, Domestic and Sexual Violence Service Providers Annual Reports, Striving to Meet the Need: Summary of Services Provided by Sexual and Domestic Violence Programs in Oregon, 2016

Economic factors

Appendix Table 10. Median Household Income by Race/Ethnicity, by State and County, 2012-2016

	Oregon	Jackson County	Josephine County
Total	$53,270	$46,343	$37,867
White, non-Hispanic	$55,125	$48,062	$37,988
Black	$32,062	$30,862	$44,732
Hispanic/Latino, any race	$42,311	$35,148	$42,125
Asian	$68,694	$68,950	--
American Indian/Alaska Native	$36,781	$25,833	--
Native Hawaiian/Other Pacific Islander	$40,333	--	--

Other race		$42,017	$40,843	$43,958
Two or more races		$46,226	$39,979	$18,101

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTE: Dashes represent where median income was not calculated due to small numbers

Appendix Table 11. Average Household Income, by U.S., State, and County, 2007-2011 and 2012-2016

	2011	2016
U.S.	$72,555	$77,866
Oregon	$65,589	$72,013
Jackson County	$57,751	$62,014
Josephine County	$50,137	$54,628

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Appendix Table 12. Median Family Income, by U.S., State, and County, 2007-2011 and 2012-2016

	2011	2016
U.S.	$64,293	$67,871
Oregon	$61,302	$65,479
Jackson County	$53,751	$56,174
Josephine County	$47,420	$47,788

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Appendix Table 13. GINI Index of Income Inequality, by U.S., State, and County, 2007-2011 and 2012-2016

	2011	2016
U.S.	0.470	0.480
Oregon	0.449	0.461
Jackson County	0.446	0.459
Josephine County	0.451	0.479

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016
NOTE: The GINI index is a measure that represents the income or wealth distribution, i.e. inequality, of a geographic area. A GINI index of 0 represents perfect equality and 1 represents maximal inequality.

Education

Appendix Table 14. Percent Students Continuing Education within 16 Months of High School Graduation, by State and School District, 2014-2015, 2015-2016, and 2016-2017

	2015	2016	2017
Oregon	60.5%	59.4%	57.4%
Ashland	55.3%	60.6%	54.2%
Butte Falls	46.2%	33.3%	30.0%
Central Point	53.2%	50.2%	55.9%
Eagle Point	42.9%	37.9%	31.0%
Medford	55.0%	49.5%	44.6%
Phoenix/Talent	41.8%	45.3%	47.3%
Prospect	52.6%	50.0%	53.8%
Rogue River	46.8%	55.8%	50.0%
Grants Pass	51.6%	51.7%	52.0%
Three Rivers	59.1%	50.6%	51.4%

DATA SOURCE: Oregon Department of Education, School and District Report Cards, 2014-2015, 2015-2016, and 2016-2017

Appendix Table 15. Percent Households by Percent of Income Spent on Housing Costs, by U.S., State, and County, 2012-2016

	Less than 20% of income	20% to 29% of income	30% or more of income
U.S.	42.1%	21.8%	32.9%
Oregon	37.9%	23.3%	36.0%
Jackson County	35.3%	22.5%	39.3%
Josephine County	37.2%	19.9%	39.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Appendix Table 16. Percent Households where Housing Costs are More than 35% of Income, by U.S., State, and County, 2012-2016

	2011		2016	
	Owner-occupied with mortgage	Renter-occupied	Owner-occupied with mortgage	Renter-occupied
U.S.	31.3%	43.5%	23.3%	42.0%
Oregon	37.5%	49.5%	25.2%	44.0%
Jackson County	39.2%	51.3%	30.0%	49.3%
Josephine County	31.3%	43.5%	34.2%	52.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Appendix Table 17. Percent Youth Reported Having Friends/Family Giving Positive Energy Every Day and Having Someone Encouraging Them to be Healthy, by State and City, 2016/2017

	Positive Energy from Friends/Family	Encouragement to be Healthy
Oregon	65.7%	67.3%
Grants Pass (Josephine County)	59.8%	62.1%

DATA SOURCE: Blue Zones Project by Healthways, brought to Oregon by Cambia Health Foundation, Survey Results, 2016 (for Grants Pass: 2017)

Appendix Table 18. Average Social Wellbeing Score, by State and City, 2016/2017

	Score
Oregon	67.9
Grants Pass (Josephine County)	65.9

DATA SOURCE: Blue Zones Project by Healthways, brought to Oregon by Cambia Health Foundation, Survey Results, 2016 (for Grants Pass: 2017)

Appendix Table 19. Means of Transportation to Work for Workers 16 Years and Over, by U.S., State, and County, 2012-2016

	Car, truck, or van - alone	Car, truck, or van - carpool	Public transportation	Other
U.S.	76.4%	9.3%	5.1%	9.2%
Oregon	71.4%	10.3%	4.4%	13.8%

Jackson County	76.0%	9.4%	1.0%	13.5%
Josephine County	81.5%	7.8%	0.5%	10.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTE: Other includes walking, working from home, and other means of transportation

Food insecurity

Appendix Table 20. Percent Households Receiving Food Stamps/SNAP Benefits, by State and County, 2012-2016

	Percent
Oregon	18.8%
Jackson County	21.6%
Josephine County	23.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Appendix Table 21. Percent Population Food Insecure, by State and County, 2014-2016

	2014	2015	2016
Oregon	15.2%	14.2%	12.9%
Jackson County	16.0%	15.3%	14.2%
Josephine County	17.3%	16.5%	15.6%

DATA SOURCE: Feeding America, Map the Meal Gap, 2014-2016

Appendix Table 22. Percent Population Under 18 Years Food Insecure, by State and County, 2014-2016

	2014	2015	2016
Oregon	24.5%	22.5%	20.0%
Jackson County	26.8%	25.1%	22.8%
Josephine County	29.4%	27.7%	25.0%

DATA SOURCE: Feeding America, Map the Meal Gap, 2014-2016

Appendix Table 23. Food Environment Index, by State and County, 2015

	Index
Oregon	7.6
Jackson County	7.3
Josephine County	7.0

DATA SOURCE: USDA Food Environment Atlas, Map the Meal Gap, as cited by County Health Rankings, 2015
NOTE: The Food Environment Index ranges from 0 (worst) to 10 (best) and equally weights two indicators of the food environment: limited access to healthy foods (the percentage of the population that is low income and does not live close to a grocery store) and food insecurity (the percentage of adults who did not have access to a reliable source of food during the past year).

Appendix Table 24. Percent 11th Grade Students Reported Eating Less than They Felt They Should Because There Was Not Enough Money to Buy Food in Past Year, by State and County, 2013, 2015, and 2017

	2013	2015	2017
Oregon	19.3%	18.5%	17.8%
Jackson County	22.5%	19.8%	21.6%
Josephine County	23.0%	NA	14.2%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017

NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Built environment

Appendix Table 25. Percent Housing Units Built Before 1980, by U.S., State, and County, 2012-2016

	Percent
U.S.	55.3%
Oregon	54.7%
Jackson County	48.7%
Josephine County	52.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Appendix Table 26. Density of Liquor Stores, by State and County, 2018

	Number of Liquor Stores	Rate per 100,000 Population
Oregon	267	6.5
Jackson County	13	6.0
Josephine County	3	3.5

DATA SOURCE: Oregon Liquor Control Commission, last updated 6-20-18, 2018

Appendix Table 27. Density of Marijuana Dispensaries, by State and County, 2018

	Number of Dispensaries	Rate per 100,000 Population
Oregon	570	13.9
Jackson County	37	17.1
Josephine County	9	10.5

DATA SOURCE: Oregon Liquor Control Commission, last updated 6-8-18, 2018

Appendix Table 28. Number of Active Recreational Marijuana Licenses by Type, by State and County, 2018

	Recreational Producer	Recreational Retailer	Recreational Wholesaler	Recreational Processor	Laboratory
Oregon	1013	559	122	171	22
Jackson County	201	35	15	15	2
Josephine County	137	9	5	5	0

DATA SOURCE: Oregon Liquor Control Commission, Recreational Marijuana Licensing, Approved Marijuana Licenses as of 7/27/2018, 2018

Appendix Table 29. Percent Tobacco Retailers Selling to Underage Youth, by State and County, 2016-2017

	2016	2017
Oregon	4.4%	9.9%
Jackson County	12.9%	5.6%
Josephine County	0.0%	22.2%

DATA SOURCE: Oregon Health Authority, Health Promotion and Chronic Disease Prevention, Synar Inspection Results, 2017

Appendix Table 30. Rate of Recreational and Fitness Facilities per 100,000 Population, by State and County, 2016

	Rate

Oregon	12.4
Jackson County	13.3
Josephine County	8.5

DATA SOURCE: U.S. Census Bureau, County Business Patterns, additional data analysis by CARES, as cited by Community Commons, 2016

Appendix Table 31. Rate of Fast Food Restaurants per 100,000 Population, by State and County, 2016

	Rate
Oregon	76.5
Jackson County	76.3
Josephine County	62.9

DATA SOURCE: U.S. Census Bureau, County Business Patterns, additional data analysis by CARES, as cited by Community Commons, 2016

Appendix Table 32. Rate of Grocery Stores per 100,000 Population, by State and County, 2016

	Rate
Oregon	19.3
Jackson County	17.2
Josephine County	19.3

DATA SOURCE: U.S. Census Bureau, County Business Patterns, additional data analysis by CARES, as cited by Community Commons, 2016

Appendix Table 33. Percent Population with Adequate Access to Locations for Physical Activity, by State and County, 2016

	Percent
Oregon	77.0%
Jackson County	37.0%
Josephine County	67.0%

DATA SOURCE: Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files, as cited by County Health Rankings, 2016

Appendix Table 34. Percent EPA-Regulated Public Water Systems Meeting Standards (Systems Score ≥ 11), by Water Systems, by County, 2018

	Community	Transient Non-Community	Non-Transient Non-Community	Non-EPA
Jackson County	98%	99%	100%	100%
Josephine County	100%	98%	100%	NA

DATA SOURCE: Oregon Health Authority, SDWIS, Oregon Public Health Drinking Water Online, https://yourwater.oregon.gov/, 2018
NOTE: Classifications of public water systems can be found at https://www.epa.gov/dwreginfo/information-about-public-water-systems

Appendix Table 35. Number of Confirmed or Presumptive Cases of Elevated Childhood Blood Lead Levels in Children Under 18 Years, by State and County, 2014-2017

	2014	2015	2016	2017
Oregon	144	143	170	207

Jackson County	2	0	14	7
Josephine County	1	6	1	1

DATA SOURCE: Oregon Health Authority, Orpheus, 2014-2017
NOTE: Oregon changed their Investigative Guidelines, adopting a new lower case definition value of ≥ 5 in May 2016

Appendix Table 36. Number of Extreme Heat Days, by Southern Oregon Region, 2015-2017

	2015	2016	2017
HeatRisk Magenta Days	1	0	0
HeatRisk Red Days	14	7	7
HeatRisk Orange Days	35	31	38
HeatRisk Yellow Days	135	134	115

DATA SOURCE: National Oceanic and Atmospheric Administration (NOAA), 2015-2017
NOTE: Heat risk assigned based on Medford Rogue Valley International Airport temperatures. Definitions can be found at
https://www.wrh.noaa.gov/wrh/heatrisk/

Appendix Table 37. Annual Particulate Matter Concentration (PM2.5 Weighted Annual Mean), by County, 2015-2017

	2015	2016	2017
Jackson County	12.1	7.2	15.5
Josephine County	8.3	5.8	15.8

DATA SOURCE: U.S. Environmental Protection Agency (EPA), Outdoor Air Quality Data, Air Quality Statistics Report, 2015-2017
NOTE: EPA air quality standards for PM2.5 annual is 12 µg/m3; The data presented INCLUDES exceptional events data

Appendix Table 38. Particulate Matter Concentration (PM2.5 98th Percentile), by County, 2015-2017

	2015	2016	2017
Jackson County	46	21	111
Josephine County	18	15	115

DATA SOURCE: U.S. Environmental Protection Agency (EPA), Outdoor Air Quality Data, Air Quality Statistics Report, 2015-2017
NOTE: 98th percentile of the daily average measurements in the year; EPA air quality standard for PM2.5 24-hour is 35 µg/m3; The data presented INCLUDES exceptional events data

Appendix Table 39. Percent Days that Had Good Air Quality, by County, 2015-2017

	2015	2016	2017
Jackson County	64.1%	83.6%	64.4%
Josephine County	75.9%	86.9%	68.2%

DATA SOURCE: U.S. Environmental Protection Agency (EPA), Outdoor Air Quality Data, Air Quality Statistics Report, 2015-2017
NOTE: "Good" air quality is having an Air Quality Index (AQI) value of 0 through 50

Health care access

Appendix Table 40. Percent Population Uninsured, by State and County, 2012-2016

	Percent
Oregon	10.4%
Jackson County	11.5%

Josephine County	10.9%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Appendix Table 41. Percent Population Under 65 Years Uninsured, by State and County, 2014-2016

	2014	2015	2016
Oregon	11.6%	8.4%	7.4%
Jackson County	12.9%	8.9%	8.0%
Josephine County	12.0%	8.9%	7.9%

DATA SOURCE: U.S. Census Bureau, Small Area Health Insurance Estimates: Health Insurance Interactive Data Tool, 2014-2016

Appendix Table 42. Percent Population Under 19 Years Uninsured, by State and County, 2014-2016

	2014	2015	2016
Oregon	5.1%	4.1%	3.5%
Jackson County	5.7%	4.0%	3.9%
Josephine County	5.5%	3.9%	3.8%

DATA SOURCE: U.S. Census Bureau, Small Area Health Insurance Estimates: Health Insurance Interactive Data Tool, 2014-2016

Appendix Table 43. Ratio of Population to One Primary Care Provider, by State and County, 2013-2015

	2013	2014	2015	2016
Oregon	1,070	1,070	1,070	1,070
Jackson County	1,110	1,100	1,090	1,090
Josephine County	1,190	1,160	1,280	1,280

DATA SOURCE: Area Health Resource File, as cited by Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, County Health Rankings, 2013-2015

Appendix Table 44. Ratio of Population to One Other Primary Care Physician*, by State and County, 2015

Oregon	1,341
Jackson County	993
Josephine County	1,177

DATA SOURCE: Centers for Medicare and Medicaid Services, Area Health Resource File/National Provider Identification File, as cited by Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, County Health Rankings, 2015
NOTE: Other primary care physicians include nurse practitioners (NP), physician assistants (PA), and clinical nurse specialists

Appendix Table 45. Ratio of Population to One Mental Health Provider, by State and County, 2015-2017

	2015	2016	2017
Oregon	280	250	230
Jackson County	400	340	290
Josephine County	190	160	150

DATA SOURCE: Centers for Medicare and Medicaid Services, National Provider Identification Registry, as cited by Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, County Health Rankings, 2015-2017

Appendix Table 46. Ratio of Population to One Dentist, by State and County, 2016

Oregon	1,270
Jackson County	1,250
Josephine County	1,280

DATA SOURCE: Centers for Medicare and Medicaid Services, Area Health Resource File/National Provider Identification File, as cited by Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, County Health Rankings, 2016

Appendix Table 47. Age-Adjusted Percent Adults Reported Routine Check-Up in Past Year, by State and County, 2012-2015

	Percent
Oregon	60.3%
Jackson County	56.4%
Josephine County	55.9%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 48. Percent 11th Grade Students Reported a Routine Check-Up or Physical Exam in Past Year, by State and County, 2013, 2015, and 2017

	2013	2015	2017
Oregon	59.1%	61.5%	62.2%
Jackson County	50.5%	55.6%	55.2%
Josephine County	56.6%	N/A	61.6%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017
NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Appendix Table 49. Age-Adjusted Percent Adults Reported Not Seeing Health Care Provider Due to Cost in Past Year, by State and County, 2012-2015

	Percent
Oregon	12.7%
Jackson County	20.4%
Josephine County	20.2%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 50. Age-Adjusted Percent Female Adults at Risk for Unintended Pregnancy Reported Effective Contraceptive Use, by State and County, 2012-2015

	Percent
Oregon	68.7%
Jackson County	NA
Josephine County	NA

DATA SOURCE: Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015
NOTE: Data not available for counties

Appendix Table 51. Age-Adjusted Percent Adults Reported At Least One Day of Activity Limitations in Past Month, by State and County, 2012-2015

	Percent
Oregon	27.2%
Jackson County	28.8%
Josephine County	27.1%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 52. Age-Adjusted Percent Adults Reported Poor Physical or Mental Health Limits Daily Activities and/or Health Problems Requiring Use of Special Equipment in Past Month, by State and County, 2012-2015

	Percent
Oregon	25.9%
Jackson County	27.4%
Josephine County	32.7%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 53. Years of Potential Life Lost Before Age 75 per 100,000 Population, by State and County, 2014-2016

	2014	2015	2016
Oregon	6,524.2	6,521.2	6,480.6
Jackson County	7,472.6	7,899.6	7,632.8
Josephine County	9,194.1	10,473.3	9,955.6

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2014-2016

Appendix Table 54. Age-Adjusted Heart Disease Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	137.6	137.1	134.0
Jackson County	138.6	129.2	122.0
Josephine County	136.1	119.8	146.6

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 55. Age-Adjusted Cancer Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2014	2015	2016
Oregon	160.3	160.2	155.8
Jackson County	160.4	169.3	156.9
Josephine County	173.2	180.9	192.4

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 56. Age-Adjusted Female Breast Cancer Mortality Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	20.0
Jackson County	20.4
Josephine County	32.1

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 57. Age-Adjusted Colorectal Cancer Mortality Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	13.7
Jackson County	13.4
Josephine County	15.9

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 58. Age-Adjusted Lung Cancer Mortality Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	41.7
Jackson County	42.6
Josephine County	52.8

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 59. Age-Adjusted Cervical Cancer Mortality Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	2.0
Jackson County	1.9
Josephine County	--

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015
NOTE: Rate not calculated for Josephine County due to small numbers

Appendix Table 60. Age-Adjusted Prostate Cancer Mortality Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	20.8
Jackson County	23.1
Josephine County	26.9

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 61. Age-Adjusted Accidents (Unintentional Injuries) Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017

Oregon	44.4	46.4	44.7
Jackson County	44.4	47.4	40.2
Josephine County	66.2	62.8	72.4

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 62. Age-Adjusted Chronic Lower Respiratory Disease Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	42.8	40.9	39.7
Jackson County	51.0	46.3	47.8
Josephine County	61.2	56.1	47.7

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 63. Age-Adjusted Diabetes Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	23.2	24.3	23.9
Jackson County	24.3	22.5	17.1
Josephine County	24.2	20.3	25.1

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 64. Age-Adjusted Cerebrovascular Disease Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	37.9	38.4	39.9
Jackson County	39.0	34.7	37.4
Josephine County	33.8	35.1	43.6

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 65. Falls Mortality Rate (65+) per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	98.8	96.3	96.8
Jackson County	80.2	75.5	70.5
Josephine County	61.6	97.2	82.0

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 66. Age-Adjusted Motor Vehicle Related Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	11.8	12.2	11.7
Jackson County	13.9	16.7	13.5

Josephine County	36.5	29.3	27.3

Appendix Table 67. Age-Adjusted Alcohol Induced Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	18.7	16.9	17.4
Jackson County	22.0	19.0	18.5
Josephine County	30.8	27.4	28.2

Chronic diseases and related risk factors

Healthy eating and physical activity

Appendix Table 68. Age-Adjusted Percent Adults Reported Meeting Recommendations for Fruits and Vegetables Consumption, by State and County, 2012-2015

	Percent
Oregon	19.9%
Jackson County	25.0%
Josephine County	24.5%

Appendix Table 69. Percent 11th Grade Students Reported Consuming Five or More Servings of Fruits or Vegetables Per Day, by State and County, 2013, 2015, and 2017

	2013	2015	2017
Oregon	22.2%	19.5%	18.8%
Jackson County	22.6%	20.5%	18.3%
Josephine County	19.9%	N/A	18.8%

Appendix Table 70. Age-Adjusted Percent Adults Reported Meeting Recommendations for Aerobic and Strengthening Physical Activity, by State and County, 2012-2015

	Percent
Oregon	22.9%
Jackson County	29.6%
Josephine County	32.0%

Appendix Table 71. Percent 11th Grade Students Reported Being Physical Activity (for 60+ Minutes Per Day) Each Day in Past Seven Days, by State and County, 2013, 2015, and 2017

	2013	2015	2017

Oregon	25.8%	23.7%	22.5%
Jackson County	26.9%	23.5%	21.3%
Josephine County	36.7%	N/A	32.8%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017
NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Appendix Table 72. Age-Adjusted Percent Adults Reported Consumption of Seven or More Soda Beverages (Non-Diet) Per Week, by State and County, 2012-2015

	Percent
Oregon	12.2%
Jackson County	14.3%
Josephine County	13.4%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 73. Percent 11th Grade Students Reported Consuming Soda At Least One Time in Past Seven Days, by State and County, 2013, 2015, and 2017

	2013	2015	2017
Oregon	68.1%	50.8%	67.0%
Jackson County	70.5%	46.8%	64.2%
Josephine County	64.5%	N/A	64.8%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017
NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Appendix Table 74. Age-Adjusted Percent Adults Reported Obesity or Overweight, by State and County, 2012-2015

	Percent
Oregon	63.3%
Jackson County	58.8%
Josephine County	62.0%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 75. Percent 11th Grade Students Reported to Be Overweight or Obese, by State and County, 2012, 2014, and 2016

	2013	2015	2017
Oregon	11.6%	13.5%	14.4%
Jackson County	11.5%	12.5%	9.6%
Josephine County	13.4%	13.5%	15.7%

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: BMI calculation based on self-reported height and weight

Asthma

Appendix Table 76. Age-Adjusted Percent Adults Reported Current Asthma, by State and County, 2012-2015

	Percent
Oregon	11.1%

Jackson County	11.1%
Josephine County	10.6%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Diabetes

Appendix Table 77. Age-Adjusted Percent Adults Reported Diabetes Diagnosis, by State and County, 2012-2015

	Percent
Oregon	9.1%
Jackson County	7.7%
Josephine County	7.2%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Heart disease

Appendix Table 78. Age-Adjusted Percent Adults Reported Ever Had a Heart Attack, by State and County, 2012-2015

	Percent
Oregon	3.2%
Jackson County	3.1%
Josephine County	3.3%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Cerebrovascular disease

Appendix Table 79. Age-Adjusted Percent Adults Reported Ever Had a Stroke, by State and County, 2012-2015

	Percent
Oregon	2.7%
Jackson County	2.7%
Josephine County	4.6%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Risk factors

Appendix Table 80. Age-Adjusted Percent Adults Reported High Blood Cholesterol, by State and County, 2012-2015

	Percent
Oregon	31.3%
Jackson County	30.3%
Josephine County	31.8%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 81. Age-Adjusted Percent Adults Reported High Blood Pressure Diagnosis, by State and County, 2010-2013

	Percent
Oregon	29.3%
Jackson County	27.4%
Josephine County	25.9%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Cancer

Appendix Table 82. Age-Adjusted Percent Female Adults (21-65 Years) Reported Pap Smear in Past Three Years, by State and County, 2012-2015

	Percent
Oregon	80.6%
Jackson County	82.6%
Josephine County	63.0%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015
NOTE: Out of those who did not have a hysterectomy

Appendix Table 83. Age-Adjusted Percent Female Adults (50-74 Years) Reported Mammogram in Past Two Years, by State and County, 2012-2015

	Percent
Oregon	77.1%
Jackson County	67.7%
Josephine County	72.3%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 84. Age-Adjusted Percent Adults (50-75 Years) Reported Meeting Colorectal Cancer Screening Recommendations, by State and County, 2012-2015

	Percent
Oregon	69.4%
Jackson County	61.4%
Josephine County	56.3%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 85. Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	434.0
Jackson County	427.1
Josephine County	462.4

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 86. Female Breast Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate

	Rate
Oregon	125.0
Jackson County	134.6
Josephine County	146.0

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 87. Colorectal Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	34.9
Jackson County	36.4
Josephine County	43.1

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 88. Lung Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	56.3
Jackson County	60.0
Josephine County	71.4

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 89. Cervical Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	6.8
Jackson County	6.8
Josephine County	7.7

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 90. Prostate Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	95.3
Jackson County	81.8
Josephine County	83.9

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Substance Use

Appendix Table 91. Heroin Overdose Hospitalization Rate per 100,000 Population, by State and County, 2010-2014

	Rate
Oregon	1.5
Jackson County	1.8
Josephine County	--

DATA SOURCE: Oregon Health Authority, Center for Health Statistics, Public Health Division, Oregon Hospital Discharge Data as cited by Opioid Data Dashboard, 2010-2014
NOTE: Rate not calculated for Josephine County due to small numbers

Appendix Table 92. Rate of Discharges for Hospital Stays Related to Substance Use per 100,000 Population), by State and County, 2014

	Alcohol	Cannabis	Drug-induced mental disorders	Hallucin-ogens	Opioids	Stimulants	Other
Oregon	577.6	198.4	73.8	7.7	280.7	204.7	63.7
Jackson County	694.3	250.1	87.9	18.9	406.4	236.9	78.2
Josephine County	756.6	256.1	86.9	17.6	225.6	256.1	79.9

DATA SOURCE: Agency for Health care Research and Quality, HCUPnet, 2014
NOTE: Other includes sedatives, hypnotics, anxiolytics, tranquilizers, barbiturates; note: all stay-type and substance-type rates are crude rates per 100,000 population

Communicable diseases and related risk factors

Hepatitis

Appendix Table 93. Crude Chronic Hepatitis C Rate per 100,000 Population, by State and County, 2014-2017

	2014	2015	2016	2017
Oregon	140.3	147.3	143.6	146.5
Jackson County	145.0	200.2	175.5	180.1
Josephine County	208.1	197.1	215.4	238.6

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016; Orpheus, 2017
NOTE: Rates represent newly diagnosed cases per year; 2017 rates are preliminary and were calculated using 2016 population estimates via OPHAT

Appendix Table 94. Crude Viral Hepatitis (Hepatitis A) Rate per 100,000 Population, by State and County, 2014-2016

	2014	2015	2016
Oregon	0.4	0.6	0.4
Jackson County	0.0	0.0	0.0
Josephine County	0.0	0.0	0.0

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016

HIV

Appendix Table 95. HIV Infection Rate per 100,000 Population, by State and County, 2014-2016

	2014	2015	2016
Oregon	6.1	5.6	5.5
Jackson County	8.1	6.1	6.0
Josephine County	NA	NA	NA

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016
NOTE: NA denotes rate not calculated due to small counts

Sexually transmitted infections

Appendix Table 96. Crude Early Syphilis (Primary, Secondary & Early Latent) Incidence Rate per 100,000 Population, by State and County, 2014-2017

	2014	2015	2016	2017
Oregon	10.7	14.3	14.5	14.1

Jackson County	4.3	6.6	8.4	13.8
Josephine County	8.4	N/A	N/A	12.7

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016

Appendix Table 97. Crude Gonorrhea Incidence Rate per 100,000 Population, by State and County, 2014-2017

	2014	2015	2016	2017
Oregon	57.8	80.6	106.3	122.7
Jackson County	68.5	44.9	81.7	100.2
Josephine County	88.5	93.2	97.8	98.9

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016; Orpheus, 2017

Appendix Table 98. Crude Chlamydia Incidence Rate per 100,000 Population, by State and County, 2014-2017

	2014	2015	2016	2017
Oregon	386.7	406.3	425.5	455.2
Jackson County	304.5	325.9	348.7	432.3
Josephine County	264.3	299.7	366.7	385.3

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016; Orpheus, 2017

Influenza/pneumonia

Appendix Table 99. Age-Adjusted Percent Adults Reported Had Flu Shot in Past Year, by State and County, 2012-2015

	Percent
Oregon	37.7%
Jackson County	29.7%
Josephine County	27.7%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 100. Age-Adjusted Percent Adults (65+ Years) Reported Had Flu Shot in Past Year, by State and County, 2012-2015

	Percent
Oregon	57.1%
Jackson County	47.9%
Josephine County	48.0%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Vaccinations

Appendix Table 101. Percent Children Aged Two Years Up-To-Date on Vaccines (4:3:1:3:3:1:4), by State and County, 2015-2017

	2015	2016	2017
Oregon	64%	66%	68%
Jackson County	60%	62%	63%
Josephine County	63%	60%	64%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2015-2017

Appendix Table 102. Percent Adolescents Aged 13 to 17 Years with Meningococcal Vaccination, by State and County, 2015-2017

	2015	2016	2017
Oregon	70.3%	74.0%	75.2%
Jackson County	52.7%	55.8%	59.6%
Josephine County	52.8%	55.8%	58.3%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2015-2017

Appendix Table 103. Percent Adolescents Aged 13 to 17 Years with HPV (1+) Vaccination, by State and County, 2015-2017

	2015	2016	2017
Oregon	55.9%	60.9%	64.7%
Jackson County	42.6%	47.1%	51.4%
Josephine County	36.4%	39.0%	42.6%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2015-2017

Appendix Table 104. Percent Adolescents Aged 13 to 17 Years with Up-To-Date HPV Vaccination, by State and County, 2017

	Percent
Oregon	44.3%
Jackson County	31.9%
Josephine County	27.5%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2017

Appendix Table 105. Percent Children in Kindergarten with Non-Medical Exemption for Any Vaccine, by State and County, 2016-2018

	2016	2017	2018
Oregon	6.2%	6.5%	7.5%
Jackson County	8.0%	8.9%	10.9%
Josephine County	11.8%	11.2%	13.5%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2016-2018

Appendix Table 106. Percent Youth (K-12) with Non-Medical Exemption for Any Vaccine, by State and County, 2016-2018

	2016	2017	2018
Oregon	4.1%	4.7%	5.2%
Jackson County	6.5%	7.1%	8.2%
Josephine County	8.2%	9.4%	10.1%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2016-2018

Maternal and child health

Appendix Table 107. Percent Low Birth Weight Births, by State and County, 2014-2016

	2014	2015	2016
Oregon	6.3%	6.4%	6.5%

Jackson County	6.9%	6.5%	6.6%
Josephine County	6.7%	8.1%	6.0%

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2014-2016
NOTE: Low birth weight is defined as under 2,500 grams

Appendix Table 108. Percent Preterm Births, by State and County, 2014-2016

	2014	2015	2016
Oregon	7.7%	7.6%	7.9%
Jackson County	8.2%	8.1%	8.5%
Josephine County	10.0%	9.1%	8.1%

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2014-2016
NOTE: Preterm is defined as gestation less than 37 weeks

Appendix Table 109. Percent Births with Prenatal Care in First Trimester, by State and County, 2014-2016

	2014	2015	2016
Oregon	77.5%	79.0%	79.7%
Jackson County	78.0%	80.4%	78.2%
Josephine County	77.5%	80.4%	76.7%

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2014-2016
NOTE: Prenatal care began in first trimester

Appendix Table 110. Percent Births with No Prenatal Care, by State and County, 2014-2016

	2014	2015	2016
Oregon	0.7%	0.7%	0.8%
Jackson County	0.8%	0.9%	0.8%
Josephine County	0.8%	0.9%	1.8%

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2014-2016

Appendix Table 111. Teen Birth Rate (Mothers Aged 15-17), by State and County per 1,000 Females, 2014-2016

	2014	2015	2016
Oregon	8.5	8.0	6.6
Jackson County	9.7	9.2	8.1
Josephine County	10.2	11.7	7.0

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2014-2016

Appendix Table 112. Teen birth rates (White, Non-Hispanic Mothers Aged 15-17) per 1,000 Females, by State and County, 2008-2010, 2011-2013, and 2014-2016

	2010	2013	2016
Oregon	9.7	7.2	5.2
Jackson County	10.8	11.2	7.5

		13.1	11.1	9.1
Josephine County				

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2008-2010, 2011-2013, and 2014-2016

Appendix Table 113. Teen birth rates (Hispanic Mothers Aged 15-17), by State and County per 1,000 Females, 2008-2010, 2011-2013, and 2014-2016

	2010	2013	2016
Oregon	42.9	25.7	16.2
Jackson County	39.5	21.4	16.5
Josephine County	17.0	12.6	14.2

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2008-2010, 2011-2013, and 2014-2016

Appendix Table 114. Percent Mothers Currently Breastfeeding or Feeding Pumped Milk to Infant, by State and County, 2013-2015

	2013	2014	2015
Oregon	70.8%	73.2%	74.7%
Jackson County	76.2%	65.3%	74.6%
Josephine County	--	--	--

DATA SOURCE: Oregon Health Authority, Oregon Pregnancy Risk Assessment Monitoring System, 2013-2015
NOTE: Data not available for Josephine County due to small numbers

Appendix Table 115. Infant Mortality Rate per 1,000 Live Births, by State and County, 2014-2016

	2014	2015	2016
Oregon	5.1	5.1	4.6
Jackson County	5.2	4.6	5.2
Josephine County	5.8	8.1	5.7

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Linked Birth & Death Certificates, 2014-2016
NOTE: Includes neonatal and post-neonatal mortality

Oral health

Appendix Table 116. Age-Adjusted Percent Adults Reported Dental Visit in Past Year, by State and County, 2012-2015

	Percent
Oregon	66.8%
Jackson County	62.8%
Josephine County	62.3%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 117. Percent 11th Grade Students Reported a Dental Visit in Past Year, by State and County, 2013, 2015, and 2017

	2013	2015	2017
Oregon	74.5%	74.9%	73.8%
Jackson County	72.9%	72.2%	73.4%

Josephine County	69.6%	N/A	68.5%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017

NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015; Data includes students who went to a dentist or dental hygienist for a check-up, exam, teeth cleaning, or other dental work in past 12 months

Appendix Table 118. Age-Adjusted Percent Adults Reported One or More Permanent Teeth Removed Due to Tooth Decay or Gum Disease, by State and County, 2012-2015

	Percent
Oregon	37.8%
Jackson County	40.8%
Josephine County	52.5%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 119. Age-Adjusted Percent Adults Reported All Permanent Teeth Removed Due to Tooth Decay or Gum Disease, by State and County, 2012-2015

	Percent
Oregon	5.6%
Jackson County	4.6%
Josephine County	5.6%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 120. Percent Population Served with Water Fluoridation, by State and County, 2018

	Number of Systems	Percent of Population Served
Oregon	43	20.7%
Jackson County	0	0%
Josephine County	0	0%

DATA SOURCE: Oregon Health Authority, SDWIS, Oregon Public Health Drinking Water Online, https://yourwater.oregon.gov/fluoride.php?sort=cs, 2018

Safety and injuries

Appendix Table 121. Violent and Property Crime Rate per 100,000 Population, by State and County, 2016

	Person Crime	Property Crime
Oregon	1,055	4,748
Jackson County	1,625	7,050
Josephine County	1,215	5,094

DATA SOURCE: State of Oregon, Criminal Justice Commission, Oregon Uniform Crime Report, 2016

NOTES: Person crimes include criminal offenses where a victim is present and the act is violent, threatening, or potentially physically harmful, such as homicide, rape, sex crimes, kidnapping, and assault; Property crimes include arson, bribery, burglary, counterfeiting/forgery, embezzlement, extortion/blackmail, larceny, motor vehicle theft, robbery, stolen property, and vandalism; Classification of crimes by Oregon UCR differ from those by the National UCR

Appendix Table 122. Percent 11th Grade Students Reported Missing School Because They Felt Unsafe at School or on Their Way to/From School, by State and County, 2012, 2014, and 2016

	2014	2015	2016
Oregon	4.1%	5.7%	7.7%
Jackson County	5.1%	3.9%	6.8%
Josephine County	6.4%	6.9%	9.1%

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016

Appendix Table 123. Percent 11th Grade Students Reported Being Bullied at School (or on the Way To/From School) For Any Reason, by State and County, 2015 and 2017

	2015	2017
Oregon	19.9%	20.6%
Jackson County	19.0%	20.0%
Josephine County	NA	25.5%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2015 and 2017
NOTES: Question was asked differently in 2013; No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Appendix Table 124. Percent 11th Grade Students Reported Being in a Physical Fight on School Property in Past Year, by State and County, 2012, 2014, and 2016

	2014	2015	2016
Oregon	6.6%	5.9%	5.8%
Jackson County	9.7%	5.3%	7.1%
Josephine County	7.1%	5.3%	4.4%

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016

Forces of Change Assessment

Summary of Key Forces of Change *(listed in no particular order within each grouping)*	# Groups
Housing	4 out of 4 groups
Workforce	4 out of 4 groups
Income, Poverty, and Unemployment	4 out of 4 groups
Population Changes and Diversity	4 out of 4 groups
Legalization of Marijuana	4 out of 4 groups
Coordinated Care Organizations (CCO)	4 out of 4 groups
Technology	3 out of 4 groups
Opioid Use/Addiction	3 out of 4 groups
Mental Health System	3 out of 4 groups
Legislative/Political Climate and Processes	3 out of 4 groups
Oral Health	3 out of 4 groups
Mental Health Issues	2 out of 4 groups
Climate Change	2 out of 4 groups
Strong Regional Identity/Pride	2 out of 4 groups
Community Collaboration Efforts	2 out of 4 groups
Food Insecurity	2 out of 4 groups
Health Care Coverage Rates	2 out of 4 groups
Emergency Management System (EMS)	2 out of 4 groups
Communication Systems	2 out of 4 groups
Transportation System, Mobility	2 out of 4 groups
Child Care Costs & Access	2 out of 4 groups

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	**2**	**3**	**4**		
1. Housing	x	x	x	x	**Cost** • Availability in different price ranges - people being pushed into housing they cannot afford • High concentrations of wealth driving up housing costs • High cost • Seniors - cost burden in housing market **Quality** • People stuck in substandard housing • Habitability – in a highly competitive housing stock there is a high risk of units not being maintained **Impact on Workforce** • Workforce impact - Not being able to recruit professionals into the area • Lack of housing for service economy workforce **Homelessness** • Chronic and growing homelessness • Only dealing with homelessness through punitive measures **Stock** • Lack of housing - Need more stock **Combination of Threats** • Supply of affordable, accessible housing in the right locations **Other** • Instability in housing market due to rent increases and no cause evictions • Mobility - seniors who want to get out of a larger house into a smaller house. • Veterans impacted • Businesses impacted	**Impact on Workforce** • Trades are becoming proactive in training/expanding the workforce • Opportunity to bring businesses into working for the solutions to housing **Stock** • Increasing stock • If we are increasing stock - have opportunities to look at where we put that stock - accessibility, location, housing type **Combination of Opportunities** • Hope Village Model – people are responding well, and Medford Council just doubled units • Opportunity to extend our planning horizons for all community services. Housing stock will take many years to replenish - what else do we need to address today? **Legislative** • New community leadership looking for more comprehensive solutions to housing and homelessness • Potential legislative measures (next year) • Potential state legislative options **Other** • Need emphasis on accessible lifelong housing General recognition by all sections of housing as an issue • Medford urban growth boundary • Regionwide planning effort to address housing issues in all communities - looking at regional strategies • Relatively low density • Relative low density in local urban cores – could densify and then increase transit services

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
2. Workforce	x	x	x	x	**Housing** • Lack of housing for staff and professionals **Availability** • Lack of staff available at all professional levels • Lack of/reduced numbers of psychiatrists **Funding** • Decreased funding for case managers, navigators, community health workers, home visiting nurses • Reimbursement for case managers, navigators, community health workers, home visiting nurses **Other** • Age of providers - New providers want more of a work/life balance, potentially increasing cost of care • Workforce diversity and income diversity • Brain drain - training people up and out of the community, promotability - need to leave to get promoted	• Opportunity to grow electronic services in healthcare and consumer credit counseling - job creation • Support "without borders" • Long term handholding from case managers, navigators, community health workers, home visiting nurses

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
3. Income, Poverty, and Unemployment	x	x	x	x	**Income/Wages** • Cost living relative to income • Stagnant wage and deregulation of worker safety • Increased minimum wage – risks of expenses to businesses **Poverty** • Intergenerational poverty and associated criminality and need for addiction providers • Masked issue of poverty based on how we measure it **Other** • Low unemployment rate (less jobs, less opportunities) • Increased debt load, especially for young people (student loans) – can't afford housing, children, cars • Lack of economic diversity and vitality - Not a lot of big employers that create economic stability • Workforce diversity and income diversity	• Federal money for addiction providers • Increased minimum wage providing increased wages and benefits • Low unemployment rate means more people are employed

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		

4. **Population Changes and Diversity**	x	x	x	x	**Specific Populations**
					• Increase in LGBTQ populations
					   – Lack of educational support
					   – Increased needs for mental health support
					• POC folks feeling unwelcome, experiencing hostility
					• Bullying up in schools around race/ethnicity
					• Gentrification of communities - pushes diverse populations into specific, poorer neighborhoods
					• Aging population in our region - Trend (65+ is the fastest growing demographic group)
					   – Coming crisis in caregivers – we don't have the workforce, we don't have the wages we need to sustain this workforce
					   – Impact of aging populations on schools, development of health care areas, etc.
					   – Memory care needs are different
					• Uniqueness of millennials
					   – Disease risks
					   – Possible changes in utilization
					   – Change from untraditional PCP model
					Resources
					• Population growth - competition with bigger communities for funding, lack of adequate resources
					Other
					• Increasing diversity of the community – not recognized, lack of support
					• People are leaving our community or staying home and not accessing services, children are being held home from school
					• Local and national climate of fear
					• IP 22
						• Increased diversity of the community
						• Aging population in our region - Trend (65+ is the fastest growing demographic group)
						   – Build on community health worker model to elevate caregivers at the state level
						   – Plan how to engage people later
						• Generational change is looking like it may help with racial equity issues
						• Need to focus more resources on identifying solutions for racial equity issues that have remained largely unacknowledged and unaddressed by the wider community
						• Increased focus on equity - reach more populations (disparity)
						• Diversity conference/attract people to the field
						• Uniqueness of millennials: education

Forces (Trends, Events, Factors)	Group 1	2	3	4	Threats Posed	Opportunities Created
5. Legalization of Marijuana • Pull back on THC • More people are growing hemp now	x	x	x	x	**Money** • Economics not seen (where's $?) • Making money usable (via banks) • Lack of dollars coming back into the system **Land/Water** • Driving land prices up • Impacting food production (taking away agricultural land) • Changing the value of agricultural land • Impacts on water - environmental **Workforce** • Employment • High risk for employees **Other** • Lack of research, understanding (don't know) • Long term impact on health not known (unintended consequences for younger population who will have access that other generations have not) • Increased access for teens • Area reputation • Community security in rural areas • Pull of creation of parallel businesses can pull contractors from building housing • Disruptive	**Workforce** • Employment (jobs) • New jobs paying more than min wage • Creation of entrepreneurs **Economy** • Number of parallel business that have started (labs, garden centers, lighting, security) • Boost the economy • Tax revenue **Investments in Health** • More money for SDOH, healthcare, education • Opportunity for industry to become a good citizen and fund vital needs like SBHC **Other** • Area reputation • Limiting entry into criminal justice system • Expanded research opportunities • Some health impacts of medicinal

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
6. Coordinated Care Organizations (CCO) • The delivery system • Evolution and transition of CCO's	x	x	x	x	• Instability among private market insurance providers under the ACA • Decreased funding - will impact investment in other long-term issues, eg., SDOH • 2019 • Multiple CCOs • Competitive? • Instability with ACA providers in private market • CCO 2.0 • Funding to support goals • Changes in system of care • Unknowns make it hard to plan • Different issues for those who are insured, those who are on state insurance, and those who have no coverage. • State investments specific to Medicaid population - no one is talking about Medicare • Access issues for privately covered people • Parity issues • Lack of global budget for CCO's (things are still siloed) • Medicare population • Oregon tax system and revenue generation - all of these things we need to fund, you've got to have revenue **Increase push for coordination of care and communication** • Is it working for patients/consumers? • Are we using efficiently? Increased burden on small agency staff for paperwork and admin	• Opportunities to use CCO's in Oregon in response to threat "a" • 2019 • Innovative efforts • Create global budgets • Opportunity to use CCOs as providers under ACA to preserve coverage • Created political opportunity to have shared conversations and mobilize around how we use Medicaid dollars • CCO 2.0 • More focus on SDOH **Increase push for coordination of care and communication** • VA system successful model that is working • We have a community that knows each other • People care about this community and want to make it stronger • We have many of the core orgs that are necessary

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
7. Technology	x		x	x	**Telemedicine** • Telehealth issues • No funding for tele-med systems • Fear of the quality of services • Jobs may not stay here (tele-med can come from somewhere else in the country) • Privacy issue around tele-med, increase risk in large amounts of data being leaked (intentional or not) • Telemedicine can be outsourced **Broadband** • Low access to broadband • No existing rural platform • No money for system • Incongruity of care with people who don't have access • Rely on tech for communications, but rural areas don't have access • Access to apps and tools • Digital inequity **Other** • Whether the increase EMR was creating a burden on small agencies, and whether we are using it efficiently • Overuse of technology in things like parenting • K-12 no self-regulation because of abundant use of screens of kids entering the system	**Telemedicine** • Tele-med may make people living here more able to serve people in other areas. • Potential for work/life balance through tele-med • Increasing Health literacy - increasing • Self-care: helping people manage their disease. • Opportunity for telehealth with hard-to-recruit specialty care. Addressing needs in rural communities. **Broadband** • Leverage federal and state resources for broadband in rural areas to give services to people in poverty and leverage resources like tele-med **Other** • How to reach millennials • Explosion of apps & tools that could change health care delivery dramatically. • The tech in health care makes it easier to measure outcomes, quality (beyond tele-med) • Better integration of healthcare • Already have a great HIE here • Assessing of threats in education due to lack of self-regulation of kids entering the system

8. **Opioid Use**	x	x		x	**Health** • Increase of HepC, HIV associated with injection drug use, • Increase in STI's • Spike in deaths **Other Drugs** • As people reduce opioids, the may change to using other drugs (fentanyl, heroin) • Synthetic drugs on the market – dangerous products flooding market and people don't always know what's in the drug due to cutting **Impact on Families** • Drug affected infants • Social impact - isolation, degradation, family instability • Children who don't have hope - continues the cycle • Intergenerational drug use/ opioid use and addiction **Impact on Social Systems** • Impact on law enforcement, social services. • Secondary trauma for all service agencies • Burden on the foster system and capacity to address the needs of children and house them **Addiction System Changes** • Capacity • There is still stigma around addiction • Access to services • Oregon Administrative Rules (OAR) and training requirements are different **Other** • A lot of dangerous opioid products flooding our community because of I-5 (highway) • Transitioning veterans off of opioid pills to lifestyle very difficult and disruptive for veterans • Cannibalizes our workforce - younger people who would be otherwise contributing are lost.	**Treatment** • Opportunities to expand alternatives to opioids – need more reliable and effective alternatives • Alignment around MAT development • Expand alternatives and alternative treatments **Addiction System Changes** • Develop capacity that is needed • ARC has grown • Access - make it easier • Stigma • CCO/OHA RFI to develop residential care • Better quality of care **Funding** • Looking at federal and state grant opportunities around high intensity drug trafficking areas (HIDTAs) **Approaches/Recommendations** • Increased peer support • Exploring innovative models from other areas • Safe use injection sites • Max's Mission/Naloxone • Oregon Pain Guidance (OPG) • Support groups for families who are affected • Continuation and expansion of the Stay Safe Oregon campaign • Use the public attention to rebuild the addiction system • ROC Court - drug court • Prescription Drug Monitoring Program • To be able to educate people about taking, becoming more educated and questioning in regards to their own health care. Pharmacy led and doctor led. Questioning how much medication they need - more personal responsibility. • Challenge direct consumer marketing for medication • Transitioning veterans off of opioid pills to lifestyle
9. **Mental Health System**	x	x		x	**Youth**	**Youth**

• Change and Evolution					• Increase in need for MH services among young people (anxiety, depression, suicide - high schoolers, LGBTQ, people of color) • Trend emerging around decreasing/declining mental health among young people • We need the schools, but they are so strapped! **Navigation** • Confused clients - not knowing where to go, how to get help. **Providers** • Lack of providers to provide services to diverse communities **Stigma** • Stigma with specific population groups, stigma across all population groups **Other** • A lot of people are seeking mental health care in EDs. Number isn't changing based on data, but perception is that more people are seeking care in EDs	• Identifying kids who might be more likely to be headed for trouble - multiple ACES, or actual behaviors. • SORS leadership to help with CHA for schools in key priorities **Schools** • Use the schools, but how? • Need to seize opportunity between the school leadership and CHA process to put a bit more "how" to the plan. • Help schools do more – parenting **Stigma** • Perception that some people are not feeling as much stigma as much as struggling with access (general population). **Legislative** • Bipartisan support for investing in behavioral health • Have state and feds investing in the Medicaid arena, or indigent arena • State investments specific to Medicaid population - Need legislation for Oregon waivers for Medicare and expanding the workforce that serves that population **Other** • Looking at new and different ways to approach mental health needs (CHW, more flexibility in mental health system) • Potential for increased resources and access • Think about preventive and activities that promote positive mental health, vs. just treatment of disease. • Asking and receiving and utilizing care • Expand the health care integration across the safety net structure in the private HC structure • Defining what integrated behavioral health is - including focus on case management • We have more suicide prevention programs

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		

10. Legislative/Political Climate and Processes	x	x		x	**Process**
					• Local and state legislative/government processes lack transparency/communication
					Funding
					• Opposition to taxes, local bonds and levies
					• Need outcome-based budgeting
					• $800 million gap for 2019 Oregon Legislative Session
					   – Could collapse coverage levels
					   – Community funding could go away - CCOs transformation funds, medical system stability overall
					   – Jobs (less for FQHCs than other clinics)
					Other
					• Lacks community
					• National Election – from liberal to conservative poses risk to health care and changes to the labor system
					• Nationwide legislative anxiety
					• Government (all levels) viewed as inefficient and ineffective
					Specific Legislation
					• IP 1 – outlaw public (not federal) funding for abortion
					• IP22 – repeal sanctuary state law
					• IP37 – Ban on taxing groceries – attempt to pre-empt sugary drinks taxes
					• Measure 101 passing - political will for healthcare overage/equity of coverage
						Process
						• Need to do analysis of how process communicated, how (if) effective
						Funding
						• Opportunity for bipartisan support to aggressively fund mental health
						Other
						• More people getting engaged in local politics – attending meetings, running for office
						Specific Legislation
						• Measure 101 – Passed with a 2/3 majority - Oregonians have spoken about how important healthcare access and transformation is
						• Measure 98 - Increased schools funding could increase grades

11. Oral Health		x	x	x		

Forces (Trends, Events, Factors)	Group 1	2	3	4	Threats Posed	Opportunities Created
12. Mental Health Issues	x			x	• Social isolation – loneliness, suicide, risk of mental health • Increase in suicides **Youth** • Long-term education impact and impact on school staff of children with behavioral issues • Trauma informed care practices (ACES) - Doesn't help align with traditional practices. 3 kids murdered parents this year - drain to all systems • Widespread and growing sense of lack of hope - even in very young children • Increases in disruptive behavior in young children • Kids coming into Kindergarten not ready to learn – barriers to early learning and high cost of childcare • FORCE: early learning gaps • High rates of anxiety/depression and suicide among middle/high schoolers	• Social isolation Ability to approach community from a view of community not individuals • Trauma informed care practices (ACES) - Increased awareness of TIC, needs, issues • Increase mental health • Strengthen safety nets including social determinants of health
13. Climate Change	x			x	• Water resource management issues • Air quality issues • Impacts on most vulnerable i.e. farmworkers and homeless • Fire and smoke season and its impact on health, tourism/livelihoods, and risks to homes	• People are mobilizing/responding
14. Strong Regional Identity - State of Jefferson, Regional pride	x			x	• Distrust/skepticism of Salem/Portland/National sources, leaders, recommendations • Skepticism of evidence-based health approaches – and increase in alternative medicine • Sense that decisions are made elsewhere that impact people here and that we have little/no agency over those decisions	• Community resilience • High level of collaboration • Can do a lot with a little sometimes

Forces (Trends, Events, Factors)	Group 1	2	3	4	Threats Posed	Opportunities Created
15. Community Collaboration Efforts	x		x		• Does funding support collaboration?	• SORS, SOELS, suicide issues • CHA/CHIP • Move beyond competition
16. Food Insecurity	x			x	• Farm bill cutting SNAP benefits and access to farmers markets • Prices for agricultural land is very high • Impacts from newly legal cannabis industry on agriculture as a whole – large factor in driving prices up • Long-term impacts to health and well-being	• Increasing consciousness about food quality • Local orgs working to help people access safe, healthy, nutritious • Local movement for local food - RV Food systems Network
17. Health Care Coverage Rates	x			x	• M101 • ACA repeal effort • IP 1 - • High deductibles, makes unaffordable	• counter movement to expand coverage • RHEA • Single payer movement • 95% covered
18. Emergency Management System (EMS)	x	x				• Effective in events
19. Communication Systems	x	x			• Lack of info • Ongoing changes • Community perception without knowledge • 211	• Increases access to resources • 211
20. Transportation System, Mobility	x			x	• Threats to funding for public transit • Local bond sunsetting in 2021 • Need more infrastructure and systems • Recent survey indicated that transportation is the #1 barrier for women and #2 barrier for men for access to addiction services	• Push for walkable/active lifestyle • Planned neighborhoods and city planning – opportunity in S.O. • More accessible housing – saves money over time on repairs and retrofits and increases livability • After hours support (CCOs, hospitals, United Way) • State legislation without increase funding • Better opportunities for those in poverty
21. Child Care Costs & Access	x			x	• Increased costs • Lack of access, safety, quality • #2 barrier for women	• Improvements with early learning work

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
22. **Focus on wellness in the health system**	x				• Decreasing hospital sizes • Need for more PCPs	• Healthier community
23. **Social mobility of families**	x				• Educational attainment	• More opportunities to track families, kids, education, etc.
24. **Work requirements for SNAP recipients**	x					
25. **Justice systems**	x				• Jail space • Funding for one program vs. others	• Other opportunities vs. jail
26. **Vaccination rates**	x				• Increased outbreaks • Increased disease rate	
27. **Lack of metrics and data for quality improvement**	x				• Inability to agree on approach to improve community-based issues • Need more metrics/data • Qualitative approaches	• Long term improvements to systems
28. **Resources / Access**	x				• With 3 new urgent cares for Asante, they are seeing 67,000 visits a year. ED visits have stayed the same • Understanding of how to access • Push back to access • Stigma • Constant barriers to accessing services = overwhelming process to continue to move forward	• Resources exist
29. **Funding sources - how we address problems**			x		• Who is going to pay for what we decide? Behavioral Health… • Feels like a nearly impossible problem	

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
30. **Strong head start programs**	x					• Supports families • Serve meals
31. Grants Pass rural designation change			x			
32. Medford's urban growth boundary expansion			x			• How do we seize this opportunity to really address the population projections? •
33. **FQHC evolution and medical homes**		x			• Pharmacy costs!! Dollars are key • Mental Health drugs more locally done? • We look at data differently • People don't understand the system and the positive changes we've had	• Keep track of data to show that preventive care works • Educate public about ways to be a frugal healthcare consumer/good patient/civic engagement • Shift where to spend healthcare dollars
34. Safety Net Clinics	x				• Competitive? • Federal health $	• Helped support overall health system transformation
35. **Accountable Health Communities program**	x				• Length of time to collect info	• Screening OHP members on SDOH • Tracks outcomes/needs
36. Downsizing of Josephine County Public Health		x				

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
37. **Social Determinants of Health (SDOH)**		x				• Involving commercial HC plans in community health and SDoH • Can we encourage the workforce we need (like through STEM) • LPC vs LCSW - addiction co-training • Parity for LPCs
38. **Chronic Disease Epidemic - especially in aging population and low economic status.**			x		• Expensive to treat comorbidities • Getting it on both sides with the aging population and then the low SES	
39. **Restructuring of how we receive payments for services; how organizational structure went from OHP to CCOs**					• Federal changes, uncertainty in how ACA is funded	

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
40. Local Health System Trends				x	• Chaos in our addictions and mental health systems and barriers to access • Increase of STIs	• Build on successes of Blue Zone Projects – such as working with employers • Increased emphasis on social determinants of health and upstream work – threat is sustainable funding for CCOs and the future of OHP • New community wide emphasis on ACES (adverse childhood experiences) • Successful models • Telemedicine • Electronic medical records • Recent expansion in our region of medical interpreters in S.O. for deaf and Spanish speaking • We're doing more work getting the people actually impacted by policies into the process – increase this
41. Response to instability				x	• People feel increasingly pitted against each other	• Opportunities to emphasize the common interests – public health • Have a combined health assessment • Next step would be to take action based on collectively identified gaps

Performance Score Legend

LPHSA Performance Scores				
0% or absolutely no activity.	Greater than zero but no more than 25% of the activity described within the question is met.	Greater than 25% but no more than 50% of the activity described within the question is met.	Greater than 50% but no more than 75% of the activity described within the question is met.	Greater than 75% of the activity described within the question is met.
No Activity (0%)	**Minimal Activity (1–25%)**	**Moderate Activity (26–50%)**	**Significant Activity (51–75%)**	**Optimal Activity (76–100%)**

Average Performance Scores for Essential Services

Essential Services	Average LPHSA Performance Scores	Average Health Equity Performance Scores
Essential Service 1: Monitor Health Status to Identify Community Health Problems	37.5	25.0
Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards	80.8	16.7
Essential Service 3: Inform, Educate, and Empower People about Health Issues	55.6	43.8
Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems	53.6	25.0
Essential Service 5: Develop Policies and Plans That Support Individual and Community Health Efforts	45.8	50.0
Essential Service 6: Enforce Laws and Regulations That Protect Health and Ensure Safety	64.6	50.0
Essential Service 7: Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable	56.3	58.3
Essential Service 8: Assure a Competent Public Health and Personal Healthcare Workforce	58.3	30.0
Essential Service 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	65.4	50.0
Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems	40.9	37.5

Model Standards Average Performance Scores & Discussion Notes

Model Standards by Essential Services *At what level does the LPHS…*				Average LPHSA Performance Scores
Essential Service 1: Monitor Health Status to Identify Community Health Problems				**37.5**
Model Standard 1.1: Population-Based Community Health Assessment				**25.0**
1.1.1 Conduct regular CHAs?				50
1.1.2 Update the CHA with current information continuously?				0
1.1.3 Promote the use of the CHA among community members and partners?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• CHA's are done often by varying organizations/ communities	• While CHA's are done, they are not consistent, they are segmented, they are not all inclusive of entire system partners • Information becomes outdated quickly, measurable goals not followed up on. Information not updated with current information	• New partnership with current CHA in progress with plan for sustainability	• See ratings above.	
Model Standard 1.2: Current Technology to Manage and Communicate Population Health Data				**33.3**
1.2.1 Use the best available technology and methods to display data on the public's health?				50
1.2.2 Analyze health data, including geographic information, to see where health problems exist?				25
1.2.3 Use computer software to create charts, graphs, and maps to display complex public health data (trends over time, sub-population analyses, etc.)?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Our community has placed high value on the importance of data and outcomes for system improvement in recent years. • CCOs providing data.	• Systems remain disjointed and access to all systems is limited. No community dashboard or agreed upon metrics. • Difficult to get data at the specific community level which makes change difficult	• A database of all databases, who has access, with data dictionary.	• Investment into the PHS so organizations have the resources needed to both contribute and use data	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Model Standard 1.3: Maintaining Population Health Registries	**62.5**
1.3.1 Collect timely data consistent with current standards on specific health concerns in order to provide the data to population health registries?	75
1.3.2 Use information from population health registries in CHAs or other analyses?	50

Strengths	Weaknesses	Short-Term Improvement Opportunities	Long-Term Improvement Opportunities	
• Registries are established and integrated. They function well, and they are accessible. • Efforts to place more emphasis on chronic conditions in addition to the traditional acute issues.	• It's very funding-focused. • Not everyone knows which registries exists • Treating public health data as if it's proprietary (what are the barriers to releasing data?)	• Community, including CCOs, can come to agreement on health outcomes to prioritize as well as the sharing of data.	•	

Model Standards by Essential Services *At what level does the LPHS…*				Average LPHSA Performance Scores
Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards				**80.8**
Model Standard 2.1: Identifying and Monitoring Health Threats				**75.0**
2.1.1 Participate in a comprehensive surveillance system with national, state, and local partners to identify, monitor, and share information and understand emerging health problems and threats?				75
2.1.2 Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies, and emerging threats (natural and manmade)?				75
2.1.3 Ensure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?				75
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Strong surveillance system in place for acute and communicable disease. We do a good job in emergency preparedness and using the information for response.	• Tracking and responding to chronic, persistent disease with emphasis on mental health and addition. • Surveillance systems for dental issues. • Emerging issues related to legal state changes such as marijuana use and abuse. What is the impact of legalization? • Waiting on labs for results to report suspected diagnoses and other variations in timely reporting expectations		• Ongoing education on what should be reported to providers and individual staff members due to variation in understanding of reporting practices. • Better systems to report secondary and tertiary diagnoses.	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Model Standard 2.2: Investigating and Responding to Public Health Threats and Emergencies	**83.3**
2.2.1 Maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?	100
2.2.2 Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?	75
2.2.3 Designate a jurisdictional Emergency Response Coordinator?	100
2.2.4 Prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?	75
2.2.5 Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or and nuclear public health emergencies?	75
2.2.6 Evaluate incidents for effectiveness and opportunities for improvement (such as After Action Reports, Improvement Plans, etc.)?	75

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• We have a lot structure in policy and written procedure. • Depending on the emergency, and once the community is aware, the response is rapid and robust	• Need expanded use of exercises and drills. • Not all Emergency Response Coordinators are dedicated full-time to that role.		• Education and training on detection of various threats and how and when to notify associated response team	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Model Standard 2.3: Laboratory Support for Investigating Health Threats	**81.3**
2.3.1 Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?	75
2.3.2 Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?	75
2.3.3 Use only licensed or credentialed laboratories?	100
2.3.4 Maintain a written list of rules related to laboratories, for handling samples (including collecting, labeling, storing, transporting, and delivering), determining who is in charge of the samples at what point, and reporting the results?	75

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Strong laboratory network and access, very good at responding to emerging diseases as well. Most are open 24/7	• State lab consistency and enforcement around training by lab of specimen handling, collection, transportation. • Provider reporting suspect cases while in transport to lab. • Rules are constantly changing.			

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Essential Service 3: Inform, Educate, and Empower People about Health Issues	**55.6**
Model Standard 3.1: Health Education and Promotion	**58.3**
3.1.1 Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?	75
3.1.2 Coordinate health promotion and health education activities at the individual, interpersonal, community, and societal levels?	50
3.1.3 Engage the community throughout the process of setting priorities, developing plans, and implementing health education and health promotion activities?	50

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• SOS getting a lot of information out around ACEs • developing non-media social, so tabling, community. • Jenny direct care public information more so than policymakers and stakeholders; sharing information through collaborative efforts with other professional organizations. Folks are hearing • messaging reinforcement may be strong, but not cohesive beyond jurisdictions • a lot of community collaboration around	• a lot of red tape, slow getting priorities to the forefront • LPH caution about bringing forth political issues • strong collaborations that maybe struggle to partner with new groups/voices. • for consumers it is still challenging to find health promotion opportunities; hard to get messages out and get access to resources • calling 2-1-1 is weird and tough to navigate; funding is not stabilized so a challenge of bringing awareness to something that may not be updated	• systems of care groups in both counties (Options and Jackson County MH/JCC/Options/AC) both groups working on a common referral process; • coordinated referral system • Reliance was JHIE; has to be people who are in the system and there are e-referrals • Authentic engagement of those who are most deeply impacted; a lot of expecting people to come to us • When decisions are made without community and then the fall out of that. So how do we begin with community and get to a decision. • Gathering where people are; schools.	• normalizing asking for help; google ads for 211?	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Model Standard 3.2: Health Communication	**50.0**
3.2.1 Develop health communication plans for media and public relations and for sharing information among LPHS organizations?	25
3.2.2 Use relationships with different media providers (e.g., print, radio, television, the Internet) to share health information, matching the message with the target audience?	50
3.2.3 Identify and train spokespersons on public health issues?	75

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Seems like a lot of communications are coming out with multiple agency logos attached • Southern Oregon Meth Project; television station donated time for this. • Good at communicating urgent and emergent public health issues (e.g., fires, flu, etc.) • Getting better at matching messaging to the audience	• With shared messaging the question is always who is carrying the work? • Communication happening ad hoc among LPHS but not formally. • Need a more diverse group of spokespersons	• Messaging around syphilis • Ashland Chamber of Commerce working with ACH to develop a job satisfaction survey	• CHIP Report, monthly report out to partners	

Model Standards by Essential Services *At what level does the LPHS…*				Average LPHSA Performance Scores
Model Standard 3.3: Risk Communication				**58.3**
3.3.1 Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?				75
3.3.2 Make sure resources are available for a rapid emergency communication response?				75
3.3.3 Provide risk communication training for employees and volunteers?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Accreditation with Jackson County PH really ramped this area up. • Partners respect local government as point of contact for all emergency communications around emergencies. • Strong relationships with local media make communication with public easier. Local media sees themselves as an integral. • Internal plans are in place for risk communications, but only for those who are actually involved in communicating.	• Question: do we have communications for different language audiences? • Diversity of messengers • What does it look like if/when cell systems go down? Partners curious to know how public will be alerted. • We suspect that PIOs from the other organizations are talking to one another, but none of us here know.	• Communication to partners about how this process works	•	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems	**53.6**
Model Standard 4.1: Constituency Development	**50.0**
4.1.1 Maintain a complete and current directory of community organizations?	25
4.1.2 Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?	50
4.1.3 Encourage constituents to participate in activities to improve community health?	75
4.1.4 Create forums for communication of public health issues?	50

Strengths	Weaknesses	Short-Term Improvement Opportunities	Long-Term Improvement Opportunities	
• SOS has a big resource list of community organizations: health care, mental health care, education, early learning, public agencies, etc. Peter Buckley is the coordinator for that page. Need to promote it more broadly. • Last few years there has been new partners coming to the table as they consider how they are part of improving health. • Project Community Connect. • There are a lot of encouragements for getting constituents to improve community health; difference between encouragement and actual arrival. • People showing up for forums around marijuana, housing... • Good at engaging professionals	• We are consistently bringing community around issues we as professionals identify, as opposed to having the communities bring forth their issues. • Being flexible enough to meet the community where they are at (e.g., smoking cessation v stress reduction strategies). • Not so good at consistently engaging community around public health issues; when they do show up next steps are unclear, momentum lost	•	• Bringing together CHA/CHIP partners around a sustained CHIP implementation project (2-3) issues	

Model Standards by Essential Services	Average LPHSA Performance Scores
Model Standards by Essential Services *At what level does the LPHS…*	
Model Standard 4.2: Community Partnerships	**58.3**
4.2.1 Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	50
4.2.2 Establish a broad-based community health improvement committee?	75
4.2.3 Assess how well community partnerships and strategic alliances are working to improve community health?	50

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Great at gathering, struggle with actually developing a cohesive approach developed. • ACEs trainings really came out of the CCOs and education and law enforcement. • 3 CCOs are continually hitting their incentive metrics, quality improvement metrics. • Doing a better job of assessing outcomes of the partnership, not necessarily how well the community partnerships and strategic alliances are working.	• Energy for gathering together around an issue, sometimes struggle with work being too broad and it is hard to specify forward thrust from there • Struggle to develop collaborative, systems-wide metrics that will help us measure community health. • Can only assess based on partners that show up.	• Accountable Health Communities will help us get data to support 4.2.3	• Accountable Health Communities will help us get data to support 4.2.3	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Essential Service 5: Develop Policies and Plans That Support Individual and Community Health Efforts	**45.8**
Model Standard 5.1: Governmental Presence at the Local Level	**66.7**
5.1.1 Support the work of the local health department (or other governmental local public health entity) to make sure the 10 Essential Public Health Services are provided?	75
5.1.2 See that the local health department is accredited through the PHAB's voluntary, national public health department accreditation program?	50
5.1.3 Ensure that the local health department has enough resources to do its part in providing essential public health services?	75

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Jackson County Public Health is accredited. • CCOs provide a lot of support in Jo Co. • Both counties work with CCOs. • CCOs support syringe exchange in Jackson County	• CCOs don't support syringe exchange in JoCo. • JoCo had recently put out an RFP for many public health services.	• JoCo will be pursuing accreditation.	• JoCo will be pursuing accreditation.	

Model Standard 5.2: Public Health Policy Development	**25.0**
5.2.1 Contribute to public health policies by engaging in activities that inform the policy development process?	25
5.2.2 Alert policymakers and the community of the possible public health effects (both intended and unintended) from current and/or proposed policies?	25
5.2.3 Review existing policies at least every three to five years?	25

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Guidance from the Oregon Health Authority to local public health authorities. • OHA involves LPHAs when crafting new administrative rules. • Jackson County has a prevention coalition that makes recommendations for PH ordinances/policies	• Political climate can be challenging to pass local PH policies. • Some local county policy makers don't have in depth knowledge of public health.	• Finding local champions for policies.	•	

Model Standards by Essential Services *At what level does the LPHS…*				Average LPHSA Performance Scores
Model Standard 5.3: Community Health Improvement Process and Strategic Planning				**41.7**
5.3.1 Establish a CHIP, with broad-based diverse participation, that uses information from the CHA, including the perceptions of community members?				75
5.3.2 Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?				25
5.3.3 Connect organizational strategic plans with the CHIP?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Current JRHA process will greatly improve CHA/CHIP collaboration.	• Current CHIP doesn't have common metrics or way to evaluate	• Having all partners participate in the CHIP.	• Identifying common metrics • Have a broader CHIP, and broader CHIP organizational involvement/engagement	
Model Standard 5.4: Planning for Public Health Emergencies				**50.0**
5.4.1 Support a workgroup to develop and maintain emergency preparedness and response plans?				75
5.4.2 Develop an emergency preparedness and response plan that defines when it would be used, who would do what tasks, what standard operating procedures would be put in place, and what alert and evacuation protocols would be followed?				50
5.4.3 Test the plan through regular drills and revise the plan as needed, at least every two years?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Have Emergency Management workgroups in both counties. This included Public Health and hospitals. • Actual emergencies frequently test the plans, especially wildfires.	• Plans are revised every 5 years. • Not enough drills/exercises.			

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Essential Service 6: Enforce Laws and Regulations That Protect Health and Ensure Safety	**64.6**
Model Standard 6.1: Reviewing and Evaluating Laws, Regulations, and Ordinances	**62.5**
6.1.1 Identify public health issues that can be addressed through laws, regulations, or ordinances?	75
6.1.2 Stay up-to-date with current laws, regulations, and ordinances that prevent health problems or that promote or protect public health on the federal, state, and local levels?	75
6.1.3 Review existing public health laws, regulations, and ordinances at least once every three to five years?	25
6.1.4 Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?	75

Strengths	Weaknesses	Short-Term Improvement Opportunities	Long-Term Improvement Opportunities	
• Both counties have a wood burning stove/open burning ordinance. • Both counties have legal counsel.	• No formal policy to review existing laws. • Public opinion of local laws/ordinances.	• Put a mechanism in place to alert organizations to upcoming or proposed policy/law changes. • Put a mechanism in place to formally review existing laws.	• Put a mechanism in place to alert organizations to upcoming or proposed policy/law changes. • Put a mechanism in place to formally review existing laws	

Model Standard 6.2: Involvement in Improving Laws, Regulations, and Ordinances	**41.7**
6.2.1 Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?	25
6.2.2 Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote public health?	50
6.2.3 Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?	50

Strengths	Weaknesses	Short-Term Improvement Opportunities	Long-Term Improvement Opportunities	
• We have a lot of existing laws and local ordinances in place. • JoCo is good at creating proactive laws ordinances.	• Not having a clearly identified role or staff to review public health issues that are inadequately addressed.	• Having a person to address and review laws/ordinances	• Participation in changing existing laws and ordinances.	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Model Standard 6.3: Enforcing Laws, Regulations, and Ordinances	**80.0**
6.3.1 Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?	75
6.3.2 Ensure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?	75
6.3.3 Ensure that all enforcement activities related to public health codes are done within the law?	100
6.3.4 Educate individuals and organizations about relevant laws, regulations, and ordinances?	75
6.3.5 Evaluate how well local organizations comply with public health laws?	75

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• LPHS understand the organizations and roles to enforce public health laws.	• No formal evaluation for complying with laws.	• Establish formal evaluation for complying with laws.		

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Essential Service 7: Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable	**56.3**
Model Standard 7.1: Identifying Personal Health Service Needs of Populations	**56.3**
7.1.1 Identify groups of people in the community who have trouble accessing or connecting to personal health services?	75
7.1.2 Identify all personal health service needs and unmet needs throughout the community?	50
7.1.3 Defines partner roles and responsibilities to respond to the unmet needs of the community?	50
7.1.4 Understand the reasons that people do not get the care they need?	50

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• PH identifies veterans, developmental disabilities, pregnancy • Population-focused organizations look at particular communities such as senior & disabilities. • Inter-institutional partnerships. • Health Equity Coalition looks at specific community groups that we may have trouble accessing. • Work around pregnant women and babies in Josephine County. • Good advance in some pockets of complex problems. • Efforts towards oral health. • Integrated Behavioral Health services in other systems such as corrections, schools, etc.	• Mostly unknown about Josephine County. • Example of opiate crisis, a lot of community conversation, but limited definition of roles and responsibilities. • Although we understand, we have difficulty finding right strategies to change. Difficulties with funding and human resources. • Systems trauma.	• Need for more open-access, trauma-informed services, walk-in centers. • Improve integration, more permeability in organizational walls.	• Need to educate the community.	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Model Standard 7.2: Ensuring People Are Linked to Personal Health Services	**56.3**
7.2.1 Connect or link people to organizations that can provide the personal health services they may need?	50
7.2.2 Help people access personal health services in a way that takes into account the unique needs of different populations?	75
7.2.3 Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?	75
7.2.4 Coordinate the delivery of personal health and social services so that everyone in the community has access to the care they need?	25

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Good knowledge of each other (organizations) we link people with them, but ---> • Most organizations have staff who focuses on addressing unique needs (case managers, chws, advocates, etc.) • OHP sign ups is everywhere. • We do well with subpopulations.	• There are care coordination complications that burden the ability to link and connect people with services. • A lot of people don't qualify for OHP. • Difficulty with resources for Medicare and underinsured. • Difficulty addressing complexity, given the limitations of our scopes.			

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Essential Service 8: Assure a Competent Public Health and Personal Healthcare Workforce	**58.3**
Model Standard 8.1: Workforce Assessment, Planning, and Development	**41.7**
8.1.1 Complete a workforce assessment, a process to track the numbers and types of LPHS jobs—both public and private sector—and the associated knowledge, skills, and abilities required of the jobs?	50
8.1.2 Review the information from the workforce assessment and use it to identify and address gaps in the LPHS workforce?	50
8.1.3 Provide information from the workforce assessment to other community organizations and groups, including governing bodies and public and private agencies, for use in their organizational planning?	25

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• quarterly review of talent and gaps at Rogue Health Care workforce committee locally • 20-30 stakeholders in the room: SOU, RCC, high schools, trade schools, Asante, RV Manor • high strengths for Asante and focus on traditional healthcare • some focus on Community Health Worker model	• doesn't cover all health needs, like mental health and addictions • large complicated issues, many different perspectives • needs to be more inclusive of ancillary health workforce needs	• expand review of system to mental health, oral health, public health nursing, etc. • find a tool that can be utilized and is more comprehensive • need to assure right people are in the room	• address long term issues like housing	

Model Standards by Essential Services *At what level does the LPHS…*				Average LPHSA Performance Scores
Model Standard 8.2: Public Health Workforce Standards				**66.7**
8.2.1 Ensure that all members of the local public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and comply with legal requirements?				100
8.2.2 Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the 10 Essential Public Health Services?				50
8.2.3 Base the hiring and performance review of members of the public health workforce in public health competencies?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• MH services have moved the bar on this work at a local level in the last 5 years based on lack of support for licensure • Public Health has always been consistent • Traditional medical roles are strongly enforced, but nontraditional are less than	• Community Health Workers, including peers, have lots of hoops to get final certification • barriers for certification are really difficult • better state enforcement • for 8.2.2 and 8.2.3 moderate where appropriate: many jobs would not cover all areas of the 10 essential services and therefore would not be reflected in the job descriptions or in the performance reviews and hiring processes	• simplify processes for licensure and certification needs	• Assure all agencies are competent in getting this done • build into HR policies to assure that this is happening across the board, maintain standards through HR	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Model Standard 8.3: Life-Long Learning through Continuing Education, Training, and Mentoring	**70.0**
8.3.1 Identify education and training needs and encourage the public health workforce to participate in available education and training?	100
8.3.2 Provide ways for public health workers to develop core skills related to the 10 Essential Public Health Services?	75
8.3.3 Develop incentives for workforce training, such as tuition reimbursement, time off for attending class, and pay increases?	75
8.3.4 Create and support collaborations between organizations within the LPHS for training and education?	75
8.3.5 Continually train the public health workforce to deliver services in a culturally competent manner and understand the social determinants of health?	25

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• increased training activity with local partners for things like equity, ACEs, Trauma, etc. Many funded by CCOs • collaboration with health care institutions • social services collaborate with other social services • Asante's Smullin Center is key area used by the community for community education • Student training at schools is focused on equity and SDOH	• Lack of pay increases, some potential tuition reimbursement (not all) • more collaboration across multi-disciplinary organizations like health and social services	• get more info about a variety of other organizations like LTC, FQHCs, etc. • CNA 1's? is there more opportunity for support? • Addictions support • extended collaboration can improve economy of scale across disciplines and counties, i.e. ACES training model	• more money into addictions system to assure there is sustainability of staff as their training increases • need more management level focus on equity and poverty to extend training to agencies	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Model Standard 8.4: Public Health Leadership Development	**50.0**
8.4.1 Provide access to formal and informal leadership development opportunities for employees at all organizational levels?	50
8.4.2 Create a shared vision of community health and the LPHS, welcoming all leaders and community members to work together?	75
8.4.3 Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?	50
8.4.4 Provide opportunities for the development of leaders who represent the diversity of the community?	25

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Asante is a leader in this work for all pieces of the organization • smaller agencies encourage working at multiple levels • 8.4.2 strength of collaboration across the region and across systems with leadership	• Union structures discourage working outside of job descriptions • 8.4.3: we know that some opportunities exist within orgs and outside of orgs, but unsure of how to define questions • Diversity of opportunities is low	• encourage CNA 1 level (entry level) to remove barriers (time and cost) to moving up on the ladder	• 8.4.2 Encouragement at community level • Increase opportunities for diverse workforce.	

Model Standards by Essential Services *At what level does the LPHS…*				Average LPHSA Performance Scores
Essential Service 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services				**65.4**
Model Standard 9.1: Evaluating Population-Based Health Services				**56.3**
9.1.1 Evaluate how well population-based health services are working, including whether the goals that were set for programs and services were achieved?				75
9.1.2 Assess whether community members, including vulnerable populations, are satisfied with the approaches taken toward promoting health and preventing disease, illness, and injury?				25
9.1.3 Identify gaps in the provision of population-based health services?				75
9.1.4 Use evaluation findings to improve plans, processes, and services?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
Model Standard 9.2: Evaluating Personal Health Services				**65.0**
9.2.1 Evaluate the accessibility, quality, and effectiveness of personal health services?				50
9.2.2 Compare the quality of personal health services to established guidelines?				75
9.2.3 Measure user satisfaction with personal health services?				75
9.2.4 Use technology, like the Internet or electronic health records, to improve quality of care?				75
9.2.5 Use evaluation findings to improve services and program delivery?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
	• PH does not have electronic medical records.			

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Model Standard 9.3: Evaluating the Local Public Health System	**75.0**
9.3.1 Identify all public, private, and voluntary organizations that contribute to the delivery of the 10 Essential Public Health Services?	75
9.3.2 Evaluate how well LPHS activities meet the needs of the community at least every five years, using guidelines that describe a model LPHS and involving all entities contributing to the delivery of the 10 Essential Public Health Services?	75
9.3.3 Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?	75
9.3.4 Use results from the evaluation process to improve the LPHS?	75

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Community approach despite organizational differences.		• More dissemination of CHIP and CHA		

Model Standards by Essential Services *At what level does the LPHS…*				Average LPHSA Performance Scores
Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems				**40.9**
Model Standard 10.1: Fostering Innovation				**43.8**
10.1.1 Provide staff with the time and resources to pilot test or conduct studies to test new solutions to public health problems and see how well they actually work?				25
10.1.2 Suggest ideas about what currently needs to be studied in public health to organizations that conduct research?				25
10.1.3 Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?				75
10.1.4 Encourage community participation in research, including deciding what will be studied, conducting research, and sharing results?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• traditional academic studies are based on the researcher's ideas - now flipped to listen to community organizations identifying areas to focus on and study so research is more focused towards community needs • 10.1.1: have more opportunities with higher ed students and nurses, but time is still limited and programs is still limited • 10.1.2: strength is connection to social services, CCOs, FQHCS vs to hospitals or LTC facilities • Promising practices (vs. evidence-based practices) have increased • 10.1.3: partnerships and work with CCOs and on metrics has improved sharing best practices throughout the region, this has improved dramatically over the last 5 years	• 10.1.2 and 10.1.4: Research is more qualitative than IRB based	• increase opportunities to build further connection with academia and students • provide more opportunities for higher ed students to learn real life practices for on the ground work	• find ways to pilot projects that expand current interventions • focus more on promising practices -improve structures for 10.1.4	

Model Standards by Essential Services *At what level does the LPHS…*	Average LPHSA Performance Scores
Model Standard 10.2: Linking with Institutions of Higher Learning and/or Research	**58.3**
10.2.1 Develop relationships with colleges, universities, or other research organizations, with a free flow of information, to create formal and informal arrangements to work together?	75
10.2.2 Partner with colleges, universities, or other research organizations to conduct public health research, including community-based participatory research?	25
10.2.3 Encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education?	75

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Academic organizations include: SOU, RCC, OHSU, PSU, OSU, OIT - multiple organizations to work with on multiple projects/processes, etc. Partnerships exist from both sides of Healthcare and academia. I-CAn project as an example of also providing direct care. • Data walks with community members shared with nursing students	• 10.2.2: barriers to providing data and working together on it. Also, barriers to costs for research at the academic level • can't share HIPPA related data	• more CBPR • more access to systems resources • more collaborative work on both ends • more data provision • engage more community participants in the process of research	• reduce regulatory data if possible	

Model Standard 10.3: Capacity to Initiate or Participate in Research				**25.0**
10.3.1 Collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies?				25
10.3.2 Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?				25
10.3.3 Share findings with public health colleagues and the community broadly, through journals, Web sites, community meetings, etc.?				25
10.3.4 Evaluate public health systems research efforts throughout all stages of work from planning to effect on local public health practice?				25

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• current CHA work is leading towards this type of collaboration	• less formal research • who are researchers in the valley that we should work with • what subjects make sense to rise to this level	• identify opportunities to improve on research ideas and resources as they exist		

Health Equity Performance Scores

At what level does the LPHS…	Health Equity Performance Scores					Average Performance Scores
	No Activity (0%)	Minimal Activity (1–25%)	Moderate Activity (26–50%)	Significant Activity (51–75%)	Optimal Activity (76–100%)	
Essential Service 1: Monitor Health Status to Identify Community Health Problems						**25.0**
Conduct a community health assessment that includes indicators intended to monitor differences in health and wellness across populations, according to race, ethnicity, age, income, immigration status, sexual identify, education, gender, and neighborhood?		25				
Monitor social and economic conditions that affect health in the community, as well as institutional practices and policies that generate those conditions?		25				
Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards						**16.7**
Operate or participate in surveillance systems designed to monitor health inequities and identify the social determinants of health inequities specific to the jurisdiction and across several of its communities?		25				
Collect reportable disease information from community health professionals about health inequities?	0					
Have the necessary resources to collect information about specific health inequities and investigate the social determinants of health inequities?		25				

At what level does the LPHS…	Health Equity Performance Scores					Average Performance Scores
	No Activity (0%)	Minimal Activity (1–25%)	Moderate Activity (26–50%)	Significant Activity (51–75%)	Optimal Activity (76–100%)	
Essential Service 3: Inform, Educate, and Empower People about Health Issues						**43.8**
Provide the general public, policymakers, and public and private stakeholders with information about health inequities and the impact of government and private sector decision-making on historically marginalized communities?			50			
Provide information about community health status (e.g., heart disease rates, cancer rates, and environmental risks) and community health needs in the context of health equity and social justice?			50			
Plan and conduct health promotion and education campaigns that are appropriate to culture, age, language, gender, socioeconomic status, race/ethnicity, and sexual orientation?		25				
Plan campaigns that identify the structural determinants of health inequities and the social determinants of health inequities (rather than focusing solely on individuals' health behaviors and decision-making)?			50			
Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems						**25.0**
Have a process for identifying and engaging key constituents and participants that recognizes and supports differences among groups?		25				
Provide institutional means for community-based organizations and individual community members to participate fully in decision-making?		25				
Provide community members with access to community health data?		25				

At what level does the LPHS…	Health Equity Performance Scores					Average Performance Scores
	No Activity (0%)	Minimal Activity (1–25%)	Moderate Activity (26–50%)	Significant Activity (51–75%)	Optimal Activity (76–100%)	
Essential Service 5: Developing Policies and Plans that Support Individual Community Health Efforts						**50.0**
Ensure that community-based organizations and individual community members have a substantive role in deciding what policies, procedures, rules, and practices govern community heath efforts?			50			
Essential Service 6: Enforce Laws and Regulations that Protect Health and Ensure Safety						**50.0**
Identify local public health issues that have a disproportionate impact on historically marginalized communities (that are not adequately addressed through existing laws, regulations, and ordinances)?			50			
Essential Service 7: Link People to Needed Personal Health Services						**58.3**
Identify any populations that may experience barriers to personal health services based on factors such as on age, education level, income, language barriers, race or ethnicity, disability, mental illness, access to insurance, sexual orientation and gender identity, and additional identities outlined in Model Standard 7.1?				75		
Identify the means through which historical social injustices specific to the jurisdiction (e.g., the inequitable distribution health services and transportation resources) may influence access to personal health services?		25				
Work to influence laws, policies, and practices that maintain inequitable distributions of resources that may influence access to personal health services?				75		

At what level does the LPHS…	Health Equity Performance Scores					Average Performance Scores
	No Activity (0%)	Minimal Activity (1–25%)	Moderate Activity (26–50%)	Significant Activity (51–75%)	Optimal Activity (76–100%)	
Essential Service 8: Assure a Competent and Personal Health Care Workforce						**30.0**
Conduct assessments related to developing staff capacity and improving organizational functioning to support health equity initiatives?			50			
Identify staff perspectives on the facilitators and barriers to addressing health equity initiatives?		25				
Include staff members that are often excluded from planning and organizational decision-making processes in workforce assessments?		25				
Recruit and train staff members from multidisciplinary backgrounds that are committed to achieving health equity?		25				
Recruit and train staff members that reflect the communities they serve?		25				
Essential Service 9: Evaluate the Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services						**50.0**
Identify community organizations or entities that contribute to the delivery of the Essential Public Health Services to historically marginalized				75		
Monitor the delivery of the Essential Public Health Services to ensure that they are equitably distributed?		25				

At what level does the LPHS…	Health Equity Performance Scores					Average Performance Scores
	No Activity (0%)	Minimal Activity (1–25%)	Moderate Activity (26–50%)	Significant Activity (51–75%)	Optimal Activity (76–100%)	
Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems						**37.5**
Encourage staff, research organizations, and community members to explore the root causes of health inequity, including solutions based on research identifying the health impact of structural racism, gender and class inequity, social exclusion, and power differentials?			50			
Share information and strategize with other organizations invested in eliminating health inequity?			50			
Use Health Equity Impact Assessments to analyze the potential impact of local policies, practices, and policy changes on historically marginalized communities?		25				
Facilitate substantive community participation in the development and implementation of research about the relationships between structural social injustices and health status?		25				

Appendix D - Focus Group Discussion Guide

> Goals of the focus groups:
>
> • To identify the perceived health needs and assets in Jackson and Josephine Counties
>
> • To gain an understanding of people's barriers to health and how these barriers can be addressed
>
> • To identify areas of opportunity to address needs

 [NOTE: THE QUESTIONS IN THE FOCUS GROUP GUIDE ARE INTENDED TO SERVE AS A <u>GUIDE</u>, BUT NOT A SCRIPT.]

[NOTE: GUIDE WILL BE TAILORED FOR EACH GROUP.]

I.   BACKGROUND (5-10 MINUTES)

- Welcome everyone. My name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are <u>no right or wrong answers</u> during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.

- The Jefferson Regional Health Alliance is conducting a community health assessment to gain a greater understanding of the health issues facing community members, how those needs are currently being addressed, and where there are opportunities to address these needs in the future. We want to hear from you about all the things that can affect the health of a community, which can include not just health care but also other things related to where people live, work, play, and pray. The information you provide is a valuable part of this assessment and improving health in the community.

- As you can see, I have a colleague with me today, [NAME], who is taking notes during our discussion. She works with me on this project. I want to give you my full attention, so she is helping me out by taking notes during the group and she doesn't want to distract from our discussion.

- [NOTE AUDIOTAPING IF APPLICABLE] Just in case we miss something in our note-taking, we are also <u>audio-taping</u> the groups tonight. We are conducting several of these discussion groups around the area, and we want to make sure we capture everyone's opinions. After all of the groups are done,

we will be writing a summary report of the general opinions that have come up. In that report, I might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In our report, nothing you say here will be connected to your name.

- You might also notice that I have a stack of papers here. I have a lot of questions that I'd like to ask you tonight. I want to let you know that so if it seems like I cut a conversation a little short to move on to the next question, please don't be offended. I just want to make sure we cover a number of different topics during our discussion tonight.

- Lastly, please turn off your <u>cell phones</u> or at least put them on silent or vibrate mode. The group will last only about 80-90 minutes. If you need to go to the restroom during the discussion, please feel free to leave, but we'd appreciate it if you would go one at a time.

- Any questions before we begin our introductions and discussion?

II.   INTRODUCTION AND WARM-UP (5-10 MINUTES)

1. Now, first let's spend a little time getting to know one another. Let's go around the table and introduce ourselves. Please tell me: 1) Your first name; 2) what community you live in; and 3) something about yourself – such as how many children you have or what activities you like to do in your spare time. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III.   COMMUNITY AND HEALTH PERCEPTIONS (20-30 MINUTES)

2. Today, we're going to be talking a lot about the community or that you live in. How would you describe your community?

    a. If someone was thinking about moving into your community, what would you say are some of its biggest strengths or the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

3. What are some of the biggest problems or concerns in your community? [PROBE ON ISSUES IF NEEDED – transportation, affordable housing; financial stress; food security; violence; employment, etc.]

    a. Just thinking about day-to-day life –working, getting your kids to school, things like that – what are some of the challenges or struggles <u>you</u> deal with on a day-to-day basis?

4. What do you think are the most pressing <u>health</u> concerns in your community? [PROBE ON SPECIFIC ISSUES IF NEEDED, E.G. CHRONIC DISEASES/CONDITIONS, MENTAL HEALTH, SUBSTANCE ABUSE, ETC.; ENSURE ADEQUATE DISCUSSION TIME; PROBE ON HEALTH CARE ACCESS IF MENTIONED]

      i. How have these health issues affected your community? [PROBE FOR SPECIFICS]

5. Thinking about health and wellness in general, what helps keep you healthy?

    a. What makes it <u>easier</u> to be healthy in your community?

      i. What supports your health and wellness?

    b. What makes it <u>harder</u> to be healthy in your community?

IV.   PERCEPTIONS OF PUBLIC HEALTH/PREVENTION SERVICES AND HEALTH CARE (20-30 minutes)

6. Let's talk about a few of the health issues you mentioned. [SELECT TOP HEALTH CONCERNS] What <u>programs, services, and policies</u> are you aware of in the community that currently focus on these health issues?

    a. What's missing? What programs, services, or policies are currently not available that you think should be?

    b. What do you think the community should do to address these issues? [PROBE SPECIFICALLY ON WHAT THAT WOULD LOOK LIKE AND WHO WOULD BE INVOLVED TO MAKE THAT HAPPEN]

7. What do you think are some things a community could do to make it easier for people <u>to be healthy</u>? [PROBE ON SPECIFICS IF NEEDED: What would these programs/services include? Where should they be offered? During what hours?]

8. [IF NOT ALREADY MENTIONED] I'd like to ask specifically about <u>health care</u> in your community. Have you or someone close to you ever experienced any challenges in trying to get health care? What specifically? [PROBE FOR BARRIERS: INSURANCE ISSUES, LANGUAGE BARRIERS, LACK OF TRANSPORTION, CHILD CARE, ETC.]

    a. [NAME BARRIER] was mentioned as something that made it difficult to get health care. What do you think would help so that people don't experience the same type of problem that you did in

getting health care? What would be needed so that this doesn't happen again? [REPEAT FOR OTHER BARRIERS]

V.   VISION OF COMMUNITY AND PROGRAM/SERVICE ENVIRONMENT (5 minutes)

9. I'd like you to think ahead about the future of your community. When you think about the community 3 years from now, what would you like to see? What is your vision for the future?

    a.   What do you think needs to happen in the community to make this vision a reality?

VI.   CLOSING (5 MINUTES)

Thank you so much for your time and sharing your opinions. Before we end the discussion, is there anything that you wanted to add that you didn't get a chance to bring up earlier?

I want to thank you again for your time. And we'd like to express our thanks to you. [DISTRIBUTE STIPENDS AND HAVE RECEIPT FORMS SIGNED].

As I mentioned before, we are conducting these groups around Jackson and Josephine Counties, and we're also talking to people who work at organizations. After all this is over, we're going to be writing up a report. Jefferson Regional Health Alliance will post this report on their website.

Thank you again. Your feedback is greatly valuable, and we greatly appreciate your time and thank you for sharing your opinion.

Appendix E - Key informant interview guide

> Goals of the Key Informant Interview
>
> - To gather perceptions of the health strengths and needs of Jackson and Josephine Counties
> - To identify health-related gaps, challenges, and assets
> - To explore opportunities for addressing community health needs more effectively

[NOTE: QUESTIONS FOR THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A <u>GUIDE</u>, NOT A SCRIPT.]

BACKGROUND (5 minutes)

- Hi, my name is _____ and I am with Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to speak with me today.

- As you may know, the Jefferson Regional Health Alliance is conducting a community health assessment to gain a greater understanding of the health issues of Jackson and Josephine County community members, how those needs are being addressed, and whether there might be opportunities to address these issues more effectively.

  o As part of this process, we are conducting interviews with leaders in the community and focus groups with community members and other stakeholders to understand different people's perspectives on these issues. We greatly appreciate your feedback, insight, and honesty. We are also gathering quantitative data on a wide range of community and health issues.

- Our interview will last about 45 – 60 minutes. After all of the interview and focus group discussions are completed, we will be writing a summary report of the general themes that have emerged during the discussions. This report will be public, but we will not include any names or identifying information in that report. All names and responses will remain confidential. Nothing sensitive that you say here will be connected to directly to you in our report.

- Do you have any questions before we begin our introductions and discussion?

THEIR AGENCY / ORGANIZATION (5 minutes)

[SKIP THIS SECTION FOR ELECTED OFFICIALS]

1. Can you tell me a bit about your organization/agency? [TAILOR PROBES DEPENDING ON AGENCY]

   a. [PROBE ON ORGANIZATION: What is your organization's mission/services? What communities do you work in? Who are the main clients/audiences?]

      i. What are some of the biggest challenges your organization faces in conducting your work in the community?

   b. Do you currently partner with any other organizations or institutions in any of your work?

COMMUNITY ISSUES (10 minutes)

2. How would you describe the community served by your organization/ that you serve as [INSERT TITLE]?

   c. What do you consider to be the community's strongest assets/strengths?

   d. What are some of its biggest concerns/issues in general? What challenges do community members face in their day-to-day lives? [PROBE ON: transportation; affordable housing; financial stress; food security; violence; employment]

      i. What populations (geography, age, race, gender, income/education, etc.) do you see as being most affected by these issues?

HEALTH ISSUES (10 minutes)

3. What do you think are the most pressing health concerns in the community? Why? [PROBE ON SPECIFICS]

   [MODERATOR INSTRUCTIONS: AFTER PARTICIPANTS TALK ABOUT DIFFERENT HEALTH ISSUES, SELECT THE TOP 3 AND ASK THE FOLLOWING SERIES OF QUESTIONS FOR EACH ISSUE.]

   a. How has [HEALTH ISSUE] affected the/ your community? [PROBE FOR DETAILS: IN WHAT WAY? CAN YOU PROVIDE SOME EXAMPLES?]

b. Who do you consider to be the populations in the community most vulnerable or at risk for [THIS CONDITION / ISSUE]?

c. From your experience, what are peoples' biggest challenges to addressing [THIS ISSUE]?

    i. [PROBE: Barriers to accessing medical care, barriers to accessing preventive services or programs, barriers to receiving information on these issues, etc.]

PROGRAM / SERVICE ENVIRONMENT (10 minutes)

4. Let's talk about a few of the health issues you mentioned previously. [SELECT TOP HEALTH CONCERNS] What programs, services, or policies are you aware of in the community that address some of these health issues? [PROBE FOR SPECIFICS]

a. In your opinion, how effective have these programs, services, or policies been at addressing these issues? Why?

    i. How coordinated are these programs or services, if at all?

b. Where are the gaps? What program, services, or policies are currently not available that you think should be?

c. What do you think needs to be done to address these issues?

    i. Do you see opportunities currently out there that can be seized upon to address these issues? For example, are there some "low hanging fruit" – current collaborations or initiatives that can be strengthened or expanded?

5. [IF HEALTH CARE NOT YET MENTIONED/DISCUSSED] What do you see as the strengths of the health care services in your community? What do you see as its limitations?

a. What challenges do community members in your community face in accessing health care? [PROBE IN DEPTH FOR BARRIERS TO CARE: LACK OF TRANSPORTATION, INSURANCE ISSUES, LANGUAGE BARRIERS, CHILD CARE, ETC.]

    i. You mentioned [NAME BARRIER] as something that makes it difficult for community members to get health care. What do you think needs to happen in your community to help community members overcome or address this challenge? [REPEAT FOR OTHER BARRIERS]

VISION OF THE FUTURE (10 minutes)

6. I'd like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what would you like to see?   What is your vision for the future?

    a. What is your vision specifically related to people's <u>health</u> in the community?

        i. What do you think needs to happen in the community to make this vision a reality?

        ii. Who should be involved in this effort?

CLOSING (2 minutes)

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today?

As I mentioned before, we are conducting discussions all around Jackson and Josephine Counties. After collecting all the data and completing these interviews, we're going to be writing up a report which will be posted on the JRHA website.

Thank you again. Have a good afternoon.

Appendix F - Survey instrument

Jefferson Regional Health Alliance is conducting a community health assessment to better understand the health of Jackson and Josephine County community members. The assessment will inform future regional activities to improve the community's health.

We are asking community members to give us your thoughts and suggestions about health-related concerns and services in Jackson and Josephine Counties by completing this survey by July 3rd. All responses are completely anonymous. There are no right or wrong answers; it's your opinion that matters!

You can complete this survey online at: https://www.surveymonkey.com/r/JRHACHA2018

Or return it by mail to: JRHA, 670 Superior Ct., Ste 208, Medford, OR 97504

Your input is valuable and we appreciate your participation!

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1. **What county do you live in?**
   ☐ Jackson   ☐ Other [If other, skip to the end/not eligible]
   ☐ Josephine

2. **Are you a health or social service provider in Jackson or Josephine County?**
   ☐ Yes
   ☐ No

3. **In general, how would you describe the health of the community in which you live?**
   ☐ Excellent   ☐ Fair
   ☐ Very Good   ☐ Poor
   ☐ Good

4. **Please select <u>THE TOP HEALTH ISSUES</u> that have the largest impact on you and/or your family, and your community as a whole.**

   (Please select <u>up to 5</u> issues under "you/your family" and <u>up to 5</u> issues under "your community." You can select the same or different issues.)

	YOU AND/OR YOUR FAMILY	YOUR COMMUNITY
Affordable housing	☐	☐
Aging health concerns (Alzheimer's, arthritis, dementia, falls, etc.)	☐	☐
Air quality	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Cost of living (e.g., housing, child care, groceries, etc.)	☐	☐
Dental/oral health	☐	☐
Diabetes	☐	☐
Disabilities (including lack of services for individuals with disabilities)	☐	☐
Getting health care (transportation, health insurance, cost, etc.)	☐	☐
Heart disease/ heart attacks	☐	☐
High blood pressure/hypertension	☐	☐
Homelessness	☐	☐
Infectious/contagious diseases (tuberculosis, pneumonia, flu, etc.)	☐	☐
Mental health and stress	☐	☐
Obesity/ overweight	☐	☐
Physical activity opportunities	☐	☐
Public safety	☐	☐
Sexually transmitted infections (STIs) (Chlamydia, Gonorrhea, etc.)	☐	☐
Smoking	☐	☐
Substance Use (alcohol, marijuana, heroin, meth, etc.)	☐	☐
Teenage pregnancy	☐	☐
Transportation (e.g. schedules, cost, accessibility)	☐	☐
Other (please specify): _____	☐	☐

5. **Have any of these issues ever made it more difficult for you to get the health or social services that you needed? (Check all that apply.)**

☐ Lack of transportation
☐ Have no regular doctor/source of health care
☐ Cost of care/co-pays
☐ Lack of evening and weekend services/lack of convenient times and locations
☐ Insurance problems/lack of coverage/not enough coverage
☐ Language problems/could not communicate with provider or office staff
☐ Discrimination/unfriendliness of provider or office staff

☐ Providers won't accept me as a patient
☐ Afraid to have health check-up
☐ Afraid due to my immigration status
☐ Don't know what type of services are available
☐ No available providers near me
☐ Long waits for appointments
☐ Health care information is not kept confidential
☐ I have never experienced any difficulties getting care
☐ Other (please specify): _____

6. Which of the following health and social services are currently <u>lacking</u> in your community? (Please select all that apply.)

☐ Services for older adults
☐ Services for people with disabilities

☐ Services for veterans
☐ Services for new immigrants

- ☐ Services for youth
- ☐ Educational support services (including language services)
- ☐ Transportation services
- ☐ Affordable housing
- ☐ Affordable child care services
- ☐ Substance abuse services
- ☐ Mental health care services
- ☐ Health care services (including primary care, specialty care, hospital services)
- ☐ Exercise and physical activity opportunities

- ☐ Employment services (including job training and readiness)
- ☐ Financial assistance services
- ☐ Housing services (including services for the homeless or housing insecure)
- ☐ Food services (including food stamps, food pantries, nutrition education and support)
- ☐ I don't know
- ☐ Other (please specify): _____

7. The following questions ask you to rate your concern for specific community issues. Please indicate how high of a concern each of the following topics are to you as a community member in Jackson or Josephine County.

Cost of Living	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Housing costs and issues associated with home ownership (e.g., mortgage payments, property taxes)	☐	☐	☐	☐	☐
Housing costs and issues associated with renting (e.g., rent payments, evictions, housing conditions)	☐	☐	☐	☐	☐
Cost of utilities (e.g., heat, electricity, water, etc.)	☐	☐	☐	☐	☐
Support for low-income families and individuals	☐	☐	☐	☐	☐
Availability of healthy, affordable food options	☐	☐	☐	☐	☐
Cost of child care (e.g., in-home, center based, or after school care)	☐	☐	☐	☐	☐
Availability of jobs	☐	☐	☐	☐	☐
Wages	☐	☐	☐	☐	☐

Transportation	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Transportation to work	☐	☐	☐	☐	☐
Transportation to activities other than work (e.g., grocery shopping, medical appointments, etc.)	☐	☐	☐	☐	☐
Availability of public transportation (e.g., regional bus)	☐	☐	☐	☐	☐
Motor vehicle safety	☐	☐	☐	☐	☐
Pedestrian safety	☐	☐	☐	☐	☐
Bike safety	☐	☐	☐	☐	☐

Disabilities	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Availability of services for physical disabilities	☐	☐	☐	☐	☐
Availability of services for developmental disabilities	☐	☐	☐	☐	☐
Accessibility of public buildings and housing for community members with disabilities (i.e. compliance with the Americans with Disabilities Act)	☐	☐	☐	☐	☐

Accessibility of public transportation for community members with disabilities	☐	☐	☐	☐	☐

Older Adults and Aging	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Affordable housing for older adults	☐	☐	☐	☐	☐
Mental health and social isolation for older adults	☐	☐	☐	☐	☐
Support for independent living	☐	☐	☐	☐	☐
Memory care services (e.g., services for dementia and Alzheimer's)	☐	☐	☐	☐	☐
Support services for low-income older adults	☐	☐	☐	☐	☐
Issues related to healthy living for older adults (e.g., nutrition services, physical activity, medical care, etc.)	☐	☐	☐	☐	☐
Access to medical specialists	☐	☐	☐	☐	☐

Mental Health and Stress	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Ability to get mental health care services (e.g., affordable, timely, proximity, etc.)	☐	☐	☐	☐	☐
Real or perceived stigma associated with seeking mental health care	☐	☐	☐	☐	☐
Mental health and stress among middle and high school aged youth	☐	☐	☐	☐	☐
Mental health and stress among immigrants	☐	☐	☐	☐	☐
Mental health and stress among low-income families and individuals	☐	☐	☐	☐	☐
Mental health and stress among homeless	☐	☐	☐	☐	☐
Mental health and stress among veterans	☐	☐	☐	☐	☐

Substance Abuse	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Ability to get substance abuse services (e.g., affordable, timely, proximity, etc.)	☐	☐	☐	☐	☐
Real or perceived stigma associated with seeking substance abuse services	☐	☐	☐	☐	☐
Opioid abuse (e.g., prescription pain killers, heroin, etc.)	☐	☐	☐	☐	☐
Alcohol abuse among youth	☐	☐	☐	☐	☐
Alcohol abuse among adults	☐	☐	☐	☐	☐
Tobacco use among youth (including vaping and e-cigarettes)	☐	☐	☐	☐	☐
Tobacco use among adults	☐	☐	☐	☐	☐
Methamphetamine use	☐	☐	☐	☐	☐
Drug use among youth (including misuse of prescriptions, use of other illicit drugs)	☐	☐	☐	☐	☐
Marijuana use among youth	☐	☐	☐	☐	☐
Recreational marijuana use among adults	☐	☐	☐	☐	☐
Other substance abuse	☐	☐	☐	☐	☐

Public Safety	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Violent crime	☐	☐	☐	☐	☐
Property crime	☐	☐	☐	☐	☐
Neighborhood safety	☐	☐	☐	☐	☐
Adequate law enforcement system, including jail, parole, and probation	☐	☐	☐	☐	☐

Community and Civic Engagement	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Opportunities for physical activity (e.g., affordable gyms, public walking paths, etc.)	☐	☐	☐	☐	☐
Availability of health care services (e.g., primary care services, specialty care, urgent care, etc.)	☐	☐	☐	☐	☐
Availability of social services (e.g., food pantries, employment services, education services, etc.)	☐	☐	☐	☐	☐
Availability of community-wide activities (e.g., classes or programs for youth or families, library programming, community concerts, etc.)	☐	☐	☐	☐	☐
Inclusion of new community members into the community	☐	☐	☐	☐	☐
Participation in civic activities (e.g., voting in local elections, opportunities to participate in community meetings or forums)	☐	☐	☐	☐	☐

8. Are there any other issues of concern – not listed previously – that are of high concern to you as Jackson or Josephine County community member?
   ☐ No
   ☐ Yes, please specify: _____

The following items are related to your own demographic characteristics. We are asking these questions in order to make sure this survey has reached all population groups that live in Jackson and Josephine Counties. Your input is valuable and we appreciate your response to these questions!

9. What's your zip code? _____

10. How old are you?
    ☐ Under 18 years old   ☐ 35-44 years old
    ☐ 18-24 years old   ☐ 45-64 years old
    ☐ 25-34 years old   ☐ 65+ years old

11. What is your gender?
    ☐ Male   ☐ Other (please specify) _____
    ☐ Female

12. How would you describe your ethnic/racial background? (Please check all that apply.)
   - ☐ African American or Black
   - ☐ American Indian or Alaskan Native
   - ☐ Asian
   - ☐ Hispanic/Latino(a)
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White
   - ☐ Other (please specify) _____

13. What language do you speak most often at home? (Please choose one.)
   - ☐ English
   - ☐ Spanish
   - ☐ Other (please specify) _____

14. What is the highest level of education that you have completed?
   - ☐ Less than high school
   - ☐ High school graduate or GED
   - ☐ Some college
   - ☐ Associate or technical degree/certification
   - ☐ College graduate
   - ☐ Graduate or professional degree

15. What is your household income?
   - ☐ Less than $25,000
   - ☐ $25,000 to $49,999
   - ☐ $50,000 to $74,999
   - ☐ $75,000 to $99,999
   - ☐ $100,000 or more

16. Have you or someone in your family experienced housing insecurity or homelessness in the last 12 months?
   - ☐ Yes
   - ☐ No

17. How long have you lived in Jackson or Josephine County?
   - ☐ Less than one year
   - ☐ At least 1 year but less than 5 years
   - ☐ At least 5 years but less than 10 years
   - ☐ At least 10 years but less than 15 years
   - ☐ At least 15 years but less than 20 years
   - ☐ 20 years or more

18. Do you have difficulty with any of the following? (Please check all that apply.)
   - ☐ Hearing (deafness or severe hearing impairment)
   - ☐ Vision (blindness or severe vision impairment)
   - ☐ Mobility (walking, climbing stairs)
   - ☐ Cognitive Functioning (concentrating, remembering, making decisions)
   - ☐ Independent Living (dressing, bathing)
   - ☐ Other (please write): _____

Jefferson Regional Health Alliance

www.jeffersonregionalhealthalliance.org

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Tom Wuest MD, Chief Medical Officer, Health Net of Oregon

Curry County

Community Health Assessment 2018

Acknowledgments

Consulting & Technical Writing by:
V Consulting & Associates Inc.

Contents

Introduction and Purpose

The 2018 Community Health Assessment (CHA) is a view into the health status of the people that live in Curry County. The assessment process results in an increased understanding of key health issues facing the community, aids in better planning of services and helps to identify strengths and challenges to address with health care resources. The development of the assessment also engages community members by listening to their perceptions and experiences about what influences health. The process includes comprehensive data collection and analysis, working across multiple sectors and bringing many local organizations together.

2018 marks the first time all of the partners collaborated on a single health assessment, with a desire to reduce duplication and share resources. The process of the CHA is as important and vital to the community as the document that is produced. The resulting CHA document assists organizations in planning and prioritizing efforts that ultimately improve health outcomes, the health of individuals and communities.

Community Health Assessment Approach & Model

The 2018 Community Health Assessment committee began meeting in 2017 to build a collaborative including the local hospital, the local federally qualified health center, public health, early learning and child focused groups, the local Coordinated Care Organizations (CCO), tribal representation, dental organizations and many other vital health and human service organizations. The desire to pool resources, reduce duplication of effort and meet individual requirements for health assessments drove the group to engage with a consultant to lead and facilitate the 2018 Community Health Assessment in the fall of 2017.

Organization Partners in 2018 Curry Community Health Assessment

Curry General Hospital

Oregon Coast Community Action (ORCCA)

Curry Health Network

Advanced Health (formerly WOAH)

AllCare Health

South Coast Regional Early Learning Hub

Advantage Dental

Coast Community Health Center

Curry Community Health

Tolowa Dee-Ni Nation

Oregon Health Authority

The Mobilizing for Action through Planning and Partnerships (MAPP) model was the approach chosen by the committee. The MAPP process is a national best practice. It is a community driven process that results in engagement of new stakeholders, provides a broad understanding of community health issues and helps to identify both strengths and challenges related to health in a community. Due to resources and time required for a robust MAPP process, the committee agreed upon a modified MAPP model with a time line of November 2017-April 2018.

Kickoff & Visioning
November 2017

Secondary Data Collection
& Analysis
November 2017-January 2018

Community Input:
Primary Data Collection
December 2017-January
2018

Data Analysis & Writing
November 2017-February
2018

Review & Finalize
April 2018

The work of the CHA was completed by both the consultant and the CHA committee. The CHA committee provided leadership to the process, assisted with primary data collection including focus groups and surveys and were key in engaging community voice and input. Specific methods of data collection are outlined in the data section.

Collaborative Partner Key Requirements

Many community organizations are required to complete a health assessment. The regulatory bodies that require these assessments vary widely in their frequency, focus and requirements for assessments. They include a broad spectrum of organizations, from the IRS to the Oregon Health Authority. Although vastly different, the regulatory requirements for assessments all articulate a need for community organizations to seek to understand strengths and needs in a community to better prioritize health efforts and services.

There are many requirements that are shared across all entities that are required to go through a community health assessment process. These include having a balance of types of data, community engagement and input, population based health status data and some level of prioritization of health issues in the community.

Overlapping Key Requirements for Community Health Assessments

Population Based-Health Status Data

Primary & Secondary Data

Community Engagement & Input

Prioritization of Health Issues
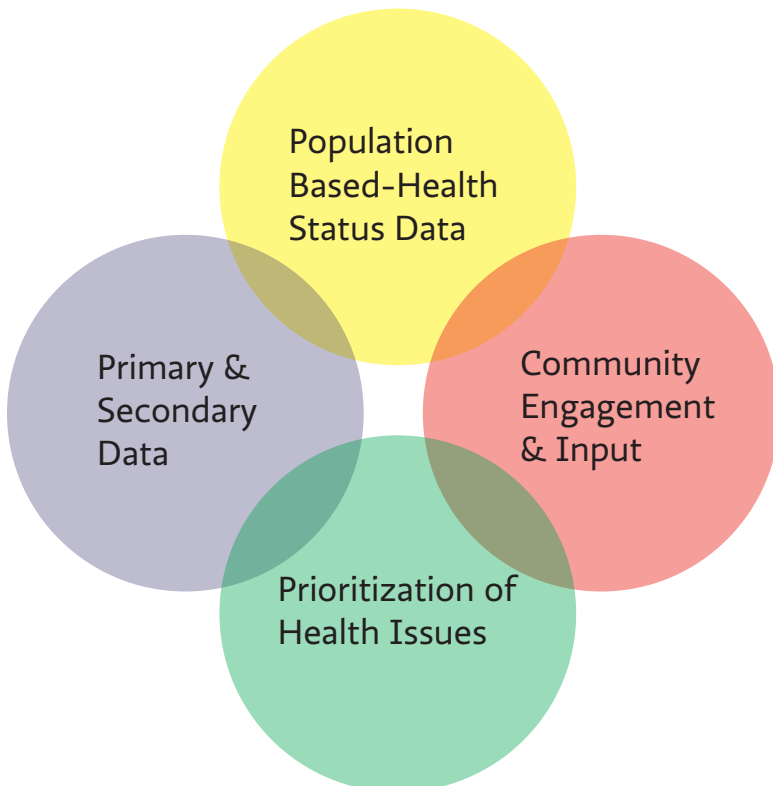
Plans and Processes Requiring Community Health Assessments

CHNA
Community Health Needs Assessment

Required by IRS

Focus is to identify and assess access and needs of community the hospital is serving.

Documentation must include written report.

See Patient Protection and Affordable Care Act requirements for 501(c)3 hospitals.
Led by hospital
Every 3 years

CCO
Coordinated Care Organization

Required by Oregon Health Authority

Purpose is to assess entire community served by CCO, not just Medicaid population. Tied to responsibility of CCO in creating the Triple Aim: Better care, better health and reduced costs.

Led by CCO, with CAC involvement.

Proposed to be every 3 years

Public Health Accreditation

Collaborative process resulting in a comprehensive community health assessment.

Led by County Public Health with collaborative partners

Every 5 years

Other

Other includes Federally Qualified Health Centers (FQHCs), Head Start, Early Learning Hubs, Tribal Health Centers

Various time lines/frequency/requirements and population focus

Vision & Values of Community Health Assessment Process

One of the first processes in the MAPP process is to have the committee discuss their vision for a healthy community and the values related to assessing and planning for that vision.

- We believe health is very connected to the social determinants of health such as education, employment, housing and food

- We believe in building on our strengths, not only looking at barriers and needs in our assessment process

- We believe it is important to focus on health equity and address inequities data when we are able to while also remembering our rural county has inequities to urban counties in the state

- We believe there is value in building on previous assessment work while not duplicating effort

- We recognize that this assessment cannot focus on all things related to health but it does identify areas we can impact

- We believe that the process we go through engages consumers of health services and incorporates the voices of those we serve

- We believe addressing poverty as a root cause of poor health is important

- We believe reducing child abuse and chronic stress in families improves health

Social Determinants of Health & Health Equity Framework

The CHA committee recognizes that multiple factors in a community impact the health of individuals, families and communities. These are often called the Social Determinants of Health. The term Social Determinants of Health is defined by the World Health Organization as "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources." The social determinants of health influence health inequities. Health inequities are the avoidable, unfair and unjust differences in health status seen within and between individuals and communities.

The traditional way to approach health assessments and health improvement was to focus on status, outcomes and health care services. More recent research and practice has expanded that perspective, to recognize that health is more than health care, more than just what happens at the doctor's office.

Social Determinants of Health

demographics | economic stability | neighborhood and physical environment

education | food | community

heath care system | health behaviors | health outcomes

2018 Curry County Community Health Assessment - 4
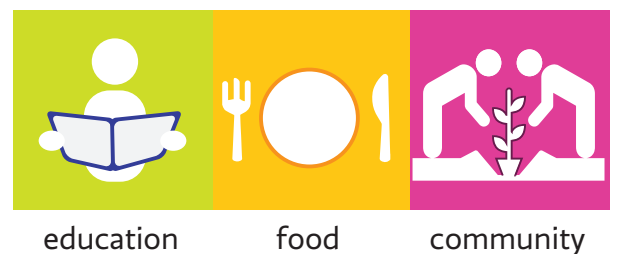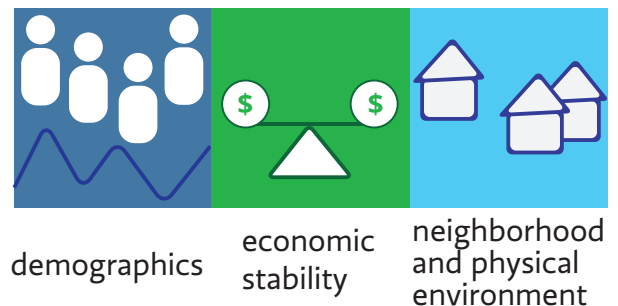
Health care itself is an important influence on health, but socioeconomic factors, our physical environment and our individual behaviors also greatly influence our health.

Many community health models suggest that up to 40% of the health in the community is related to socioeconomic factors.

Types of Data, Data Collection, Data Sources and Limitations

Data used in the community health assessment included primary and **secondary data**, qualitative and quantitative data. **Secondary data** is data collected by another organization or group. Examples are rates of morbidity and mortality from Oregon Health Authority or demographic data from the US Census. Secondary data at the county level was used most often, but when available and reliable zip code and/or census tract data was available it was highlighted. Newer data was valued over older data, although some sources were older by necessity as the data is no longer being tracked or isn't available in newer years and illustrates an important point about health status. Due to small population numbers in some areas of the county, multiple years were sometimes grouped together emphasizing trends over time instead of one-year snapshots on some data points, an important consideration for rural community assessments.

Primary data collection was collected by focus groups and surveys. Details of the primary data collection methodology and results can be viewed in the Appendix.

The Community Health Assessment has limitations, it is not meant to cover every possible factor that influences health, or every possible health related data point being tracked. It is not meant to be a complete list of all community health needs or health data. It relies heavily on other secondary data assessments and there are notable gaps in readily available local, county and national data. The CHA is not a rigorous research study or a process designed to evaluate the efficacy of services or community organizations. It is intended to provide a macro view of community data, help to identify strengths, assets and challenges and engage community in the process of addressing inequities and improving overall community health. Lastly, the CHA document is intended to be built on and added to over the years, complimenting other assessments and not standing alone.

What affects health worldwide?

Socioeconomic Factors
Education
Employment 40%
Income
Social Support
Community Safety

Health Behaviors
Tobacco use
Diet and exercise
Alcohol use
Unsafe sex 30%

Health Care
Access to care
Quality of care 20%

10%
Physical Environment
Built Env
Natural Env

Source: *County Health Rankings and Roadmap*, Robert Wood Johnson

Demographics

Introduction to Curry County

Curry County is a rural county located along the Pacific Coast in the Southwest corner of Oregon. Its boundaries include the Pacific Ocean on the West, California on the South, Coos County to the North and Josephine County on the West. The County was recognized as a county in 1855 and is the 25th most populated county (out of 36) in the state.
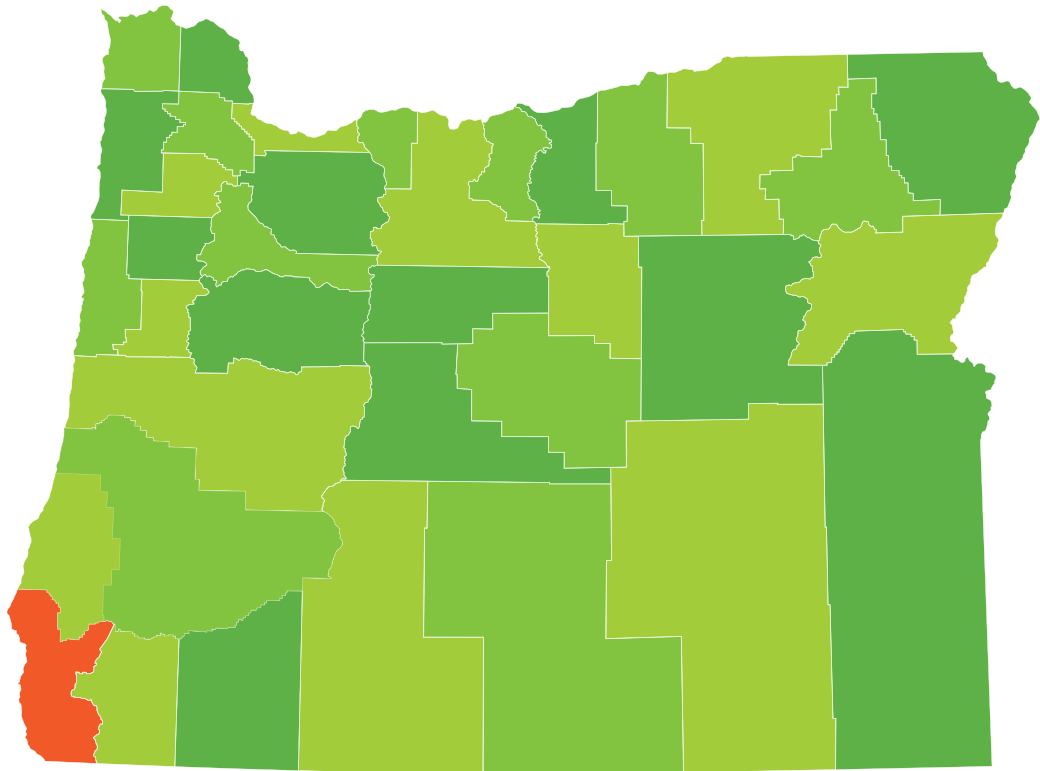
The county has an approximate population of 22,600 residents, encompassing 1648 square miles of land. The rugged mountainous terrain includes hundreds of lakes, rivers and streams stretching from mountains, through the Redwoods and to the Pacific Ocean. There are many unincorporated and isolated rural communities, presenting challenges for transportation and access to services. The three incorporated cities include Brookings, Gold Beach and Port Orford. The entire county is designated as rural, by the Oregon Office of Rural Health.

Population Growth & Characteristics

Curry County, like many other rural counties has witnessed a slower population growth than the state over the last several decades. Curry County did see a significant influx of residents in 2008-2010 but then the rate of change dipped and slowed beginning in 2010.

Rate of population change, 2002-2016, Curry County
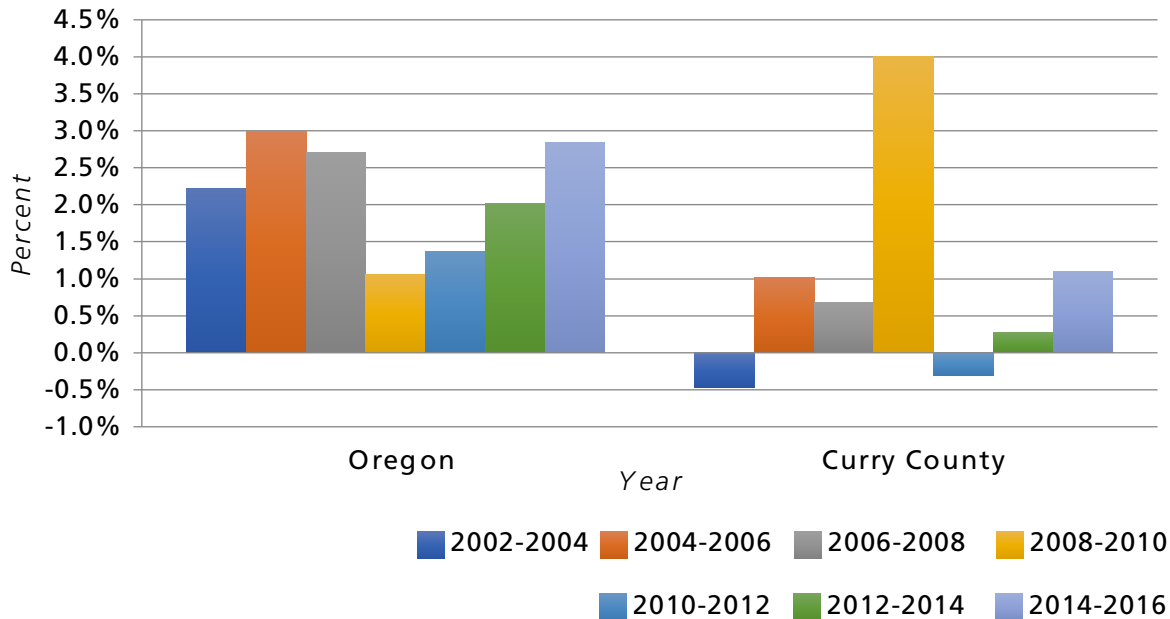
Source: PSU Population Research Center Annual Population Report

The median age of residents in Curry County is 55 years old, much older than the state median age of 39 years old. Curry County has an older population than the rest of the state, with the percentage of those over 60 years of age steadily increasing and accounting for a larger percentage of overall population. According to census estimates, 30% of the county population was over 65 years of age in 2015. The percentage of those over 60 years old is expected to increase to close to 40% by 2030. Also notable is that only 16% of the population is less than 17 years old compared to 21% in Oregon.

Age distribution, 2011-2015 Curry County and Oregon
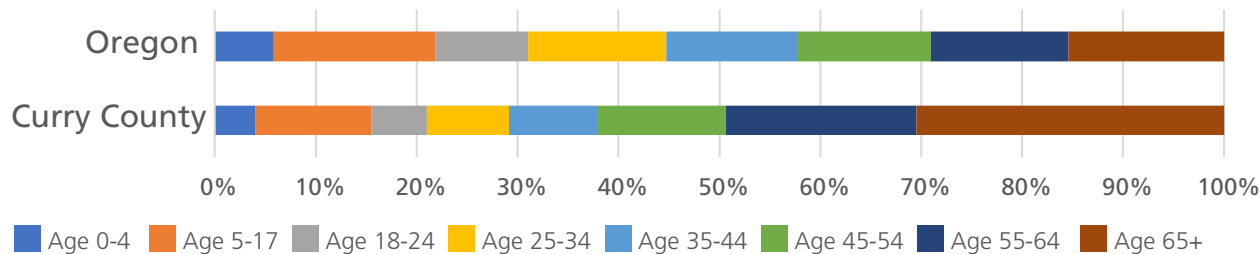
Source: US Census Bureau, American Community Survey 2011-2015

"We have retirees that need lots of assorted medical care, several types of which are not available locally." —Survey Participant

According to 2015 census estimates, there are more White residents in Curry County, than any other race or ethnicity, accounting for 87.5% of the population. The remainder of the population self-identifies as 6.29% Hispanic, 3.31% Multi-racial, 1.91% Native American, .55% Asian.

Non-English language speakers average around 4.55% of the total Curry population, considerably lower than the State and National averages which hover around 21%. Spanish is the most common non-English language spoken, 2.83% of the total population of Curry County are native Spanish speakers.

Veterans, 2011-2015 Curry County and Oregon
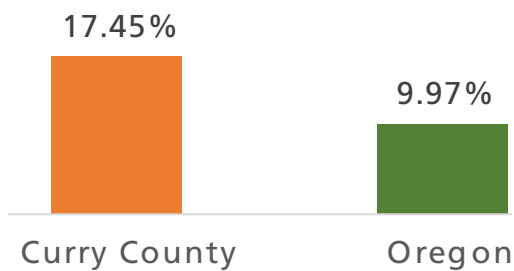
Source: US Census Bureau, American Community Survey 2011-15

Curry County has a large population of **veterans**, close to double the state average. The veterans in Curry County are also older. The majority of Veterans in Curry county served in Vietnam, 3.13 times greater than any other conflict (Data USA 2018).

Veteran community by age, 2011-15 Curry County and Oregon
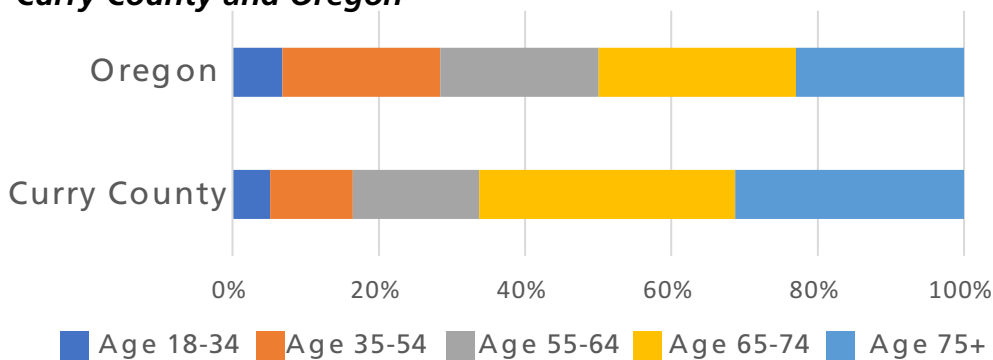
Source: US Census Bureau, American Community Survey 2011-15

Curry County also has a higher percentage of people with **disabilities** than the state average. Many of those with disabilities are 65 or older in the county.

"Curry County has more disabled people than we realize, including veterans with PTSD and hyper-vigilance." —Focus Group Participant

Disabilities, 2011-2015
Curry County and Oregon
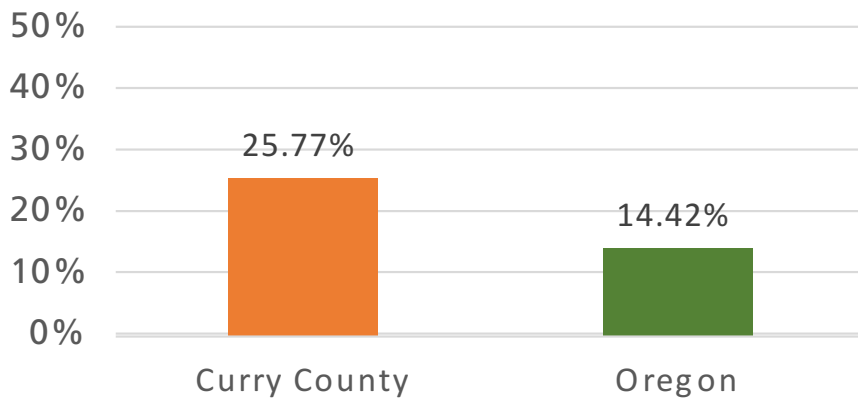
Disability by age, 2011-2015
Curry County and Oregon

■ Under Age 18   ■ Age 18 - 64   ■ Age 65 +
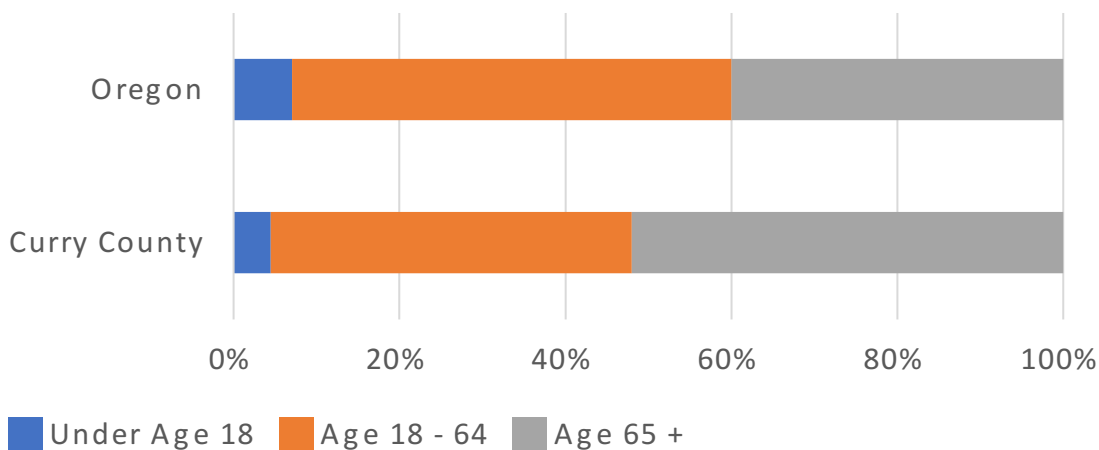
Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Indicators

The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

Demographic

Indicator	Findings (Curry County vs. Oregon)
Population	Overall growth ↓
Race & Ethnicity	Percent Hispanic or Latino ↓ Percent Native American ↓
Spanish Speakers	Decreasing percent of Spanish speakers ↓
Age	Percent population 55 and older ↑ Percent under 18 years old ↓ Percent families with children ↓
Veterans	Percent veterans, mostly men ↑
Disability	Percent disability ↑ Percent over age 65 with disability ↑
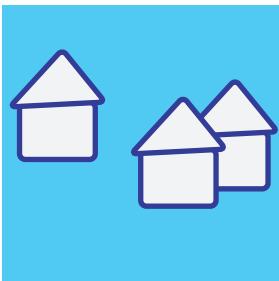
Neighborhood and Physical Environment

Physical environment is one important social determinant of health. Where somebody lives and how they move around from place to place to access basic services such as grocery stores, health care and work greatly influences health. Physical environment such as indoor and outdoor air quality also affects health outcomes. Exposure to environmental toxins and other hazards such as lead influence health conditions. Opportunities for physical recreation, either built or natural, affects health behavior.

Outdoor air quality is a **strength** in Curry County, consistently better than state and national air quality. The wildfire season in 2017 was particularly damaging and affected the air quality, but up until then, the particulate matter in the air was significantly lower than National Ambient Air Quality standards. Physical environment, including air quality and recreational opportunities, was overwhelming chosen as the biggest strength of the county, by participants in the 2018 CHA surveys and focus groups.

> *"Quality of air we breath, most especially during the fire season and how many of us in the community suffered and still are from the damaging effects of the poor air quality we breathed in during two months from the now historic Chetco Bar Fire in 2017." —Survey Participant*

> *"Having just moved here, I would say air quality, location, general environment is a strength, meaning it isn't like Los Angeles." —Focus Group Participant*

Indoor air quality data is difficult to gather in the county, but many focus group and survey participants mentioned it as being poor in the county.

> *"Quite a few houses have mold issues and are in general need of repair." —Focus Group Participant*

Natural outdoor recreation opportunities are many in the county. According to available online data, there are 40 parks in the county. There are also multiple trails for hiking, biking and recreation and dozens of beaches, lakes, forests and streams (Oregon Hometown locator). The weather can impact outdoor recreation while access to built walking and running paths are

limited in the county.

"We don't have much indoor walking during rainy season or indoor swimming pool, we need both I think." —Survey Participant

Recreation and fitness facilities, 2010-2015
Curry County and Oregon
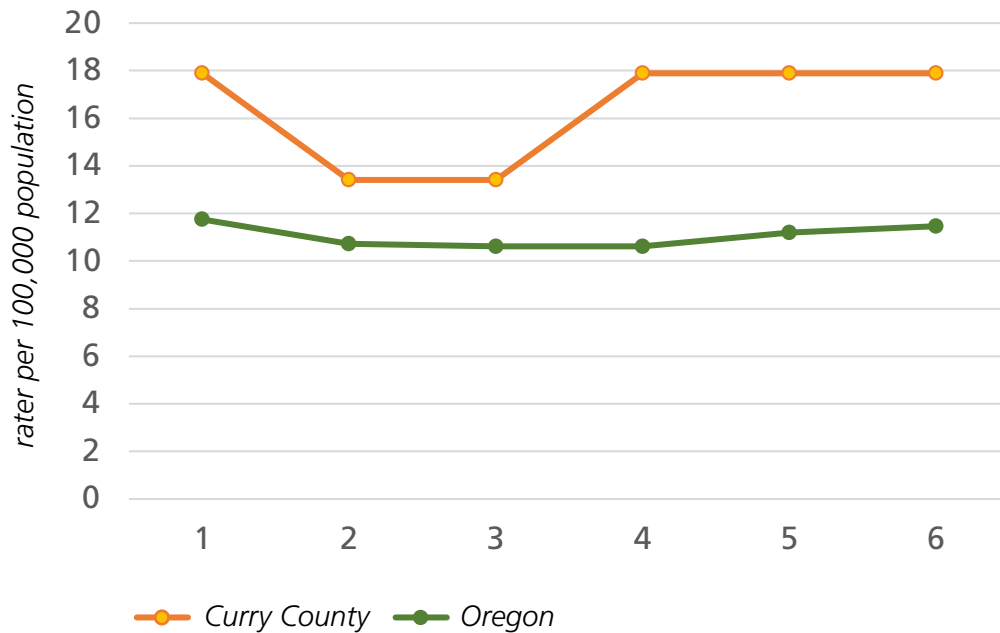
Source: US Census Bureau, County Business Patterns

There are limited built environment recreation opportunities, including limited walking and bike lanes, sidewalks and established gym facilities. The rate of establishments is higher than the state average but the number of establishments is still low at four total facilities in the entire county.

Housing

Where people live is core to quality of life. Housing **availability and quality** is a well-established social determinant of health. Household quality problems such as overcrowding, incomplete kitchen or plumbing facilities and cost burden are experienced by 39% of the population in Curry County, higher than the State average (US Census Bureau, American Community Survey 2011-2015).

Household **costs** are related to availability. 35% of households in Curry County (estimated 3,971 households) are cost burdened, meaning their rent or mortgage exceed 30% of their household income, this is higher than state levels. According to the recent Brookings Housing Needs Assessment (October 2017), the majority of the households (in Brookings) that are cost burdened have an annual income between $20,000-35,000, making a strong case for more affordable housing options and rentals. Availability of housing was second only to poverty in the biggest concern for focus group and survey participants of the 2018 CHA process.

"HUGE lack of affordable housing for the working class just adds to our problems. Even making above minimum wage a person/family has to pay a large percentage of their income just to have a roof over their head, that is often sub-par and leaves them with little to meet other requirements of living in our society. In this community one is LUCKY to find something that is under 50% of your income, this is outrageous and sets our community up for failure in the long run."—Survey Participant

"Too much planning efforts for expensive housing and not enough in affordable, family housing." —Survey Participant

"We can't attract people to fill positions because there is no housing, we need more affordable housing inventory." —Focus Group Participant

The median value of homes has decreased in the county since 2006. Curry County also has higher percentages of housing dedicated to seasonal or recreational use, close to 50% of vacant housing is used for seasonal, recreational or occasional use. The 2017 Brookings Housing Needs Assessment also listed that in Brookings, 49.8% of vacant housing is seasonal or recreational use in 2010, climbing to an estimated 61.1% in 2017 and projected to be 70% in Brookings alone by 2025, showing an increasing trend.

"Housing is limited. Some of its from vacation housing, making rent too high or not even available. Its why we have so many mobile homes here." —Focus Group Participant

Vacant housing units by housing market classification
2011-2015 Curry County

vacant housing units for sale **17%**

vacant housing units for rent **11%**

vacant housing units for other use **72%** *vacant housing units for other use includes vacation rentals
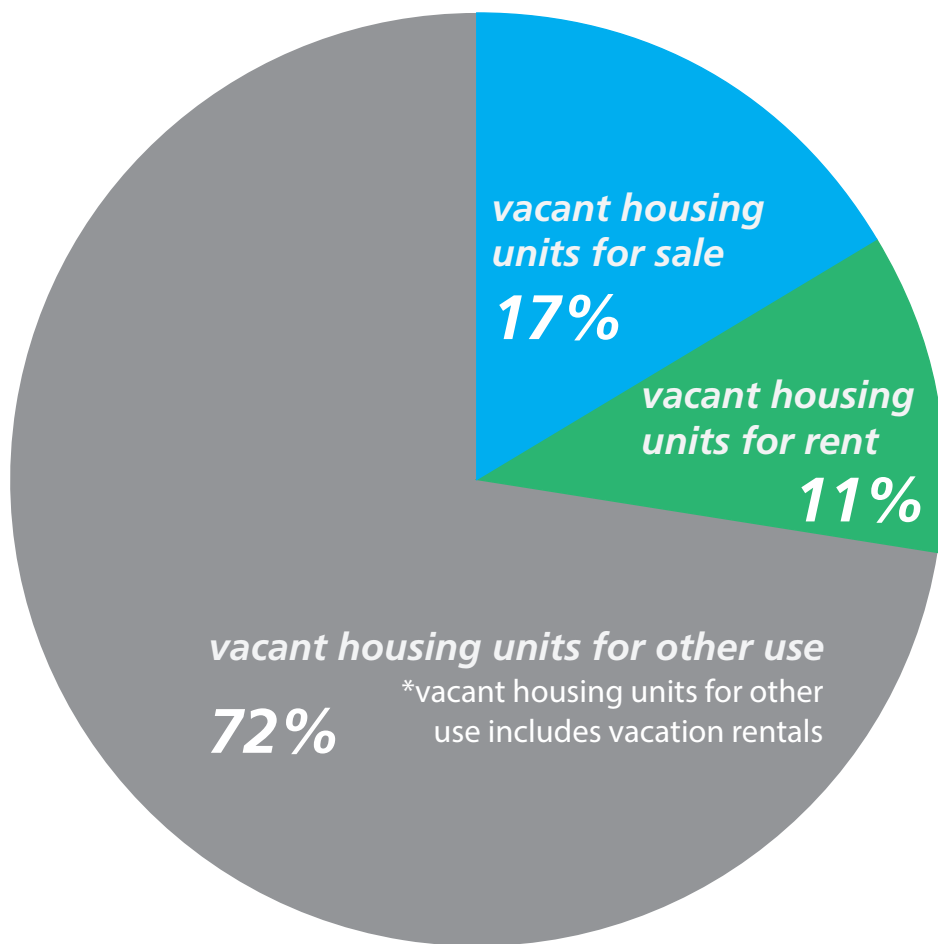
Source: US Census Bureau, American Community Survey

Housing affordability and availability was consistently listed as a concern related to recruitment of professionals to the area, specifically in the health care and education industries.

"I've come here from California, I can get a nice house way cheaper here but I can't find a place to rent while I shop. Affects doctors and teachers, I had a week to find a house when I moved here for a job and settled for something I'm not happy in." —Focus Group Participant

Homelessness

People experiencing homelessness, defined by anyone who lacks a fixed, regular and adequate nighttime residence, was listed as a significant concern in the 2018 CHA primary data focus groups and surveys. The number of homeless adults is increasing according to the annual point in time count.

The number of homeless students is also increasing and trending up county wide and in most districts. Homelessness in youth can include those without a permanent home but also includes those doubled up or "couch surfing."

"We see more grandparents living with their kids and their kids' kids or single parents going to live with other families. It affects large swaths of youth that don't have a bed or a regular room of their own." —Focus Group Participant

Homeless count, 2011-2016
Curry County
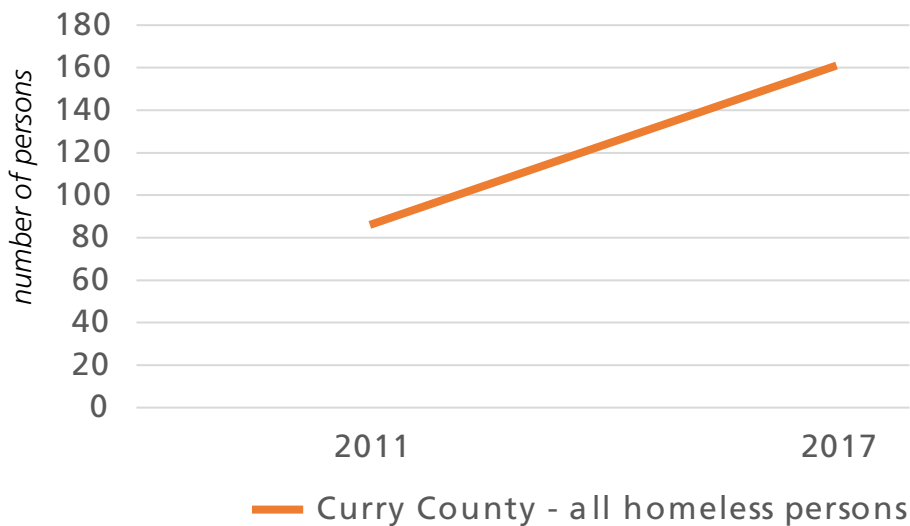
Source: Oregon Housing and Community Services 2011-2017

"Homelessness has increased, we have couch surfers that don't learn the skills they used to in school." —Focus Group Participant

Homeless students (K-12) by district, 2013-2016
Curry County
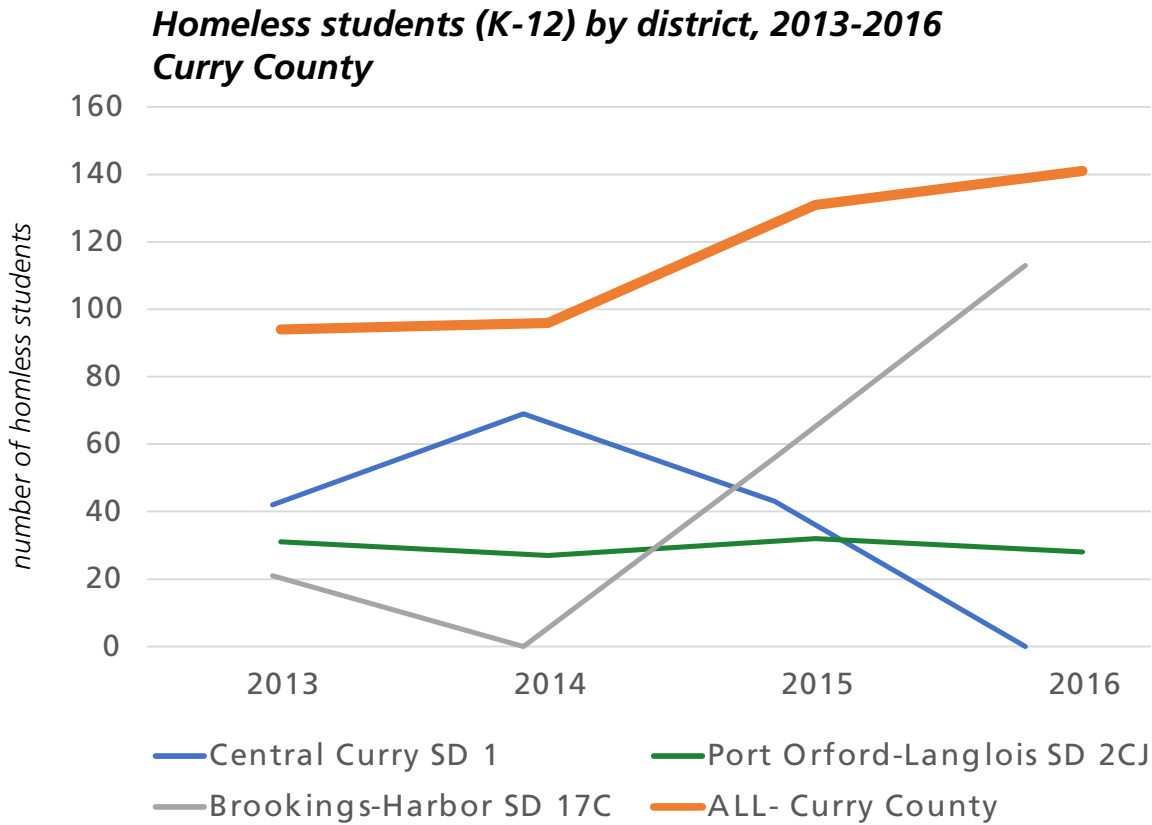
Source: Oregon Department of Education

Transportation

Limited public transit and the geographical distance and terrain affects transportation to work, school and health care, particularly for those with limited resources. According to US Census estimates, 85.5% of workers drive to work (2015), 0% used public transit, slightly over 8% walked in Curry County. Transportation, particularly to medical appointments was a consistent issue brought up in both focus groups and by survey participants.

"Transportation is a problem, some people don't have a car or reliable car or they can't afford gas." —Focus Group Participant

"Transportation is limited, most transportation here is special support from friends, if you don't have friends you don't get transportation."—Focus Group Participant

Indicators

The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percent/percentages.

Neighborhood and Physical Environment	
Indicator	*Findings (Curry County vs. Oregon)*
Housing Availability	Vacant housing dedicated to recreational/vacation or occasional use ↑
Housing Costs	Cost burdened households in rentals & homes with mortgages ↑ Median value of a house since 2006 ↓
Housing Quality and Type	Severe household problems ↑
Homelessness	Homeless students by district trending up ↑ Homeless adults trending up ↑
Air Quality	Outdoor air quality ↑
Recreation and Fitness	Recreational facilities ↑
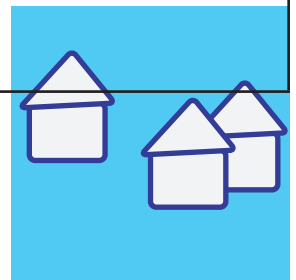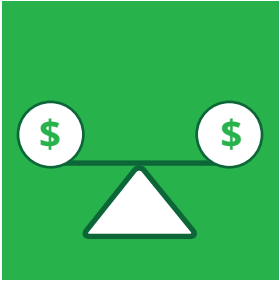
Economic Stability

Income

Economic stability is a social determinant of health and it includes issues such as poverty, income, employment and unemployment. Income and income inequality is directly linked to an individual's health. Income inequality has been shown to have health impacts including increased risk for poor health and increased risk of death. The average and median incomes in Curry County are lower than state levels. Poverty levels are increased in the County, compared to state and national percentages.

Annual family income, 2012-2016 Curry County and Oregon
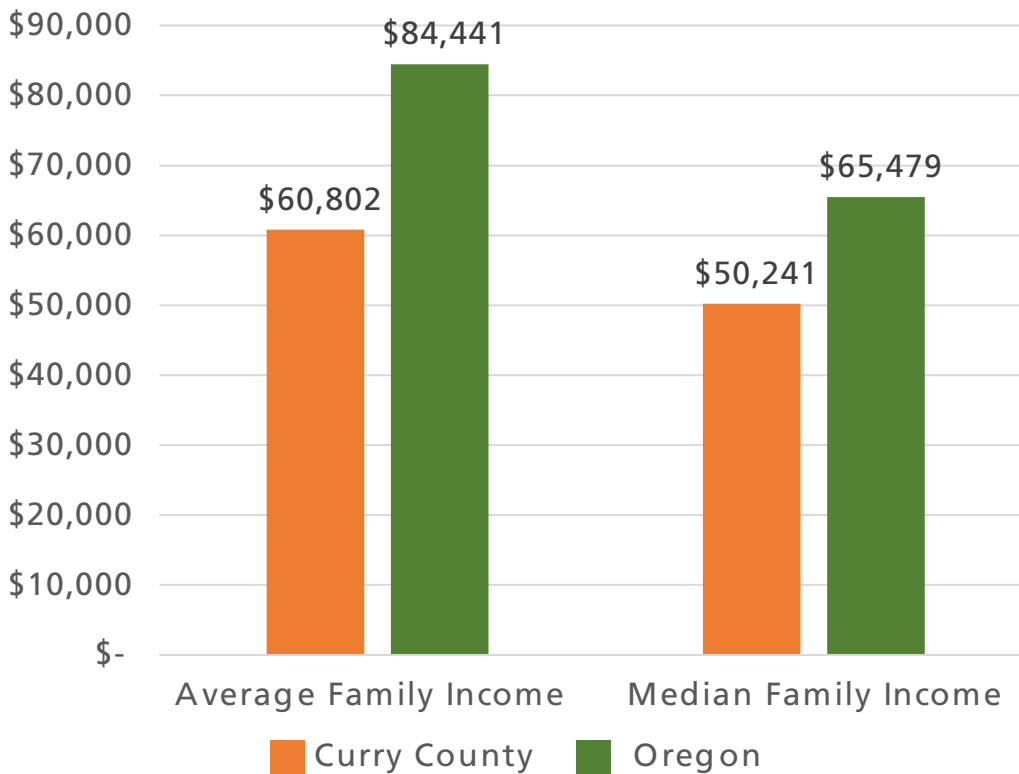
Source: US Census Bureau

When compared to state and national wages, the county has more of its jobs in the lower wage categories, most in the under $40,000 annual salary.

Distribution of various wage buckets, 2015
Regional, Oregon, National

Coos, Josephine & Curry   Oregon   National
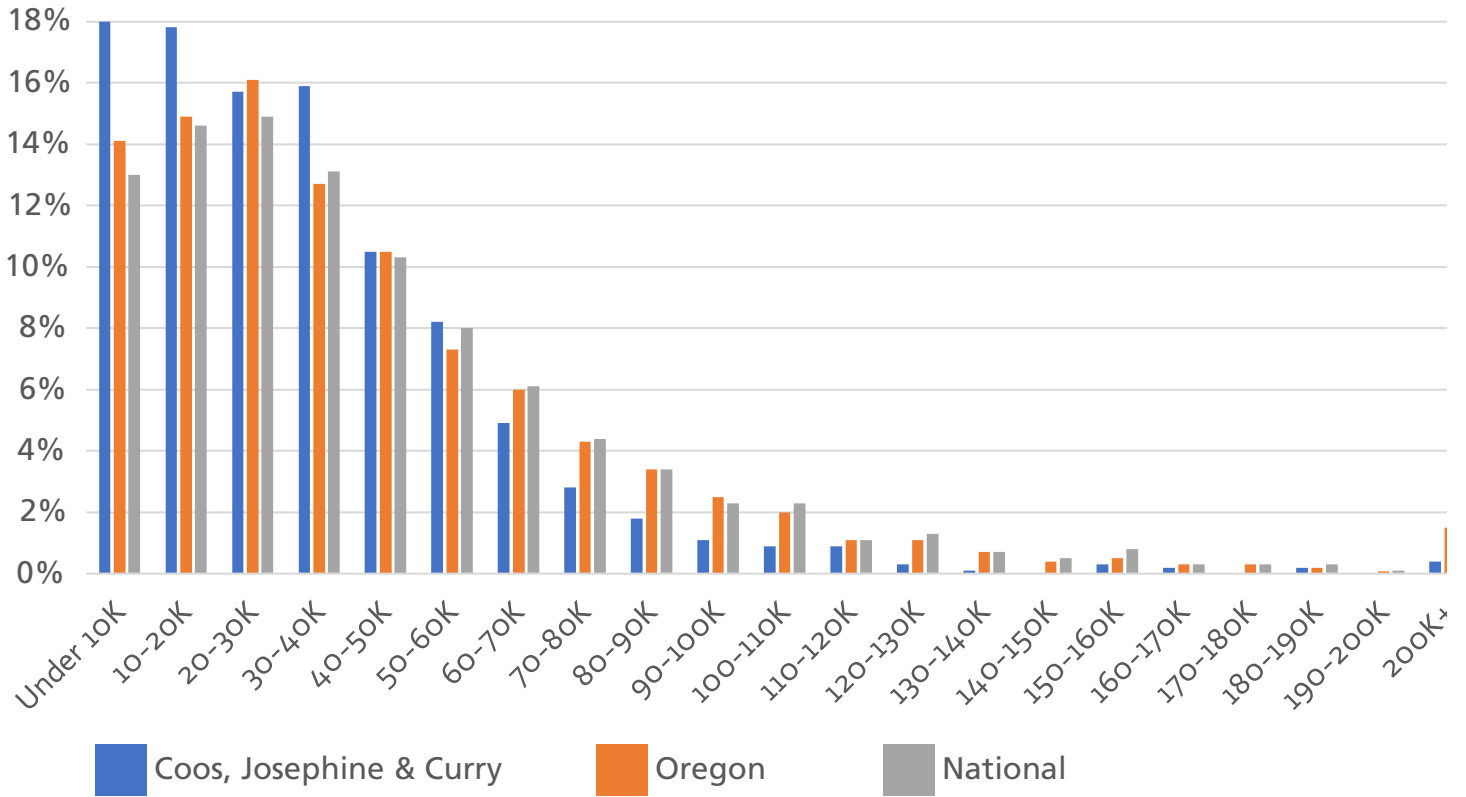
Source: American Community Survey PUMS 1-Year Estimate

Poverty

The percentage of the population living in poverty in the county ranges 17-18% depending on source.

Poverty in Oregon

Better   State Average   Worse
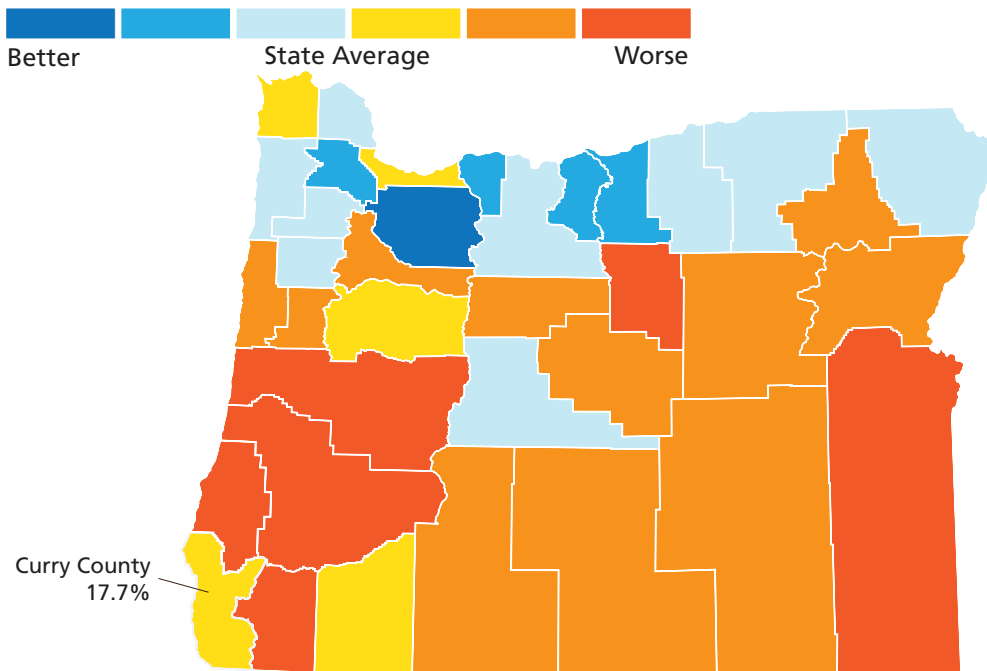
Curry County
17.7%

Poverty affects those in older age categories disproportionately in Curry County, compared to state averages. Those over 64 years of age are over twice as likely to be living in poverty than people of the same ages statewide. Furthermore, women are more likely than men to be living in poverty in Curry County. 48.5% of children under 18 live below 200% of the federal poverty level in the county, according to 2011-2015 census estimates.

Poverty level by age
Curry County and Oregon, 2012-2016
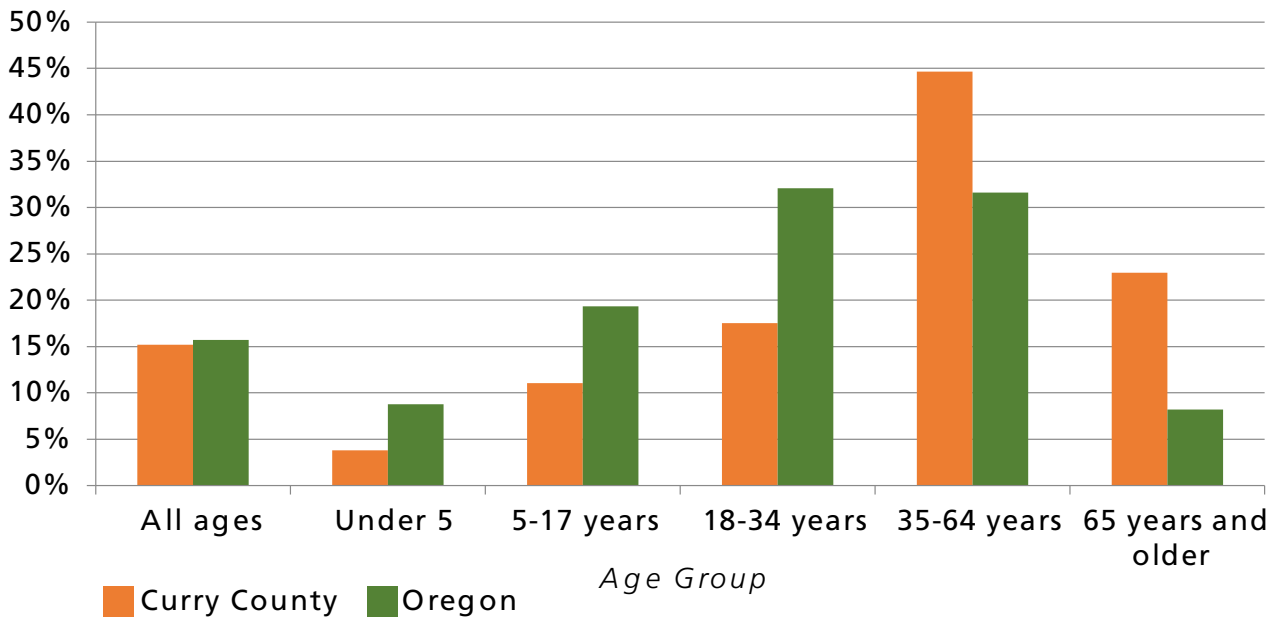
Source: U.S. Census Bureau

Another indicator of poverty includes children who are eligible for free or reduced lunches at school. In Curry County, 60% of children are eligible, more than the state average (51%) and higher than neighboring Coos county.

Students receiving free and reduced lunch select schools in Curry County, 2010-2016
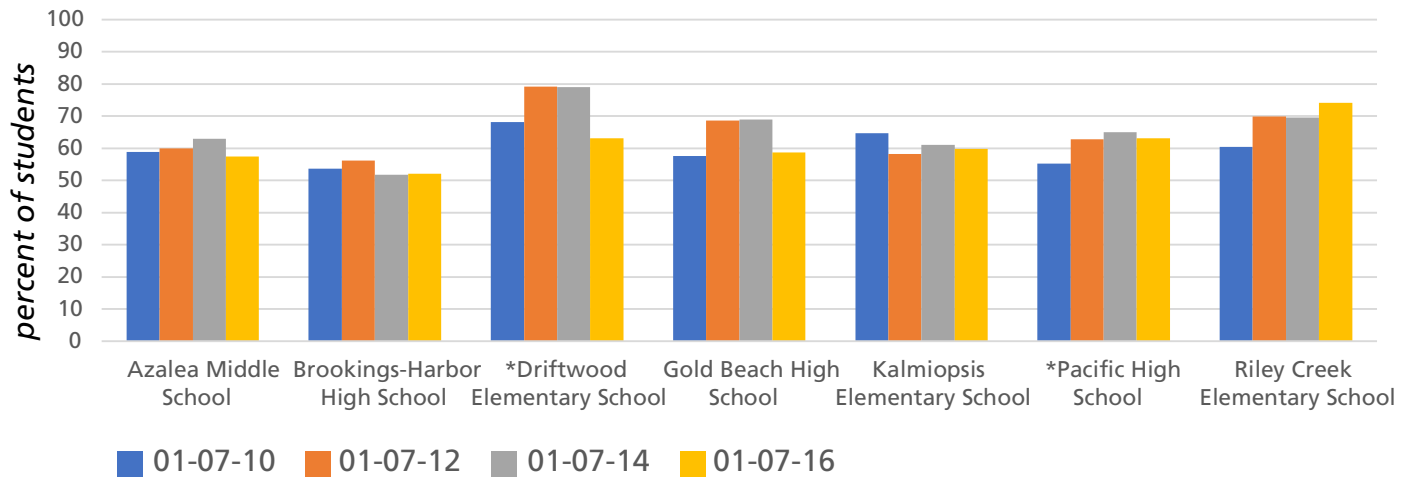
Source: Oregon Department of Education

Employment and unemployment

Employment and annual census of employees has been trending up in Curry County since 2014, a trend consistent across the region.

Annual census of employees, 2007-2016 Curry County
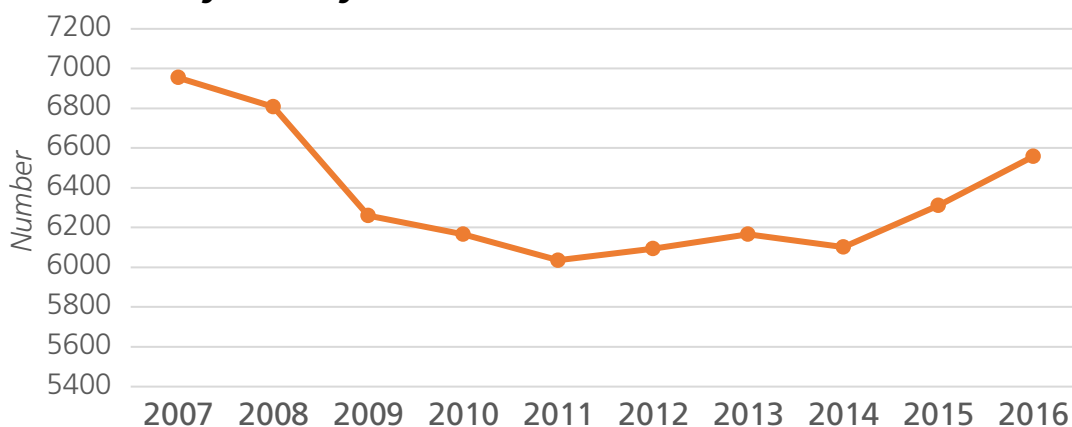
Source: US Bureau of Labor Statistics

Unemployment remains higher than the state average but has been trending down since 2009, a positive trend. Unemployment in Curry County in 2017 was 6.9%.

Unemployment, 2006-2017
Curry County and Oregon
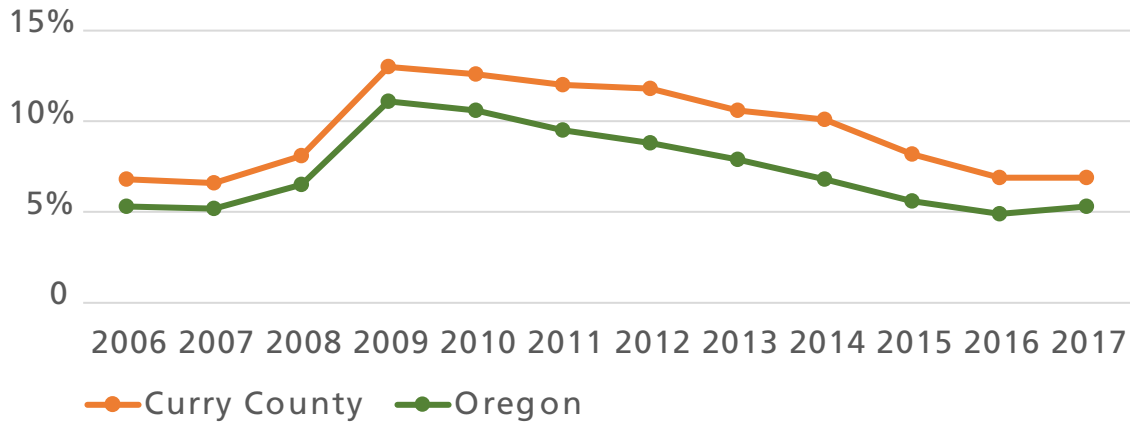
Source: US Bureau of Labor Statistics

Indicators

The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percentage/percentages.

Key
⬆ =higher (than State)
⬇ =lower (than State)

Economic Stability	
Indicator	Findings (Curry County vs. Oregon)
Income	Income ⬇ Individuals with lower wage jobs ⬆
Living in poverty	Living in poverty ⬆ Living in poverty over 65 years of age ⬆ Children live at or below 200% Federal Poverty Level ⬆
Free and Reduced-price lunches	Students qualifying for free and reduced lunch ⬆
Unemployment	Percentage unemployed ⬆
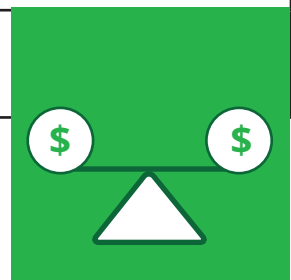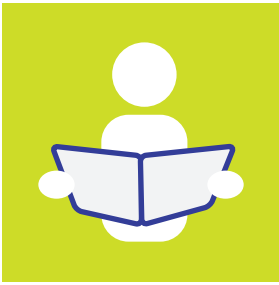
Education

Education is an important social determinant of health, as education increases a person's overall health also often increases. More education has been shown to be linked to longer life and increased income, while lower education attainment can be linked with poor health, higher levels of crime, unemployment and increased stress.

Children and Early Learning

Children in Curry County have benefited from early learning programs like Head Start. The rate of students enrolled in Head Start is significantly higher than state averages, a clear strength of the community.

Students in Head Start 2014
(per 10,000 children)

35.25 **Curry County**

8.84 **Oregon**
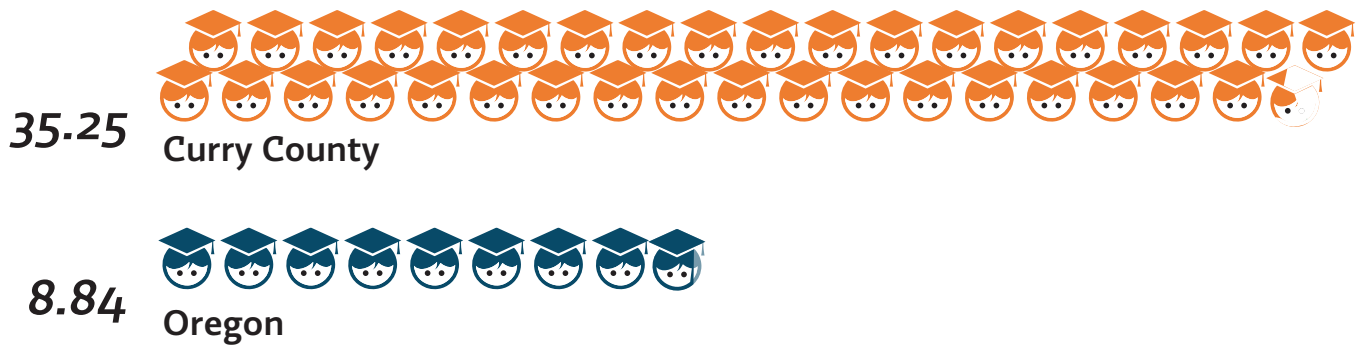
Kindergarten assessment scores are close to state averages, with Hispanic children scoring slightly better than state scores in Curry County.

"Healthy communities have support and recognition and focus on children. They are our future."—Survey Participant

Childcare availability was listed as a concern in the 2018 CHA focus groups. Data from the National Data System for Child Care showed 20 providers registered in Curry County, but only 15 choosing to be listed. All of the providers listed are in Brookings with the exception of one in Langlois and one in Gold Beach.

"We need more accessible, safe child care and activities, safe bike paths, being able to not stress about where my kids are and if they are safe while you are at work." -Focus Group Participant

"We have a childcare issue limiting families from being able to find jobs and stick with them, leading to decreased basic needs for the families." -Survey Participant

Kindergarten assessment scores, 2016-2017
Curry County and Oregon
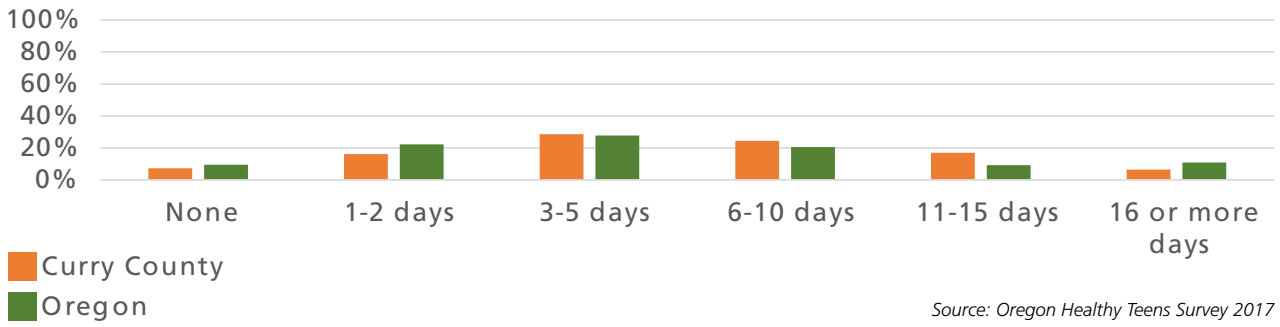

Curry County
Oregon
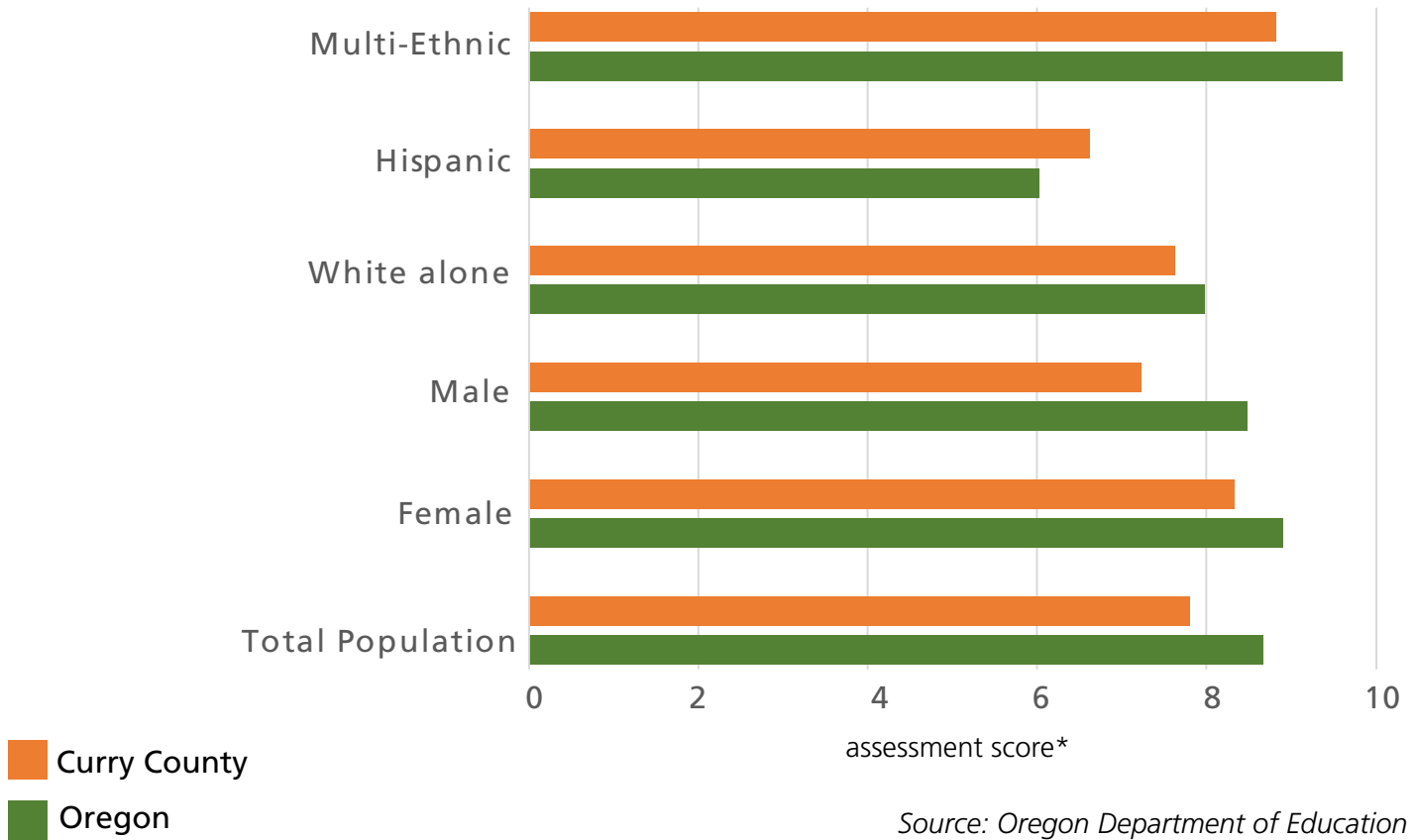
assessment score*

Source: Oregon Department of Education

*assessment score on a 0-10 scale

Absenteeism, Graduation & Education Attainment

Absenteeism in school is an indicator related to education. Curry County has higher percentages of absenteeism in 8th and 11th graders, with physical reasons being listed as the highest reason for absenteeism. One in four 8th graders missed between 3-10 days of school in 2017.

Absenteeism in 8th graders, 2017
Curry County and Oregon

Curry County
Oregon

Source: Oregon Healthy Teens Survey 2017

"We have a low graduate rate, knowledge deficit and hopeless abound." —Focus Group Participant

High school graduation has been slightly lower in Curry County than Oregon since 2011 similar to neighboring Coos County. Latest available data shows 72.6% of ninth graders graduated from high school in their cohort (4 years later) in 2015-16.

4 year cohort graduation rates, 2008-2016 Curry County and Oregon

Source: Oregon Department of Education
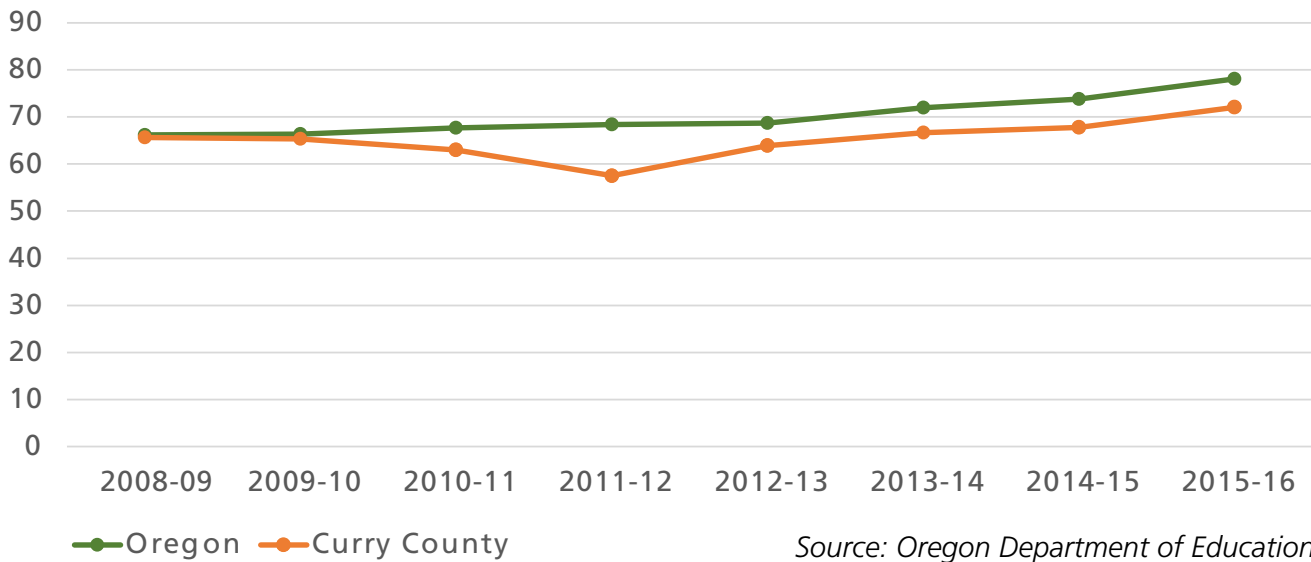
"We have a low emphasis on education." —Focus Group Participant

When compared to the state, Curry has fewer people with bachelors, graduate or professional degrees than state averages.

"With loss of logging and fishing industry its been hard. We used to have 400 kids in high school, now there are only about 100." —Survey Participant

Educational attainment 2011-2015
Curry County and Oregon

Legend:
- Graduate or professional degree
- Bachelor's degree
- Associate's degree
- Some college, no degree
- High school graduate (includes equlvalency)
- 9th to 12th grade, no diploma
- Less than 9th grade

Source: Us Census
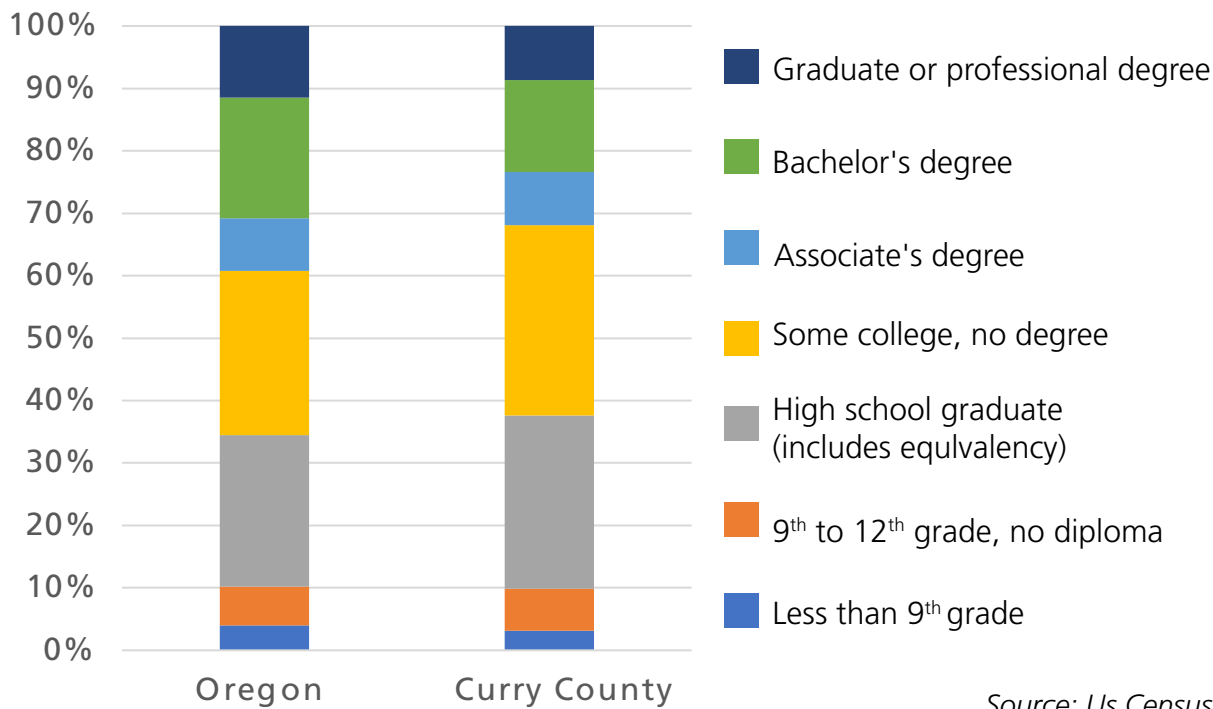
People in Curry County with less educational attainment are more likely to be living in poverty.

Poverty status by educational attainment, 2011-2015
Curry County and Oregon
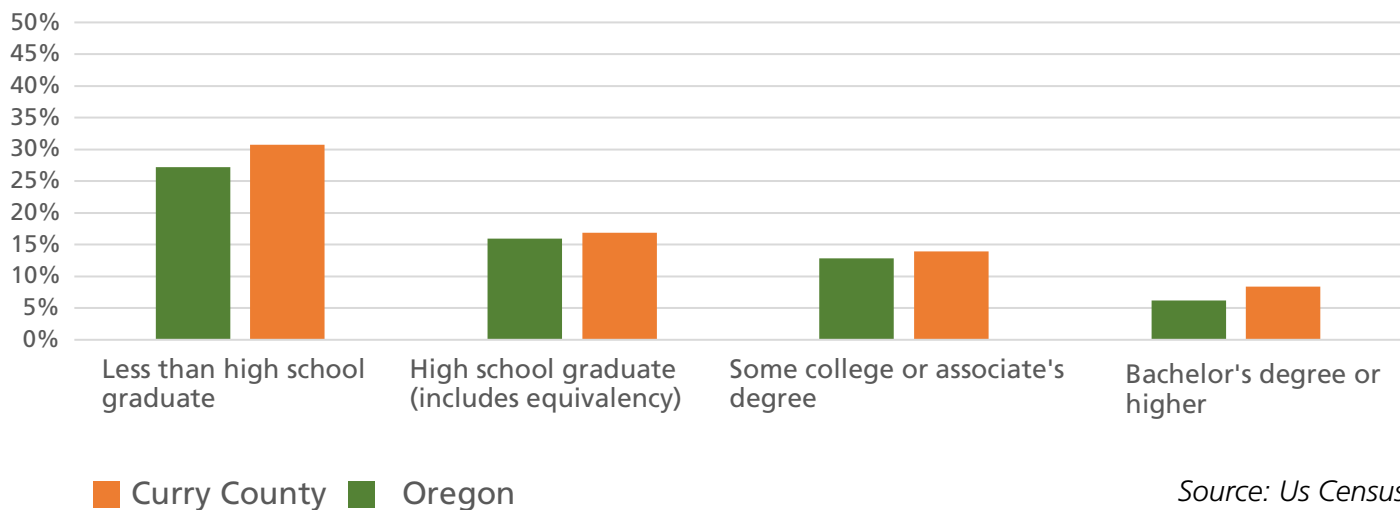
Legend: Curry County, Oregon

Source: Us Census

Indicators

The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percentage/percentages.

Education	
Indicator	*Findings* *(Curry County vs. Oregon)*
Early Childhood	Students in Head Start ↑
Graduation Rates	Graduation ↓
Educational Attainment	People with bachelors or advanced degrees ↓ Percentage of high school graduates living in poverty ↑
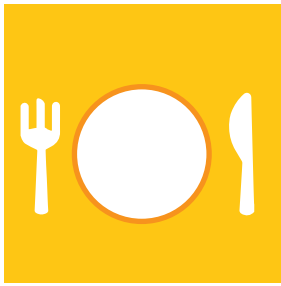
Food

Eating nutritious food and maintaining a healthy diet are important to individual health. Poor nutrition has been shown to increase risk for various chronic health conditions and to increase morbidity and mortality. A healthy food environment includes access to healthy foods and food security.

Access to food has many facets including the cost, distance and availability of fresh and healthy food options. The USDA defines food insecurity as lack of access to enough food for all members in a household and limited or uncertain availability of nutritionally adequate foods. 1 in 4 children (24.5%), aged 18 and younger in the county remain food insecure, higher than the state average. Overall, residents of Curry County experience more food insecurity than in the state as whole.

Adults and children with food insecurity, 2015 Oregon and Curry County

Source: Feeding America, 2015
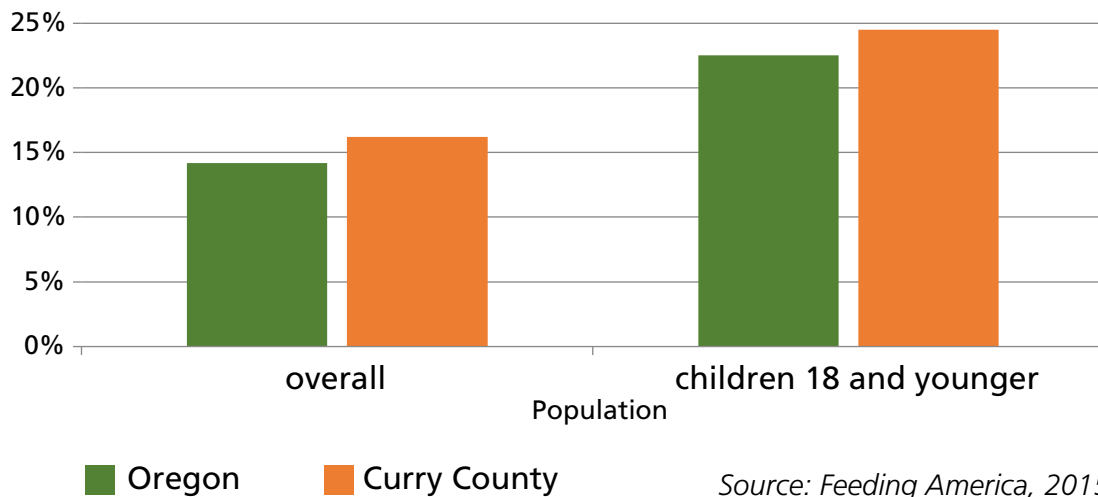
Twenty percent of 8th graders in Curry County answered yes when asked if they ate less than they felt they should because there wasn't enough money to buy food. This is higher than the 14% state average (Oregon Healthy Teens Survey 2017).

Access to healthy foods has improved since the 2013 Community Health Assessment and is better than some counties in the state. The food environment index for Curry County is 6.9, the same as neighboring Coos County. The food environment index is based a scale of one to ten, with (0) being the worst and (10) being the best. 5% of the county has limited access to healthy foods, according to the USDA Food Security Survey, Feeding America 2014 survey.

"We don't have fresh enough food. You know what they say…small communities get the least fresh food and its true here in Gold Beach." —Survey Participant

33.3% of the population in Curry County lives in a food desert, which is slightly better than state averages but still identifies a need. A food desert is defined as a low-income census tract where a substantial share of residents have low access to a supermarket or large grocery store.

"As to food, I notice a distinct lack of freshness of everything food wise. Buy fresh and its bad two days later. Everything comes "fresh" to Gold Beach is already at the end of its freshness."—Focus Group Participant

Women, Infants and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP) benefits are public programs designed to address food access and insecurity. The rate of stores that accept either WIC or SNAP benefits is more than state averages, indicating a program asset and strength while also indicating a large number of residents qualifying for benefits.
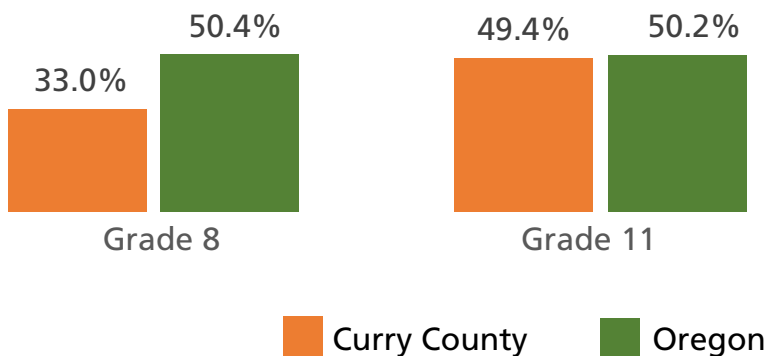
"SNAP and WIC have increased availability."— Survey Participant

SNAP (2016) and WIC (2011) authorized stores Curry County and Oregon

Rate per 100,000

■ Oregon   ■ Curry County
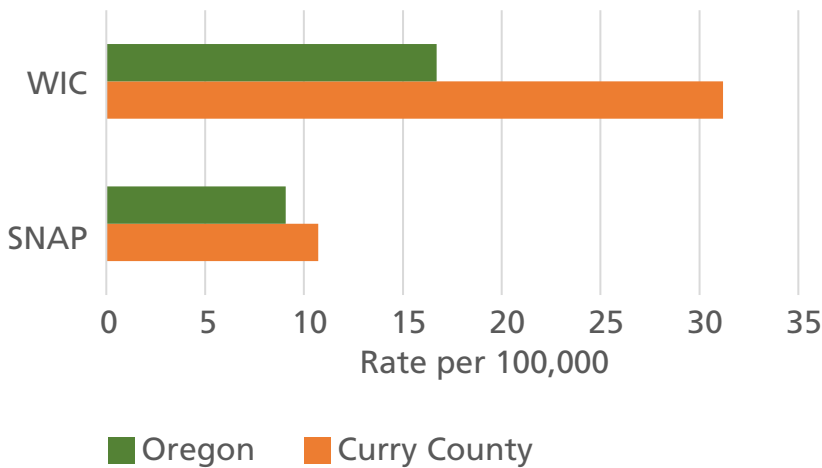
Source: US Department of Agriculture, Economic Research Service 2011

Youth drinking water four times a day or more 2017 Curry County and Oregon

Grade 8: 33.0%, 50.4%

Grade 11: 49.4%, 50.2%

■ Curry County   ■ Oregon

Source: Oregon Healthy Teen Survey, 2017

Eating five or more servings of fruits and vegetables a day is lower, for adults, in Curry than Oregon. 48% of 8th graders have consumed soda 1-3 times in the past 7 days, while water consumption in 8th graders is lower than state averages, according to 2017 Healthy Teens Survey.

Adults consuming at least 5 servings of fruits and vegetables a day, 2012-2015
Curry County and Oregon
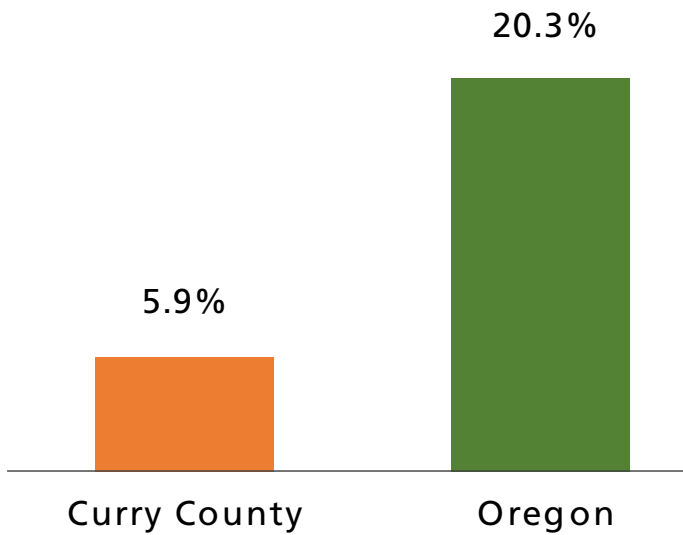
"When parents are either not working and depressed or are working multiple wage jobs, they don't and can't prepare healthy food. We need a low-cost walk-in fresh food store, combined with education on quick, low cost, healthy food preparation." —Focus Group Participant

Source: Oregon BRFSS County Combined Dataset 2012-15

What 8th graders drink 2017
Curry County and Oregon
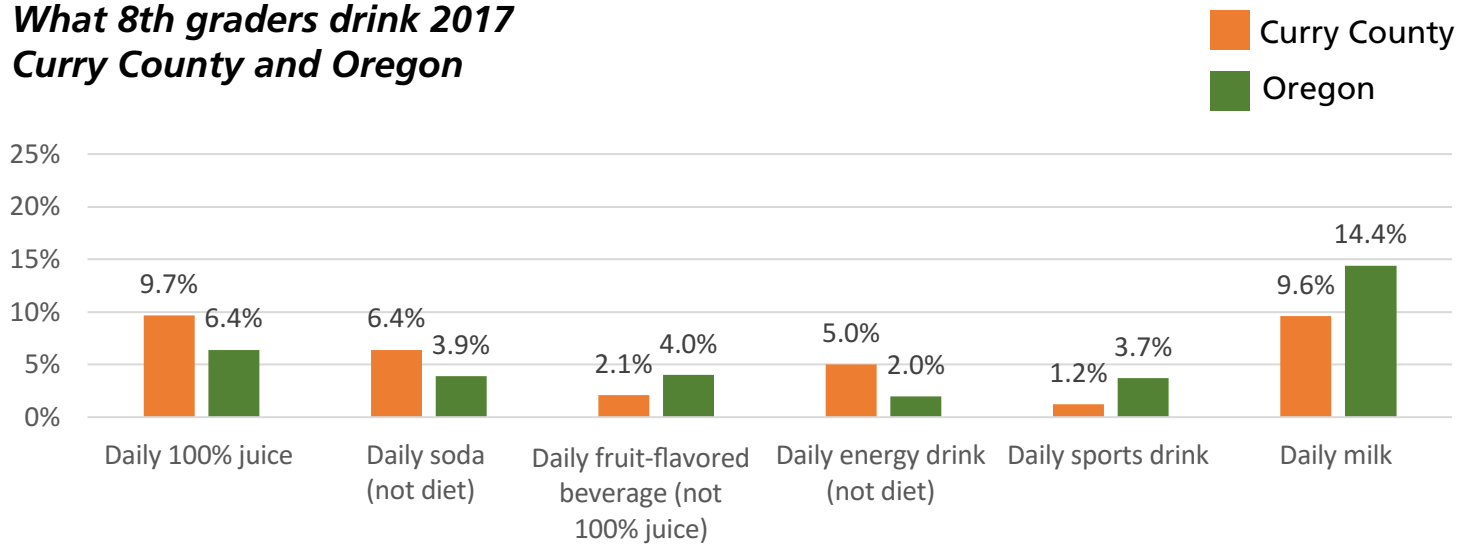
Source: Oregon Healthy Teen Survey, 2017

2018 Curry County Community Health Assessment - 30

Indicators

The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percent/percentages.

Key

↑ =higher (than State)

↓ =lower (than State)

| Food	
Indicator	*Findings* *(Curry County vs. Oregon)*
Food Insecurity	Adults and children living with food insecurity ↑
Food Access	SNAP authorized retailers ↑ WIC authorized stores ↑
Soda Consumption	8th graders drinking sodas ↑ Adult soda consumption ↑
Fresh Food Consumption	Adults consuming fruits and vegetables ↓
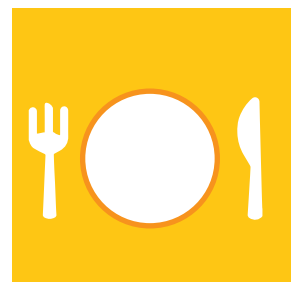
Community

Indicators related to community include social connections and crime. Social associations are one way to measure social connectivity and social cohesion in a community. Lack of social connectivity and resulting isolation can influence health outcomes of individuals and community.

The number of membership organizations such as service organizations like Rotary or Zonta, sports groups, political organizations, clubs and professional organizations indicate volunteerism and connectivity. The rate of such associations in Curry County (2014) is 11.5 per 100,000 population, higher than Oregon's average of 10.4 per 100,000, a **strength** in the county.

"The library and book clubs have saved my life because they are a supportive environment." —Focus Group Participant

Membership organizations
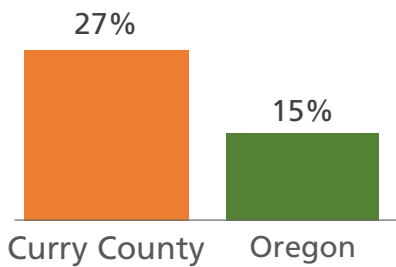### *2014 Curry County and Oregon*

Rate per 100,000
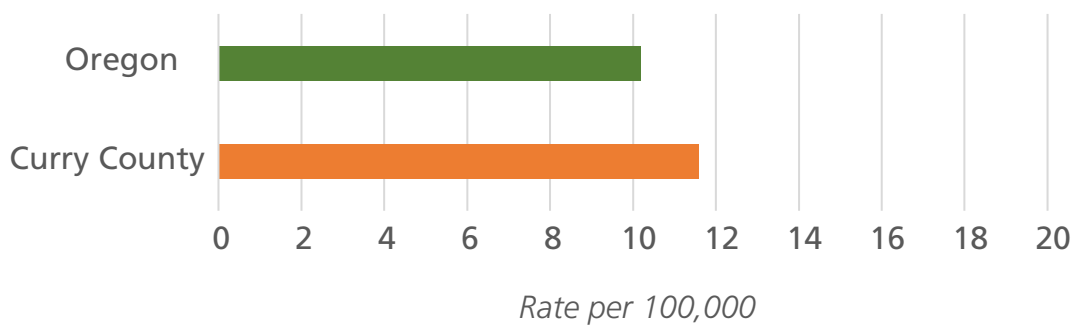
Source: County Business Patterns, 2014

Participants in the 2018 CHA focus groups and surveys universally chose social support including religious and spiritual values as the second biggest strength in the community. The third biggest strength were the people that live here, similar to neighboring rural counties.

While social associations are strong, many individuals indicate that they still don't have adequate social and emotional support. 23% of individuals in the county say they don't have adequate social and emotional support. Nearly one in three (27%) youth state that they are neither working or in school, indicating disconnection from community. This is higher than state averages.

"Need to address people who isolate themselves, pockets of isolation here. We could improve a lot of things by spending more time together, building relationships, solving problems more together. Sometimes it only takes one person to reach out and reduce isolation." Focus Group Participant

Disconnected youth, 2010-2014 Curry County and Oregon

Individuals without adequate social or emotional support, 2006-2012 Curry County and Oregon

27%

15%

Curry County   Oregon

23.2%

15.2%

Curry County   Oregon
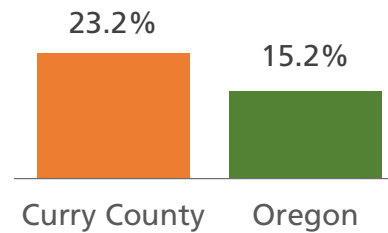
Source: Measure of America, using American Community Survey Data

Bullying in schools is also an indicator of social cohesion. 29.3% of 8th grade youth in Curry County experienced bullying in 2017, near the state average (Oregon Healthy Teens Survey 2017). The top reason for bullying was appearance (weight, clothes, acne or other physical characteristics), followed by gender (someone thought you were gay, lesbian or bisexual). The trend/percent of youth experiencing bullying is decreasing.
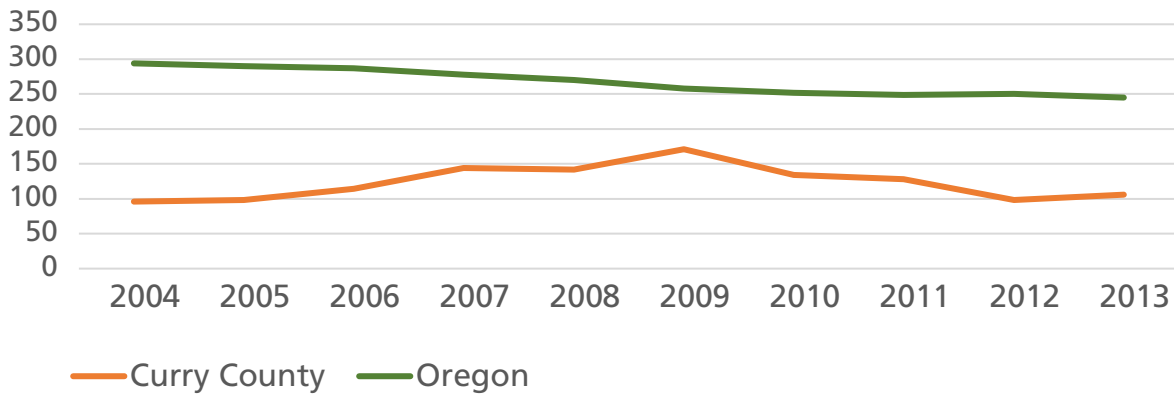
Youth experiencing bullying, 2005-2017 Curry County and Oregon
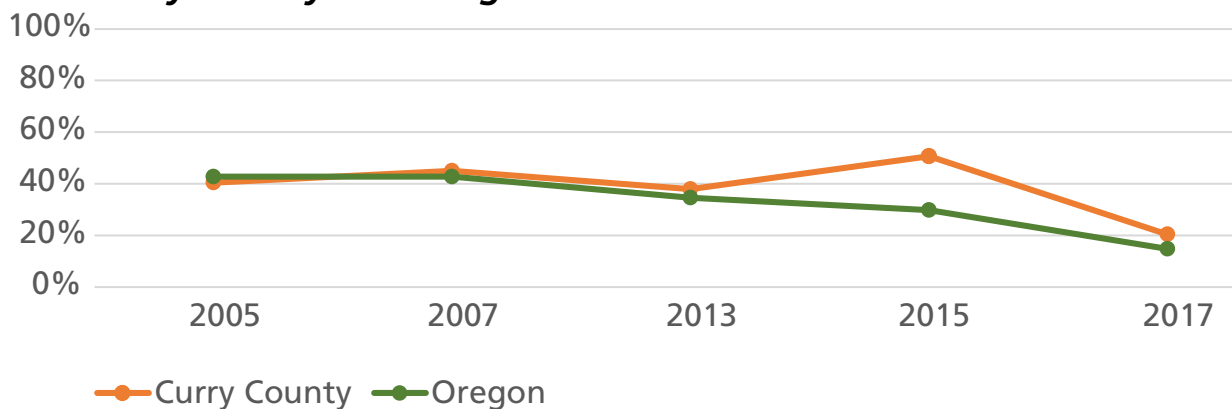
Source: Oregon Healthy Teens Survey

Violent crime is lower than state averages. Violent crime was trending up until 2009 until it began to decline again in Curry County.
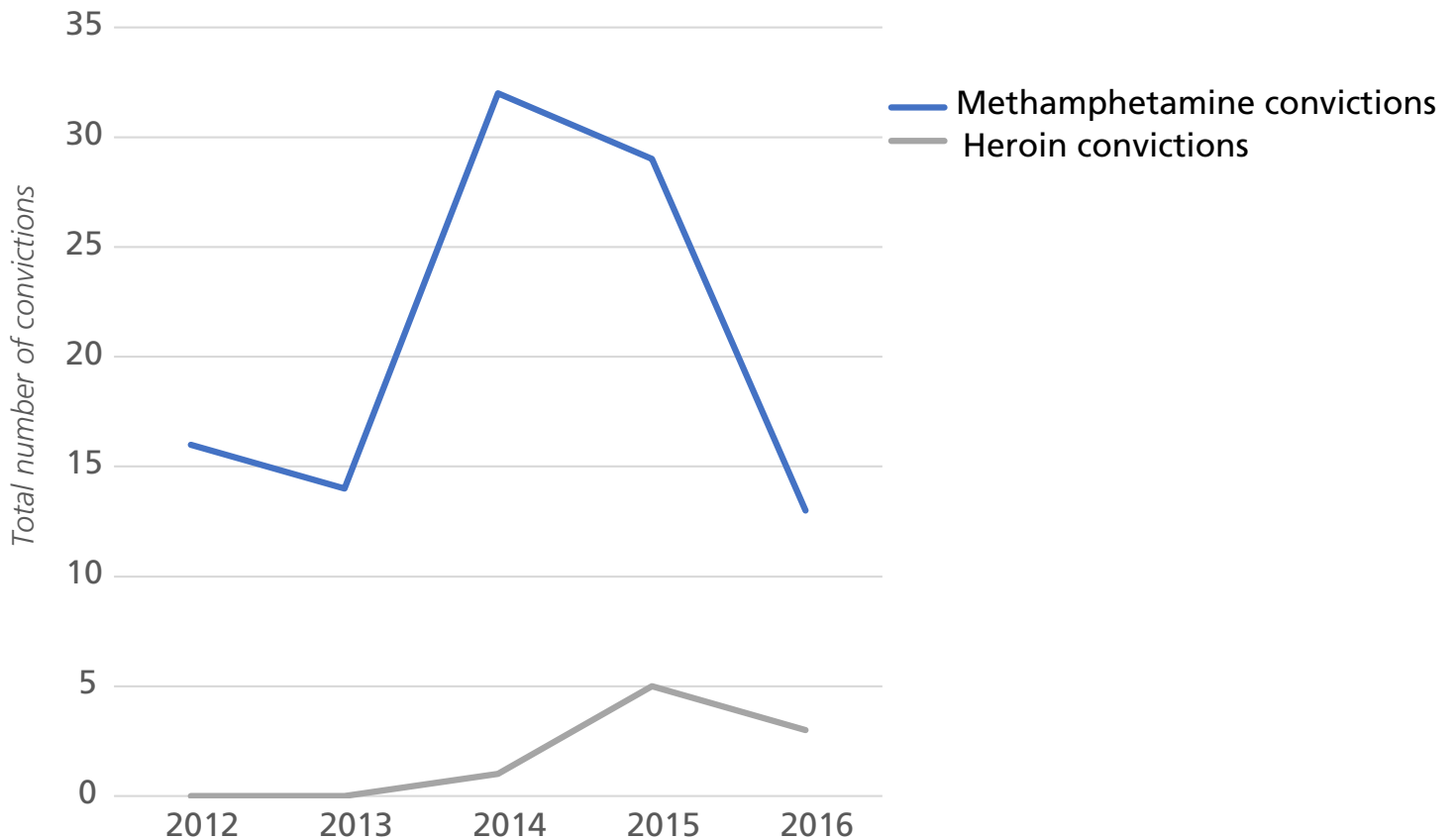
Violent crime, 2004-2013
Curry County and Oregon

Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports

The number of convictions for methamphetamine and heroin in the county are also on a downward trend.
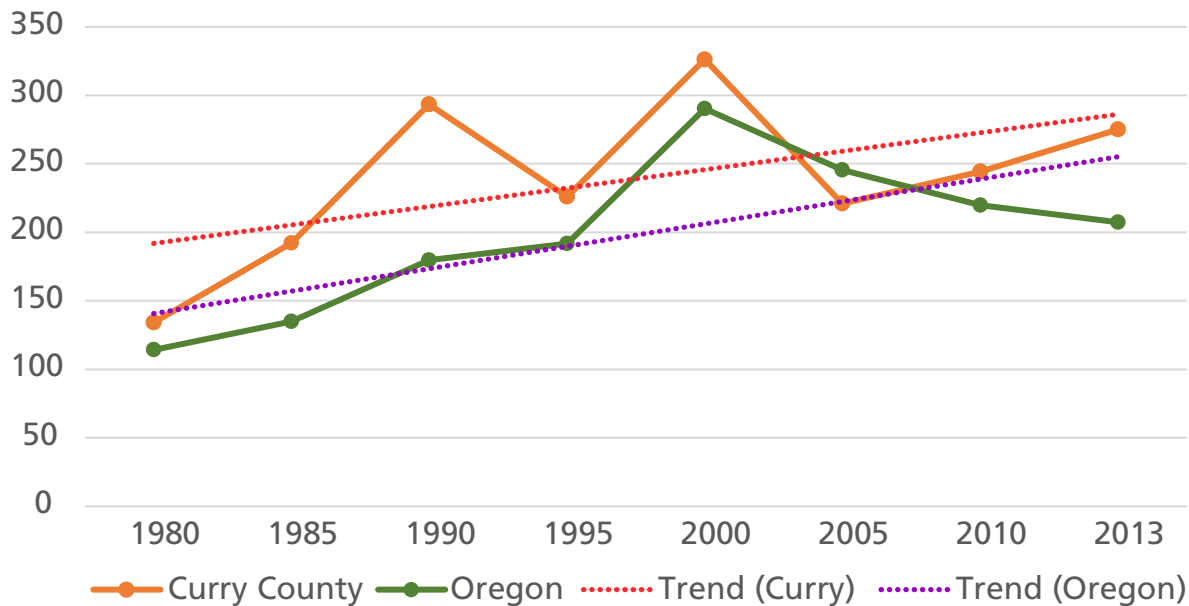
Convictions for Methamphetamine and Heroin, 2012-2016 Curry County

Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports

The institutionalized population or jail incarceration rate is higher than the state and has been on an upward trend since 1980.

**Jail incarceration, 1980-2014**
Curry County and Oregon

Source: Vera Project, Bureau of Justice Statistics (BJS) Annual Survey of Jails (ASJ) and Census of Jails (COJ). 1980-2014

The percentage of youth that report being intentionally hit or physically hurt by an adult in 2017 is nearly one in three (26.8%), higher than neighboring Coos County and state averages (Oregon Healthy Teens Survey 2017). However, the number of founded **child abuse** cases in the county is trending down. The victimization rate in Curry County is considerably lower at 8.2 per 1,000 children than state rates which hover close to 14 per 1,000 (DHS Child Welfare Data Book 2016). The number of children in foster care in the county in 2017 was 43. Foster care placement stability, which is the number of children in foster care with two or fewer placements, as a percentage of total number of children in foster care, is one of the worst in the state, ranking 32nd out of 36 counties in Oregon at 48.5% (Children's First Child Data Book, 2017).

"There is a lot of dysfunction and violence in mixed households/mixed houses and families that are mixed. You lose control of your family unit when mixed. Just because you have a warm bed you can't rationalize the other horrors and violence because its better than living in a car, sometimes it's not."
—Focus Group Participant

Child abuse reports*
2010-2016
Curry County
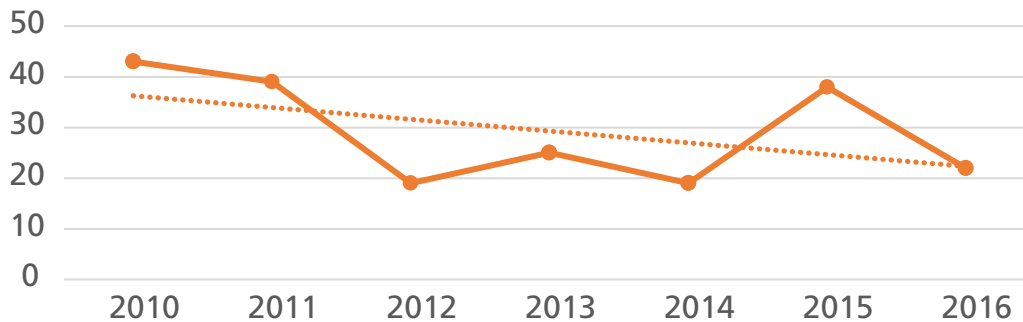
founded child abuse reports

Source: Child Welfare Data Book. 2010-16

Curry County had approximately fifty two **law enforcement** officers across all agencies (Oregon Annual Uniform Crime Reports, 2016) in 2016.

"There isn't any law enforcement here. We can't even recruit them, no money for them and too few of them. No regular policing, only if there is a severe drug issue. Really no policing in the mountains, it's scary." —Focus Group Participant

Indicators

The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

Community	
Indicator	*Findings* *(Curry County vs. Oregon)*
Social Associations and Volunteerism	Social associations/membership organization involvement ⬆
Social and Emotional Support	Individuals without adequate social support ⬆ Disconnected youth ⬆
Crime and Safety	Violent crime ⬇ Child abuse and neglect ⬇ Foster care stability ⬇

Health Care System

The health care system provides services to prevent and treat disease. It influences the health of individuals, families and communities. Health disparities, often created by the social determinants of health, affect access to health care services.

Insured and uninsured

Health insurance influences access to health care services. Curry County has a higher percentage of the population on publicly funded insurance, which includes Medicaid/Oregon Health Plan/OHP, Coordinated Care Organizations, Medicare and The Veterans Administration/VA. Estimates from Oregon DMAP and RUPRI, indicate that 65.8% of the population in the county was on either Medicaid, Medicare or both in 2017, this is higher than previous year estimates. The percentage of people on public insurance within the county is highest in Port Orford, followed by Brookings and then Gold Beach. 47.4% of those on Medicaid in Curry County, from 2011-2015, were 18-64 years old, 31.8% were under 18 year old and 20.8% were 65 years or older (US Census 5 year estimates).

Public insurance coverage by zip code, 2011-2015

Legend:
- Medicare coverage
- Any public coverage
- VA Health Care
- Medicaid / means-tested public coverage
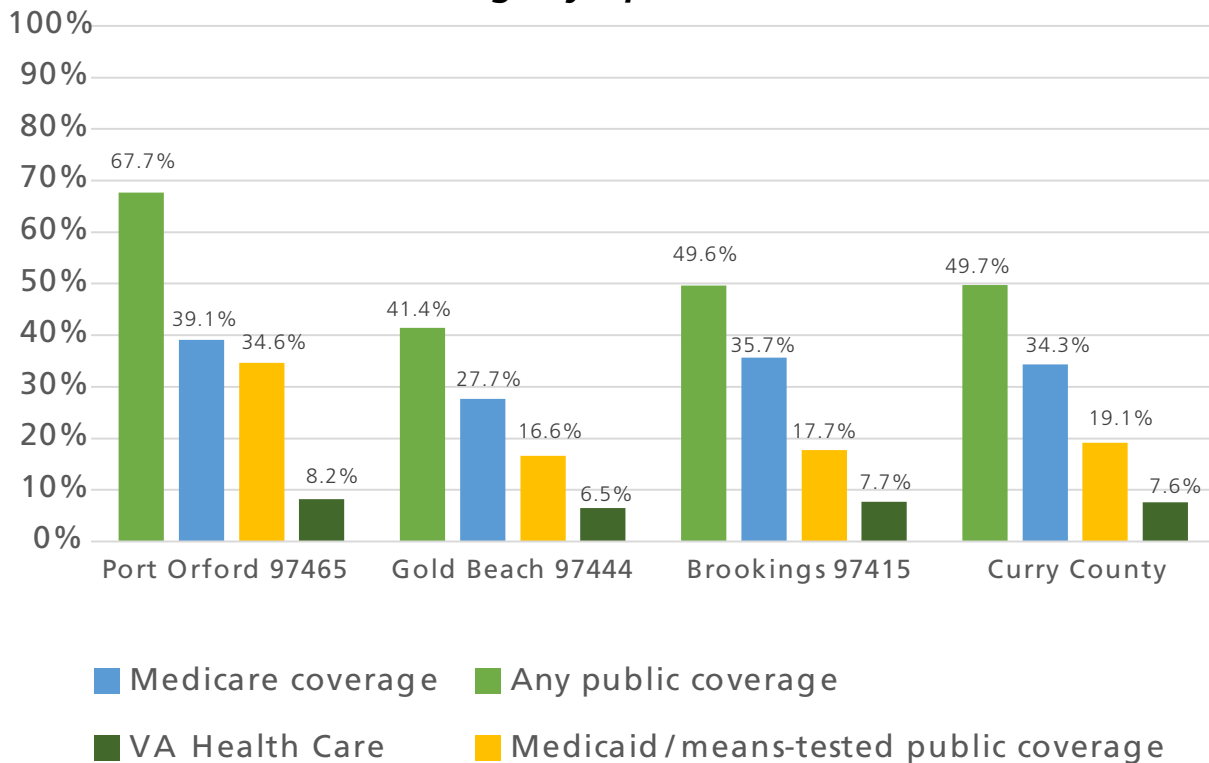
Source: U.S. Census, American Community Survey 2011-2015

The percentage of people with health insurance has been increasing statewide since 2011, with a sharp increase in 2015. It is estimated that 96.8% of Oregonians were covered by insurance in 2016 (Oregon Annual Health Insurance Report, 2018).

Access to providers

Access to providers and specific health services is another element of access to health care services. Access to primary care providers has increased since 2008, although the area continues to be experiencing a health care provider shortage. The Oregon Office of Rural Health designates Curry County a Medically Under-served Area (MUA), a Health Professional Shortage Area (HPSA), and a Health Professionals Shortage Area for Dental and Mental Health Providers. These designations show Port Orford as the highest unmet need in the county, followed by Gold Beach and then Brookings (Oregon Office of Rural Health 2017).

In 2016 the county had 18.0 FTE/Full Time Equivalent Primary Care providers, including Internal Medicine Physicians, Family Medicine Physicians and General Practice Physicians. (Oregon Office of Rural Health 2018). The majority of providers are in Brookings followed by Gold Beach.

Access to primary care, 2004-2014
Curry County and Oregon
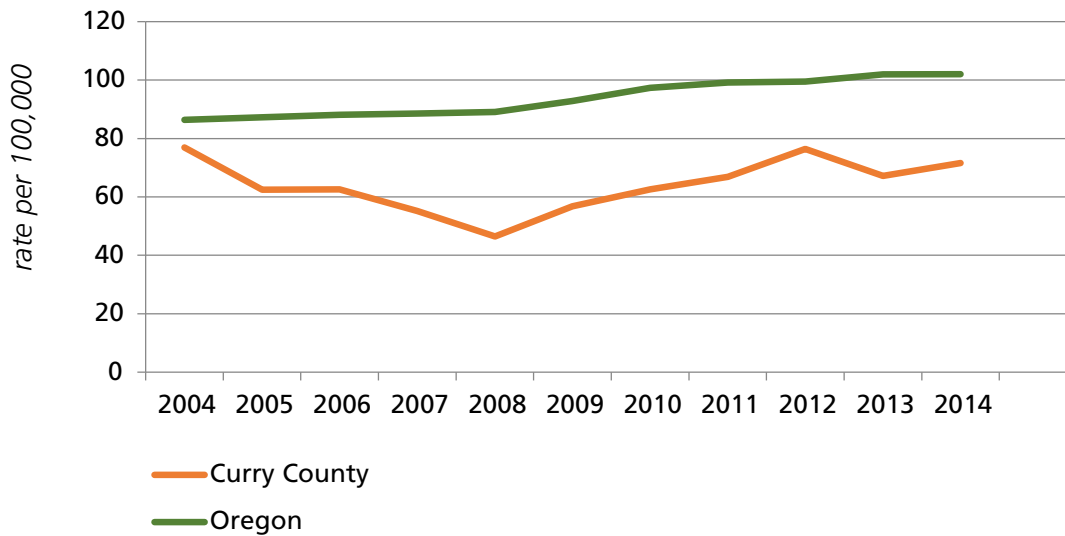
Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File

Overall scores of unmet health care needs, 2017
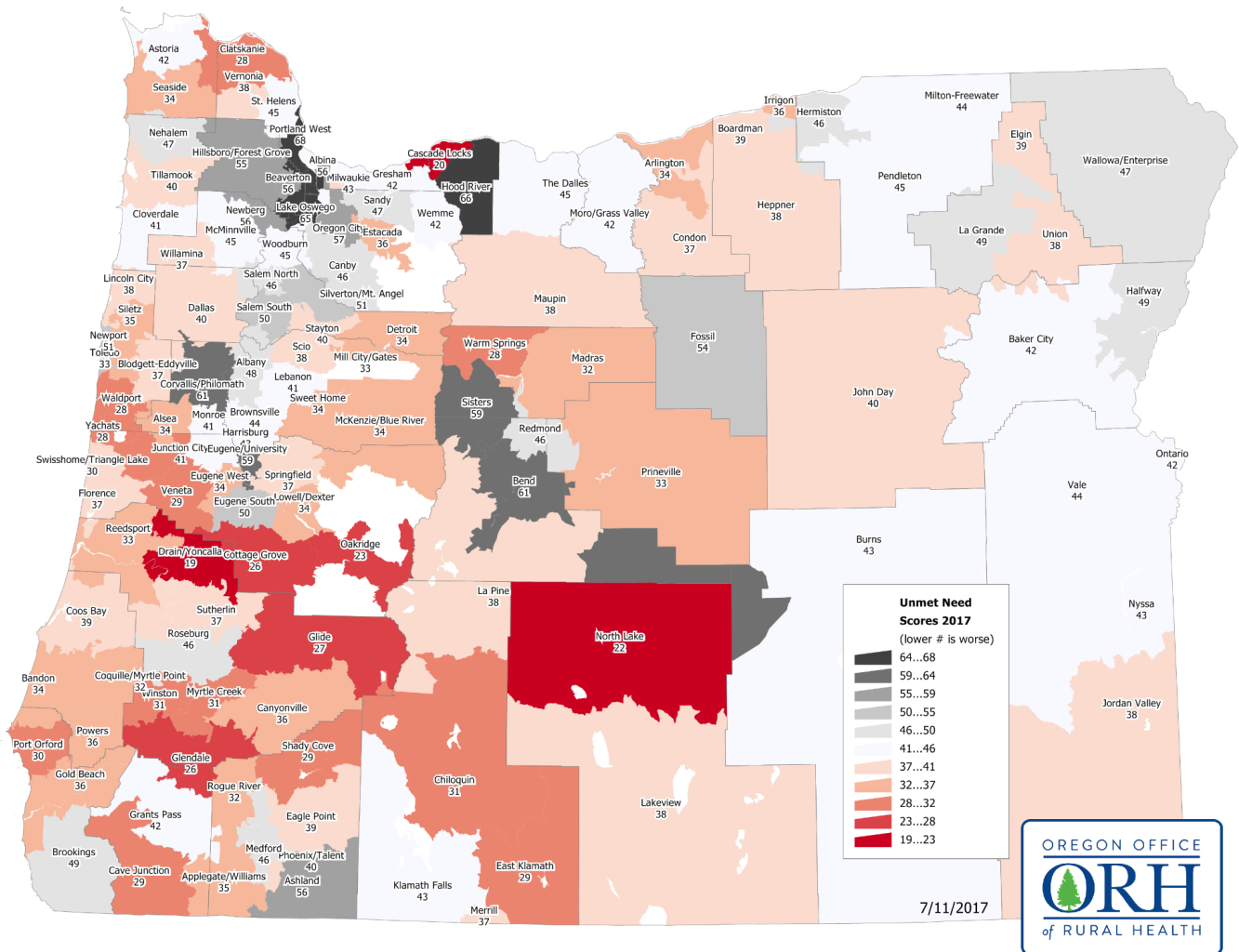
"Access to doctors is a huge problem. Just one example—I have been trying to get an appointment for my daughter for a prescription refill for over six months and can't get anyone to even call me back."—Focus Group Participant

Health Facilities

While Curry General Hospital in Gold Beach, Oregon has been in existence for more than 66 years, Curry Health District dba Curry Health Network was only established in October 1983. Located in America's Wild Rivers Coast, the District is bounded in the north by Elk River (north of Port Orford), south by Pistol River (south of Gold Beach) and includes Agness (a 35-mile drive west along the Rogue River).

The District is a municipal corporation, a form of local government as an Oregon Special District (Health Dis-trict) and derives a portion of its operating revenue from a tax base. It has been granted 501(c)(3) status by the Internal Revenue Service, and as such, has the exemptions and rights that such status affords. A board of five elected directors governs the District.

Curry General Hospital is certified as a Critical Access Hospital and is the sole hospital serving Curry County, located in the county seat of Gold Beach, Oregon. The aged hospital was replaced in 2017 with a 62,900 square foot state-of-the-art facility. The Network owns and operates Curry Medical Center in Brookings, Curry Medical Practice and Curry Medical West in Gold Beach, and Curry Family Medical in Port Orford.

Curry Health Network offers emergency medical services; inpatient and outpatient services; primary and specialty care including non-interventional cardiology, general surgery, urology, gynecology, orthopedics and pain management; cardiopulmonary services including rehabilitation; physical, occupational and speech therapy; laboratory and imaging services; and an inpatient pharmacy.

The mission of Curry Health Network is healthy communities with efficient, quality health care; our vision is to be the region's premier rural healthcare system. We share the values of integrity, compassion, accountability, stewardship, teamwork and excellence.

Recruitment and retention of providers was listed consistently as a concern in focus groups and survey participant comments.

"We have a problem with the availability of good doctors that stay so you can keep on seeing them. It's an inconvenience to drive 100 plus miles to see a good doctor or specialist."—Survey Participant

"Access to health care providers who stay in the area for more than a year and provide quality care, we don't have that here." —Survey Participant

"Providers, it's hard to get them here and to stay. They can't get their kids into good schools or have housing problems and so they move." —Focus Group Participant

Access to Specific Services

Access to **dentists** in Curry County is more difficult than statewide. The rate of dentists has been lower in the county for the last several years. The percentage of adults who have had no dental exam in the past year is also higher at 33.9% (BRFSS 2006-2010). Youth are also less likely to have accessed dental care in the county than in the state. 71.3% of 8th graders and 59.8% of 11th graders in the county accessed dental care in 2017 (Oregon Healthy Teens Survey 2017).
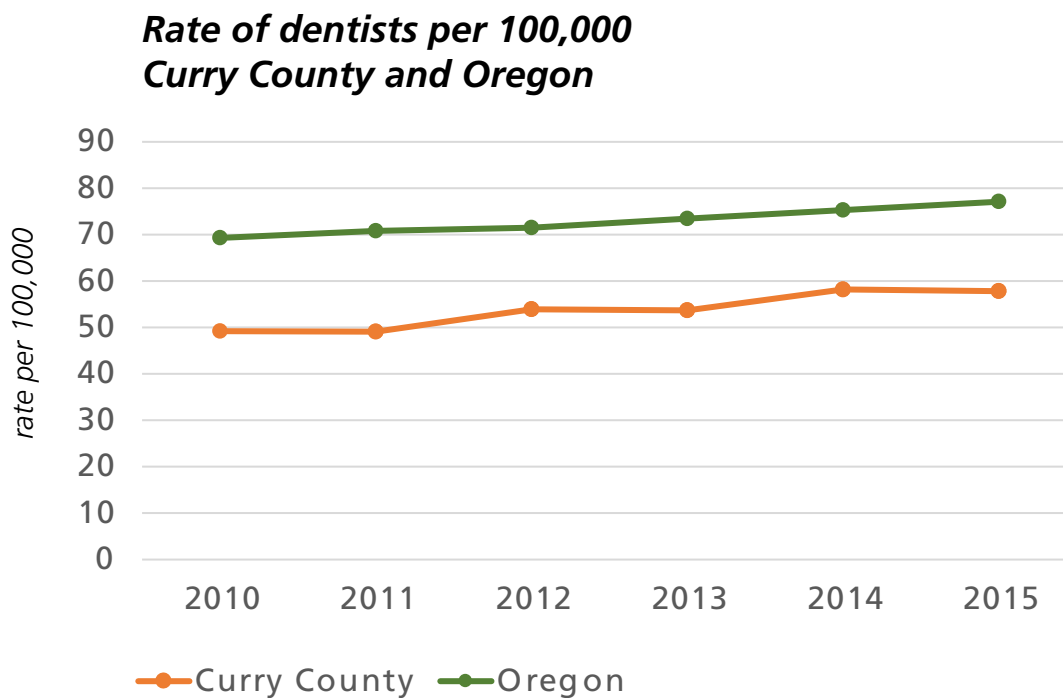
Rate of dentists per 100,000 Curry County and Oregon

rate per 100,000

	2010	2011	2012	2013	2014	2015
Curry County	49	49	54	54	58	58
Oregon	69	71	71	73	75	77

Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2015

The percentage of a population that has preventive screenings is an indicator of access to care, specifically the quality and availability of care and timeliness of access. The screenings provided the most often include cholesterol testing, blood sugar testing, colon cancer screening by sigmoidoscopy or colonoscopy and mammogram. Curry County performs fewer screenings than the state overall. Mammograms are particularly lower for Curry County women age 50-74. Blood sugar testing is the only screening that exceeds state percentages.

"We don't have access to affordable and quality preventative health care. A lot of people have health issues, or they let it go too long and can't get preventative care." —Survey Participant

Preventive Screenings 2012-2015 Curry County and Oregon

Percent of applicable* population

■ Curry County
■ Oregon

Source: BRFSS 2012-2015
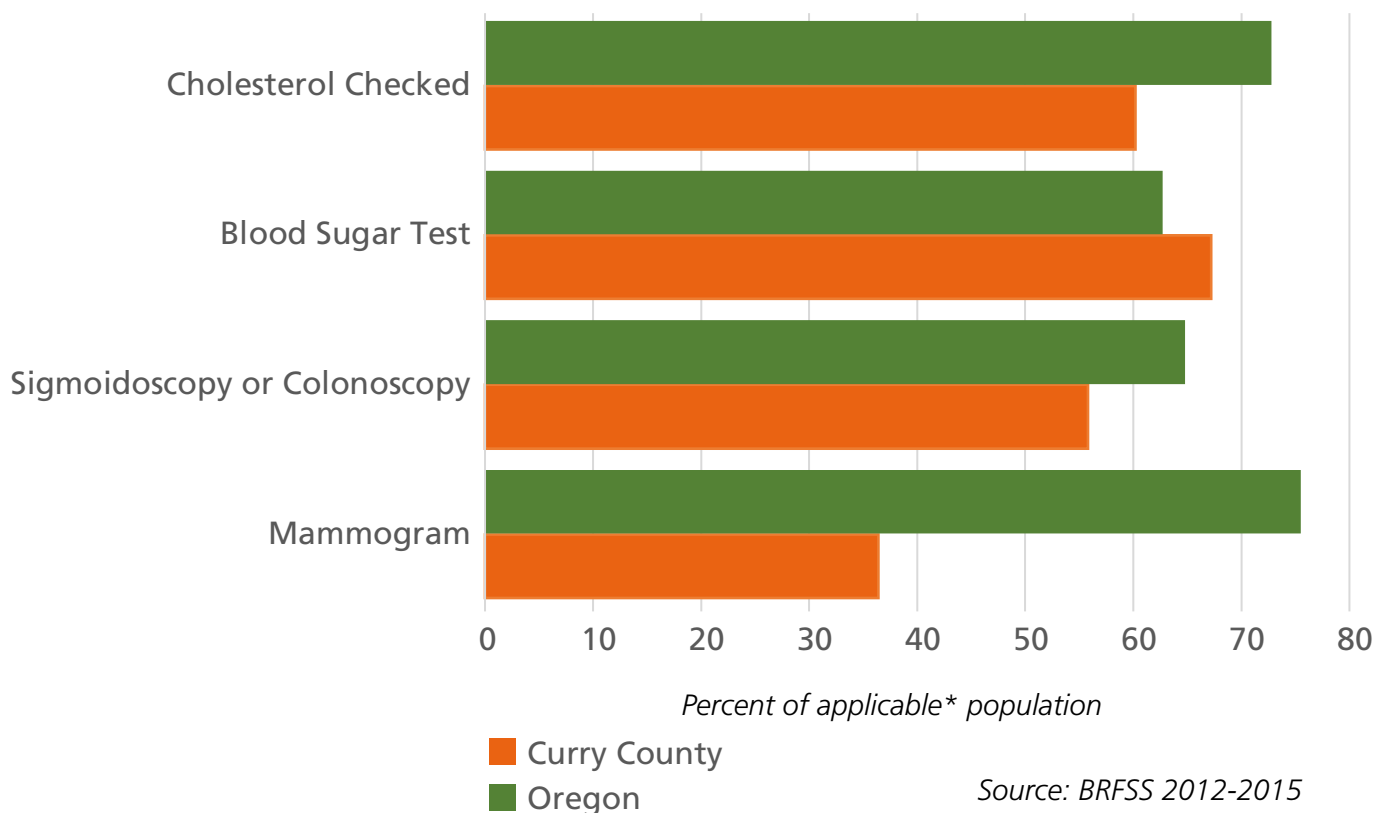
*Applicable populations:
Percent cholesterol checked within last 5 years; Percent blood sugar test in past 3 years; Percent current on colorectal cancer screening, 50-75 years old; Percent of mammogram w/in past 2 years 50-74 years old.
*pap test numbers too small in Curry County to be statistically reliable

Prenatal care is an indicator of maternal and child health services access. Curry County has higher percentages of women receiving inadequate prenatal care than the state. Inadequate prenatal care is less than 5 visits prior to delivery or care began in third trimester or after.

The percentage of women who are receiving adequate prenatal care is lower than state percentages. In 2016, 90% of women in the county received adequate prenatal care, compared to state percentages of 94% (Oregon Vital Statistics 2016). Inadequate prenatal care, defined as less than 5 visits prior to delivery or if care begins in third trimester or after. 10% of women in the county received inadequate prenatal care in the 2016 (Office of Rural Health 2017).

"Our rural community is lacking basic health care needs and services such as OB services, putting a strain on young growing families." -Survey participant

School-Based Health Centers provide physical and behavioral health services in elementary, middle and high schools in the county. Curry Community Health currently has a family nurse practitioner in Brookings Harbor High School two days a week, offering primary cares services. Of the three school districts in the county, there are 1.2 FTE therapists assigned to the schools.

Hospitals

The preventive hospitalizations for patients on Medicare with conditions that are ambulatory care sensitive is higher in Curry County. Ambulatory care sensitive conditions include pneumonia, dehydration, asthma, diabetes and other conditions which could have been prevented if adequate primary resources were available and accessed. This indicator illustrates challenges in primary care access.

Preventable Hospitalizations for Medicare Enrollees, 2014
Curry County and Oregon
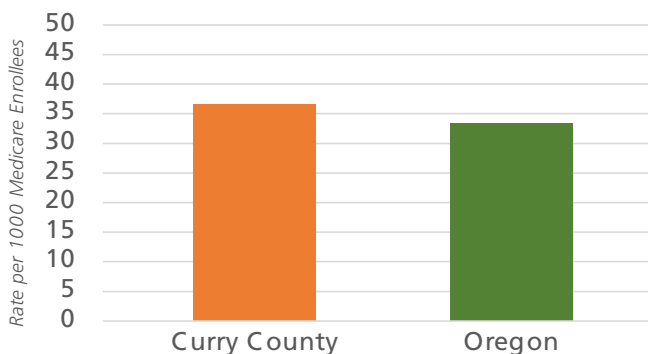
Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care

Curry County patients have to travel out of the county for inpatient hospital services. The reasons for traveling out of the county are many including rural geography, health care provider shortage and limited specialty services.

"I have to travel all the way to Los Angeles for specialists and I am disabled." —Survey Participant

"Many of our people travel a long and dangerous road to Medford for care. We now have this new hospital, let's try to keep some of those dollars here." —Survey Participant

Top 3 Hospitals Medicaid Patients, from Curry County, are going to outside of Curry County 2016-2017	
1st most visited	Sutter Coast Hospital
2nd most visited	Bay Area Hospital
3rd most visited	Asante-Rogue Regional Medical Center

Top 3 Reasons Medicaid Patients, from Curry County, are going outside of county for inpatient care, 2016-2017	
1st	Sepsis
2nd	Live-born infant both Cesarean and vaginal delivery
3rd	Myocardial Infarction

Source: Coordinated Care Organization Enrollee data, 2016-2017

Indicators

The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percent/percentages.

Health Care System		Key
		⬆ =higher (than State) ⬇ =lower (than State)
Indicator	*Findings* *(Curry County vs. Oregon)*	
Insured and Uninsured	Population on public insurance coverage (Medicaid, Medicare and VA) ⬆	
Access to Providers	Access to primary care physician ⬇ Access to mental health providers ⬇ Access to dental providers ⬇	
Oral/Dental Health Accessibility	Adults with no dental exam ⬇ Youth with no dental exam ⬇	
Preventative Screening	Colorectal Cancer Screening ⬇ Mammogram within last 2 years ⬇ Cholesterol checked in last 5 years ⬇ Blood sugar test within last 3 years ⬆	
Prenatal Care Accessibility	Moms getting adequate prenatal care ⬇	
Hospitalizations	Preventable hospitalizations ⬆	

Health Behaviors

Individual health behaviors such as tobacco use, inadequate physical activity and addictions, have significant influence on the health of individuals and communities in Curry County.

Tobacco use is a modifiable health behavior that has significant health consequences. Premature death, various cancers, lung and respiratory issues, low birth weight and cardiovascular disease are all linked to tobacco use. The tobacco mortality rate has been higher in Curry than the state rate for over a decade.

The percentage of adults in Curry County that are current smokers continues to be one of the highest in the state. More than 60% of adults have ever smoked in Curry County, more than one in four adults (25.6%) are currently smoking cigarettes (BRFSS 2015). 7.4% of 11th graders in the county smoked cigarettes in the last 30 days. Nearly 5% of 11th graders in the county have used e-cigarettes or other vaping products in the last 30 days (Oregon Healthy Teens Survey 2017).

Tobacco-linked mortality
Curry County and Oregon, 2006-2016
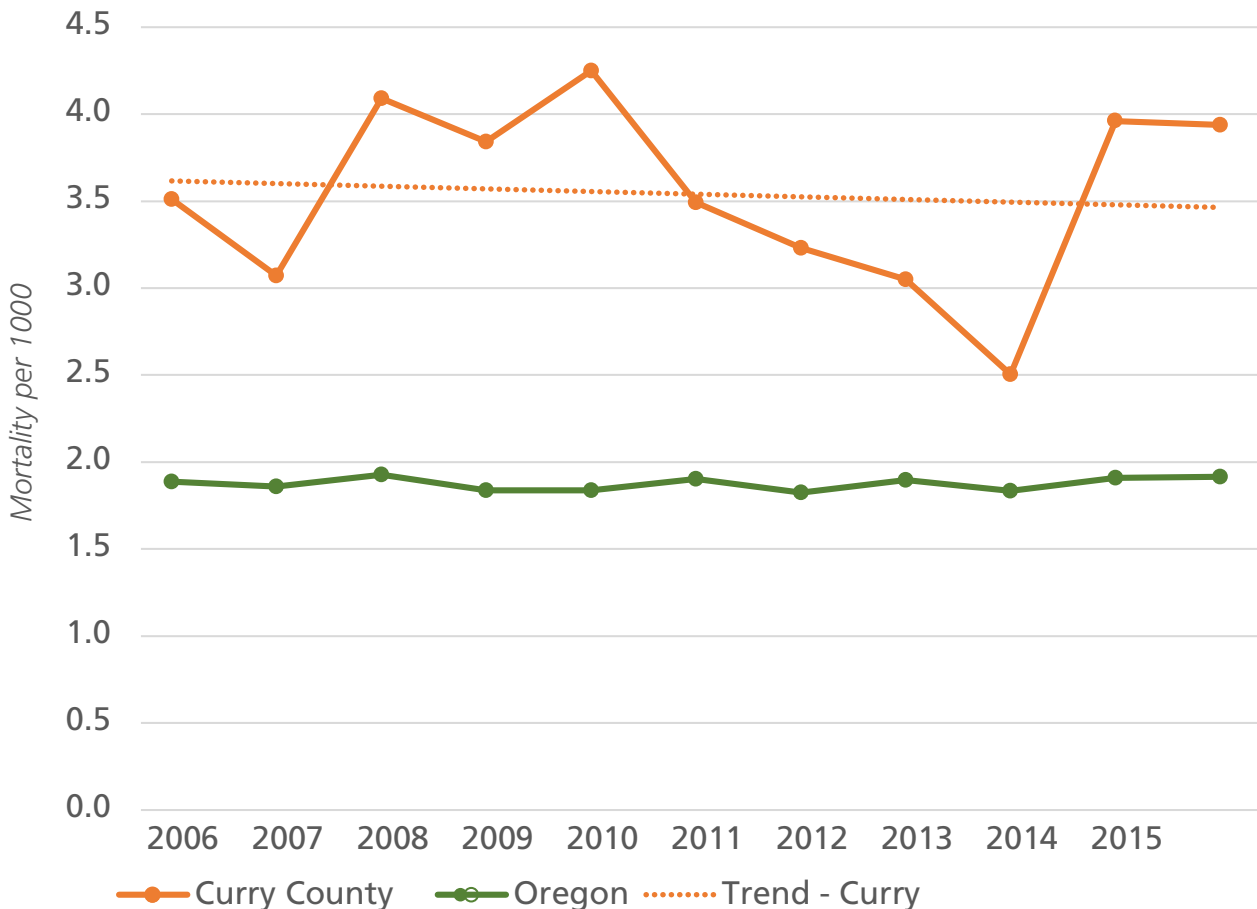
Source: Oregon Vital Statistics Annual Reports

The financial impact of tobacco in the county is also substantial. The latest tobacco fact sheets from the Oregon Health Authority estimates that Curry County experiences 16.3 million dollars in tobacco related medical costs and 13.1 million in lost productivity due to premature tobacco-related deaths. 1,598 people are estimated to have a serious illness caused by tobacco in Curry County (Oregon Health Authority Tobacco Fact Sheets 2014).

Alcohol and other drugs

Excessive heavy **alcohol** consumption and binge drinking contribute to chronic health issues, including heart disease, cirrhosis of the liver, high blood pressure, stroke and even death. More than 20% of adults in the county report binge drinking in the past month while over 50% of residents twelve and older, in the region of Coos, Douglas, Jackson and Curry Counties report using alcohol in the past month. Binge drinking is increasing in the county, exceeding percentages at the State level.

"Not enough activities for kids so they drink and drive and party. There are a lot of accidents from that on Hwy 101 in our county, at night during the summer especially." —Focus Group Participant

**Adults binge drinking, 2012-2015
Curry County and Oregon**
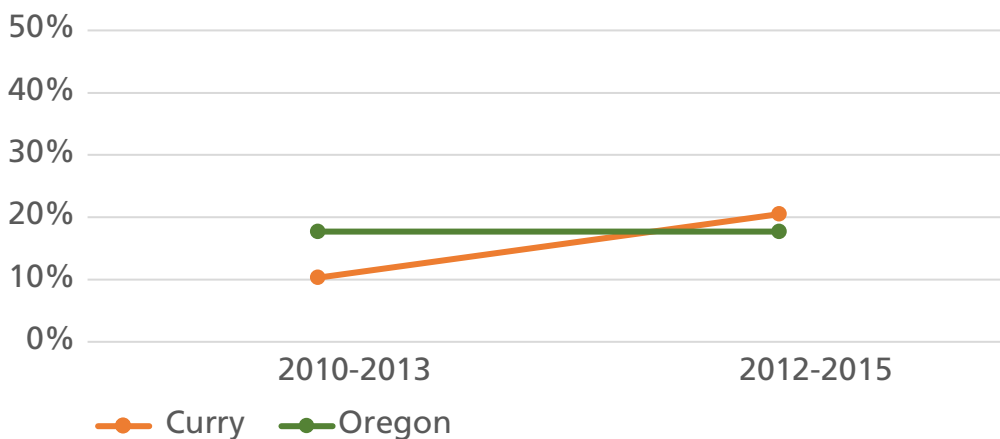
Source: National Survey on Drug Use and Health, Annual Averages Based on 2012, 2013, and 2014

"I'm not a doctor so don't know the answer, but my observation on most people is they tend to drink a lot of alcohol." —Survey Participant

75.8% of 8th graders stated they had never had a drink of alcohol, indicating nearly one in four 8th graders had already drank more than a few sips of alcohol (Oregon Healthy Teens Survey 2017).

Regional data on **illicit drug use** show that 12.5% of people in the region (Coos, Curry, Douglas, Jackson, Josephine and Klamath) had used an illicit drug in the past month, higher than national percentages.

"We all know drugs are a problem, but people that use drugs are still just people, jails aren't the answer. They should be seen as people first, to help the problem in our community." —Focus Group Participant

Marijuana use by youth (1 or more days in the past 30 days) was reported by 6.7% of 8th graders and 20.9% of 11th graders in Curry County in 2017 (Oregon Healthy Teens Survey 2017). How they consumed marijuana was not available as the numbers were too small to be statistically reliable. Reliable numbers for marijuana use by adults, since legalization, are not available but comments about using marijuana for pain were brought up several times in the 2018 CHA focus group and surveys.

"I chose medical marijuana, so I can choose to control my meds and be off of prescriptions." —Focus Group Participant

"I smoke it every day, helps with harm reduction, helps me forget about my pain." —Focus Group Participant

"We don't stigmatize people with heart disease for eating red meat, we must educate and treat addicts like people. I didn't wake up and say I want to be an addict, I didn't want to lose my family." -Focus Group Participant

Drug use, 2012-2014
Region, State and National

Legend:
- US (gray)
- Oregon (green)
- Region 4 - Coos, Curry, Douglas, Jackson, Josephine, Klamath (yellow)
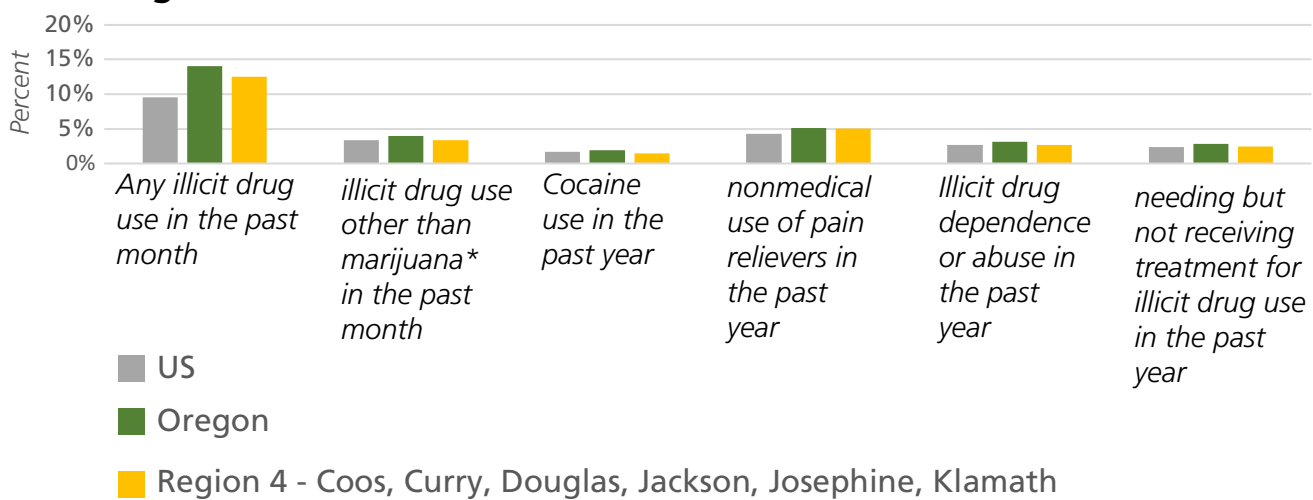
Source: National Survey on Drug Use and Health: Annual Averages Based on 2012, 2013, and 2014.

*data collected prior to legalization

Opioid and other drug use

The morbidity and mortality associated with inappropriate use of opiate drugs such as codeine, oxycodone, morphine and methadone, have a negative impact on the health of the community. Prescribing patterns for Curry residents on Medicare for 2013-2014 show higher rates of opioid prescriptions than state and national trends. Curry County had a 8.17% prescribing rate for Opioids in 2013 and 8.86% rate in 2014. This is consistent with prescription patterns in the Medicaid/Oregon Health Plan population, narcotic analgesics (opioids) were the second most prescribed medication in 2016-2017 within the Medicaid population of the county. According to the Oregon Opioid Dashboard Curry county has the highest rate in the state of individuals receiving opioids per 1,000. Among the youth, 25.5% of 11th graders in Curry County say that it would be either easy or very easy to get prescription drugs not prescribed to them in 2017 (Healthy Teens Survey 2017).

> *"I understand that its expensive and people get addicted, but we need more options for managing chronic pain without strict numbers, if something works for somebody, we should be able to adapt and be case by case, individualize for needs." —Focus Group Participant*

Curry County has a high burden of the **hepatitis C virus** (Oregon Health Division 2017). High burden is defined as the number of people living with cases, chronic case reports and acute hepatitis C virus (HCV). Risk factors for HCV include injection drug use, health care exposure, multiple sex partners and other risk factors such as street drug use, tattoo, piercing or other blood exposure. Curry County has higher rates of those living with HCV and acute reports than the state. The region (Coos and Curry counties) has the highest mortality rate, in the state, from chronic hepatitis within the Medicaid/CCO population (Oregon Health Division 2017).

Vaccinations

Vaccinations are a modifiable health behavior. Immunizations are an effective tool for preventing disease and death and Curry County has lower rates of vaccinating 2 year old children than in the state. The percentage of vaccinated 2-year olds in Curry County is 47% compared to 64% in Oregon as a whole (Oregon Immunization Program, 2008-2015).

Adults 65+ who received vaccination within past year, 2010-2013 Curry County and Oregon
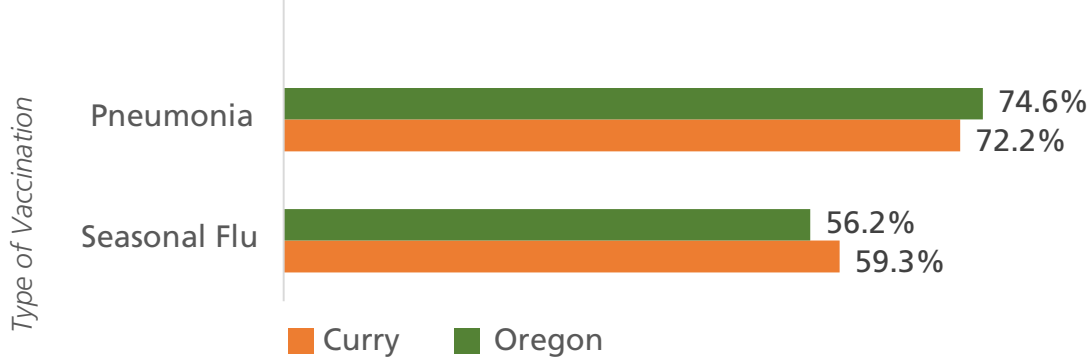
Source: BRFSS 2010-2013

Two-year old immunization rates, 2014-2017 Curry County and Oregon
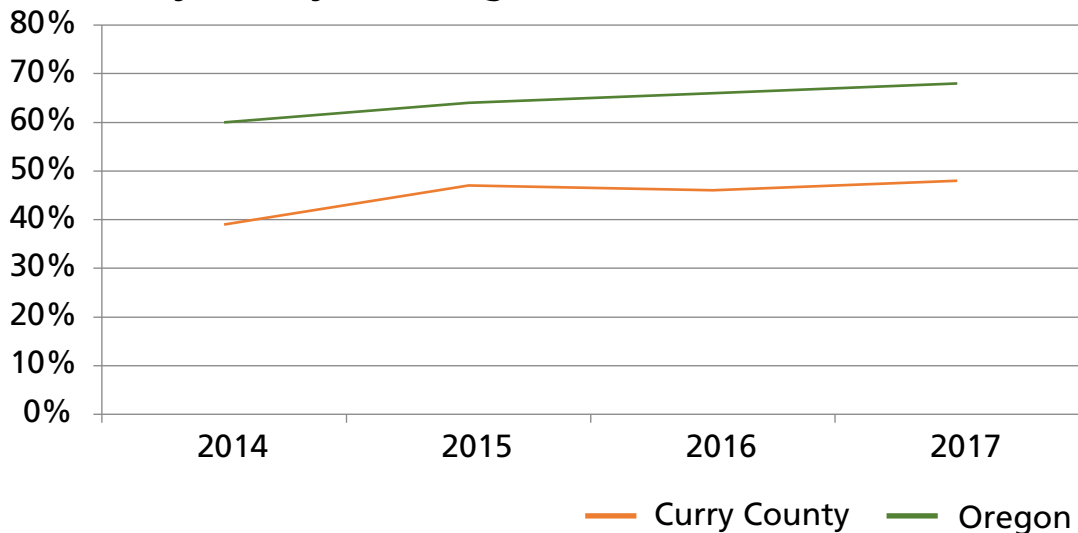
Source: Oregon Immunization Program, 2008-15

Obesity is a modifiable risk factor for several chronic conditions. Obesity is defined as a Body Mass Index (BMI) of 30 or higher. BMI is calculated using both height and weight. Being obese has been associated with increased risk of coronary heart disease, type 2 diabetes, cancer, high blood pressure, stroke, liver and gallbladder disease, among other morbidity and mortality. 38% of people in the county are obese, higher than the state average of 27.1% (BRFSS 2015). Only 65.8% of youth are considered a healthy weight in the county.

"We must combine eating 'habits,' access to healthy foods and exercise as one behavior." —Survey Participant

Youth Weight 2017
Curry County and Oregon
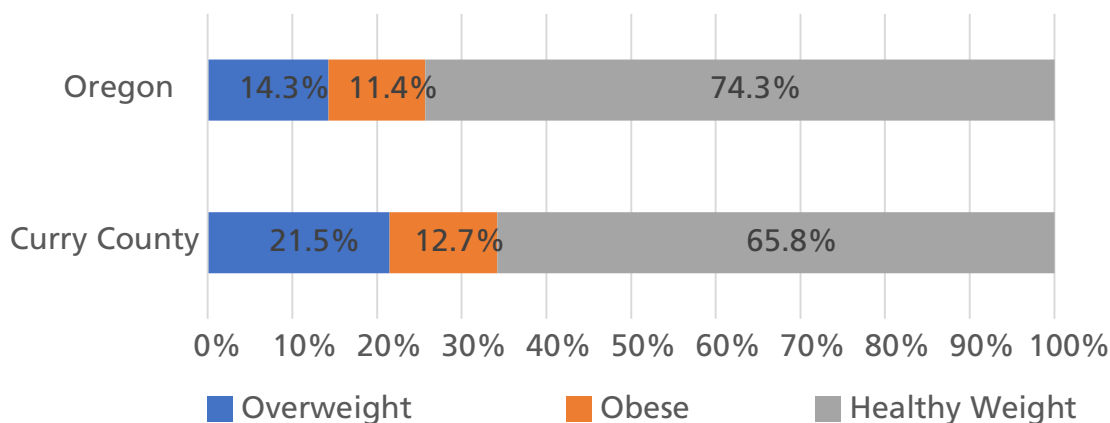
Source: Oregon Healthy Teens Survey 2017

"We all have to take personal responsibility, make better decisions, be more disciplined. People spend tons of money at DQ, McDonalds, KFC and Taco Bell, they then sit in their car and pig out at the port. Health begins in the mindset." —Survey Participant

The percentage of the population that is considered obese has been on an increase for decades in the county and statewide.

Obesity trend 2002-2015
Curry County and Oregon

Source: BRFSS 2010-2013

Indicators

The indicator table provides an overview of indicators in the county/service area, including comparison with Oregon overall averages, percent/percentages.

Health Behaviors

Indicator	Findings *(Curry County vs. Oregon)*
Tobacco	Population smoking ↑
Alcohol and Other Drugs	Higher rates of binge drinking ↑ Opioid prescribing rates ↑ Illicit drug use ↑
Vaccinations	2-year old immunization rates ↓ Adult vaccinations ↓
Obesity	Rates of obesity ↑

Mortality

Causes of death (mortality) has changed in the county over the last 80 years, consistent with state and national trends. Advances in science, medical care, living and working conditions have influenced causes of death and disability in the county.

Curry County has higher rates of several **leading causes of death**. The leading cause of death in the county is cancer followed by heart disease. Breast, lung and prostate cancer are the most common types of cancer in Curry County.

Leading causes of death, 2011-2015
Select cities in Curry County and Oregon

Legend:
- Oregon
- Curry County
- Port Orford
- Brookings
- Gold Beach

Categories (top to bottom): Flu and Pneumonia, Alcohol Induced, Suicide, Diabetes, Alzheimer's Disease, Cerebrovascluar disease, Unintentional injuries, Chronic lower respiratory disease, Heart Disease, Cancer

X-axis: Rate per 100,000 (0, 100, 200, 300, 400, 500)
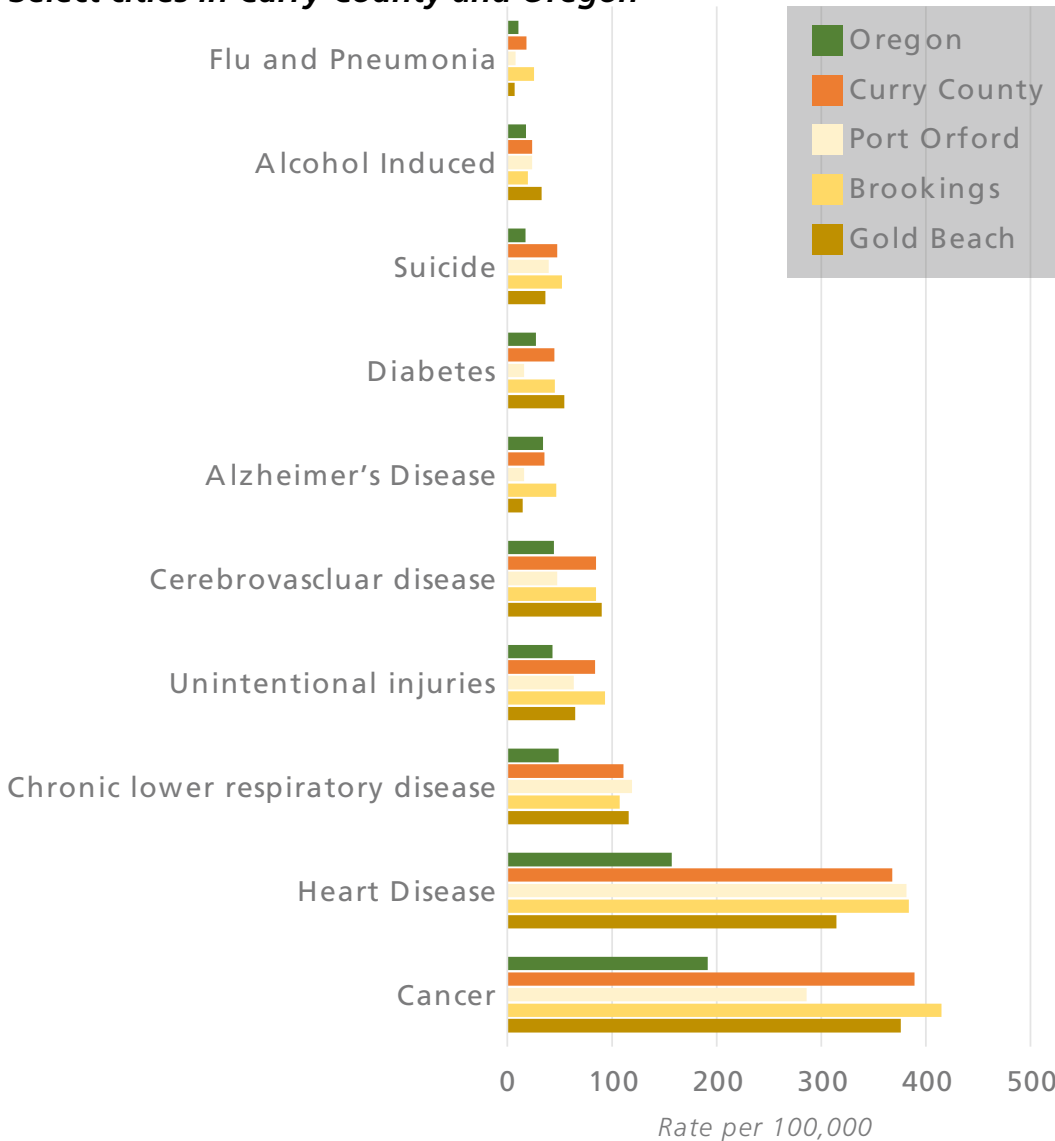
Sources: Vital Statistics Annual Report, Oregon Health Authority
*crude death rates by cause

"The air quality is not good with factories spewing chemical pollution into the air and wood burning fireplaces emitting large air particulates which causes asthma and lung cancer." —Survey Participant

Leading Types of Cancer*
2010-2014, Curry County and Oregon
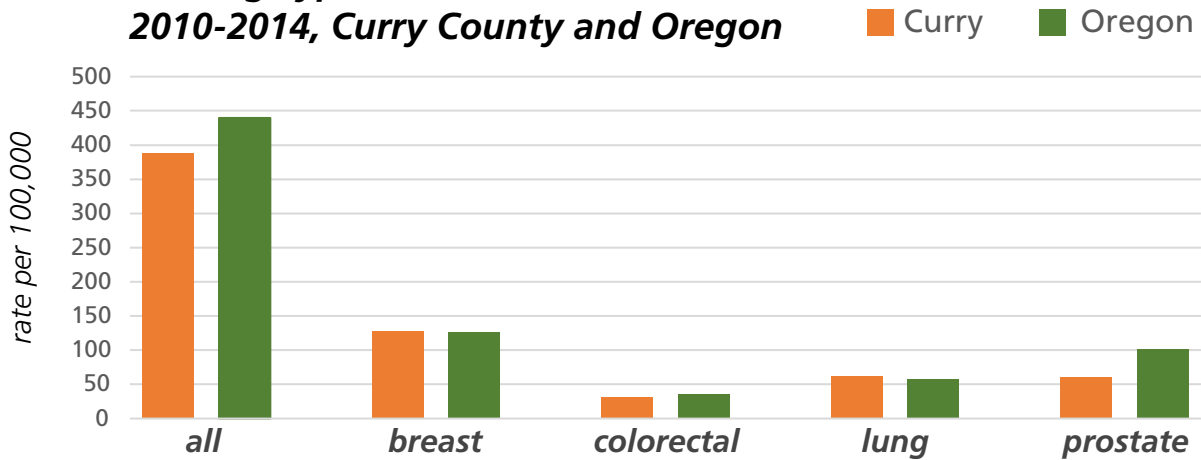
*new cases

Source: Oregon State Cancer Registry, 2010-2014

Mortality from **diabetes** is high in Curry County and also remains higher than state rates. Deaths attributed to **tobacco**, as already mentioned in the modifiable health behavior section, are also higher in Curry County than Oregon and considerably higher than the Healthy People 2020 national goals.

Diabetes-related mortality, 2006-2016
Curry County and Oregon

Source: Oregon Vital Statistics Annual Reports

2018 Curry County Community Health Assessment - 55
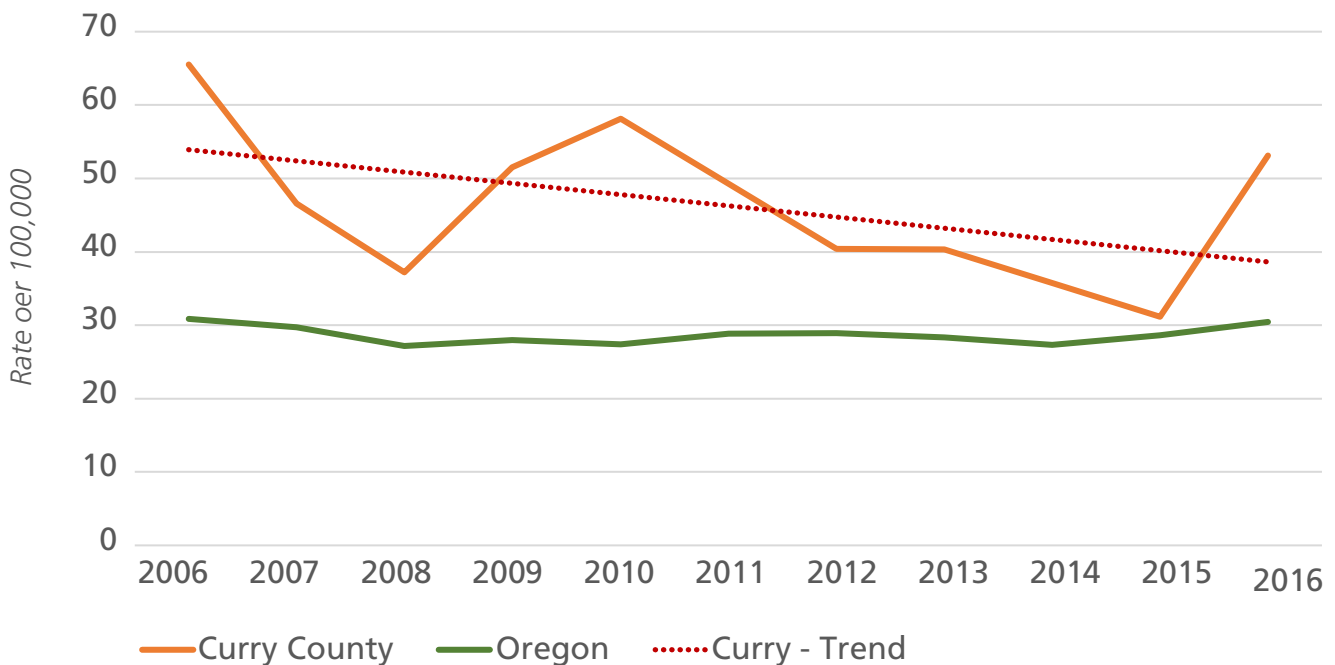
Tobacco-related mortality, 2016
Curry County, Oregon, Healthy People 2020
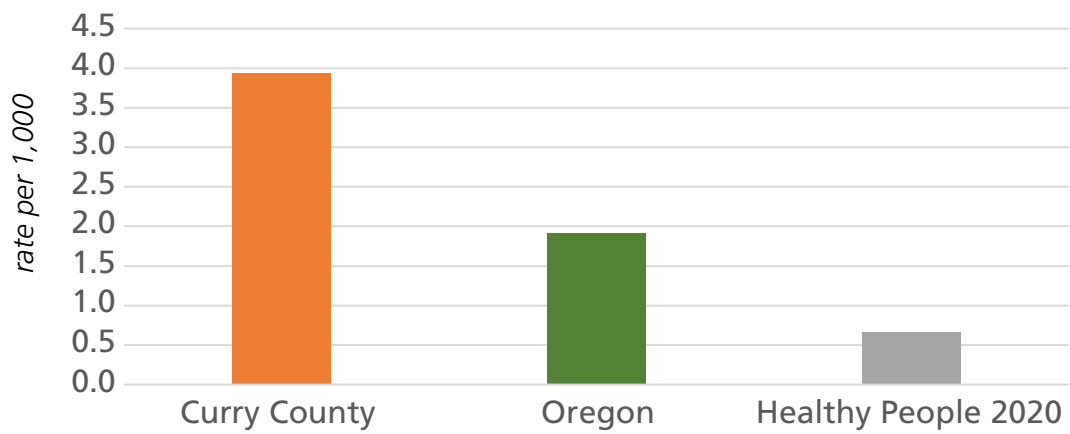
Source: Oregon Vital Statistics Annual Reports

The prevalence and burden of **chronic conditions** is high in Curry County and higher when compared to the state. Nearly 50% of adults in the county have one or more conditions of angina, arthritis, asthma, cancer, COPD, depression, diabetes, heart attack or stroke. This illustrates a very high burden of chronic disease in the county. Also notable is that Curry County has higher percentages of the population with asthma, cancer, COPD and cardiovascular disease than state percentages.

"Smoking and alcoholism are choices that also lead to other chronic conditions."—Survey Participant

Chronic conditions among adults, 2012-2015
Curry County and Oregon
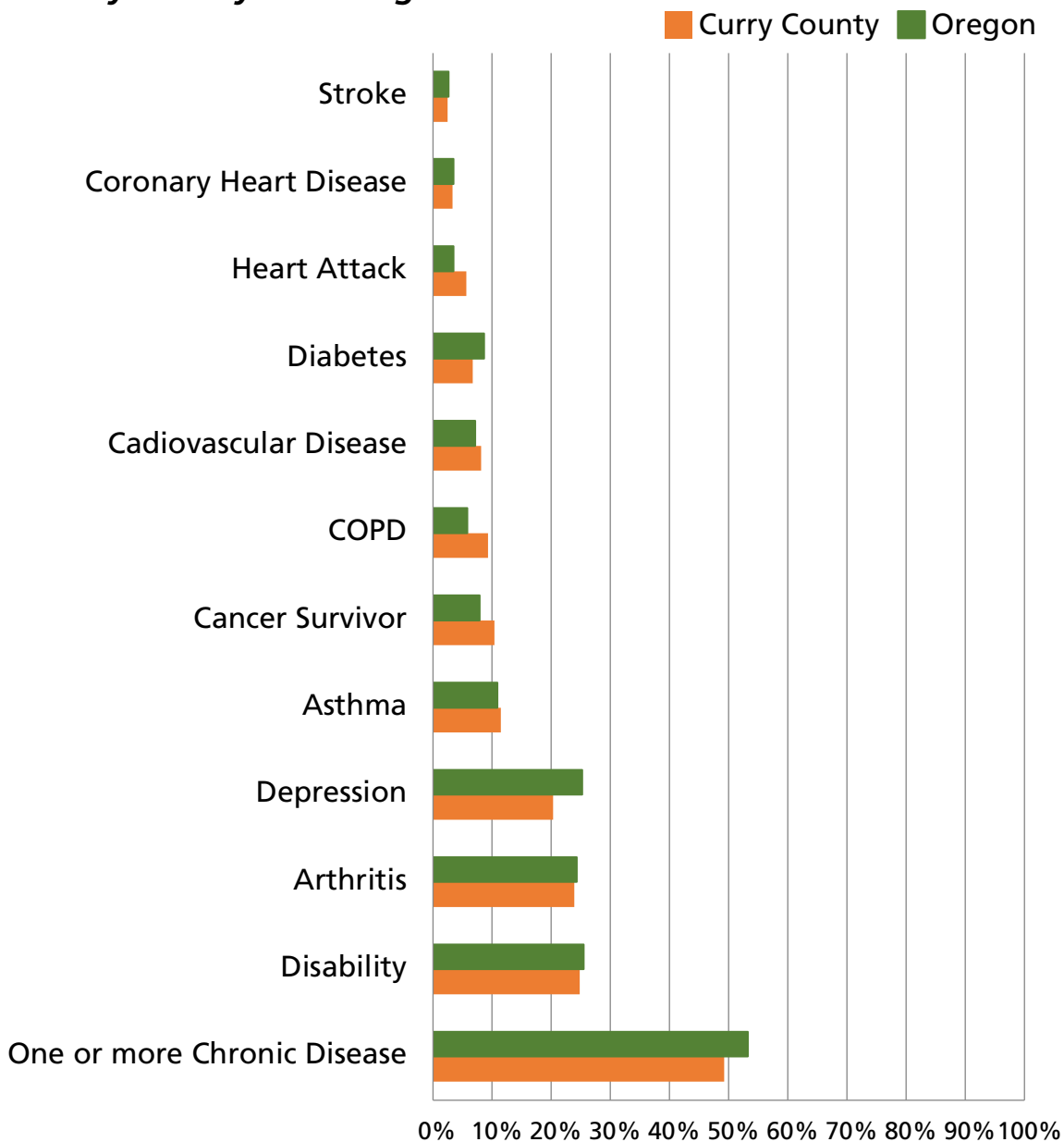
The majority of deaths due to alcohol or drugs are from chronic alcoholic liver disease followed by unintentional injuries. There have been zero deaths marked as from opioids since 2012 in Curry County.

Deaths due to alcohol or drugs, 2016
Curry County

Number of deaths due to alcohol or drugs

Number of Deaths due to Alcohol or Drugs

Chronic alcoholic liver disease	4
Unintentional injuries	2
Other alcohol induced	1
Other drug induced	1
Suicides	0
Opioid	0
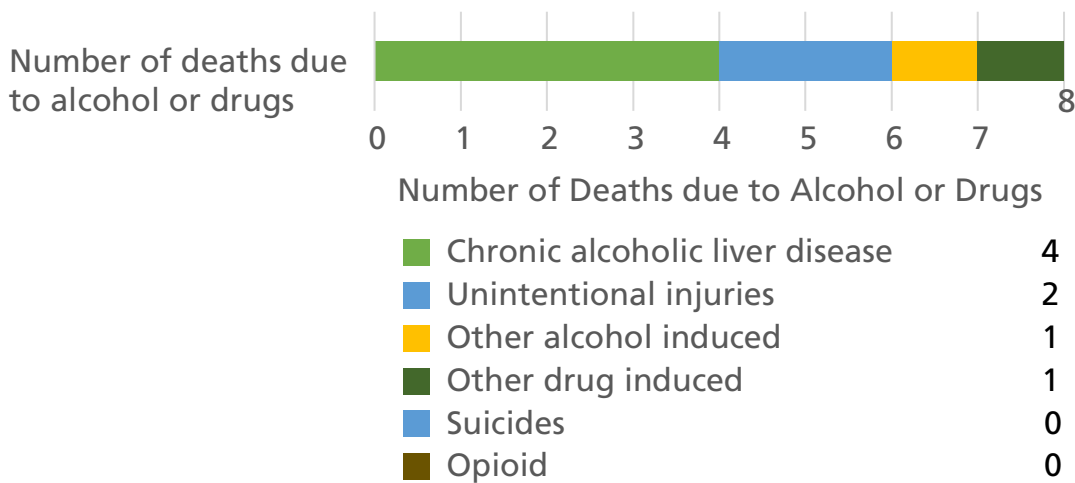
Source: Oregon State Vital Statistics

Mental Health & Suicide

Mental health and **depression** were listed as top concerns by the 2018 CHA focus groups and survey participants. Indicators of mental and behavioral health include suicide rates and percentages of the population experiencing depression.

Youth depression, 2017
Curry County and Oregon

29.3% 30.1% 30.5% 32.2%

8th graders   11th graders

Curry County   Oregon

Source: Oregon Healthy Teens
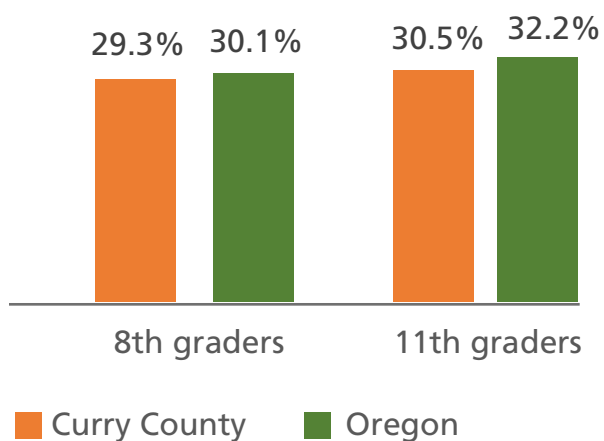
Self reported mental health and depression remain a problem in Curry County youth. A third of 8th graders and 11th graders indicate they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities (Oregon Healthy Teens Survey 2017). Youth considering suicide is significantly higher in Curry County than Oregon. 21.1% of 8th graders in the county in 2017 seriously considered attempting suicide, 4.5% actually attempted 6 or more times in the past 12 months, nearly four times that of state percentages.

"Suicide here is huge because of lack of sun, lack of mental health services and isolated communities." —Focus Group Participant

Suicide as a cause of death in all populations in the county show an alarming upward trend in number and rate.

Suicide
Curry County and Oregon, 2000-2016
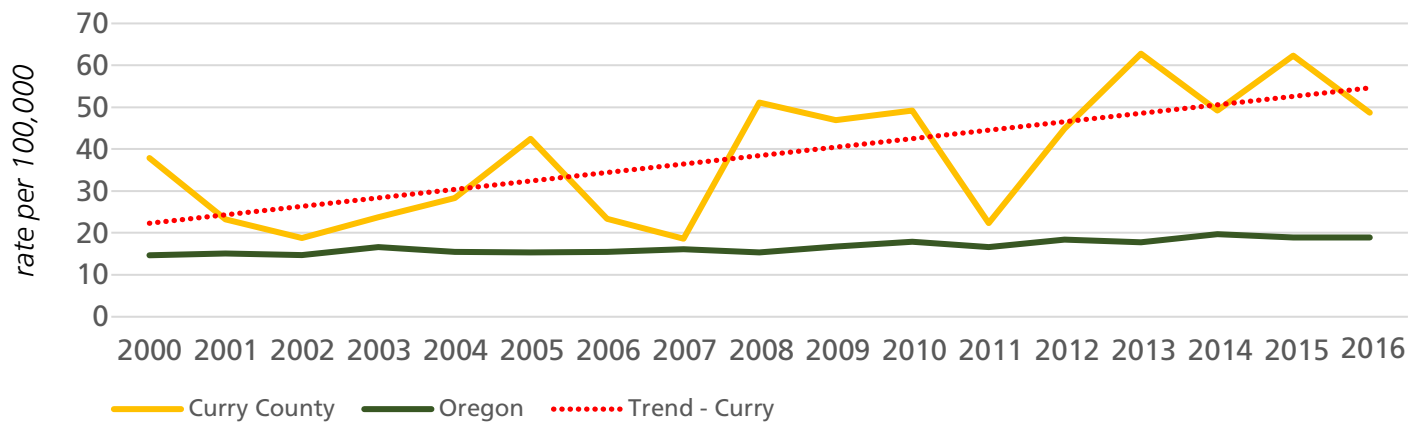
Source: Oregon Vital Statistics

20.3% of adults reported depression in Curry County while 34.1% of adults on Medicaid in the county listed either a mild to serious mental health condition in 2015.

Mental health conditions, Medicaid population, 2015 Curry County

Category	Percent
Adults (26 and older) with serious MH condition	11.0%
Adults (26 and older) with mild to moderate MH condition	23.1%
Young adults (18 to 25) with serious MH condition	5.5%
Young adults (18 to 25) with mild to moderate MH condition	22.2%
Youth (12 to 17) with MH condition	33.5%
Children under 12 with MH condition	24.7%
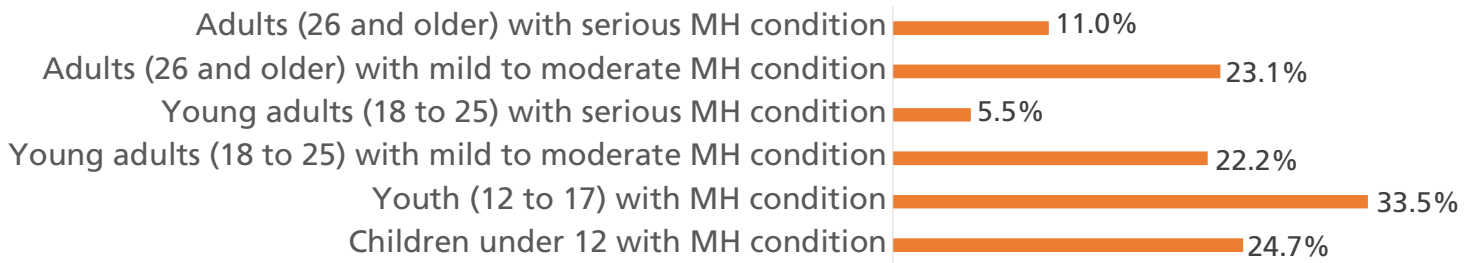
*MH is Mental Health

Oral Health

A third of the population of adults in the county indicate poor dental health, twice that of the state percentage. Youth in the county are less likely to have seen a dentist or dental hygienist for a check-up in the last year than youth statewide. In 2017, only 59.8% of 11th graders in the county had seen a dentist or dental hygienist for a check-up, exam, teeth cleaning or other dental work in the last 12 months (Oregon Healthy Teens Survey 2017). Additional data on access to dental care is in the previous health services section.

Percent of adults with poor dental health, 2006-2012 Curry County and Oregon

Curry County	Oregon
30.7%	13.6%
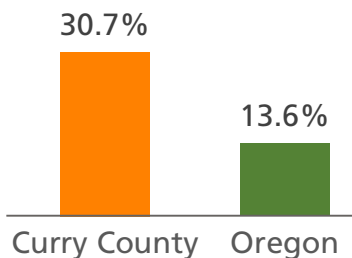
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES

Births

Low birth weight is an indicator of general maternal and child health in a community. Babies born with low birth weight typically have more long-term disabilities and developmental issues. The rates of low birth weight and infant mortality in the county have bounced up and down since 2005, typical of a rural County with lower overall population numbers. The Infant Mortality Rate (IMR) in the county has varied from 0-11.7 since 2005. An IMR of higher than 9.9 usually indicates an at risk population for federal programs such as Healthy Start.

Birth rate, low birth weight and infant mortality rate, 2005-2016 Curry County and Oregon
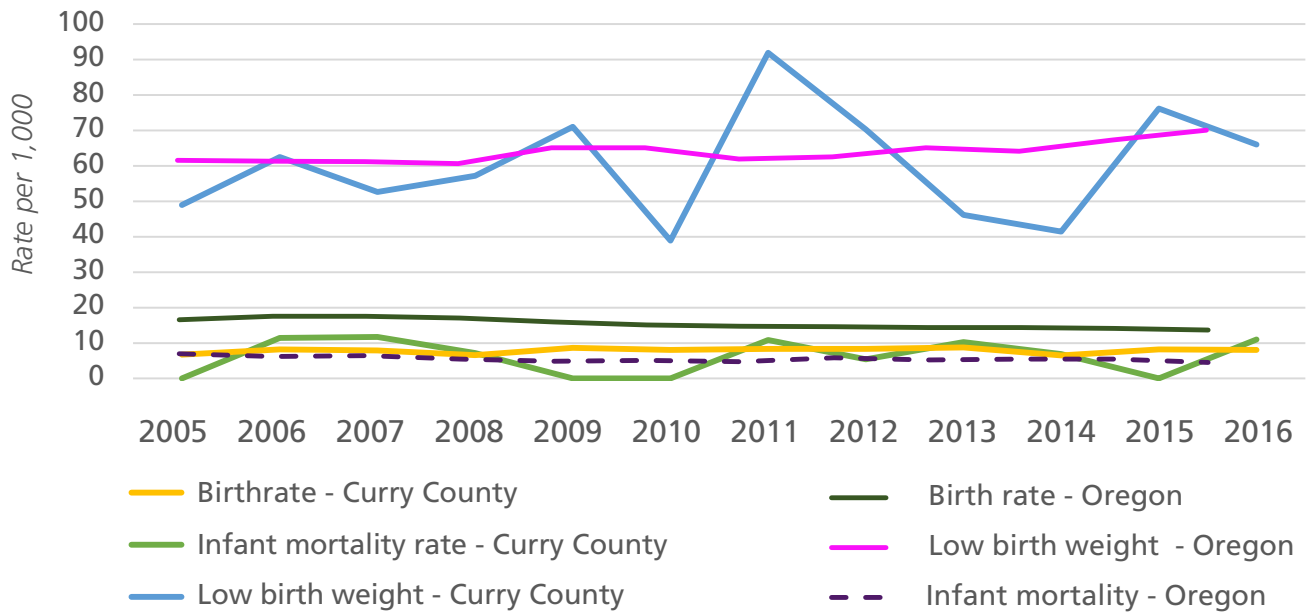
Source: Oregon Vital Statistics, 2005-2016

Teen births, defined as births happening to young women age 15-19, is higher than the state average and trending up while the state trend is going down. Teen births are an important indicator as often teen parents have unique social, economic and health services support needs. High rates of teen pregnancy can also indicate prevalence of unsafe sex practices.

Teen births, 2011-2016 Curry County and Oregon
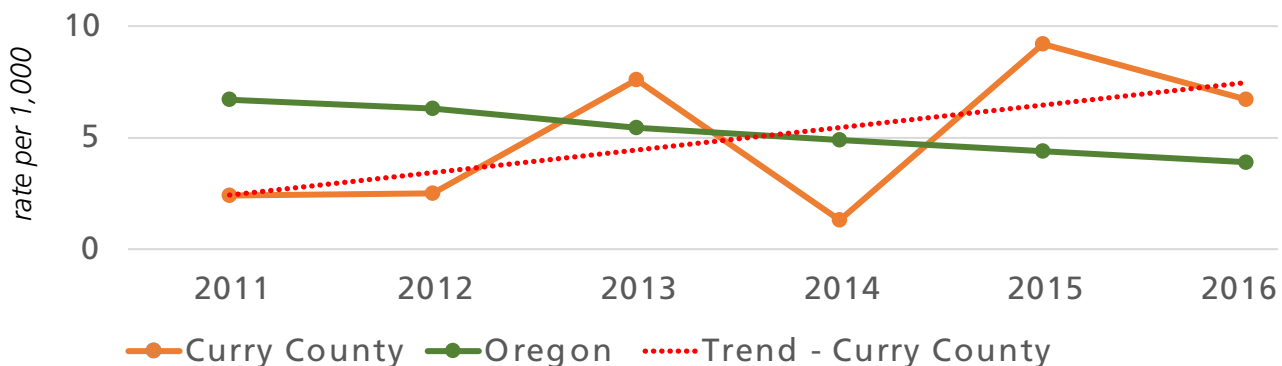
Source: Oregon Health Authority, Center for Health Statistics

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The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages.

Key

↑ =higher (than State)

↓ =lower (than State)

Health Status and Outcome Indicators	
Indicator	*Findings* *(Curry County vs. Oregon)*
Leading causes of death	Diabetes mortality ↑ Tobacco mortality ↑
Chronic conditions	Asthma, cancer, COPD, cardiovascular disease and heart attack ↑
Cancer	Breast and lung cancer ↑
Suicide	Suicide adults ↑ Suicide attempts youth ↑
Dental / oral health	Dental health poor ↑
Maternal and pediatric health	Teen births ↑ Infant mortality rate ↑ Low birth weight ↑ Birth rate ↓

Gaps and Next Steps

The CHA document is a snapshot of health in Curry County. The CHA has limitations, it is not meant to cover every possible factor that influences health nor is it an evaluation of services or efficacy of the health care system itself. The CHA is limited by what data is currently being gathered and published while also being limited by the validity, frequency and level of data that other entities gather and report. The CHA committee identified several data gaps in the CHA process, with the hope that the list will drive future data collection and study.

Data Gaps, Possible Future Data Collection and/or Study Topics
Homelessness & housing availability
Dental & oral health
Opioid use & abuse
Access to specialty health care
Provider retention efforts
Transportation

The CHA is intended to inform and build on current health efforts in the community. The CHA is one step in an ongoing process of community health assessment, planning and improvement. Future work includes prioritization of health issues and interventions and exploration of how to compliment and integrate work that is already being done in the community.

Appendices

Primary Data Collection Summary

2018 Curry Community Health Assessment

Process & Methods

Two primary methods were used to solicit feedback from the community regarding the 2018 Curry Community Health Assessment. Primary data collection, through focus groups and a community wide survey, provides additional data and context to the secondary data cataloging and analysis. The purpose of the primary data collection was to gather perceptions about health priorities, experiences and gain an understanding of what community members believe influences health the most. Methods included surveys (both paper and online) and targeted focus groups. The primary data collection process is part of a larger community health assessment, following a modified Mobilizing for Action through Planning and Partnerships model (MAPP).

The community survey was written for easy reading and comprehension, resulting in a 98% completion rate. Survey questions mirrored the questions in the targeted focus groups. The survey was available online and in paper/hard copy format, in English and in Spanish language. Additional accommodation for language and/or reading and comprehension was offered. The survey was advertised in many formats, including flyers, social media and via email. 310 people took the survey, eliciting both quantitative health priority ranking data and 298 unique comments.

The 2018 Curry CHA collaborative committee also sponsored ten targeted community focus groups. Forty-six (46) community members participated in the focus groups. The meetings were held around the county during January 2018. The committee identified and prioritized which groups of individuals they wanted to have targeted feedback from, after lengthy discussion. The committee then chose local champions for each group. The role of the local focus group champion was to lead recruitment, coordination of focus group location, selection of small incentives for participants and introduction of the consultant and facilitator to the participants of the group.

Prioritized Populations for 2018 Curry Community Health Assessment Focus Groups

- *Health Care Providers*
- *Tribal Community*
- *Education*
- *Seniors and retirees*
- *Behavioral Health & Addictions*
- *Chronic pain*

Data was gathered in the focus groups with a combination of instant polling questions utilizing "clickers" that captured instant demographic data and polling on health priorities and perceptions. The second type of tool were open-ended discussion questions. The multiple feedback collection tools ensured 100% of focus group participants. Light refreshments and $10 gift cards or equivalent were provided to focus group participants as incentives. The focus groups were complete within two hours and averaged almost nine people per group. 268 unique comments were gathered from focus groups.

Total primary data collection 2018	
Total focus group participants	46
Total surveys completed	310
Total individual participants (both survey and focus group)	356
Total qualitative comments	566

Qualitative and quantitative data were reviewed for themes in both the survey and focus groups. A combined number of 566 unique qualitative comments and several quantitative ranking questions were reviewed for themes. The combined themes and summary data are as follows.

Primary data themes

3 Biggest strengths in community

- **Physical Environment (such as air quality and recreational opportunities etc.)**
- **The people that live here**
- **Social Support (including religious/spiritual values, volunteerism etc.)**

3 Things that would most improve quality of life here

- **Improved Access to affordable housing**
- **Access to affordable health care**
- **Improving availability of jobs**

3 Behaviors with the most influence on health

- **Alcohol and/or drug abuse**
- **Eating habits and nutrition**
- **Not getting health care when you need it**

3 Community Conditions you see the most

- **Poverty or ability to meet financial responsibilities**
- **Homelessness/availability of housing**
- **Lack of health care facilities and services**

3 Health issues you see the most

- **Mental health problems**
- **Substance abuse**
- **Cancer**

Health Equity

59% of participants don't believe that everyone in Curry County has an equal opportunity to live a long healthy life if they choose to.

There are limitations to focus group and survey data. Neither should stand on its own, the processes are meant to compliment and balance the secondary data analysis. The primary data collection methods used in the 2018 Curry CHA are also not random and instead are considered a convenience sample, not intended to be a complete and random sampling of the community but instead, to provide insight into the health concerns, perceptions and experiences of specific groups within the county. The selection of populations for the focus group and the advertising of the survey were driven by the local CHA committee.

Helpful acronyms	
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CCO	Coordinated Care Organization
CHA	Community Health Assessment
CHNA	Community Health Needs Assessment
CMS	Centers for Medicare and Medicaid Services
CT	Computerized Tomography
HCV	Hepatitis C Virus
IMRT	Intensity-modulated radiation therapy
MAPP	Mobilizing for Action through Planning and Partnerships
MRI	Magnetic Resonance Imaging
OHA	Oregon Health Authority
ORCCA	Oregon Coast Community Action
PET	Polyethylene Terephthalate
PHAB	Public Health Accreditation Board
SNAP	Supplemental Nutrition Assistance Program
WIC	Special Supplemental Nutrition Program for Women, Infants and Children

PHAB Measures for Accreditation Chart PHAB 1.5	Reference Page of Report
1.1.1.1 Community Partners	1
1.1.1.2 Regular Meetings	1 (see documentation)
1.1.1.3 Process to identify health issues	1-5
1.1.1.2a Qualitative and quantitative data, primary and secondary data	6-62 65-67
1.1.2.1 b, 3.2.6.1 Demographics of population	6-10
1.1.2.1 d Factors that contribute to specific populations' health challenges	11-62
1.1.2.1 e Existing assets and resources that address health issues	38-46
1.1.2.2 Community review and contribution to CHA	see documentation
7.1.1.1 Availability of health care services	38-46
7.1.3.2 Geographic distribution of providers	38-46
7.1.3.1 & 7.1.3.2 Identification of causes of specific gaps and barriers to care	63

CHNA list for nonprofit hospitals IRS Form 990, Schedule H (2015)	Reference page of Report
Part V Section B Line 3a A definition of the community served by the hospital facility	6-10
Part V Section B Line 3b Demographics of the community	6-10
Part V Section B Line 3c Existing health care facilities and resources in the community that are available to respond to the health needs of the community	38-46
Part V section B Line 3d How data was obtained	1-5 65-67
Part V Section B Line 3e Significant health needs of the community	6-62
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons and minority groups	54-62
Part V Section B Line 3g Process for identifying and prioritizing community health needs and services to meet the community health needs	1-5 65-67
Part V Section B Line 3h Process of consulting with persons representing the community's interests	1-5 65-67
Part V Section B Line 3i Information gaps that limit the hospitals ability to assess the community health needs	63

2018-2020
Health Equity Plan

AllCare Health, Inc.

Table of Contents

Summary

Health equity is defined as all people and communities having the opportunity to attain their full potential and highest level of health.

Achieving health equity requires valuing everyone equally while focusing on eliminating inequities experienced by groups that have encountered obstacles to health. Some of these obstacles may be based on their racial or ethnic group, income, gender identity, sexual orientation, neighborhood, disability, language, religion, insurance status, political affiliation or other characteristics historically linked to discrimination or exclusion.

Health equity requires looking for solutions inside and outside of the health care system. This includes addressing social, economic and environmental conditions (such as housing, employment, public safety, education, bias and discrimination) that create unjust differences in health status and opportunities. It must address policies and systemic structures that create barriers to equitable outcomes for all.

Health Equity and Inclusivity Action Team

Steering Committee

Establish a cross departmental Health Equity Steering Committee to advance policy, systems, and environmental changes that promote equity and address social determinants of health. The Committee shall prioritize health disparities for underrepresented populations; including racially and ethnically diverse communities, people with disabilities, age, gender, protected classes, mental illness, LGBT communities, and low income individuals.

The Steering Committee maintains AllCare Health's health equity strategic plan and provides oversight for the implementation of initiatives to staff, First-Tier, Downstream, and Related Entities.

Steering Committee Membership

The Steering Committee shall consist of 12-14 Stakeholders. The Committee shall strive to include at least 51% representation from the following priority populations: persons of color, persons of non-dominant sexual orientation or gender identity, persons with disabilities, and persons from disadvantaged socio-economic backgrounds. The Steering Committee will consist of one member from each county that represents the Community Advisory Council in that county and a decision maker from each of the following internal AllCare Health departments:

- Member Services
- Provider Services
- Medical Director
- Population Health
- Member Services
- Human Resources

- Executive
- E-Health
- Marketing
- Claims
- Finance
- Creative Services

Committee Workgroups

- Community Engagement
- Culturally Specific Material
- Health Equity Data

- Language Access
- Policy
- Training and Education

Committee Workgroup Membership

All workgroups shall strive to include at least 51% representation from the following priority populations: limited English Proficiency (LEP), persons of color, persons of non-dominant sexual orientation or gender identity, persons with disabilities, persons from disadvantaged socio-economic backgrounds. The groups will consist of at least one member from each of the following Subject Matter Expert (SME) areas.

- Provider
- Human Resources
- Quality
- Member Services
- Brand & Creative Services
- Utilization Management
- Care Coordination
- Behavioral Health
- Downstream Behavioral Health Organizations

- Oral Health
- Downstream Dental Health Organizations
- Regional Health Equity Coalition
- Community Group's
- Limited English Proficiency
- Interpreters
- Community Advisory Council

Committee Workgroup Commitment

The group shall meet twelve 12 times per year. Meeting times are adjusted to accommodate community member schedules. Attendance can be in person, by phone, or by sending a representative. A minimum of 75% of scheduled meetings must be attended each year.

AllCare Health Mission Statement and Brand Promise

Working together to provide quality, cost-effective healthcare for our communities.

Changing healthcare to work for you.

Keys to Success

AllCare Health is a unique organization comprised of employees motivated by altruism. They continually apply that ideology to identify financial reasons to drive improvement in healthcare. AllCare Health is an organization made of experienced professionals within all levels of healthcare — in both clinical settings and the social determinants of health.

Who is AllCare Health?

AllCare Health is a physician-led organization, striving to be a leader within our communities in providing better healthcare and services for southern Oregon and its people.

Our integrated network of clinical professionals is delivering healthcare at the right time and the right place, while controlling costs for both patients and taxpayers. Our brand is based on the foundational ideas of Care, Coverage and Compassion.

AllCare Health and subsidiary companies are designated "Benefit Companies" by the state of Oregon. AllCare Health is also achieved the Certified B Corporation status from non-profit B Lab™. These designations are public recognition of both our history and our present culture of stewardship—and an important step to formalize our ongoing commitment to our communities.

Lines of Business

AllCare Advantage:

AllCare Advantage/AllCare Health Plan, Inc. is the only locally owned Medicare Advantage (HMO) Plan for Medicare-eligible beneficiaries in Southern Oregon.

AllCare CCO:

AllCare CCO provides Medicaid enrollees in Southern Oregon with easy access to coordinated care. AllCare CCO's service area covers Jackson, Josephine, Curry, and Southern Douglas counties.

AllCare eHealth Services:

AllCare eHealth Services provides clinics with low-cost access to a fully integrated electronic medical record and practice management system. It also offers Revenue Cycle Management (medical billing services), Chronic Care Management services, and consulting services for local providers. Our local presence in the Rogue Valley allows us to provide high quality, responsive service for our provider offices.

AllCare Health Independent Physician Association:

Established in 1994 as Mid Rogue Independent Physician Association (IPA), AllCare IPA is a local association of independent doctors, nurse practitioners, and ophthalmologists in Southern Oregon .AllCare Health IPA represents more than 70 independent physicians in private practice in Josephine County and the city of Rogue River in Jackson County. Our mission is to advance the independent practice of medicine in Southern Oregon.

Service Area and Membership

AllCare Health currently serves Jackson, Josephine, and Curry counties and the communities of Glendale and Azalea in southern Douglas County. Not all lines of business are available in every county.

Strengths, Weaknesses, Opportunities, Threats (S.W.O.T.)

Strengths

- Positive influence on healthcare within the region. This includes, but is not limited to administrative policies, provider education, and management trainings.
- Responsive implementation of programs that address member needs.
- Active presence throughout the southern Oregon region.
- Involvement with the Regional Health Equity Coalitions.
- Internal culture driving achievement of health equity.
- Three (3) years of strong committee development and formal reporting structure.

Weaknesses

- Development of new programs may not always have key stakeholder involvement. This can cause unintended consequences.
- Inability to implement large changes quickly across all systems within the organization.
- Inadequate communication between departments.

Opportunities

- Leverage the Oregon Health Authority (OHA) Incentive dollars to address health inequities.
- Integrate internal staff with local efforts to address the Social Determinants of Health & Equity.
- Identify and utilize data that is available from many different sources.
- Develop focus groups with members, providers, and stakeholders.
- Build training opportunities with local stakeholders and provider offices.
- Strengthen health equity focus within the current corporate culture.

Threats

- Limited regional resources that are committed to the Social Determinants of Health & Equity.
- Gatekeepers, healthcare professionals, with unconscious bias. As the first encounter with a patient, they control the patient's entry into the healthcare system. Unaddressed internal biases result in both real and perceived barriers to care.
- Collaborating organizations who are unwilling to implement programs due to strong institution bias or inability to identify issues within the healthcare delivery system.

Purpose Statements of Each Workgroup

Community Engagement

The Community Engagement Workgroup is an ad-hoc group of the Health Equity Steering Committee. All workgroups have the expectation to work with the community directly impacted by the policies and processes being developed. For larger Community Forums, the Steering Committee will hold a Multicultural Storytelling Listening Session. These sessions follow the model developed by the Minneapolis Multicultural Health Storytelling Project.

Multicultural communities often convey health information and knowledge qualitatively through sharing stories. Professionals tend to rely more upon quantitative methods to gather information such as data collection. Storytelling and other qualitative methods can help professionals understand and determine the meaning behind the numbers. This relationship is key to effective policy and program development. In addition, sharing a personal story can empower the storyteller and aid with his/her healing process. This is especially true when heard by those in leadership positions who can influence positive changes to address elements shared within the story.

www.youtube.com/watch?v=2lR_HVIjagE&feature=youtu.be

Culturally Specific Materials Workgroup

The Culturally Specific Materials Workgroup is a sub-group of the Health Equity Steering Committee. The workgroup's purpose is to provide effective, equitable, understandable, and respectful materials that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Focus Areas: This group will focus on the three (3) following priorities:

1. Collaborate with the community to design, implement, and evaluate policies, practices, and services that ensure cultural and linguistic appropriateness.

2. Establish culturally and linguistically appropriate goals and accountability to be infused throughout AllCare Health's planning and operations.

3. Collect and maintain accurate, reliable demographic data used to monitor and evaluate the impact of Culturally Specific Materials Workgroup on health equity and outcomes. Data will also help to inform service delivery.

Health Equity Data Workgroup

The Health Equity Data Workgroup is a sub-group of the Health Equity Steering Committee. The workgroup's purpose is to identify disparities between subgroups of Medicare and Medicaid beneficiaries (e.g., racial and ethnic groups). The group will focus primarily on the areas of health outcomes, utilization, and spending.

Focus Areas: This group will focus on the three (3) following priorities:

1. Create and produce a quarterly Health Equity Report to identify health disparities in our region.
2. Identify methods to incorporate regional Census Data into data dashboards.
3. Utilize data to inform policy decisions and to target populations and geographies for potential interventions.

Language Access Workgroup

The Language Access Workgroup is a sub-group of the Health Equity Steering Committee. The workgroup's purpose is to address the specific language needs of the Limited English Proficient (LEP) beneficiaries, in a method consistent with the core objectives of the federally assisted programs or activities. The group must identify and evaluate the specific language needs for both oral and written information. These needs may operate as artificial barriers to full and meaningful participation in AllCare Health, Inc. programs, activities, or services.

Focus Areas: This group will focus on the three (3) following priorities:

1. Create a yearly Language Access Assessment and Work plan for AllCare Health.
2. Assess quality of AllCare Health's Language Access Services including:
   a. Interpreters
   b. Translations
   c. Training on interpreter use for First Tier, Downstream, and Related entities.
   d. Internal staff trainings
3. Create and maintain AllCare Health's Language Access Policy

Policy Workgroup

The Policy Workgroup is a sub-group of the Health Equity Steering Committee. The workgroup's purpose is to provide resources and support for reviewing AllCare Health, First Tier, Downstream, and Related Entities policies with an "Equity Lens."

Focus Areas: This group will focus on the three (3) following priorities:

1. Create a policy evaluation process that aligns with the Culturally Appropriate Standards in Health and Healthcare.

2. Engage First Tier, Downstream, and Related Entities to advocate policies that support the social determinants of health and health equity.

3. Review, refine, and implement equitable hiring practice policies in coordination with Human Resources.

Training and Education

The Training and Education Workgroup is a sub-group of the Health Equity Steering Committee. The workgroup's purpose is to provide resources and support for improving the cultural competence of AllCare Health staff and First Tier, Downstream, and Related Entities within AllCare Health's service area.

Focus Areas: This group will focus on the three (3) following priorities:

1. Develop training and education with community input.

2. Train-the-trainers within AllCare Health's service area to broaden the reach of available trainings.

3. Develop and update criteria for approving external cultural competence continuing education opportunities.

Work Group Goals 2018-2020

Community Engagement Workgroup

1. Hold four (4) listening sessions with the Native American and Severe and persistent Mentally Ill (SPMI) populations inn Jackson and Josephine counties.

2. Hold three (3) listening sessions with the LGBTQIA+ population in Jackson, Josephine, and Curry counties.

3. Present feedback from Native American and SPMI Listening Sessions to providers in Jackson and Josephine counties.

4. Hold one (1) listening session with providers.

Culturally Specific Materials Workgroup

1. Increase awareness of Pre-Exposure Prophylaxis (PrEP)

2. Develop a provider education plan for having culturally appropriate sexual history conversations with patients.

3. Develop culturally appropriate PrEP educational member materials for the LGBTQIA+ community.

Health Equity Data Workgroup

1. Create and produce a quarterly Health Equity Report to identify health disparities in our region.

2. Identify methods to incorporate regional Census Data into data dashboards.

3. Add one (1) member of each Coordinated Care Organization (CCO) to workgroup.

4. Obtain at least one (1) signed Memorandum of Understandings with additional CCOs to allow for the sharing of Quality Metrics Data in creating a regional CCO Health Equity Dashboard.

5. Create Language Access Dashboards for the Language Access Workgroup aid review of interpreter services utilization.

Language Access Workgroup

1. Establish internal interpreter training that fulfills the 60-hour requirement for becoming a Qualified or Certified Interpreter with the State of Oregon.

2. Utilize training opportunity to add thirty (30) Certified Medical Interpreters to the region.

3. Create and Implement a Language Access Policy that requires a Language Access Assessment yearly.

4. Finalize interpreter directory for First Tier, Downstream, and related entities of AllCare Health.

5. Complete and implement translation of website into Spanish.

6. Implement claims reimbursement policy to allow interpreter billing through AllCare Health claims system.

Policy Workgroup

1. Create a policy evaluation process that aligns with the Culturally Appropriate Standards in Health and Healthcare.

2. Engage First Tier, Downstream, and Related Entities to advocate policies that support the social determinants of health and health equity.

3. Review, refine, and implement equitable hiring practice policies in coordination with Human Resources.

Training and Education

1. Train three (3) trainers from First Tier, Downstream or Related Entities in AllCare Health's internal Health Equity Training Curriculum.

2. Train 100% of staff yearly on AllCare Health's internal Health Equity Training series.

3. Develop and update criteria for approving external cultural competence continuing education opportunities.

4. Develop four (4) trainings to offer as part of the 2019-2020 training sessions.

5. The trainings will focus on:
   a. How to access and use interpreter services
   b. Implicit bias
   c. Priorities received from AllCare Health's community listening sessions
   d. Social determinants of health

Work Group Goals Met 2018-2020

Native American and SPMI Listening Sessions

Background: Through the use of demographic and claims data, AllCare Health's subsidiary, AllCare CCO, identified that a disparity in Emergency Department utilization exists for two populations. The data shows that in Jackson and Josephine counties, members who identify as Native American or are diagnosed with a Severe and Persistent Mental Illness (SPMI) have a significantly higher rate of Emergency Department utilization for physical health when compared to the rest of AllCare CCO's population. Our goal was to determine the reasons these members access the Emergency Department and assist them in engaging or re-engaging with their Primary Care Provider (PCP).

Sessions: Four (4) listening sessions were held in the Spring of 2018. One for each demographic within each county where the disparities were found.

The demographic data included Spanish speakers within each group. All invitations were distributed in both English and Spanish. Interpreters were made available for each session.

For the sessions held in Josephine County, AllCare CCO partnered with Primary Health of Josephine County. Both CCO's identified the same disparity in their population data. This collaboration allowed for feedback from a broader population.

For the sessions held in Jackson County, Jackson Care Connect declined to participate.

For all listening sessions, the regional Health Equity Coalition, So Health-E, collaborated with AllCare and assisted in facilitation of the sessions.

In Summary: Listening session feedback was combined into two (2) categories: Access and Communication.

Access:

- Need provider offices in the region who offer accessibility outside the hours of 9 a.m. to 5 p.m.
- Referrals and authorizations cause barriers.
  - If authorizations are denied, members will go to the Emergency Department to be seen.
  - If a member feels they need a service their provider refuses to submit an authorization or referral for, they visit the Emergency Department to access the service.
- Need additional interpreters for Limited English Proficiency (LEP) individuals.

- In some areas, barriers to alternative care exist.
  - ‣ Providers are not providing referrals for these services.
- Scheduled appointments are too far out.
  - ‣ Members want to go to their Primary Care Provider (PCP), if possible.
- Dental access is a priority to members.
- Members desire "On-Demand" ride availability from ReadyRide.

Communication:

- Desire increased awareness from providers on how they talk with members.
- Need improved health literacy awareness.
- Members want to partner with their providers in their healthcare.
  - ‣ Experience a lot of talking-down.
  - ‣ Fearful of dismissal as patients.
  - ‣ Aware of the opioid crisis. Members do not want a lecture at every visit.
  - ‣ Desire solutions to their problems.
- CCO can improve communication around member benefits.
- Everyone in the health system needs to LISTEN to the members about THEIR healthcare.

Current Interventions from Feedback:

1. AllCare Health's Language Access Workgroup is assessing all points of contact for Limited English Proficient speakers. Refer to the Language Access Workgroup Goals for more information. For an example of provider education developed, please see **Appendix A**.

2. Referral criteria restrictions for alternative therapies are now less restrictive. Utilization of alternative therapies has increased.

3. AllCare Health has created a "Day's to Third next Appointment" quality measure as part of our Alternative Payment Models (APMs). This increases understanding of access within the region.

4. AllCare Health now includes "wait time to appointments" as part of our quarterly network adequacy review.

5. Health literacy training has become a key focus for the organization.

   a. Both internal and external trainings are available.

LGBTQIA+ Listening Sessions

Background: Providers who participate in AllCare Health's Alternative Payment Models (APMs) are surveyed annually. These surveys help determine patient satisfaction with both their provider and their access to care. In an effort to make the program more equitable, the following question is included in the survey:

> *Do you feel that you were treated differently from other patients because of any of the following? (Check all that apply) Insurance Type, Race, Gender, Age, LGBTQ, Disabled, Language, Other*

In the satisfaction surveys, LGBTQIA+ continues to be selected as a common reason members feel they are treated differently. AllCare CCO's Community Advisory Councils (CACs) in each county continue to hear voiced concerns of discrimination for those that identify as transgender. These discrimination concerns include both verbal and physical abuse.

Sessions: Three (3) listening sessions were held in the Fall of 2018. One (1) each in Jackson, Josephine, and Curry counties.

Participants included the public; invitation was not limited to AllCare Health plans.

Consideration of caterer selection gave preference to those who identified as LGBTQIA+ for each event.

All participants received a $25.00 gift card for participation.

In Summary: Listening session feedback was combined into two (2) categories: Access and Culturally Competent Care.

Access:
- Appointments are scheduled too far out.
  ‣ Everyone prefers to go to their Primary Care Provider, if possible.
- In emergencies, alternative ways to seek advice on care help.
  ‣ Nurse Help Lines
  ‣ Crisis Lines
  ‣ Suicide Hotlines
  ‣ Mental Health Crisis Lines
- Participants appreciate patient portals, allowing for access without worry of in-person discrimination. However, provider follow-through is important. Participants had the following frustrations:
  ‣ Lack of response to emails through portal.
  ‣ Lab results not posted to portal.

- Most providers in the region are great, especially Nurse Practioners.
- Many barriers occur with gatekeepers to care:
  ‣ At the specialist office
  ‣ Receptionist
- Stigmas seem to be increase for other factors:
  ‣ Hearing loss
  ‣ Ageism
  ‣ Weight
- In the rural areas, transportation is big barrier.
- Individuals travel to Eugene for more Culturally Competent Care.
  ‣ Specialists
  ‣ Hospitals
  ‣ HIV Testing
- Gender identity questions are included on some forms at some hospitals.
  ‣ There is a lack of cultural competency training on how to ask the questions.
- Sexual orientation questions are not asked.

Culturally Competent Care:
- Providers who complete sexual orientation and gender identity training offer a more welcoming environment.
- Significant dismissal of sexual orientation and gender identity as a factor in one's healthcare.
  ‣ Individuals that identify as Lesbian forced to take pregnancy tests before procedures.
  ‣ Transgender Male forced to explain to lab staff the reason for a BRCA gene test.
  ‣ Therapist removed gender dysphoria from diagnosis. Individual had to explain importance to provider.
- Education given to the provider community by the LGBTQIA+ population on needed care.
- STI discussions need to occur in a more Culturally Appropriate way.
  ‣ PrEP education is unavailable in the region.
  ‣ Use of incorrect STI tests on partners who are negative for HIV and have HIV positive partners.
  ‣ Failure to test partners when one is facing an STI scare.

- LGBTQIA+ individuals are very vulnerable in the medical setting.
  ‣ Advertise that you welcome LGBTQIA+ individuals.
  ‣ Rainbow flags in waiting rooms would be appreciated.
  ‣ Be humble about mistakes and apologize.
- Need cultural competency for gender identity.
  ‣ Transgender male's wife was asked to undress for mammogram.
  ‣ Transgender male's wife was asked, in front of partner, if "felt safe" with this individual.

Current Interventions from Feedback:

1. AllCare Health has created a "Day's to Third next Appointment" quality measure as part of our Alternative Payment Models (APMs). This increases understanding of access within the region.

2. AllCare Health now includes "wait time to appointments" as part of our quarterly network adequacy review.

3. LGBTQIA+ Culturally Competent Care training has become a key focus for the organization. For an example of provider education, please see **Appendix B** for an example.

   a. Both internal and external trainings are available.

Qualified Interpreters Listening Sessions

Background: In 2015, the Regional Health Equity Coalition (So Health-E) held a listening session with the Latino Community. Overwhelmingly, the identified greatest need was for trained Medical Interpreters.

Current Interventions from Feedback:

1. AllCare Health has trained five (5) internal staff interpreters.

2. Formalized pay differential policy for Bilingual AllCare Health staff. Please see **Appendix C**.

3. Added a Health Equity measure to the Alternative Payment Models. To pass, a provider office must:

   a. Have at least one Certified or Qualified Medical Interpreter on staff.

   b. Or, have 70% of the staff participate in a Cultural Competency training.

3. Created an internal 64-hour interpreter-training program for the region. Currently this course is held two (2) times a year. Please see **Appendix D**.

4. Current count of Certified and Qualified Interpreters is 75. Please see **Appendix E**.

Health Equity Dashboard Workgroup

Background: In 2017, a Health Equity report was created. The Health Equity and Inclusivity Steering Committee reviews it quarterly. The report breaks out OHA CCO Incentive Measure performance using various demographic data (e.g. race, language spoken, county) to help identify disparities. The initial report highlighted the increased Emergency Room utilization for physical health reasons by Severe and Persistent Mentally Ill members as well as our Native American population in Jackson and Josephine Counties. This information supported the decision to hold Listening Sessions with these members to better understand what the data was showing us. Ongoing review of this report allows the Committee to monitor performance and propose additional projects to address issues that are contributing to identified disparities. Please see **Appendix G**.

Training and Education Workgroup

Background: In 2016, AllCare Health trained 100% of staff and another 800 individuals in Southern Oregon, through a five (5) hour Cultural Humility Training. The training was developed from the CLAS standards in partnership with So Health-E. Intent was to provide participants with the ability to:

- Understand the fundamentals of cultural competency, diversity, and inclusion.

- Examine their own personal lenses and biases.

- Examine the concept of cultural humility and the link to life-long learning and service equity.

- Understand the impact of privilege and unconscious bias on health outcomes for marginalized populations.

- Examine the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare.

- Identify current challenges and barriers to providing health care, educational, and social services to culturally, ethnically, linguistically and socially diverse populations in Southern Oregon.

- Learn strategies for providing culturally responsive services and strategies to improve community engagement and increase inclusion of diverse communities.

2017-2018: To encourage a shared understanding of health equity for AllCare Health staff and the community, four (4) one (1) hour trainings were developed with input from community organizations.

Cultural Agility: Provides participants with the skills for adapting to cultural differences while remaining agile during interactions with co-workers and members.

Health Literacy: Gives the definition of health literacy and explains how marginal health literacy can be a barrier to a patient's healthcare and health outcomes.

Implicit Bias: Helps participants understand implicit bias, its effect on healthcare, and how it can be overcome.

Creating An Affirming Setting for Non-Binary (those who don't identify as man or woman) People: Includes important terms, data, and expert-informed practices. Offers suggestions for how an individual can implement simple changes to improve the experiences of patients with non-binary gender identities.

2018-2019: AllCare Health will continue providing the five (5), one (1) hour training sessions developed from community input. AllCare is also offering a Train-the-Trainer session to help others share the information and broaden understanding further within our communities. Please see **Appendix F**.

Health Literacy 1.0: Defines health literacy and why low health literacy is a barrier to health.

Health Literacy 2.0: This workshop will teaches participants skills to create Plain Language forms. They are required to complete Health Literacy 1.0 to register.

Unnatural Causes: Episode Five-Place Matters- Participants watch "Place Matters" from Unnatural Causes. Then discuss why your address is a predictor of your health.

Social Determinants of Health (SDoH) Game: This training helps participants understand the impacts of SDoH. The game has three goals:

- Discuss the SDoH
- Build empathy
- Learning in a fun setting

Barriers to care: This training explores these barriers to care:

- Social Determinants of Health
- Unconscious Bias
- Low Health Literacy
- Language Access

"Not everything that is faced can be changed, but nothing can be changed until it is faced."   - James Baldwin

Appendix A

Deaf & Hard of Hearing Forum

An event to help the medical provider overcome communication barriers which present with Deaf patients. Presenters will explain Deaf and Hard-of-Hearing needs, impacts of misdiagnosis and language deprivation, Deaf culture and communication etiquette, legal duties, pitfalls, and how to avoid the latter.

Sept. 27th - 2825 E Barnett Rd, Medford   **Sept. 28th - 1701 NE 7th St., Grants Pass**

Agenda (both locations)	
Registration	7:45 a.m. – 8:15 a.m.
Deaf Culture Chad/Denise	8:15 a.m. - 9:30 a.m.
Stories Panel	9:30 a.m. - 10:00
Break	10:00 a.m. - 10:15 a.m.
When to use an Interpreter Stick/Mavel	10:15 a.m. - 11:15 a.m.
Expert Panel	11:15 a.m. - 12:00 p.m.
Questions/ Wrap-up	12:00 p.m. - 12:30 p.m.

Register online at:
surveymonkey.com/r/Deaf_Forum

Chad A. Ludwig, MSW, ADAC, DI
Chad is a Director for Regional Resource Center on Deafness (RRCD) with Western Oregon University (WOU). Chad works as a freelance Deaf and DeafBlind Interpreter (DI) on the side in the community.

Denise Thew Hackett, Ph.D., MSCI, CRC
is an Associate Professor and Program Coordinator for the Rehabilitation and Mental Health Counseling Graduate Program at Western Oregon University. Denise is the Principal Investigator of the Deaf and Hard of Hearing Oregonian Community Needs Assessment.

Stick Crosby, AllCare Health Network & Health Equity Mgr.
Stick is the Network & Health Equity Manager for AllCare Health. In this position he is able to look at inequities on a systems level within the provider network and find ways that we can change the system to work for everyone.

Mavel Morales
Mavel is the ADA Coordinator and Civil Rights Investigator for OHA service recipients. Mavel is fluent in Spanish. Mavel provides technical assistance to OHA staff and OHA contractors in the areas of nondiscrimination, Section 1557 and ADA compliance.

Appendix B

Earn **CME & CEU** Credits!

allcare health®

Health Equity Training Series

Blood-Borne and Sexually Transmitted Infections
Talking with your patients in a culturally appropriate way

Wednesday, February 13th, 2019
5:00 p.m. to 7:00 p.m.
Jacksonville Inn
Dinner will be provided.

Featuring:

Chris Evans, MD, MPH, AAHIVS
AETC Presentation:
Update on STD screening
and treatment.
**This presentation qualifies as
1 hour CME or CEU!**

Jennifer Mappus, PharmD:
Prescribing Pre Exposure
Prophylaxis.

Dawn Cogliser, FNP:
Culturally Appropriate
ways to have discussions
with underserved
populations.

RSVP to Amy DeChenne at:
https://www.surveymonkey.com/r/HEAETC
or Amy.Dechenne@AllCareHealth.com

Appendix C

AllCare Health

Human Resources
Policies and Procedures

AllCareHealth.com

Language Proficiency Pay Differential Policy

Revision number:	Revision date:
1	2/22/2019
Approved by:	**Approval date:**
Kathy Charles	2/22/2017

Table of Contents

Purpose

AllCare Health is committed to ensuring good communication between staff and individuals who depend on our services. The organization also is committed to supporting staff in the development and use of abilities that increase their ability to communicate with the communities we serve. Fulfilling this commitment through a language proficiency policy will result in improved outcomes for staff and our members.

Description

This policy details the requirements for training, hiring and providing a pay differential for staff who are multi-lingual.

Policy

1. AllCare Health Human Resources (HR) shall coordinate with organization programs to develop and maintain a list identifying non-English languages commonly needed by AllCare Health employees, including American Sign Language.
2. Qualifying employees of AllCare Health required to use their skills in more than one language in the performance of their assigned duties, including oral or written communication such as interpretation and written translation or the use of sign language, may be offered a pay differential for proficiency in a non-English language.
3. Differential pay is based on operations and position need as well as current demographic data and measurable outcomes specific to each position.
4. To qualify for a language pay differential, AllCare Health employees shall meet language proficiency standards.

{POLICY OR PROCEDURE NAME} / 1

Appendix C

AllCare Health
Human Resources
Policies and Procedures

Language Proficiency Pay Differential Policy

Revision number:	Revision date:
1	2/22/2019
Approved by:	**Approval date:**
Kathy Charles	2/22/2017

5. AllCare Health shall employ an independent third-party assessor of language abilities to determine levels of proficiency and create standardized language performance measures.

6. Assigned duties determining eligibility for a pay differential based on non-English language proficiency vary for each position and shall be specified within each individual position description.
   a. Managers may request that non-English language proficiency be added to a position description.
   b. The addition of non-English proficiency to a position description shall be reviewed and approved by HR.

7. Supervising managers shall immediately notify HR when an employee is no longer eligible for a language pay differential.

8. AllCare Health employees may test for language proficiency during their employment, whether or not they are in a position requiring non-English language proficiency.
   a. HR shall add a proficiency designation and the language in which proficiency has been established to the personnel file of each employee passing the proficiency test.
   b. The names of employees with passing proficiency scores will be added to an HR list of staff "pre-qualified" for bilingual positions.

9. AllCare Health shall contract with a language testing service to assess the language proficiency of employees and candidates for employment when those employees will receive a pay differential based on the use of non-English language skills in the performance of their assigned duties.

10. In order to receive a pay differential for proficiency in a non-English language, or be offered a position requiring proficiency in a non-English language, staff and candidates must achieve:
    a. A level of "High Intermediate" fluency on the oral assessment.
    b. Written language proficiency, at the request of the supervising manager based on job responsibilities.

11. Employees or applicants may have testing waived by providing approved documentation such as:
    a. A previously documented ASL proficiency interview test score of Level 3 or above.
    b. A college degree or diploma from a country with a national language applicable to the desired position.
    c. National or state certification as an interpreter in a legal, medical or other setting.

Appendix C

AllCare Health
Human Resources
Policies and Procedures

Language Proficiency Pay Differential Policy

Revision number:	Revision date:
1	2/22/2019
Approved by:	**Approval date:**
Kathy Charles	2/22/2017

12. Prospective staff applying for positions requiring non-English language proficiency (including current staff applying for promotion or transfer) shall have one opportunity during the application process to pass the proficiency assessment.

13. All AllCare Health staff receiving a language proficiency pay differential when this policy goes into effect shall be assessed to ensure interpretive (oral) language proficiency in the target language within six months of the implementation of this policy.
    a. Employees may test twice within a six month period in order to demonstrate proficiency.
    b. Based on operational needs and budget constraints, AllCare Health may support skill enhancement for employees who do not pass their initial proficiency assessment.
    c. Employees who do not demonstrate proficiency within a six month period of their initial testing may have their pay differential removed and non-English language responsibilities reassigned.

Revision History

- 01/30/2016: Document created

Appendix D

allcare health™

Sponsored by AllCare CCO

Become a Qualified Medical Interpreter

Meet the State of Oregon's requirements for Medical Interpreting

Picture yourself as one of the many Limited English Proficient (LEP) people across the United States. Those who struggle or are unable to speak English. Imagine the feelings you have as your knowledge of your health is in someone else's hands. This could feel scary or stressful.

This is why health care interpreters matter. They are the only bridge between health care and the LEP patient. Not only do these interpreters speak both languages, they have also been trained to explain medical terminology. Their job exists to make sure all patients get the same quality of health care as everyone else.

AllCare CCO is a licensed training site for the Bridging the Gap 64 hour interpreter training that meets the state of Oregon's requirements to become a Qualified Medical Interpreter.

The cost is $750.00 for the 8 day training and $100.00 for the text book. Lunch will be provided. Course requirements are on the back of this flyer.

*Scholarships Available

For Scholarship information and to register:

https://www.surveymonkey.com/r/BTGREG

Appendix D

AllCare Health™

Sponsored by AllCare CCO

Medical Interpreter Course Requirements

AllCare will facilitate the application process to Oregon Health Authority for participants completing this training to become a qualified medical interpreter with the state of Oregon.

*Be at least 18 years of age

*Must have a high school diploma or GED

*Are not on the Medicaid exclusion list

*Complete a language proficiency test in the target language. A high school diploma from a country that predominantly speaks that language will be accepted.

*You can schedule a language proficiency test with AllCare. The cost is $75.00

*A letter on your employer's letterhead attesting to 15 hours of documented interpreting experience.

*A clear copy of a driver's license, state-issued ID card or passport for your background check.

The training will be held at AllCare's main headquarters 1701 NE 7th St. Grants Pass, Or. The dates for the training will be **Tuesday, March 11th 2019** through **Friday, March 15th 2019** and **Tuesday, March 18th 2019** through **Friday, March 21st 2019.** You must attend all 8 days to meet the 60 hour requirement by Oregon Health Authority. Each session will begin at 8:00 am and end at 5:00 pm

Appendix E

Count of Certified and Qualified Interpreters by year and language(Jackson,Josephine,Curry)

Credential
- Certified ASL interpreter
- Certified Spanish Interpreter
- Qualifed Spanish Interpreter
- Qualified ASL Interpreter
- Qualified Chinese Interpreter
- Qualified Chinese Mandarin Interpreter
- Qualified Malay Interpreter
- Qualified Marshallese Interpreter
- Qualified Palauan Interpreter
- Qualified Persian (Farsi) Interpreter
- Qualified Russian Interpreter
- Qualified Samoan Interpreter
- Qualified Spanish and Portuguese Interpreter
- Qualifed Spanish Interpreter
- Qualified Vietnamese Interpreter

Total of 75 Interpreters
12/24/2018

Support of Interpreter services
begins in the region

Appendix E

Count of Certified and Qualified Interpreters by year and language(Jackson,Josephine,Curry)

Total of 75 Interpreters 12/24/2018

Support of Interpreter services begins in the region

Year	Count of Credential
2014	1
2015	3
2016	4
2017	29
2018	38

Appendix F

Train the Trainer

Are you trying to address health disparities in a meaningful way, within your organization? AllCare Health is offering five "Train the Trainer" sessions to help improve communication and understanding with members and co-workers.

Friday, February 22

8:00 a.m. to 5:00 p.m.

AllCare Health Community Room, 1701 NE 7th Street, Grants Pass, OR

Register early — Only 20 participants will be accepted!

Contact amy.dechenne@AllCareHealth.com to register.

Trainings include:

Health Literacy 1.0
Defines what health literacy is and why low health literacy is a barrier to health. Only offered twice in 2019.

Health Literacy 2.0
Teaches the skills needed to create Plain Language forms.

Cultural Agility
Skills for adapting to cultural differences while being agile during interactions with patients and co-workers.

Implicit Bias
Understand what implicit bias is, its effect, and how to overcome implicit bias in healthcare.

Barriers to care
Explore these barriers to care:

- Social Determinants of Health
- Unconscious Bias
- Low Health Literacy

Social Determinants of Health (SDoH) Game
Understand the impacts of SDoH. The game has three goals:

- Discuss the SDoH
- Build empathy
- Learn in a fun setting

Appendix G

2017 AllCare Health Equity Dashboard

Adolescent WellCare by Race

	African American	American Indian/Alaskan Native	Asian American	Hawaiian/Pacific Islander	Hispanic/Latino	Euro American	Other	Unknown
July 2014	21.6%	25.8%	30.0%	14.3%	21.2%	21.4%	0.0%	22.5%
July 2015	26.1%	20.2%	34.1%	13.3%	23.3%	23.3%	21.6%	23.8%
July 2016	31.3%	35.6%	21.2%	14.3%	33.7%	34.9%	32.0%	32.2%
July 2017	41.9%	39.3%	26.7%	23.5%	39.9%	36.7%	33.3%	35.4%
December 2017	38.7%	38.3%	32.3%	26.7%	45.7%	41.1%	31.9%	39.3%
2014 Target	24.2%	24.2%	24.2%	24.2%	24.2%	24.2%	24.2%	24.2%
2015 Target	26.1%	26.1%	26.1%	26.1%	26.1%	26.1%	26.1%	26.1%
2016 Target	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%	33.0%
2017 Target	38.4%	38.4%	38.4%	38.4%	38.4%	38.4%	38.4%	38.4%

Adolescent WellCare by County

	Curry	Jackson	Josephine/Douglas
July 2014	19.1%	22.0%	21.4%
July 2015	18.3%	24.0%	23.6%
July 2016	28.9%	31.0%	38.8%
July 2017	35.8%	31.0%	43.4%
December 2017	35.8%	36.5%	46.4%
2014 Target	24.2%	24.2%	24.2%
2015 Target	26.1%	26.1%	26.1%
2016 Target	33.0%	33.0%	33.0%
2017 Target	38.4%	38.4%	38.4%

Appendix G

Adolescent WellCare by Language

	English	Spanish
July 2015	22.6%	28.3%
July 2016	35.0%	35.7%
July 2017	35.9%	42.3%
December 2017	39.5%	49.7%
2015 Target	26.1%	26.1%
2016 Target	33.0%	33.0%
2017 Target	38.4%	38.4%

Adolescent WellCare by Age

	12-14 Years Old	15-17 Years Old	18-21 Years Old
July 2014	29.2%	21.7%	12.0%
July 2015	34.2%	24.2%	12.7%
July 2016	43.9%	35.5%	20.8%
July 2017	45.9%	40.0%	21.2%
December 2017	51.8%	41.1%	24.7%
2014 Target	24.2%	24.2%	24.2%
2015 Target	26.1%	26.1%	26.1%
2016 Target	33.0%	33.0%	33.0%
2017 Target	38.4%	38.4%	38.4%

Appendix G

Effective Contraceptive Use by Race

Legend: July 2015 | July 2016 | July 2017 | December 2017 | 2015 Target | 2016 Target | 2017 Target

	African American	American Indian/Alaskan Native	Asian American	Hawaiian/Pacific Islander	Hispanic/Latino	Euro American	Other	Unknown
July 2015	35.7%	30.2%	26.9%	42.3%	37.7%	35.2%	37.7%	33.0%
July 2016	26.7%	34.8%	26.3%	35.0%	35.7%	33.7%	34.1%	36.4%
July 2017	52.4%	37.9%	28.0%	57.1%	36.6%	40.9%	45.7%	43.1%
December 2017	54.5%	44.4%	30.0%	45.5%	41.7%	45.8%	46.8%	45.2%
2015 Target	38.1%	38.1%	38.1%	38.1%	38.1%	38.1%	38.1%	38.1%
2016 Target	38.1%	38.1%	38.1%	38.1%	38.1%	38.1%	38.1%	38.1%
2017 Target	44.3%	44.3%	44.3%	44.3%	44.3%	44.3%	44.3%	44.3%

Effective Contraceptive Use by County

Legend: July 2015 | July 2016 | July 2017 | December 2017 | 2015 Target | 2016 Target | 2017 Target

	Curry	Jackson	Josephine/Douglas
July 2015	30.8%	37.2%	32.5%
July 2016	30.4%	35.4%	34.1%
July 2017	35.3%	40.3%	44.5%
December 2017	43.0%	43.8%	47.5%
2015 Target	38.1%	38.1%	38.1%
2016 Target	38.1%	38.1%	38.1%
2017 Target	44.3%	44.3%	44.3%

Appendix G

Effective Contraceptive Use by Language

	July 2015	July 2016	July 2017	December 2017	2015 Target	2016 Target	2017 Target
	English	Spanish					
July 2015	36.3%	37.7%					
July 2016	35.8%	35.8%					
July 2017	42.0%	25.0%					
December 2017	47.0%	36.5%					
2015 Target	38.1%	38.1%					
2016 Target	38.1%	38.1%					
2017 Target	44.3%	44.3%					

Effective Contraceptive Use by Age

	15-17	18-24	25-30	31-35	36-40	41-45	46-50
July 2015	34.4%	57.3%	45.5%	30.8%	23.1%	13.9%	6.4%
July 2016	31.3%	53.6%	45.0%	32.7%	22.9%	14.6%	8.9%
July 2017	36.5%	56.2%	52.6%	37.9%	32.1%	24.5%	15.1%
December 2017	36.3%	61.8%	56.4%	46.2%	36.1%	27.4%	18.9%
2015 Target	38.1%	38.1%	38.1%	38.1%	38.1%	38.1%	38.1%
2016 Target	38.1%	38.1%	38.1%	38.1%	38.1%	38.1%	38.1%
2017 Target	44.3%	44.3%	44.3%	44.3%	44.3%	44.3%	44.3%

Appendix G

Developmental Screening by Race

	African American	American Indian/Alaskan Native	Asian American	Hawaiian/Pacific Islander	Hispanic/Latino	Euro American	Other	Unknown
July 2014	31.6%	19.0%	52.9%	42.9%	28.2%	37.0%	40.0%	32.4%
July 2015	50.0%	25.8%	31.6%	63.6%	51.1%	51.7%	36.4%	50.7%
July 2016	70.0%	51.5%	16.7%	90.0%	60.1%	56.8%	49.2%	60.8%
July 2017	50.0%	52.8%	44.4%	54.5%	63.5%	55.8%	42.9%	60.0%
December 2017	54%	70%	57%	50%	61%	63%	60%	65%
2014 Target	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%
2015 Target	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%	43.8%
2016 Target	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
2017 Target	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%

Developmental Screening by County
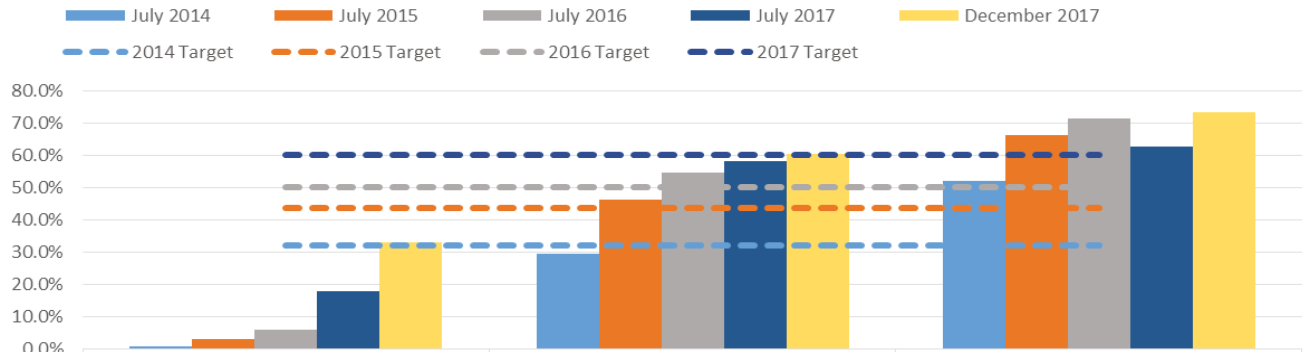
	Curry	Jackson	Josephine/Douglas
July 2014	0.6%	29.3%	51.9%
July 2015	3.0%	46.1%	66.2%
July 2016	5.8%	54.8%	71.4%
July 2017	17.9%	58.2%	62.8%
December 2017	33.1%	60.4%	73.3%
2014 Target	32.0%	32.0%	32.0%
2015 Target	43.8%	43.8%	43.8%
2016 Target	50.0%	50.0%	50.0%
2017 Target	60.0%	60.0%	60.0%

Appendix G

Developmental Screening by Language

Legend: July 2015 · July 2016 · July 2017 · December 2017 · 2015 Target · 2016 Target · 2017 Target

	English	Spanish
July 2015	51.8%	55.2%
July 2016	59.1%	63.2%
July 2017	58.0%	73.3%
December 2017	63.4%	68.7%
2015 Target	43.8%	43.8%
2016 Target	50.0%	50.0%
2017 Target	60.0%	60.0%

Dental Sealants by Race

Legend: July 2015 · July 2016 · July 2017 · December 2017 · 2015 Target · 2016 Target · 2017 Target

	African American	American Indian/Alaskan Native	Asian American	Hawaiian/Pacific Islander	Hispanic/Latino	Euro American	Other	Unknown
July 2015	14.1%	8.8%	19.1%	0.0%	17.6%	13.3%	18.8%	15.9%
July 2016	29.8%	29.4%	29.4%	15.8%	26.6%	25.2%	18.4%	24.5%
July 2017	21.6%	30.3%	42.9%	23.5%	23.6%	23.0%	21.3%	23.1%
December 2017	20.0%	31.5%	44.4%	5.0%	30.4%	22.8%	26.0%	24.3%
2015 Target	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%
2016 Target	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%
2017 Target	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%

Appendix G

Dental Sealants by County

Legend: July 2015, July 2016, July 2017, December 2017, 2015 Target, 2016 Target, 2017 Target

	Curry	Jackson	Josephine/Douglas
July 2015	17.5%	14.1%	14.4%
July 2016	32.1%	24.3%	25.0%
July 2017	32.6%	23.8%	21.1%
December 2017	31.0%	25.0%	22.2%
2015 Target	15.0%	15.0%	15.0%
2016 Target	20.0%	20.0%	20.0%
2017 Target	20.0%	20.0%	20.0%
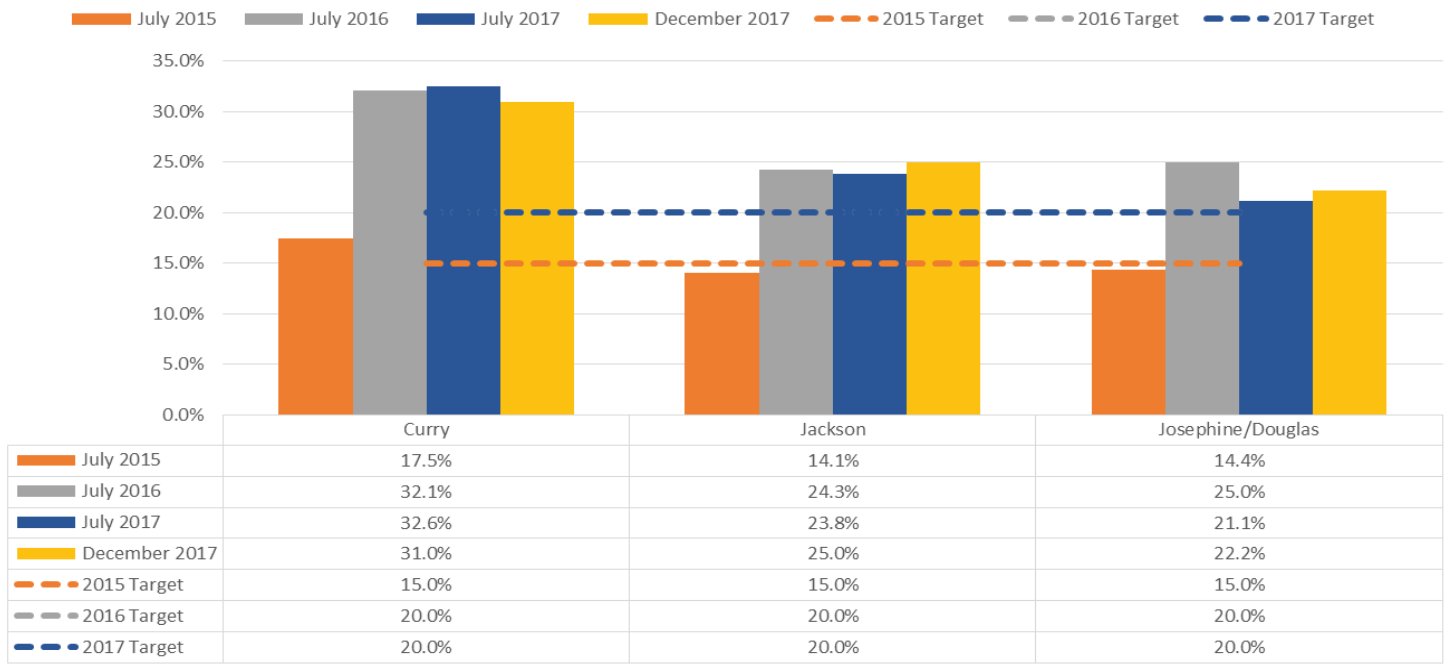
Dental Sealants by Language

Legend: July 2015, July 2016, July 2017, December 2017, 2015 Target, 2016 Target, 2017 Target

	English	Spanish
July 2015	13.8%	22.3%
July 2016	25.3%	31.6%
July 2017	22.9%	29.0%
December 2017	23.5%	31.9%
2015 Target	15.0%	15.0%
2016 Target	20.0%	20.0%
2017 Target	20.0%	20.0%
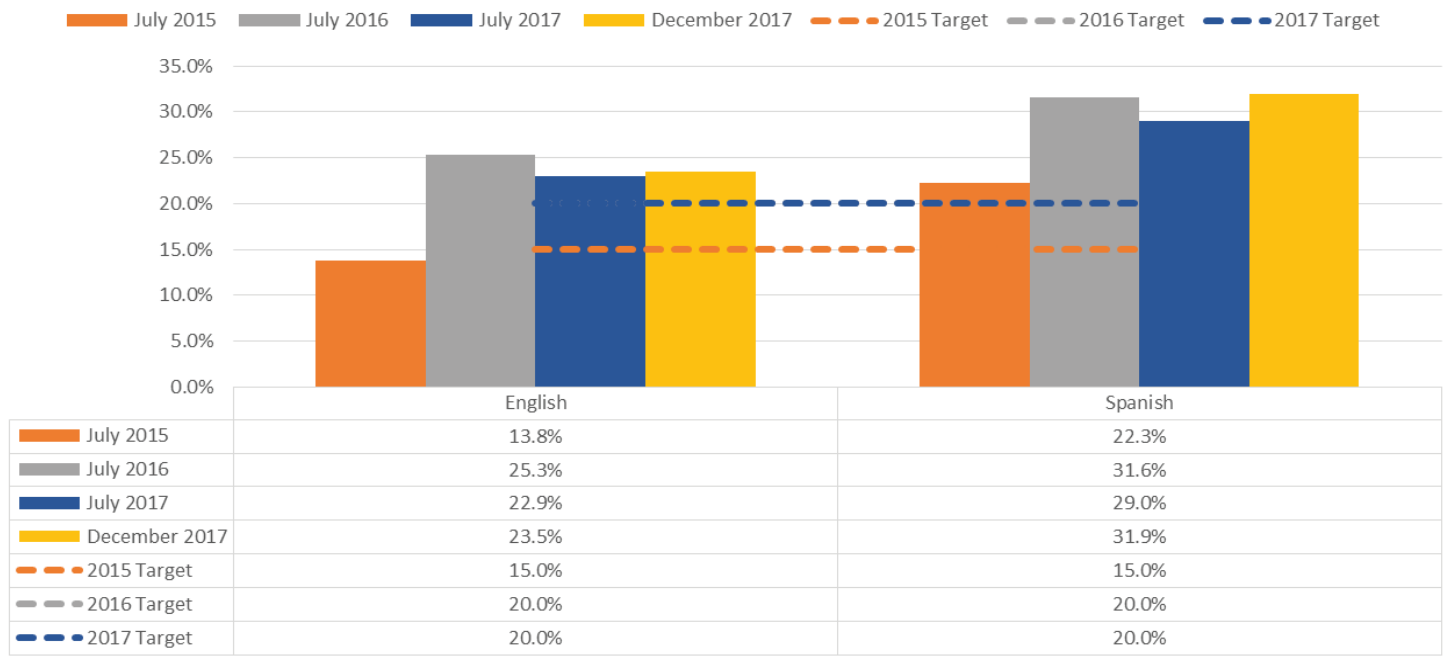
Appendix G

ED Utilization by County
(Lower Score is Better)

	Curry	Jackson	Josephine/Douglas	Rural Jackson	Urban Jackson
July 2014	29.4	44.5	42.2	34.6	48.2
July 2015	21.2	41.3	36.9	31.7	45
July 2016	32.6	39.6	37.2	32.2	42.4
July 2017	28.3	40.4	34.9	35.2	42.4
December 2017	31.1	40.3	34.8	35.4	42.2
2014 Target	45.0	45.0	45.0	45.0	45.0
2015 Target	41.2	41.2	41.2	41.2	41.2
2016 Target	39.8	39.8	39.8	39.8	39.8
2017 Target	42.9	42.9	42.9	42.9	42.9
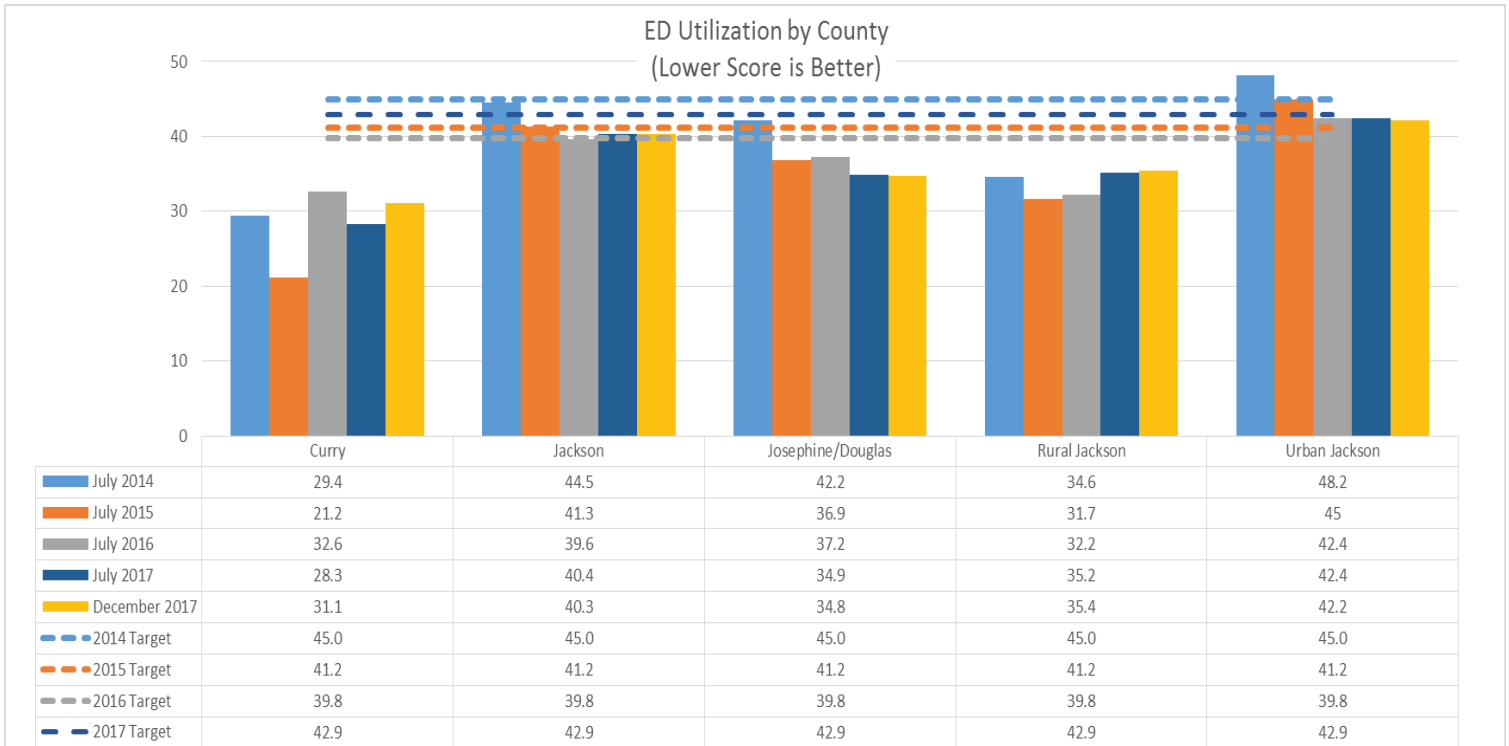
ED Utilization by Language
(Lower Score is Better)

	English	Spanish
July 2015	42.4	27.5
July 2016	41.6	26.2
July 2017	39.3	31.3
December 2017	38.9	28.6
2015 Target	41.2	41.2
2016 Target	39.8	39.8
2017 Target	42.9	42.9
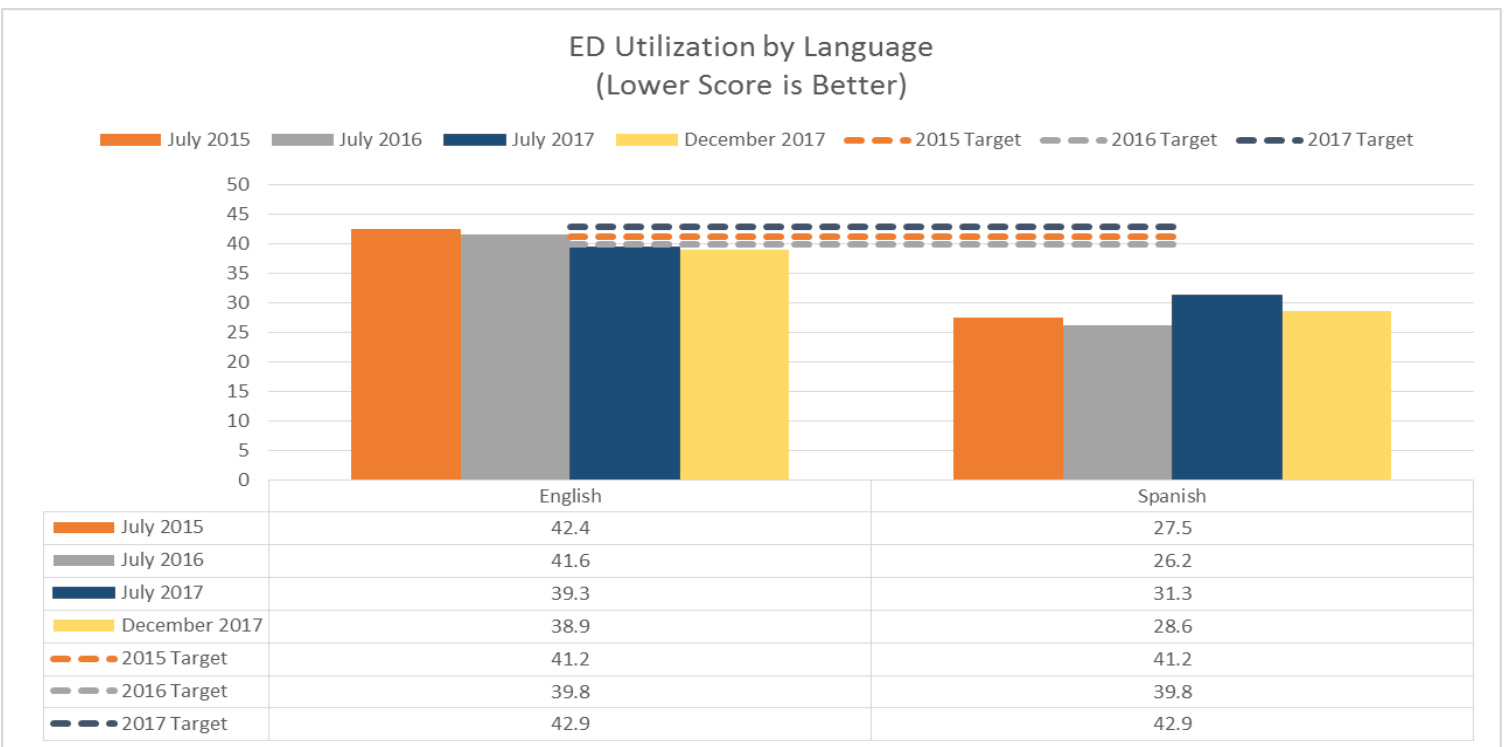
Appendix G

ED Utilization by SPMI & Disability
(Lower Score is Better)
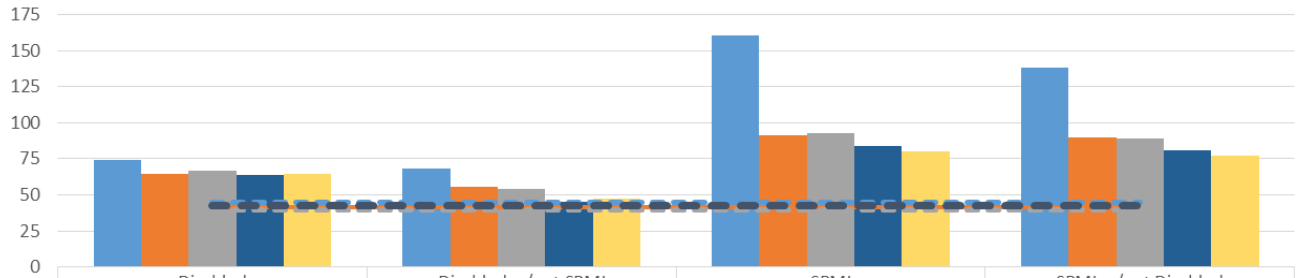
	Disabled	Disabled w/out SPMI	SPMI	SPMI w/out Disabled
July 2014	74.2	68.1	160.4	137.9
July 2015	64.7	55.7	91.6	90.1
July 2016	66.7	54.2	92.5	89.2
July 2017	63.9	45.5	83.5	81
December 2017	64.8	47.3	80.0	77.1
2014 Target	45.0	45.0	45.0	45.0
2015 Target	41.2	41.2	41.2	41.2
2016 Target	39.8	39.8	39.8	39.8
2017 Target	42.9	42.9	42.9	42.9

ED Utilization by Substance Use Disorder
(Lower Score is Better)
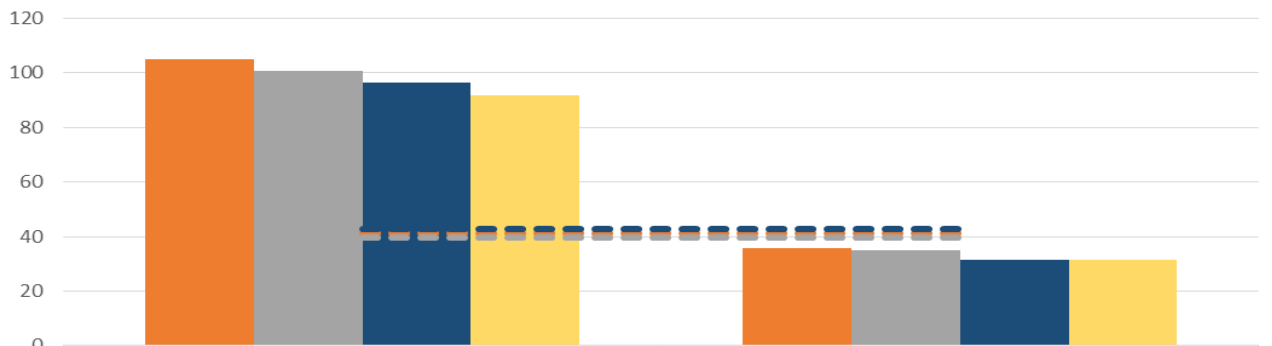
	Substance Use Disorder	w/out Substance Use Disorder
July 2015	105	35.8
July 2016	100.8	34.9
July 2017	96.4	31.3
December 2017	91.8	31.3
2015 Target	41.2	41.2
2016 Target	39.8	39.8
2017 Target	42.9	42.9

Appendix G

ED Utilization by Race
(Lower Score is Better)

	African American	American Indian/Alaskan Native	Asian American	Hawaiian/Pacific Islander	Hispanic/Latino	Euro American	Other	Unknown
July 2014	41.7	53.4	27.1	48.6	36.7	44.3	39.3	40.5
July 2015	48.9	43.1	24.7	39.5	39	40.3	26.7	31.4
July 2016	48.6	54.8	21.2	36.5	38.1	39.9	28	36.7
July 2017	55.1	42.3	12.1	48.9	38.0	38.8	24.6	37.6
December 2017	43.6	44.0	10.7	52.1	38.7	39.3	20.5	37.1
2014 Target	45.0	45.0	45.0	45.0	45.0	45.0	45.0	45.0
2015 Target	41.2	41.2	41.2	41.2	41.2	41.2	41.2	41.2
2016 Target	39.8	39.8	39.8	39.8	39.8	39.8	39.8	39.8
2017 Target	42.9	42.9	42.9	42.9	42.9	42.9	42.9	42.9

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Grants Pass
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Grants Pass, OR 97526
Tel (541) 471-4106

Medford
3629 Aviation Way
Medford, OR 97504
Tel (541) 734-5520

Toll free (888) 460-0185
TTY 711
Fax (541) 471-3784
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2018
Health Equity Plan

AllCare Health, Inc.

Certified

B

Corporation

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Summary

Health equity is defined as, all people and communities having the opportunity to attain their full potential and highest level of health.

Achieving health equity requires valuing everyone equally while focusing on eliminating inequities experienced by groups that have encountered obstacles to health based on their racial or ethnic group, income, gender identity, sexual orientation, neighborhood, disability, language, religion, insurance status, political affiliation or other characteristics historically linked to discrimination or exclusion.

This requires looking for solutions inside and outside of the health care system. It requires addressing social, economic and environmental conditions (such as housing, employment, public safety, education, bias and discrimination) that create unjust differences in health status and opportunities for health in communities. It must address policies and systemic structures that create barriers to equitable outcomes for all.

Goals

- Have all staff trained in mandatory Diversity Equity and Inclusion Trainings
- Provider offices participating in the APMs surveyed regarding equity issues
- Thirty (30) Certified Medical Interpreters in Southern Oregon
- Equity Wins/Awareness/Champions
- Develop culturally-specific materials to assist Hepatitis-C/HIV patients and their providers.
- Materials sent to members developed with an alternative language version
- Complete two (2) Multicultural Health Listening sessions in 2018
- Adoption of Diverse hiring practices
- Development of audit program for contracted provider offices around accessibility for Disabled members.

Mission Statement and Promise

Working together to provide quality, cost-effective healthcare for our communities.

Changing Healthcare to Work for You.

Keys to Success

AllCare Health is a unique organization whose employees have self-selected work in this field. They are individuals that are not only driven by altruism but can take that ideology and find financial reasons to drive improvement in healthcare. AllCare Health is an organization made up of professionals experienced with all levels of healthcare, impacted by both clinical and social determinants of health.

Who is AllCare Health?

AllCare Health is a physician-led organization leading the way to better healthcare for Southern Oregon and its people, with a range of health plans designed to meet the state's diverse communities and their health needs.

Our integrated network of clinical professionals is delivering healthcare at the right time and the right place, while controlling costs for both patients and taxpayers. Our brand is based on the foundational ideas of Care, Coverage, and Compassion.

Recently, AllCare Health and its subsidiary companies were designated "Benefit Companies" by the state of Oregon. This designation is public recognition of both our history and our present culture of stewardship—and an important step toward formalizing an enduring commitment to our communities.

Lines of Business

AllCare Advantage:

> AllCare Advantage/AllCare Health Plan, Inc. is the only locally-owned Medicare Advantage (HMO) Plan for Medicare-eligible beneficiaries in Southern Oregon.

AllCare MediGap:

> AllCare MediGap/AllCare Health Plan, Inc. offers two Medicare Supplement policies for Medicare-eligible beneficiaries the State of Oregon.

AllCare CCO:

> AllCare CCO provides Medicaid enrollees in Southern Oregon with easy access to coordinated care located in Josephine, Jackson, Curry and Southern Douglas county.

AllCare eHealth Services:

> AllCare eHealth Services provides clinics with low-cost access to a fully integrated electronic medical record and practice management system. eHealth Services also offers Revenue Cycle Management (Medical Billing Service), Chronic Care Management services, and Consulting services for local providers. Our local presence here in the Rogue Valley allows us to provide high quality, responsive service for our provider offices, which further differentiates us from others.

AllCare Health Independent Physician Association:

> Established in 1994, AllCare Health Independent Physician Association (IPA) is an independent provider association in Southern Oregon. AllCare Health IPA was created by a group of local independent physicians in Southern Oregon who wanted to have a voice in the local delivery of healthcare. AllCare Health IPA represents more than 70 independent providers in private practice in Josephine County and Rogue River in Jackson County. Our mission is to advance the independent practice of medicine in Southern Oregon.

Service Area and Membership

> AllCare Health currently serves Jackson, Josephine, and Curry Counties and the communities of Glendale and Azalea in southern Douglas County. Not all product lines are available in every county. AllCare Health has a history of service area expansions and will likely grow market share through new product lines as well as geographic expansion.

S.W.O.T. (Strengths, Weaknesses, Opportunities, Threats)

Strengths

- Influence on several levels of healthcare in the region such as administrative policies, provider education, and management trainings
- Quick implementation of programs and addressing member needs
- Presence throughout Southern Oregon
- Active participation in the Regional Health Equity Coalitions
- Internal culture is striving to achieve health equity

Weaknesses

- Development of new programs may not always have key stakeholder involvement, causing "unintended consequences"
- Organization unable to implement large changes across all systems quickly
- Communication issues between departments

Opportunities

- Utilize OHA Incentive dollars to address health inequities
- Internal staff integrated with local efforts to address The Social Determinants of Health
- Data available from many different sources
- Develop focus groups with members
- Training opportunities with local stake holders and provider offices
- Incorporate health equity into current culture

Threats

- Limited regional resources to commit to the Social Determinants of Health
- Gatekeepers with unconscious bias - A healthcare professional who has the first encounter with a patient and controls the patient's entry into the healthcare system. Unaddressed internal biases result in perceived and real barriers to care from the "Gatekeepers" in the system
- Partnering organizations with strong institutional bias not willing to implement programs, or unaware of issues in the healthcare delivery system

Goals

Have all staff trained in internal Diversity Equity and Inclusion Trainings
(June 2017-August 2018)

The Health Equity & Inclusivity Action Team has put together four (4) training's to build upon AllCare's five (5) hour Cultural Humility Training that was offered in 2016-2017. The four courses that will be offered are:

Cultural Agility

This will provide skills for adapting to cultural differences while being agile during interactions with co-workers, members and stakeholders.

Health Literacy

This will define what health literacy is and why marginal health literacy can be a barrier to health care and health outcomes for our members.

Creating an affirming setting for Non-Binary (those who don't identify as man or woman) People

This training includes important terms, data, and expert-informed practices, which will offer suggestions for how any staff member can implement simple changes to improve the experiences of patients with non-binary gender identities.

Implicit Bias

This training will help you understand what implicit bias is, its effect on health care, and overcoming implicit bias in health care.

Alternative Payment Model participant offices surveyed *(Aug 2017-March 2018)*

Provider offices that participate in AllCare Health's Alternative Payment Models (APM) are surveyed annually to determine patient satisfaction with access to care their Provider. In an effort to make the program more equitable the following question was added to the survey:

> **Do you feel that you were treated differently from other patients because of any of the following? (Check all that apply) Insurance Type, Race, Gender, Age, LGBTQ, Disability, Language, Other**

The surveys will be completed by January 2018 and will be used as a baseline to evaluate the provider's office as AllCare Health implements a large education campaign focused on cultural humility and transgender health.

This question was added to the 2018 CHAPS survey for the Medicare Advantage line of business.

Training of thirty (30) Medically Certified Interpreters *(Sep 2017-Mar 2018)*

AllCare Health is a Certified Medical Interpreter Testing Site through the Certification Commission for Healthcare Interpreters (CCHI), just the third CCHI location in the state to offer testing for medical interpreters, and the first location outside of Portland to offer both the written and oral tests. The testing will be offered year-round. Both the Grants Pass and Medford offices are testing sites.

Equity Wins/Awareness/Champions *(Jan 2018)*

Spotlighting our internal equity champions and projects monthly.

Complete two (2) Multicultural Health Listening sessions in 2018

Multicultural communities often convey health information and knowledge qualitatively – through sharing stories – while professionals tend to rely more upon quantitative methods – such as data collection – to gather information. Storytelling and other qualitative methods can help professionals understand and determine the meaning behind the numbers, which is key to effective policy and program development. In addition, sharing a personal story has the added benefit of empowering the storyteller and, if applicable, can also help with his/her healing process. This is especially true when the story is heard by those in leadership positions who can influence positive changes to address elements shared within the story.

Develop culturally-specific materials to assist Hepatitis-C/HIV patients and their providers *(Jun 2018-Nov 2018)*

Development of culturally-specific materials for members with Hepatitis-C to educate and understand the diagnosis and treatment plans. Develop provider education materials regarding cultural barriers to Hepatitis-C treatments.

Ad-Hoc materials sent to members developed with an alternative language version *(Jun 2018-Dec 2018)*

AllCare Health currently ensures all materials sent to members from the Member Services Department is translated into Spanish. Other departments in the organization do not have this policy, they also do not have standardized letter templates for communications sent to members. This causes barriers when needing to communicate to members that speak a language other than English.

Adoption of Diverse hiring practices *(Jan 2018-Dec 2018)*

In May of 2017 two (2) AllCare Health employees, the HR Director and Contracts Manager, participated in "Embedding an equity lens into HR practice". This was a training hosted by So-Health E, the Regional Health Equity Coalition in Southern Oregon.

This presentation provided an overview of best practices for hiring and retaining a diverse work force. The following areas were included:

- Recruitment
- Position Descriptions
- Hiring Practices
- Supervision
- Evaluation and Discipline

Development of an audit program for contracted provider offices around accessibility for Disabled members *(Jun 2018-Dec 2018)*

AllCare currently surveys all contracted provider offices on the accessibility of the office for members that may have Disabilities. There is not currently an audit program to insure that the responses from the contracted offices are valid.

Key Performance indicators

Have all staff trained in internal Diversity Equity and Inclusion Trainings

An internal dashboard has been created to display at each monthly Health Equity and Inclusivity Action Team meetings. This will display the current number of internal and external employees that have been trained.

Year-end report of APM offices surveyed

A year-end report will be developed to show the data collected from the survey process. The report will be broken down by provider specialty and county.

Development of internal dashboard for OHA incentive measures. Dashboard developed by both departments and I.T. for the OHA incentive measures and APM measures

Training of thirty (30) Medically Certified Interpreters:

Certification of interpreters

Development of internal interpreter training program

APM incentive for certified interpreters in provider offices *(AllCare CCO only)*

Equity Wins/Awareness/Champions

Implementation of Equity Champions suggested by the Health Equity and Inclusivity Action team monthly.

Monthly award and recognition poster developed

Complete two (2) Multicultural Health Listening sessions (AllCare CCO only)

Hold sessions

Deliver report back to community from sessions

Decrease ED utilization with the Native American population

Culturally-specific materials to assist Hepatitis-C/HIV patients and their providers

Culturally-specific materials for members with Hepatitis-C/HIV to educate and understand the diagnosis and treatment plans.

Provider education materials regarding cultural barriers to Hepatitis-C/HIV treatments.

Policies developed for alternative language versions of Ad-Hoc documents

Policies by each department for member related materials.

Standardized letter templates for member communications.

Translations of standard letter member templates.

Adoption of Diverse hiring practices

Implementation of standard hiring practices

Manager training on standard interview practices

Development of audit program for contracted provider offices around accessibility for Disabled members.

Audit program created to evaluate contracted offices on site for accessibility based off of the Northwest ADA Center calculator for accessibility.

"You may choose to look the other way, but you can never say again that you did not know." —William Wilberforce

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1701 NE 7th Street,
Grants Pass, OR 97526
Tel (541) 471-4106

Medford
3629 Aviation Way
Medford, OR 97504
Tel (541) 734-5520

Toll free (888) 460-0185
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Fax (541) 471-3784
AllCareHealth.com

2017 Health Equity Plan

AllCare Health

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Year-end report of APM offices surveyed

Medically Certified Interpreters

Equity Wins/Awareness/Champions added to employee newsletter

Preferred Language Cards added to member packets.

LGBTQ Health Training for Primary Care Providers

Culturally-specific materials to assist Hepatitis-C/HIV patients and their providers.

Policies developed for alternative language versions of documents

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Goals

- Have all staff trained in internal Cultural Humility Training
- Offices participating in the APMs surveyed with equity
- Implementation of Provider Network Transformation Services (PNTS) and Population Health Work Group addressing Health Inequities (Data Driven)
- Training of Medically Certified Spanish Language Interpreters- Two (2)
- Equity Wins/Awareness/Champions added to employee newsletter
- Preferred Language Cards added to member packets.
- Development of LGBTQ Health Training for Primary Care Providers
- Develop culturally-specific materials to assist Hepatitis-C/HIV patients and their providers.
- Materials sent to members developed with an alternative language version

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AllCare MediGap:

AllCare MediGap/AllCare Health Plan, Inc. offers two Medicare Supplement policies for Medicare-eligible beneficiaries the State of Oregon.

AllCare PEBB:

AllCare PEBB/AllCare Health Plan, Inc. is a cost effective health plan available to eligible public employees in Southern Oregon. Created by local doctors in consultation with the Oregon Public Employees' Benefit Board, AllCare PEBB provides our members with more choices, greater access to providers, and the highest quality service.

AllCare CCO:

AllCare CCO provides Medicaid enrollees in Southern Oregon with easy access to coordinated care we're located in Grants Pass, Medford, and Brookings and want to see our Southern Oregon neighbors stay healthy.

eHealth Services:

AllCare eHealth Services provides clinics with low-cost access to a fully integrated electronic medical record and practice management system. It also offers billing

services. Our local presence here in the Rogue Valley allows us to provide high-touch, responsive service for our provider offices, which further differentiates us from others.

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Established in 1994, AllCare Health Independent Physician Association (IPA) is an independent physician association in Southern Oregon. AllCare Health IPA was created by a group of local independent physicians in Southern Oregon who wanted to have a voice in the local delivery of healthcare. AllCare Health IPA represents more than 70 independent physicians in private practice in Josephine County and Rogue River in Jackson County. Our mission is to advance the independent practice of medicine in Southern Oregon.

Service Area and Membership

AllCare Health currently serves Jackson, Josephine, and Curry Counties and the communities of Glendale and Azalea in Douglas County. Not all product lines are available in every county. AllCare Health has a history of service area expansions and will likely grow market share through new product lines as well as geographic expansion.

Current Membership by Plan –
as of October 24, 2016
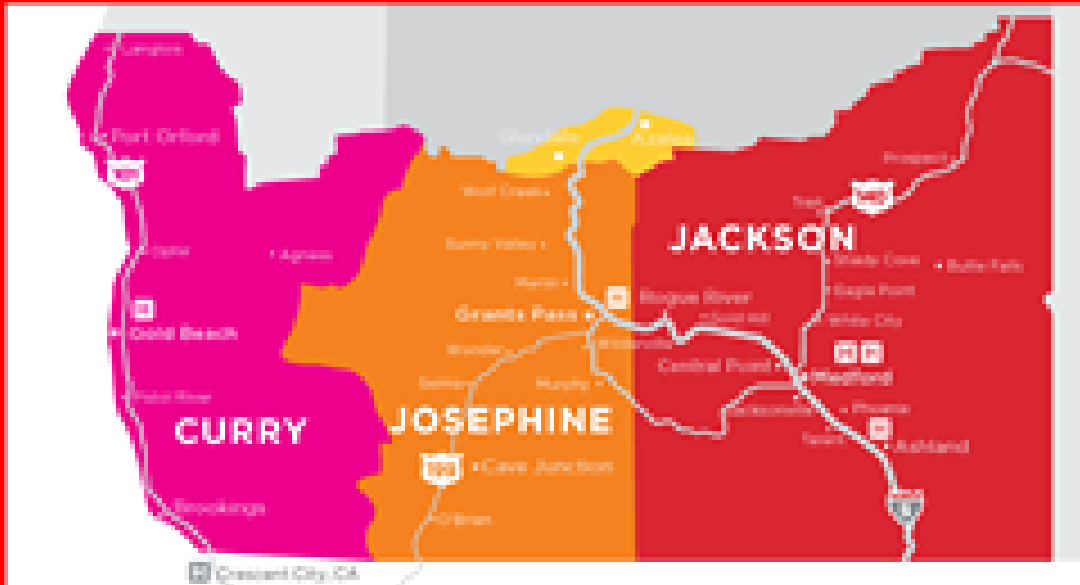
AllCare Advantage: **1,934**
AllCare CCO: **49,255**
AllCare PEBB: **2,038**

TOTAL MEMBERSHIP: 53,227

S.W.O.T. (Strengths, Weaknesses, Opportunities, Threats)

Strengths

- Influence on several levels of healthcare in the region such as administrative policies, provider education, and management trainings
- Quick implementation of programs and addressing member needs
- Presence throughout South Western Oregon
- Active participation in the Regional Health Equity Coalitions
- Internal culture is striving to achieve health equity

Weaknesses

- Development of new programs may not always have key stakeholders causing "unintended consequences"
- Organization unable to implement large changes across all systems quickly
- Selective mutism (when a person who is normally capable of speech does not speak in specific situations or to specific people) between departments

Opportunities

- OHA Incentive dollars to address health inequities
- Internal staff integrated with local efforts to address The Social Determinants of Health
- Data available from many different sources
- Develop focus groups with members
- Training opportunities with local offices
- Incorporate health equity into current culture

Threats

- Limited regional resources to commit to the Social Determinants of Health
- Gatekeepers with unconscious bias - A healthcare professional who has the first encounter with a patient and who thus controls the patient's entry into the healthcare system. Unaddressed internal biases result in barriers to care from the "Gatekeepers" in the system
- Partnering organizations with strong institutional bias not willing to implement programs, or unaware of issues in the healthcare delivery system

Goals

Have all staff trained in internal Cultural Humility Training

The Health Equity & Inclusivity Action Team has put together a training to replace AllCare Health's current online cultural competency training. This training is developed from the CLAS (Culturally and Linguistically Appropriate Services) standards. It is intended for those that participate to have the ability to:

- Understand the fundamentals of cultural competency, diversity and inclusion

- Examine your own personal lenses and biases

- Examine the concept of cultural humility and the link to life-long learning and service equity

- Understand the impact of privilege and unconscious bias on health outcomes for marginalized populations

- Examine the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and healthcare

- Identify current challenges and barriers to providing health care, educational, and social services to culturally, ethnically, linguistically and socially diverse populations in Southern Oregon

- Learn strategies for providing culturally responsive services and strategies to improve community engagement and increase inclusion of diverse communities

Alternative Payment Model participant offices surveyed

Provider offices that participate in AllCare Health's Alternative Payment Models (APM) are surveyed annually to determine patient satisfaction with access to care and their provider. In an effort to make the program more equitable the following question was added to the survey:

Do you feel that you were treated differently from other patients because of any of the following? (Check all that apply) Insurance Type, Race, Gender, Age, LGBTQ, Disabled, Language, Other

The surveys will be completed by January 2017 and will be used as a baseline to evaluate the provider's office before AllCare Health implements a large education campaign around cultural humility and transgender health.

Implementation of Provider Network Transformation Services (PNTS) and Population Health Work Group addressing Health Inequities (Data Driven)

AllCare Health has seen much success through the development of the PNTS department developed with local stakeholders and providers. This new work group will be developed to look at health inequities within the OHA incentive measures and identify areas of improvement. The PNTS data analysts will work with the Population Health Department to develop a dashboard to start to trend inequities for each incentive measure. The group will look at the measures by Race, Ethnicity, Age, Language, Disability, and SPMI diagnoses to identify opportunities for improvements. Disparities with a population greater than 35 will be trended.

Training of Medically Certified Spanish Language Interpreters: Two (2)

AllCare Health currently has two Community Health Workers that are fluent in both Spanish and English. They are going through a program to become medically certified as interpreters. AllCare Health will continue to actively recruit employees that speak the languages that our members prefer in their homes and medically certify those interpreters.

Equity Wins/Awareness/Champions added to employee newsletter

AllCare Health currently has an employee newsletter that goes out weekly and will begin to integrate spotlighting our internal equity champions and projects monthly in this newsletter.

Preferred Language Cards added to member packets

OHA's Office of Equity and Inclusion provides preferred language cards for members that speak a language other than English. AllCare Health Member Services will develop a policy to include one of these cards in each member's packet that speaks a language other than English.

Development of LGBTQ Health Training for Primary Care Providers

AllCare Health will train one medical director to become a trainer in LGBTQ health for primary care providers in the 3 county region that we serve. For offices that identify a need for staff education around LGBTQ needs there will be a companion training curriculum developed for non-provider staff around Cultural Humility with a LGBTQ focus. Finally for offices that may not have the resources to commit the time to these trainings. A menu of online trainings will be created that contracted AllCare providers can participate in.

Develop culturally-specific materials to assist Hepatitis-C/HIV patients and their providers

Development of culturally-specific materials for members with Hepatitis-C to educate and understand the diagnosis and treatment plans. To develop provider education materials for cultural barriers to Hepatitis-C treatments.

Materials sent to members developed with an alternative language version

AllCare Health currently ensures all materials sent to members from the Member Services Department is translated into Spanish. Other departments in the organization do not have this policy, they also do not have standardized letter templates for communications sent to members. This causes barriers when needing to communicate to members that speak a language other than English.

Key Performance indicators

All staff trained in internal Cultural Humility Training

An internal dashboard has been created to display at each monthly Health Equity and Inclusivity Action Team meeting. This will display CLAS related policies that the organization has in place and is continuing to develop.

Year-end report of APM offices surveyed

A year-end report will be developed to show the data collected from the survey process. This will be broken down by provider specialty and county.

Development of internal dashboard for OHA incentive measures. Dashboard developed by both departments and I.T. for the OHA incentive measures and APM measures

Medically Certified Interpreters

Certification of interpreters

Policy in place to continue to recruit and train medically certified interpreters.

APM incentive for certified interpreters in provider offices

Equity Wins/Awareness/Champions added to employee newsletter

Implementation of Champions added to newsletter suggested by Health Equity and inclusivity action team monthly.

Preferred Language Cards added to member packets.

Implementation of preferred language cards added to Member Packets

LGBTQ Health Training for Primary Care Providers

One Medical Director trained in LGBTQ health for Primary Care Providers

Training curriculum developed for non-provider staff around cultural humility with a LGBTQ focus.

Menu of online trainings that contracted AllCare providers can participate in focus on LGBTQ care.

Culturally-specific materials to assist Hepatitis-C/HIV patients and their providers.

Culturally-specific materials for members with Hepatitis-C/HIV to educate and understand the diagnosis and treatment plans.

Provider education materials for cultural barriers to Hepatitis-C/HIV treatments.

Policies developed for alternative language versions of documents

Policies by each department for member related materials.

Standardized letter templates for member communications.

Translations of standard letter member templates.

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

–Dr. Martin Luther King

AllCare CCO, Inc.
Community Advisory Council
COMMUNITY INVESTMENT APPLICATION

AllCare proudly works to support innovative, community-based projects that seek to affect the health of our community. We ask that you please fill out the following application with as much detail as possible. For more information regarding funding criteria and priorities, please contact the indicated AllCare team member for details.

Please be sure to indicate the date you need a response by If not indicated, allow 30-60 days for a response to your request. AllCare may require more information before approving funding requests.

Submit this completed form to the Community Engagement & Investment Team member with whom you have been working (listed below, as well). You can also call (541) 471-4106 for more information.

Project or Event Name	
Organization Information *Operating Name:* *Legal Name (if applicable):* *Address:*	**Tax ID / EIN #**
Contact Information *Contact Person: Phone:*	**Website/Social Media**

Date of Request Submission	**Funding Amount Requested**	**Date Response Need By**
	Non-Monetary Request n/a	☐ Check if Urgent (less than 2 weeks)

Division(s) of AllCare to Which the Current Report is being Submitted

    ☐ Oral Health Integration (Send to: Laura McKeane, laura.mckeane@allcarehealth.com)

    ☐ Health & Education/Social Services Integration (Send to: Susan Fischer, susan.fischer@allcarehealth.com)

    ☐ Behavioral Health Integration   (Send to Lana McGregor, lana.mcgregor@allcarehealth.com)

    ☐ Health & Nutrition Integration (Send to Sam Engel, sam.engel@allcarehealth.com)

    ☐ Health & Housing Integration (Send to Sam Engel, sam.engel@allcarehealth.com)

    ☐ Other (Send to Carrie Prechtel, carrie.prechtel@allcarehealth.com)

County(s) AllCare Serves for Which the Current Request is Being Made:

    ☐ Curry

    ☐ Jackson

    ☐ Josephine/southern Douglas

    ☐ OTHER: _____

New or Continuing Funding Request	**Timeframe for Project**
☐ New ☐ Continuation Year(s) Previously Funded: _____	

Background on Requesting Organization

Mission:

History, Capacity, and Demographics:

Statement of Need:

Are you an equal opportunity employer and provider? If no, please explain:

Publicity and/or Sponsor Recognition

Project Outline

Brief Project Description with Service Area and/or Focus Population:

Project Objectives – What will change because of this investment?:

Project Activities – How will you achieve these objectives?:

Proposed Outputs – How will you measure and evaluate success?:

Specific Connections to Health:

Reporting –
If the project is funded, a reporting schedule will be provided in the award letter)

Are you able to provide information about the outcomes of the project or event? ☐ Yes ☐ No

If yes, please list outcomes that will be provided.
Note: This can be either qualitative or quantitative and pictures are welcomed.

Budget Detail and Narrative

Please provide a detailed budget in a separate Excel document and explain your plan for cost allotments during the project.

Are there other entities contributing to the funding this project? ☐ Yes ☐ No
If yes, please list the other contributors, their funding amount, and time frame that funding will be available.

If the current proposal is for a long-term project or event, what sustainability plan is in place for stable funding?

AllCare CCO
COMMUNITY INVESTMENT APPLICATION

AllCare proudly works to support innovative, community-based projects that seek to affect the health of our community. We ask that you please fill out the following application with as much detail as possible. For more information regarding funding criteria and priorities, please contact the indicated AllCare team member for details.

Please be sure to indicate the date you need a response by. If not indicated, allow 30-60 days for a response to your request. AllCare may require more information before approving funding requests.

Submit this completed form to the Community Engagement & Investment Team member with whom you have been working. You can also call (541) 471-4106 for more information.

Project or Event Name		
Organization Information *Operating Name/DBA:* *Legal Name (if applicable):* *Address:*		**Tax ID / EIN #**
Contact Information *Contact Person:* *Email:* *Phone:*		**Website/Social Media**

Date of Request Submission	**Funding Amount Requested**	**Date Response Need By**
	Non-Monetary Request	☐ Check if Urgent (less than 2 weeks)

Division(s) of AllCare to Which the Current Application is being Submitted

☐ Oral Health Integration (Send to: Laura McKeane, laura.mckeane@allcarehealth.com)

☐ Education or Social Service Integration (Send to: Susan Fischer, susan.fischer@allcarehealth.com)

☐ Behavioral Health Integration   (Send to Lana McGregor, lana.mcgregor@allcarehealth.com)

☐ Domestic or interpersonal violence (Send to Jennifer Gustafson, Jennifer.Gustafson@allcarehealth.com)

☐ Housing or Nutrition Integration (Send to Sam Engel, sam.engel@allcarehealth.com)

☐ Community Advisory Council requests and applications (Send to Carrie Prechtel, carrie.prechtel@allcarehealth.com)

☐ Health Equity Integration (Send requests to Stick Crosby, stick.crosby@allcarehealth.com)

County(s) AllCare Serves for Which the Current Request is Being Made:

☐ Curry   ☐ Jackson   ☐ Josephine   ☐ Southern Douglas

☐ OTHER: _____

New or Continuing Funding Request	**Timeframe for Project**
☐ New* ☐ Continuation Year(s) Previously Funded: _____ *If new, please include your **IRS W-9**	

Background on Requesting Organization

Mission:

History, Capacity, and Demographics:

Statement of Need:

Are you an equal opportunity employer and provider? _____ If no, please explain:

Does this project address (check all that apply)
☐ Physical Health; ☐ Oral Health; ☐ Social Determinants of Health; ☐ Mental/Behavioral Health; ☐Equitable Health Outcomes

Publicity and/or Sponsor Recognition

Project Outline

Brief Project Description with Service Area and/or Focus Population:

How does this project fit into your organization's strategic plan?

Project Objectives – What will change because of this investment?

Project Activities – How will you achieve these objectives?

Proposed Outputs – How will you measure and evaluate success?

Specific Connections to Health:

Reporting

If the project is funded, a reporting schedule will be provided in the award letter)

Are you able to provide information about the outcomes of the project or event?   ☐ Yes   ☐ No

If yes, please list outcomes that will be provided.
Note: This can be either qualitative or quantitative and pictures are welcomed.

Can you report on the number of or specific AllCare Health members that you serve? ☐ Yes   ☐ No
  Description of reporting or barriers to reporting:

Data collection

Can you collect and report participant specific data? (name, date of birth, CCO, dates and type of service, etc.?) Please describe:

Budget Detail and Narrative

Please provide a detailed budget in a separate Excel document and explain your plan for cost allotments during the project. Please include secured and pending requests related to this project.

Are there other entities contributing to the funding this project?   ☐ Yes   ☐ No
If yes, please list the other contributors, their funding amount, and time frame that funding will be available.

If the current proposal is for a long-term project or event, what sustainability plan is in place for stable funding?

Additional required documents

_____ Current W9
_____ List of current board members and affiliations
_____ Equity or non-discrimination policy

FOR OFFICE USE ONLY:

Date received? _____

☐ CAC Submission
   Funded?
     ☐ Yes
     ☐ No

Resubmit to CHIP Team?
     ☐ Yes
     ☐ No

☐ CHIP Submission
   Funded?
     ☐ Yes
     ☐ No

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AllCare Health
Policies and Procedures

Language Access Policy

Policy number: 834	Revision number:	Revision date:
Line of Business: All	**Approved by:** Will Brake, COO	**Approval date:** 1/1/2019

Table of Contents

Overview

To address, consistent with the core objectives of the federally assisted programs or activities, the specific language needs of Limited English Proficient (LEP) beneficiaries which operate as artificial barriers to full and meaningful participation in the federally assisted program or activity. This requires that AllCare Health, Inc. (AllCare) and subsidiary companies evaluate how a LEP person's inability to understand oral and written information provided by and about AllCare program's or activity's might adversely impact his or her ability to fully participate in or benefit from that program or activity.

Policy

It is the policy of this agency to provide timely meaningful access for LEP persons to all AllCare programs and activities. All personnel shall provide free oral and written language assistance services to LEP individuals whom they encounter or whenever a LEP person requests language assistance services. All personnel will inform members of the public that language assistance services are available free of charge to LEP persons and that AllCare will provide these services to them.

Definitions

Title VI- The overarching federal law governing language access of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin in programs and activities receiving Federal financial assistance.

AllCare Health
Policies and Procedures

Language Access Policy

Policy number: 834	Revision number:	Revision date:
Line of Business: All	Approved by: Will Brake, COO	Approval date: 1/1/2019

Program or Activity- a department, agency, special purpose district, or other instrumentality of a State or of a local government; or the entity of such State or local government that distributes such assistance and each such department or agency (and each other State or local government entity) to which the assistance is extended, in the case of assistance to a State or local government. AllCare HealthPlan, Inc. and AllCare CCO, Inc. fall under this definition.

Limited English Proficient (LEP) beneficiaries- Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP." These individuals may be entitled language assistance with respect to a particular type or service, benefit, or encounter.

Section 1557- a section of the Patient Protection and Affordable Care Act which was enacted in 2010 by the US legislature. Section 1557 requires any health care entity receiving federal financial assistance to engage in certain practices to prevent discrimination on the basis of age, race, color, nationality, or gender, including gender identity.

Bilingual Staff Member- Employees that have proficiency in a non-English and English language at a level of "High Intermediate" fluency on the ACTFL scale oral assessment or equivalent recognized by the Oregon Health Authority.

Qualified Medical Interpreter- An individual that is licensed by the Oregon Health Authority as a "Qualified Interpreter"

Certified Medical Interpreter- An individual that is licensed by the Oregon Health Authority as a "Certified Interpreter"

Language Access Assessment- A self-assessment that identifies language service needs, and evaluates the bilingual, translation, and interpretation resources already available to help LEP individuals access AllCare's benefits, programs, services, information, or other operations. Assessments approved by the Oregon Office of Equity and Inclusion, Oregon Health Care Interpreter Council, or a Regional Health Equity Coalition will be recognized in this policy.

Regional Health Equity Coalition- are collaborative, community-led, cross-sector groups organized regionally to identify and address health equity issues. The RHEC model works by building on the inherent strengths of local communities so they can lead identifying sustainable, long-term, policy, system and environmental (PSE) solutions to increase health equity in Oregon. Coalitions prioritize communities of color as primary populations of focus.

AllCare Health
Policies and Procedures

Language Access Policy

Policy number:	Revision number:	Revision date:
834		
Line of Business:	Approved by:	Approval date:
All	Will Brake, COO	1/1/2019

Desk Procedure

Language Access Assessment:

1. Yearly the Language Access WorkGroup shall complete a Language Access Assessment.
2. The assessment will then be reviewed by the Health Equity and Inclusivity Action team for Language Access Barriers.
   a. Identified barriers will be added to the yearly Health Equity Strategic Plan.
   b. Assessment and any Strategic Priorities will be shared with the Regional Health Equity Coalition.

Training:
1. At all new higher orientations staff will be trained on how to access:
   a. An in person interpreter
   b. A phone interpreter
2. All staff will be trained yearly on how to access:
   a. An in person interpreter
   b. A phone interpreter
3. A one page document shall be provide upon contracting and yearly to all provider offices and delegates on how to access:
   a. An in person interpreter
   b. A phone interpreter

Contracting of Interpreters:
1. All interpreters must follow the policies and processes of Contracting and Credentialing with AllCare Health, Inc.
2. AllCare will pay for credentialed in office interpreters when submitted on a claim using cpt code T1013 for every fifteen (15) minutes of interpretation.
   a. Payment will be determined annually by the executive staff of AllCare.

Translation of materials:
1. Please see translation policy

Policy number:	Revision number:	Revision date:
834		
Line of Business:	**Approved by:**	**Approval date:**
All	Will Brake, COO	1/1/2019

Reporting

OHP Materials Spread Sheet

834 file

Quality Performance Dashboard

LEP Claims Dashboard

References

§ 504 Rehabilitation Act & Americans with Disabilities Act

Title II of the ADA

Title III of the ADA

Title VI of the Civil Rights Act

42 U.S.C. § 2000d.

42 U.S.C. § 2000d-4a(1).

§ 1557 of the Affordable Care Act

Revision History

- 1/01/2019: Document created

Language Access Workgroup Purpose

Purpose: To address, consistent with the core objectives of the federally assisted programs or activities, the specific language needs of Limited English Proficient (LEP) beneficiaries which operate as artificial barriers to full and meaningful participation in AllCare Health, Inc. programs or activities. This requires that AllCare evaluate how a LEP person's inability to understand oral and written information provided by and about AllCare program's or activities might adversely impact his or her ability to fully participate in or benefit from that program or activity.

Focus Areas: This group will focus on the three following priorities.

1. A yearly Language Access Assessment of AllCare and a work plan.
2. Quality of Language Access Services
   a. Interpreters
   b. Translations
   c. Training of First Tier, Downstream, and Related entities of working with an interpreter.
   d. Internal Staff Trainings
3. Policy

Members: The Committee shall strive to include at least 51% representation from the following priority populations (limited english proficiency, persons of color, persons of non-dominant sexual orientation or gender identity, persons with disabilities, persons from disadvantaged socio-economic backgrounds). The group will consist of at least one member from each of the following Subject Matter Expert areas.

A. Provider
B. Quality
C. Member Services
D. Marketing and Creative Services
E. Utilization Management
F. Care Coordination
G. Mental Health(MHO)
H. Oral Health(DCO)
I. Regional Health Equity Coalition
J. Community Group
K. Limited English Proficiency Person
L. Community Advisory Council

1701 NE 7th St.
Grants Pass, OR 97526
Phone (541) 471-4106
Fax (541) 471-3792
Toll free (888) 460-0185
TTY (800) 735-2900
AllCareHealth.com

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Work Group Commitment: The group shall meet twelve 12 times per year rotating the meeting times to accommodate for the community. Members shall attend in person, by phone, or send a representative a minimum of 75% of scheduled meetings each year.

Fist to Five Voting: Fist to Five voting offers all members an opportunity to communicate their vote in a means beyond a simple yes or no. This voting method provides discussion surrounding all questions and looks for paths that will allow the entire group to come to an agreement and feel positive about the final decision.

In this voting model a fist is equivalent to a no and yes can vary by the number of fingers raised at the time of the vote. Raised fingers will hold the following meanings:

1.   5 fingers raised means that the member is in complete agreement with the decision, supports the work group, and will help implement the task.

2.   4 fingers raised means that the member supports the decision.

3.   3 fingers raised means that the member is neutral to the decision and is willing to agree with passing it.

4.   2 fingers raised means that the member has some reservations about the decision but is willing to support it.

5.   1 finger raised means that the member does not support the decision and needs to discuss the issue further or offer changes in order to support it.

6.   No fingers raised (fist) means that the member does not agree with the decision at all and requires more discussion and can offer suggestions.

Final Vote Process:
1. When a decision is on the table for voting, all members of the steering committee will raise their hands to place a vote.
2. All members will observe the number of fingers raised by each member. If the vote requires confidentiality, all members will write their vote on a piece of paper and hand to the Chair.
3. The Group will offer members who vote 2 fingers or less the opportunity to express their reservations, and suggest changes they view as necessary in order to vote in support of the decision.
4. The group will then discuss the concerns.
5. A.second and final vote will be taken.

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6. A decision can be passed once the majority of the Group members have voted 3 or more fingers. If there is a majority of 1s and 2s, the issue will be tabled for discussion at a later date.
7. If there is a small number of 1s and 2s, the group will move to a traditional consensus vote.
8. Members with a conflict of interest will be asked to leave the room during the vote.

Chair: Members shall elect a Chair of the group. The Chair shall be the official representative of the group, and shall collaborate with conducting the business of the group. The term of office of the Chair shall be one year.

Documentation: All meetings shall be documented with the approved Health Equity And Inclusivity Action Team Meeting Agenda and Minutes Template.

History:

- *Adopted 1/1/2019*
- *Amended 1/30/2019*

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TTY (800) 735-2900
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AllCare Health
Policies and Procedures

Translation Policy

Policy number:	Revision number:	Revision date:
822		
Line of Business:	**Approved by:**	**Approval date:**
All	Will Brake, COO	1/1/2019

Table of Contents

Overview and Purpose

Overview

AllCare Health, Inc. is an organization that serves Limited English Proficient speakers in Southern Oregon. Communications with members and stakeholders should, whenever appropriate, be available to them in the language of their choice. It is essential that terms and/or concepts keep the same meaning in both languages. All translations and the manner in which they are presented must be of the highest possible quality as they are a visible expression of the AllCare reputation and brand, and commitment to providing excellent service to its members, stakeholders and the public.

Purpose

The Translation Policy defines the policies, fundamental principles, basic guidelines and procedures with regard to translation services at AllCare.

AllCare Health
Policies and Procedures

Translation Policy

Policy number: 822	Revision number:	Revision date:
Line of Business: All	Approved by: Will Brake, COO	Approval date: 1/1/2019

Policy

1. The requirement to translate documents will be based on three main factors: General requirement, Evaluation of compliance, and Content.

   a. General Requirement:

      i. A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities.

   b. Evaluation of compliance:

      i. In evaluating whether AllCare has met its obligation under paragraph (a) of this section, AllCare shall:
         1. Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and
         2. If, by plan, 5% of the total enrollment or 35 individual AllCare member's speak a particular language other than English, all documents will be translated into this language.

   c. Content:

      i. Vital documents such as consent forms, member education materials, appeals and grievance forms, financial and program application forms and plan instructions should be made available in translation for the major language groups served by AllCare. When no translation is available for a particular language, an employee will explain the content of the document to the member with the assistance of an interpreter. It is not appropriate to have an interpreter orally translate a document because translating a complex document requires time, profound knowledge of the subject matter, and a whole set of skills that an interpreter might not possess. The employee that is familiar with the content of the document should explain it in layman terms to the member with the assistance of the interpreter. Translation requests are handled separately from interpretation requests. Depending on the nature and volume of the requests,

| | | AllCare Health | Translation Policy |

AllCare Health
Policies and Procedures

Policy number: 822	Revision number:	Revision date:
Line of Business: All	Approved by: Will Brake, COO	Approval date: 1/1/2019

the Member Services Director will decide how the request is going to be fulfilled, either by internal translators or outside vendors.

Definitions

1. Translation is best seen as a communication process allowing the transfer or the transposition of a message/written content from a source language into a target language. It is a complex process involving, in addition to the information transfer from language to another, ensuring a semantic equivalency (consistency of words and their meaning). The translation process also includes a revision process, which must be factored in as part of the planning and estimation of translation times.
2. Translation can be done by an AllCare employee who has completed the following requirements:
    a. Passed an ACTFL language proficiency test of Advanced Low or higher.
    b. Recognized as a State of Oregon Qualified or Certified Healthcare interpreter
    c. Completed an AllCare approved translation training program. At this time the only approved training is online through Pima College.
    d. Completed any necessary training required by OHA for translation.
3. Translations not done by an AllCare Employee can be completed by an external vendor. Currently the only authorized company to do translations is Verbio.

Desk Procedure

All Translation Requests are to be:

1. Sent to the Director of Brand & Creative Services
2. Director of Brand & Creative Services will verify the document is following brand guidelines, is written in appropriate reading level, and will work with Director of Member Services (OHA) or the Marketing Supervisor (CMS) to ensure the document has been reviewed/approved by the appropriate governing entities (OHA or CMS).
3. Once document receives appropriate approval in English, the completed and approved document will be forwarded to the Director of Member services for translation.
    a. Director of Member Services will determine if Internal Translators will be assigned project or an outside organization.
4. Translated document will be returned to Brand & Creative Services after translation is complete.
5. Brand & Creative Services with finalize file formats for internal users and will release the final document to internal users.

AllCare Health
Policies and Procedures

Translation Policy

Policy number: 822	Revision number:	Revision date:
Line of Business: All	Approved by: Will Brake, COO	Approval date: 1/1/2019

Oversight and Monitoring

All documents will be tracked through current monitoring process established by Director of Member Services. Each department is responsible for tracking their own documents on the P:Drive.

References

42 U.S.C. § 2000d.

Title VI of the Civil Rights Act

Title II of the Americans with Disabilities Act

Section 1557 of the Affordable Care Act

HR - 016 - Language Proficiency Pay Differential Policy

Revision History

- 1/1/2019 Document Created

AllCare Health

Provider Services
Policies and Procedures

Reimbursement Policy Interpretive Services		
Policy number: 8	**Revision number:** 1	**Revision date:** 12/1/2019
Line of Business: All	**Approved by:** Stick Crosby	**Approval date:** 1/1/2019

Table of Contents

Overview and Purpose

Overview

This policy addresses coding and coverage for interpreter services. Coverage is a responsibility for all AllCare Health, Inc. (AllCare) Lines of Business that receive federal financial assistance defined in 42 U.S.C. § 2000d-4a(1).

Purpose

It is the policy of AllCare to provide timely meaningful access for LEP persons to all AllCare programs and activities. All contracted First Tier, Down Stream, and Related Entities shall provide free language assistance services to LEP individuals whom they encounter or whenever an LEP person requests language assistance services. All personnel will inform members of the public that language assistance services are available free of charge to LEP persons and that AllCare will provide these services to them.

Policy

Definitions

	Reimbursement Policy Interpretive Services		
AllCare Health	**Policy number:** 8	**Revision number:** 1	**Revision date:** 12/1/2019
Provider Services Policies and Procedures	**Line of Business:** All	**Approved by:** Stick Crosby	**Approval date:** 1/1/2019

Interpretation: The oral replacement of one spoken language (source language) into another spoken language (target language). Four modes of interpretation exist: consecutive, simultaneous, summarization and sight translation (when the interpreter reads text in one language and speaks it in another language). Includes sign language services.

Translation: The written replacement of text from one language (source language) into an equivalent text in another language (target language).

Person with Limited English Proficiency (LEP): A person not able to speak, read, write, or understand English at a level that allows him or her to interact effectively.

Interpreter services include non-English language interpreters as well as sign language interpreters.

- Medical and Behavioral Health providers are responsible for scheduling the interpreter service and paying the interpreter. Providers should use the same principles normally used when hiring, contracting with, or arranging for new employees.
- Three people must be present for the service to be covered: the provider, the patient and the interpreter.
- The interpreter may be on a video screen when using video remote interpreter services for sign language interpreter services.
- The interpreter may communicate by phone or teleconference for spoken language interpreter services.
- If the provider delivers a medical service while communicating in the recipient's language, it is not interpreting and not separately billable as an interpreter service.

Policy Statement

Primary care clinics, physician specialty clinics and behavioral health clinics are required to arrange and bill for interpreter services provided at their site. The medical or behavioral health clinic is responsible for scheduling the interpreter at the time of scheduling the appointment. Interpreter services provided to AllCare Members must be rendered by a Qualified or Certified interpreter with State of Oregon per Oregon Administrative Rule (OAR) 333-002-0000. All providers contracted with AllCare are accountable for ensuring that employed or contracted interpreters meet these requirements.

Services provided by interpreters who do not meet the qualifications outlined in 333-002-000 are ineligible for payment and should not be billed to AllCare. As an example, minor children and other family members should not be used as interpreters. Interpreters who are not properly qualified cannot bill AllCare or the subscriber.

AllCare will not reimburse the following provider types for interpreter services:

- Community health workers (CHW) – included in CHW service rates.
- Day treatment & habilitation (DT&H) providers – included in the DT&H rate.

AllCare Health
Provider Services
Policies and Procedures

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- ICF/DDs – included in the facility rate.
- Indian Health Service (IHS) for federally funded encounter rate recipients – included in the encounter rate.
- Nursing facilities – included in the per diem rate.
- Transportation providers – the service of transporting a patient does not include interpreter service reimbursements.

The following providers may directly access and schedule an interpreter for appointments.

- County agencies.
- Skilled Home Care.
- Care Coordinators.
- Home Care Agencies that provide PCA Assessments.
- Social Service Providers Contracted with AllCare

Non-Covered Services

The following services are not covered and should not be billed to AllCare.

- Translation of paper documents.
- Completing clinic forms.
- Travel time.
- Wait time (includes time waiting in the lobby, exam room or any office space when a medical service is not being delivered) mileage.
- No shows.
- Cancellations.
- Parking fees.
- Meals.
- Weekend or after hours premium fees.
- Assisting members with administrative processes such as paperwork or medical records

Billing Guides

Note: Rounding rules apply to all services below. A minimum of eight minutes face-to-face time must be spent report one unit.

AllCare Health

Provider Services
Policies and Procedures

Reimbursement Policy Interpretive Services

Policy number:	Revision number:	Revision date:
8	1	12/1/2019
Line of Business:	**Approved by:**	**Approval date:**
All	Stick Crosby	1/1/2019

Code	Modifier	Description
T1013		Face-to-face spoken language interpreter service, per 15 minutes
T1013	UN UP UQ UR US	2 patients served 3 patients served 4 patients served 5 patients served 6 or more patients served Report T1013 for each patient in the group setting • Append the modifier indicating how many patients in the group • Report one unit per 15 minutes per patient

- Bill only for the direct face-to-face service time.
- Claims should be submitted through an 837P transaction or a CMS 1500 form.

Providers must document the following in the patient's chart when billing for interpreter services,

- Indicate that an interpreter was used
- Record the date and time the interpreter was used (11/21/2017, 1:00 p.m. – 1:15 p.m.)
- The name of the interpreter and state registry number.

Credentialing

All interpreters working within a contracted AllCare entity must be credentialed through AllCare's Credentialing process.

Coverage

Eligible members enrolled in any AllCare Plan are eligible for interpreter services. Eligibility can be verified through AllCare's "Provider Portal".

Reimbursement

At this time AllCare will reimburse **$7.50** per 15 minutes for T1013 Interpreter Services when a **Certified Medical Interpreter** is utilized. For **Qualified Medical Interpreters** AllCare will reimburse **$6.25** per 15 minutes for T1013

AllCare Health

Provider Services
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All	Stick Crosby	1/1/2019

Interpreter Services. These rates are reviewed annually and any changes will be posted to AllCare's "Provider Portal" 90 days prior to the change in reimbursement.

Reporting

A quarterly report identifying the utilization of this code will be distributed to the Health Equity and Inclusivity Action Team at AllCare

References

OAR 333-002-000

ORS 413.550, 413.558

§ 504 Rehabilitation Act & Americans with Disabilities Act

Title II of the ADA

Title III of the ADA

Title VI of the Civil Rights Act

42 U.S.C. § 2000d.

42 U.S.C. § 2000d-4a(1).

§ 1557 of the Affordable Care Act

AllCare Health

Provider Services
Policies and Procedures

Reimbursement Policy Interpretive Services		
Policy number:	**Revision number:**	**Revision date:**
8	1	12/1/2019
Line of Business:	**Approved by:**	**Approval date:**
All	Stick Crosby	1/1/2019

Revision History

- 11/1/2018: Document created
- 11/6/2018: Approved by Doug Flow

AllCare Health

Provider Services
Policies and Procedures

Reimbursement Policy Interpretive Services		
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Overview and Purpose

Overview

This policy addresses coding and coverage for interpreter services. Coverage is a responsibility for all AllCare Health, Inc. (AllCare) Lines of Business that receive federal financial assistance defined in 42 U.S.C. § 2000d-4a(1).

Purpose

It is the policy of AllCare to provide timely meaningful access for LEP persons to all AllCare programs and activities. All contracted First Tier, Down Stream, and Related Entities shall provide free language assistance services to LEP individuals whom they encounter or whenever an LEP person requests language assistance services. All personnel will inform members of the public that language assistance services are available free of charge to LEP persons and that AllCare will provide these services to them.

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Reimbursement Policy Interpretive Services		
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Person with Limited English Proficiency (LEP): A person not able to speak, read, write, or understand English at a level that allows him or her to interact effectively.

Interpreter services include non-English language interpreters as well as sign language interpreters.

- Medical and Behavioral Health providers are responsible for scheduling the interpreter service and paying the interpreter. Providers should use the same principles normally used when hiring, contracting with, or arranging for new employees.
- Three people must be present for the service to be covered: the provider, the patient and the interpreter.
- The interpreter may be on a video screen when using video remote interpreter services for sign language interpreter services.
- The interpreter may communicate by phone or teleconference for spoken language interpreter services.
- If the provider delivers a medical service while communicating in the recipient's language, it is not interpreting and not separately billable as an interpreter service.

Policy Statement

Primary care clinics, physician specialty clinics and behavioral health clinics are required to arrange and bill for interpreter services provided at their site. The medical or behavioral health clinic is responsible for scheduling the interpreter at the time of scheduling the appointment. Interpreter services provided to AllCare Members must be rendered by a Qualified or Certified interpreter with State of Oregon per Oregon Administrative Rule (OAR) 333-002-0000. All providers contracted with AllCare are accountable for ensuring that employed or contracted interpreters meet these requirements.

Services provided by interpreters who do not meet the qualifications outlined in 333-002-000 are ineligible for payment and should not be billed to AllCare. As an example, minor children and other family members should not be used as interpreters. Interpreters who are not properly qualified cannot bill AllCare or the subscriber.

AllCare will not reimburse the following provider types for interpreter services:

- Community health workers (CHW) – included in CHW service rates.
- Day treatment & habilitation (DT&H) providers – included in the DT&H rate.

AllCare Health	Reimbursement Policy Interpretive Services		
Provider Services	**Policy number:**	**Revision number:**	**Revision date:**
Policies and Procedures	8	1	12/1/2019
	Line of Business:	**Approved by:**	**Approval date:**
	All	Stick Crosby	1/1/2019

- ICF/DDs – included in the facility rate.
- Indian Health Service (IHS) for federally funded encounter rate recipients – included in the encounter rate.
- Nursing facilities – included in the per diem rate.
- Transportation providers – the service of transporting a patient does not include interpreter service reimbursements.

The following providers may directly access and schedule an interpreter for appointments.

- County agencies.
- Skilled Home Care.
- Care Coordinators.
- Home Care Agencies that provide PCA Assessments.
- Social Service Providers Contracted with AllCare

Non-Covered Services

The following services are not covered and should not be billed to AllCare.

- Translation of paper documents.
- Completing clinic forms.
- Travel time.
- Wait time (includes time waiting in the lobby, exam room or any office space when a medical service is not being delivered) mileage.
- No shows.
- Cancellations.
- Parking fees.
- Meals.
- Weekend or after hours premium fees.
- Assisting members with administrative processes such as paperwork or medical records

Billing Guides

Note: Rounding rules apply to all services below. A minimum of eight minutes face-to-face time must be spent report one unit.

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Reimbursement Policy Interpretive Services

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Code	Modifier	Description
T1013		Face-to-face spoken language interpreter service, per 15 minutes
T1013	UN	2 patients served
	UP	3 patients served
	UQ	4 patients served
	UR	5 patients served
	US	6 or more patients served
		Report T1013 for each patient in the group setting
		• Append the modifier indicating how many patients in the group
		• Report one unit per 15 minutes per patient

- Bill only for the direct face-to-face service time.
- Claims should be submitted through an 837P transaction or a CMS 1500 form.

Providers must document the following in the patient's chart when billing for interpreter services,

- Indicate that an interpreter was used
- Record the date and time the interpreter was used (11/21/2017, 1:00 p.m. – 1:15 p.m.)
- The name of the interpreter and state registry number.

Credentialing

All interpreters working within a contracted AllCare entity must be credentialed through AllCare's Credentialing process.

Coverage

Eligible members enrolled in any AllCare Plan are eligible for interpreter services. Eligibility can be verified through AllCare's "Provider Portal".

Reimbursement

At this time AllCare will reimburse **$7.50** per 15 minutes for T1013 Interpreter Services when a **Certified Medical Interpreter** is utilized. For **Qualified Medical Interpreters** AllCare will reimburse **$6.25** per 15 minutes for T1013

Certified
B
Corporation

AllCare Health

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Interpreter Services. These rates are reviewed annually and any changes will be posted to AllCare's "Provider Portal" 90 days prior to the change in reimbursement.

Reporting

A quarterly report identifying the utilization of this code will be distributed to the Health Equity and Inclusivity Action Team at AllCare

References

OAR 333-002-000

ORS 413.550, 413.558

§ 504 Rehabilitation Act & Americans with Disabilities Act

Title II of the ADA

Title III of the ADA

Title VI of the Civil Rights Act

42 U.S.C. § 2000d.

42 U.S.C. § 2000d-4a(1).

§ 1557 of the Affordable Care Act

AllCare Health

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AllCareHealth.com

Reimbursement Policy Interpretive Services

Policy number:	Revision number:	Revision date:
8	1	12/1/2019
Line of Business:	**Approved by:**	**Approval date:**
All	Stick Crosby	1/1/2019

Revision History

- 11/1/2018: Document created
- 11/6/2018: Approved by Doug Flow

AllCare Health

Policies and Procedures

Translation Policy

Policy number: 822	Revision number:	Revision date:
Line of Business: All	Approved by: Will Brake, COO	Approval date: 1/1/2019

Table of Contents

Overview and Purpose

Overview

AllCare Health, Inc. is an organization that serves Limited English Proficient speakers in Southern Oregon. Communications with members and stakeholders should, whenever appropriate, be available to them in the language of their choice. It is essential that terms and/or concepts keep the same meaning in both languages. All translations and the manner in which they are presented must be of the highest possible quality as they are a visible expression of the AllCare reputation and brand, and commitment to providing excellent service to its members, stakeholders and the public.

Purpose

The Translation Policy defines the policies, fundamental principles, basic guidelines and procedures with regard to translation services at AllCare.

Policy number: 822	Revision number:	Revision date:
Line of Business: All	Approved by: Will Brake, COO	Approval date: 1/1/2019

Policy

1. The requirement to translate documents will be based on three main factors: General requirement, Evaluation of compliance, and Content.

    a. General Requirement:

        i. A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities.

    b. Evaluation of compliance:

        i. In evaluating whether AllCare has met its obligation under paragraph (a) of this section, AllCare shall:
            1. Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and
            2. If, by plan, 5% of the total enrollment or 35 individual AllCare member's speak a particular language other than English, all documents will be translated into this language.

    c. Content:

        i. Vital documents such as consent forms, member education materials, appeals and grievance forms, financial and program application forms and plan instructions should be made available in translation for the major language groups served by AllCare. When no translation is available for a particular language, an employee will explain the content of the document to the member with the assistance of an interpreter. It is not appropriate to have an interpreter orally translate a document because translating a complex document requires time, profound knowledge of the subject matter, and a whole set of skills that an interpreter might not possess. The employee that is familiar with the content of the document should explain it in layman terms to the member with the assistance of the interpreter. Translation requests are handled separately from interpretation requests. Depending on the nature and volume of the requests,

AllCare Health Policies and Procedures		**Translation Policy**

Policy number: 822	**Revision number:**	**Revision date:**
Line of Business: All	**Approved by:** Will Brake, COO	**Approval date:** 1/1/2019

the Member Services Director will decide how the request is going to be fulfilled, either by internal translators or outside vendors.

Definitions

1. Translation is best seen as a communication process allowing the transfer or the transposition of a message/written content from a source language into a target language. It is a complex process involving, in addition to the information transfer from language to another, ensuring a semantic equivalency (consistency of words and their meaning). The translation process also includes a revision process, which must be factored in as part of the planning and estimation of translation times.
2. Translation can be done by an AllCare employee who has completed the following requirements:
    a. Passed an ACTFL language proficiency test of Advanced Low or higher.
    b. Recognized as a State of Oregon Qualified or Certified Healthcare interpreter
    c. Completed an AllCare approved translation training program. At this time the only approved training is online through Pima College.
    d. Completed any necessary training required by OHA for translation.
3. Translations not done by an AllCare Employee can be completed by an external vendor. Currently the only authorized company to do translations is Verbio.

Desk Procedure

All Translation Requests are to be:

1. Sent to the Director of Brand & Creative Services
2. Director of Brand & Creative Services will verify the document is following brand guidelines, is written in appropriate reading level, and will work with Director of Member Services (OHA) or the Marketing Supervisor (CMS) to ensure the document has been reviewed/approved by the appropriate governing entities (OHA or CMS).
3. Once document receives appropriate approval in English, the completed and approved document will be forwarded to the Director of Member services for translation.
    a. Director of Member Services will determine if Internal Translators will be assigned project or an outside organization.
4. Translated document will be returned to Brand & Creative Services after translation is complete.
5. Brand & Creative Services with finalize file formats for internal users and will release the final document to internal users.

AllCare Health

Policies and Procedures

Translation Policy

Policy number: 822	Revision number:	Revision date:
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Oversight and Monitoring

All documents will be tracked through current monitoring process established by Director of Member Services. Each department is responsible for tracking their own documents on the P:Drive.

References

42 U.S.C. § 2000d.

Title VI of the Civil Rights Act

Title II of the Americans with Disabilities Act

Section 1557 of the Affordable Care Act

HR - 016 - Language Proficiency Pay Differential Policy

Revision History

- 1/1/2019 Document Created

Attachment 10 — Social Determinants of Health and Health Equity

A. Community Engagement

1. Evaluation Questions

a. Did Applicant obtain Community involvement in the development of the Application? Yes; AllCare worked in partnership with the Jefferson Regional Health Alliance to develop the 2019 collaborative Community Health Assessment (CHA) for Jackson and Josephine County. Other participants included two other local CCOs, both regional hospitals, local public health agencies, FQHCs and local mental health agencies. Simultaneously, AllCare partnered with stakeholders in Coos and Curry Counties to develop a collaborative CHA through a process that included representatives of local public health, mental health, physical health, consumers, and community programs serving the underserved populations. As a result, we are now involved in the development of a collaborative CHIP in both regions.

In addition, AllCare supports the local Regional Health Equity Coalition, So Health-E. Through this partnership, AllCare receives community input which serves as an external local advocate for underserved communities. This information has been used to establish Board priorities and corporate strategies that are described within this application.

b. Applicant will submit a plan via the RFA Community Engagement Plan for engaging key stakeholders, including OHP consumers, Community-based organizations that address disparities and the social determinants of health, providers, local public health authorities, Tribes, and others, in its work. The Plan will include strategies for engaging its Community Advisory Council and developing shared Community Health Assessments and Community Health Improvement Plan priorities and strategies. AllCare has included its Community Engagement Tables as *EXHIBIT 10.1-Community Engagement Plan Tables,* outlining how we engaged key stakeholders to address social and health disparities and the SDOH over the last three years. The Plan also addresses how we intend to continue our community engagement through local partnerships over the CCO 2.0 five-year cycle.

2. Requested Documents

Completed RFA Community Engagement Plan, including all required elements as described in RFA Community Engagement Plan Requirement Components and attaching required Tables in RFA Community Engagement Plan Required Tables (page limit: 4 pages, excluding tables)

Please refer to the following exhibits:
- *EXHIBIT 10.1a-AllCare Community Engagement Plan narrative*;
- *EXHIBIT 10.1-Community Engagement Plan Tables*;

Behavioral Health Compliance Review Outline

☐ Checkbox indicates AllCare is requesting the information prior to on-site visit

I. BUSINESS ADMINISTRATION (CCO CONTRACT)

   ☐ Copy of Organizational Chart or Governance Structure
   ☐ Staff Directory with Credentials – AllCare Health's Credentialing Department will review a sample of personnel files during onsite review
   ☐ Proof of insurance for worker's compensation, malpractice and professional liability insurance
   ☐ Disaster Recovery/Business Continuity Plan

II. PERSONNEL (OAR 309-019-0110 & 0125 -0130, CCO CONTRACT)
    Please provide the policies and specific procedures for the following:

   ☐ Personnel qualifications and competencies
   ☐ Service staff orientation and continued training
   ☐ Service staff supervision
   ☐ Mandatory abuse reporting
   ☐ Criminal records & background check.
   ☐ Fraud, waste and abuse in Federal Medicaid and Medicare programs
   ☐ Drug free work place
   ☐ Monitoring and auditing of subcontracted providers, including example audit documents
   ☐ Provider Selection and Retention
   ☐ Code of Conduct

III. SERVICE DELIVERY (OAR 309 DIVISIONS 12, 14, 15, 18, 19, 22, 32 & 40 AND OAR 410-172, 410-141 AND CCO CONTRACT)
     Please provide the policies and specific procedures for the following:

   ☐ Fee Agreements
   ☐ Confidentiality compliance (HIPAA and 42 CFR part 2)
   ☐ Compliance with Title II of ADA
   ☐ Grievances and appeals w/ a sample AllCare Member Notice of Action
   ☐ Individual rights
   ☐ Quality assessment and performance monitoring, evaluation and improvement
   ☐ Trauma informed service delivery
   ☐ Provision of culturally and linguistically appropriate services
   ☐ Crisis Prevention and Response
   ☐ Incident Reporting
   ☐ Peer delivered services

☐ Referral and care coordination for client's who have special needs (hearing impairment, high medical/dental and/or Co-Occurring disorders)

☐ Prohibition of psychological and physical abuse, seclusion, restraint (including mechanical and chemical), withholding basic necessities or supports for physical functioning, discipline for receiving services by another and titration of medications prescribed for the treatment of opioid dependence as a condition of receiving or continuing treatment

Please provide a copy of the following Documents:

☐ Client orientation/intake packet including (English & Spanish)

☐ Policy and Procedure for compliance with the OHA formatting and readability standards

☐ Most recent fidelity review of Assertive Community Treatment program, including any variances approved by the Authority

☐ Most recent Fidelity review of IPS/ Supported Employment program, including any variances approved by the Authority

☐ Policy and procedure for prior authorization and service delivery for Applied Behavior Analysis

☐ Policy and procedure for System of Care Wraparound Initiative

☐ Policy and procedure for Children's Intensive Services

☐ Policy and procedure for Emergency psychiatric holds and alternatives to involuntary psychiatric care

☐ Policy for medical protocols in outpatient SUD treatment

☐ Policy and Procedures for utilization management/review and Inter-Rater Reliability Testing (including timelines for UM Pre-Service/Prior Authorizations, second opinions and out of network services)

☐ Clinical Practice Guidelines and procedures for dissemination to staff

IV. CLINICAL SERVICES (OAR 309-019-0135, 0140 & 0165, 0225-0255 &0270-0295, OAR 309-022-0100 – 0192, OAR 410-172-0760 – 0770 AND CCO CONTRACT)

    a) Review of Assessments

    b) Review Individualized Support and Service Plan

    c) Review Individual Service Notes

    d) Review of Services Provided Compared to the Service Plan Objective, Assessed DX and level of service provider for continuity of care and medically appropriate

    e) Review of Children's Services (If Applicable):

        1. Intensive Outpatient Supports and Services

        2. SOC Wraparound Initiative Services – CCO Contract and Oregon Best Practice Guide

        3. Intensive Treatment Services

        4. Applied Behavior Analysis

    f) Review of Adult Fidelity Services (If Applicable):

        1. Assertive Community Treatment

        2. Individual Placement & Support/Supported Employment

V. MEDICAL SERVICES (OAR 309-019-0105 & 0200 AND CCO REQUIREMENT)

    a) Medication Administration Records (if applicable)
    b) Licensed Medical Practitioner following best practices and standards of care
    c) Medically appropriate psychiatric services including:
        1. Metabolic Disease Risk for Patients on Atypical Antipsychotics
        2. Lithium Maintenance Labs
        3. AIMS Administration for Patients on Antipsychotics
    d) Progress notes show the difference and needs of patient for each visit or encounter – US DHHS & CMS Provider Guide 2008

VI. ENCOUNTER DATA REVIEW (OAR 309-019-0135, 0140, 0165, OAR 410-141-3320 AND CCO CONTRACT)

    a) Client Access
    b) Written voluntary consent prior to services
    c) Assessment prior to ISSP
    d) Individualized Support Plan(ISSP) Signed prior to services with appropriate credentials
    e) Service is listed on ISSP
    f) Service record demonstrates specific service/supports to match claim including:
        A. Date
        B. Length/Units of Service
        C. Location

VII. ONSITE INTERVIEW QUESTIONS (CCO CONTRACT)
Please be prepared to have subject matter experts available to answer/demonstrate the following:

1) How does your programs maintain a direct service network of appropriate providers to sufficiently provide adequate access to covered services?
2) If the program is unable to provide a necessary covered services in network how are timely and adequate services provided outside the direct service network?
3) How does your program meet OHA standards for timely access to routine, urgent and emergent care and services, taking into account the urgency of the need for services?
4) How does program monitor timely access to and availability of care and services?
5) What measures have been taken to ensure the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency, diverse cultural and/or ethnic backgrounds?
6) What is your UM process for pre-service and concurrent determinations (Acute, Subacute, PRTS, Day Treatment, etc.)? Including any clinical guidelines used, credentials of individuals making decisions and logic for frequency of UM review.

7) What is your process to ensure that all clinicians that are making utilization management decisions are consistent with your clinical guidelines?

Good Morning AllCare Staff,

June 18th was the final training for the AllCare Cultural Humility Training. I am thrilled to say that 100% of our staff have completed this training, along with 81 individuals from 15 of our community partners. Thank you all for your participation and continued support. We were also able to meet our requirement for our CCO Transformation Plan.

Moving forward to meet our 2018 requirement, the Health Equity and Inclusivity Action Team put together four one-hour trainings for all of our staff. We received your feedback from last year's training and included it in these trainings. They will be one hour and offered throughout the year and at various times of the day. The trainers are internal staff that have been trained to present these courses.

It is Mandatory for you take at least one of these courses by August of 2018. Kaitlyn Massa will send out an email 2 weeks before each training for you to register. We will only be able to accept 30 staff per session. You will also be able to take more than one course. Staff that have not yet participated will be the priority for each training. Please work with your supervisor on scheduling for the training.

The four courses that will be offered are:

Cultural Agility-This will give you the skills for adapting to cultural differences while being agile during interactions with co-workers and members.

Health Literacy- This will define what health literacy is and why marginal health literacy can be a barrier to health care and health outcomes for our members.

Creating an affirming setting for Non-Binary (those who don't identify as man or woman) People- This training includes important terms, data, and expert-informed practices, which will offer suggestions for how any staff member can implement simple changes to improve the experiences of patients with non-binary gender identities.

Implicit Bias- This training will help you understand what implicit bias is, its effect on health care, and overcoming implicit bias in health care.

Thanks,

Stick Crosby

The schedule for 2017-18 is:

Cultural Agility 8/4/2017 8:00 am Grants Pass Community Room A

Health Literacy 8/14/2017 12:00 pm Grants Pass Community Room A

Creating an affirming setting for non-binary people 9/8/2017 5:00 pm Grants Pass Community Room A

Implicit Bias 9/11/2017 8:00 am Grants Pass Community Room A

Cultural Agility 9/20/2017 12:00 pm Medford Conference Room

Cultural Agility 10/6/2017 12:00 pm Grants Pass Community Room A

Health Literacy 10/9/2017 5:00pm Grants Pass Community Room A

Creating an affirming setting for non-binary people 11/3/2017 8:00 am Grants Pass Community Room A

Implicit Bias 11/13/2017 12:00pm Grants Pass Community Room A

Cultural Agility 12/1/2017 5:00 pm Grants Pass Community Room A

Health Literacy 12/11/2017 8:00 am Grants Pass Community Room A

Health Literacy 12/20/2017 5:00 pm Medford Conference Room

Creating an affirming setting for non-binary people1/6/2018 12:00 pm Grants Pass Community Room A

Implicit Bias 1/9/2018 5:00 pm Grants Pass Community Room A

Cultural Agility 2/3/2018 8:00 am Grants Pass Community Room A

Health Literacy 2/13/2018 12:00 pm Grants Pass Community Room A

Creating an affirming setting for non-binary people 3/3/2018 5:00 pm Grants Pass Community Room A

Implicit Bias 3/13/2018 8:00 am Grants Pass Community Room A

Creating an affirming setting for non-binary people 3/22/2018 12:00 pm Medford Conference room

Cultural Agility 4/7/2018 12:00 pm Grants Pass Community Room A

Health Literacy 4/10/2018 5:00 pm Grants Pass Community Room A

Creating an affirming setting for non-binary people 5/5/2018 Grants Pass Community Room A

Implicit Bias 5/15/2018 12:00 pm Grants Pass Community Room A

Cultural Agility 6/2/2018 5:00 pm Grants Pass Community Room A

Health Literacy 6/12/2017 8:00 am Grants Pass Community Room A

Implicit Bias 6/21/2018 12:00 pm Medford Conference room

Creating an affirming setting for non-binary people7/7/2018 12:00 pm Grants Pass Community Room A

Implicit Bias 7/10/2018 5:00 pm Grants Pass Community Room A

AllCare Staff,

We met our goal of all staff being trained in one of last year's Health Equity Trainings. 700 staff from our local provider offices were also trained. Thank you all for helping to meet this goal.

It is **Mandatory** to take one of these trainings this year:

Barriers to care-This training will explore these barriers to care:

- Social Determinants of Health
- Unconscious Bias
- Low Health Literacy

Health Literacy 1.0 - This will define what health literacy is and why low health literacy is a barrier to health. This will only be offered twice this year.

Health Literacy 2.0-This workshop will teach you skills to create Plain Language forms. You must complete Health Literacy 1.0 to register.

Social Determinants of Health (SDoH) Game- This training will help you understand the impacts of SDoH. The game has three goals:

- Discuss the SDoH
- Build empathy
- Learning in a fun setting

Unnatural Causes: Episode Five-Place Matters- We will watch "Place Matters" from Unnatural Causes. Then discuss why your address is a predictor of your health.

To register:

- Email Amy DeChenne amy.dechenne@allcarehealth.com
- Discuss with your manager on which training you will take.
- Only 30 staff for each session.
- You can take more than one training.
- Staff that have not been trained will be the priority for each training.

2018-19 Health Equity Training Schedule:

Unnatural Causes: Episode Five-Place Matters- 9/17/18 8:00 am Grants Pass

Social Determinants of Health Game-10/11/18 8:00 AM   Grants Pass

Health Literacy 1.0-10/29/2018 8:00 AM Grants Pass

Barriers to care-11/7/2018 8:00 AM   Grants Pass

Unnatural Causes: Episode Five-Place Matters-11/16/18 12:00 PM <mark>Medford</mark>

Social Determinants of Health Game-12/10/18 12:00 PM Grants Pass

Barriers to care-1/7/2019 8:00 AM Grants Pass

Unnatural Causes: Episode Five-Place Matters-1/15/19   5:00 PM Grants Pass

Health Literacy 2.0-1/28/2019 12:00 PM Grants Pass

Social Determinants of Health Game-2/8/19 5:00 PM Grants Pass

Barriers to care-3/7/2019 12:00 PM <mark>Medford</mark>

Unnatural Causes: Episode Five-Place Matters 3/18/19 8:00 AM Grants Pass

Social Determinants of Health Game-4/9/19 12:00pm Grants Pass

Health Literacy 1.0-4/19/2019   8:00 AM Grants Pass

Health Literacy 2.0-4/29/2019   8:00 AM Grants Pass

Barriers to care-5/6/2019 5:00 PM Grants Pass

Unnatural Causes: Episode Five-Place Matter - 5/15/19   12:00 PM Grants Pass

Social Determinants of Health Game-6/10/19 12:00 PM   Grants Pass

Barriers to care-6/28/2019 8:00 AM   Grants Pass

Unnatural Causes: Episode Five-Place Matters-7/12/19   5:00 PM Grants Pass

Health Literacy 2.0-7/18/2019   5:00 PM   Grants Pass

Health Literacy 2.0-7/26/2019   12:00 PM Grants Pass

Social Determinants of Health Game- 8/7/19 5:00 PM Grants Pass

Barriers to care-8/14/2019 12:00 PM   Grants Pass

Attachment 11 – Behavioral Health Benefit

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Include reasons why your organization is able to effectively complete the CCO service delivery and program design requirements, and how this will be accomplished in time to meet the needs of Members on implementation.

Page limit for this Behavioral Health Questionnaire is 58 pages, items that are excluded from the page limit will be noted in that requirement.

A. Behavioral Health Benefit (recommended page limit 8 pages)

> **Applicant must be fully accountable for the Behavioral Health benefit to ensure Members have access to an adequate Provider Network, receive timely access to the full continuum of care, and access effective treatment. Full accountability of the Behavioral Health benefit should result in integration of the benefit at the CCO level. Applicant may enter into Value-Based Payment arrangements; however, the arrangement does not eliminate the Applicant's responsibility to meet the contractual and individual Member need. Applicant must have sufficient oversight of the arrangement and intervene when a Member's need is not met or the network of services is not sufficient to meet Members' needs.**

AllCare was founded in Grants Pass, Oregon in Josephine County. Josephine County is located in between Jackson County to its east, and Curry County to the west. AllCare has three regions in its service area: the Josephine County region which also includes two contiguous zip codes on its north side in Douglas County; the Jackson County region, which includes Medford, the largest city in the service area; and the Curry County region, which includes a wide swath of rural and forested land between Grants Pass and small cities on the coast line (service area).

The behavioral health benefit includes Substance Use Disorder (SUD) and mental health. AllCare executes all aspects of the Substance Use Disorder benefit with the same degree of oversight that AllCare executes for the entire CCO benefit package. AllCare oversight includes: regulatory compliance and quality oversight, provider network contracting and adequacy analysis, Utilization Management, the full continuum of care coordination services, Member Services, claims processing, and provider/Member appeals and grievances.

AllCare shares administration of the Mental Health benefit with Options for Southern Oregon (Options) and Curry Community Health (CCH). AllCare oversight includes: regulatory compliance and quality oversight, assurance of network adequacy, Member Services, claims processing, and provider/Member appeals and grievances. The following services are shared with the Subcontractors in the administration of the Mental Health benefit: Utilization

Management oversight and care coordination. Both Subcontractors employ a variety of Mental Health clinicians and contract additional providers that together, make up a larger Mental Health network available to AllCare members.

In addition to the services described above, AllCare's Behavioral Health (BH) Department provides numerous governance and supportive functions to our Behavioral Health providers. These services include: compliance and quality assurance with regular review of all services provided, technical assistance and utilization management oversight. Additionally, our BH Department works with our community partners to develop integration opportunities, improve all BH delivery systems and facilitate effective communication.

AllCare performs an extensive review and on-site audit of all our BH Subcontractors annually, with corrective action plans and follow up as needed until all identified issues are resolved to AllCare's satisfaction. Please see AllCare's Behavioral Health Compliance Review Outline included as *EXHIBIT 11.2-Behavioral Health Compliance Review Outline & Document Request 2018*.

1. **How does Applicant plan to ensure that Behavioral Health, oral health and physical health services are seamlessly integrated so that Members are unaware of any differences in how the benefits are managed?** AllCare members have the same points of contact with the CCO, regardless of whether they have physical, oral or behavioral health needs. The same toll-free phone number is used to reach Member Services, and all Members use the same website, member handbook and walk-in offices are available in each of the three regions. AllCare has provided start-up funding to physical, behavioral, and oral health contractors to develop a variety of integrated models. Our goal is to ensure that integrated care is seamless, for both our Members and providers throughout our service area in a setting of the Members' preference. We provide Patient Centered Primary Care Home (PCPCH) training and technical assistance to clinics to support the development of integrated BH/physical care for our Members. Primary care homes, coached by AllCare, that are focused on internal medicine, family practice, and pediatrics have integrated BH clinicians into their workflows and provide consultations, Warm Handoffs, assessments and BH treatment in the PCPCH. There are approximately 100 access points of outpatient BH care. Many are integrated into a variety of locations, including: The Women's Health Center (focused on prenatal and post-natal care in Josephine County); School Based Health Centers throughout the entire service area; Head Start Programs; probation and parole offices; and in homeless programs. AllCare also sponsored the integration of primary care into the largest BH treatment location in its service area (Options for Southern Oregon's Certified Community Behavioral Health Clinic (CCBHC)) focused on evidenced-based care to serve Severe and Persistent Mental Illness (SPMI) Members and their families in a 'one-stop shop' model that includes a full array of mental health, primary health, substance use disorder services, psychiatric medication consultation, Medication Assisted Treatment (MAT), a dispensing pharmacy, and oral hygienist services. It became the first 5 Star PCPCH integrated into a BH clinic in Oregon.

Curry Community Health also offers mental health, primary care and substance use disorders (SUD) in all three of their locations in the county.

AllCare start-up funding supported efforts to move towards integration of behavioral health services into the school-based clinic. Curry Community Health is in the process of integrating oral hygienists into their integrated clinic sites to improve historically low access to services in Curry County. Because Curry County is rural and parts are mountainous with difficult roadways during winter, Curry Community Health has invested in telehealth services to ensure access to behavioral health services and treatment. AllCare will continue to support these efforts.

Throughout the CCO service area, AllCare Members have convenient, integrated care options in a variety of settings. We provide these many options for integrated care so that physical, oral and behavioral health care is easy and convenient to obtain, without care silos, in a setting that is desired by our Members.

2. **How will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner meaning that Applicant will not identify a pre-defined cap on Behavioral Health spending, nor separate funding for Behavioral Health and physical health care by delegating the benefit coverage to separate entities that do not coordinate or integrate?** While we delegate our mental health services, we have a very strong program that coordinates, integrates and oversees the quality of services across all settings between our delegated entities and AllCare staff. Factors that influence AllCare's payment rates for BH services include:
   - AllCare's targets for improvements in the impact of the SDOH-HE on outcomes;
   - Patient acuity; and
   - Indicators of access needs, including waiting time for appointments, utilization of low-acuity emergency room services, hospitalizations, readmissions, and grievance and appeals.
   - AllCare flexes its financial support of BH services and support based upon population needs that are identified throughout the year. For instance, in 2017, at mid-year of the budget cycle, AllCare analyzed the penetration rate of mental health services in Jackson County compared to services delivered and discovered a trend of under-utilization. In response, AllCare made a comprehensive change to reorganize programs and BH contracts in Jackson County. AllCare sought expertise and advice to increase access for children and adults' mental health services, and funded the development of a new provider network in Jackson County, one of many positive changes to meet service demand. Within a year, utilization of mental health treatment services increased over 50% adults and more than doubled for children.

AllCare's Global Budget is flexed based on the prevalence of conditions, member needs and the needs of the locale whether rooted in physical, behavioral, or oral care.

3. **How will Applicant fund Behavioral Health for its Service Area in compliance with the Mental Health Parity and Addiction Equity Act of 2008?** AllCare's most recent review performed by the OHA's contractor to assess AllCare's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) was completed in March 2019. A 3-step action plan was completed, and is in compliance with the MHPAEA. AllCare has several strategies to support parity in benefit design and access to physical and behavioral health services. As part of AllCare's analysis of services and providers, AllCare compares provider access for its BH network to its physical health network at least annually. The analysis is based on providers per 1,000 Member within a 10-mile travel radius, closed and open practices, and waiting time for appointments. We use this information for provider recruiting and network development. An analysis in Q1 2019 compared AllCare's BH provider network favorably to its physical health provider network. Please see the analysis summary in the table below.

Physical Health Network		Behavioral Health Network
Primary Care	Medical Specialist	Mental Health & SUD
1.7 per 1,000	15.6 per 1,000	9.6 per 1,000

Because we have physical health, behavioral health and oral health services integrated within AllCare, we can regularly review all policies, procedures and any benefit changes, through the parity lens to ensure compliance. To compliment this effort, AllCare has purchased Milliman Care Guidelines (MCG) a nationally recognized, evidence based tool used to provide practice guidelines to be utilized throughout physical and BH health services.

The AllCare Compliance Team will continue to conduct an annual audit of the CCO's anticipated benefit changes, to ensure that financial requirements, network adequacy and treatment limitation requirements as defined by the MHPAEA will be met.

4. **How will Applicant monitor the need for Behavioral Health services and fund Behavioral Health to address prevalence rather than historical regional spend? How will Applicant monitor cost and utilization of the Behavioral Health benefit?** AllCare monitors the need for BH services through a variety of sources. These include reporting on prevalence of BH conditions and treatment from governmental organizations such as the OHA and SAMHSA. We compare prevalence and treatment rates from their reports to prevalence and treatment rates in our Member population for BH services. We also gather data on BH service needs from our community. Community information sources we include are: our Community Advisory Councils (CACs), AllCare Board members, and the collaborative Community Health Assessments for our service area. AllCare also has several outreach and information gathering initiatives to solicit input on BH needs and services. These include regular meetings and information gathering from our primary care and BH providers, Member Listening Sessions, and internal research and reports on health

equity for special populations such as our SPMI members. Provider and Member satisfaction data, both at the health-plan and all clinic levels will continue to be reviewed.

AllCare monitors cost and utilization of the BH benefit in several ways. These include internal reporting on utilization from systems tracking, UM processes, claims, encounters, and financial systems. AllCare analyzes cost and utilization for the Behavioral Health Benefit on a quarterly basis for each of its three regions and for the service area as a whole using:

- Professional expense in total and by PMPM,
- Professional visits/1,000 Members,
- Facility expense in total and per admit, and
- Facility only expense per admit.

AllCare conducts a drill-down of utilization data using the following measures to track annual trends in the BH benefit:

- Number and rate of referrals/month;
- Number and rate of Members currently in BH treatment month by month;
- Time from referral to BH initial assessment;
- Time from initial BH assessment to treatment;
- Number of Members and denial rate for Members seeking Applied Behavioral Analysis treatment; and
- Number of currently contracted providers of Applied Behavioral Analysis and the number of ABA providers per Members seeking ABA treatment for the period.

AllCare uses the following approach to address prevalence, rather than historical spend, in funding Behavioral Health. AllCare's Finance Department and management team review data on prevalence of BH conditions, their treatment in the state, and we compare them to AllCare's Membership and rates of treatment when we determine budget and program changes. Resources that AllCare uses to analyze cost and utilization for the BH benefit package include the OHA's Behavioral Health Profile. This Profile shows the prevalence of Mental Health Conditions and of SUD Conditions by age-band for Medicaid Members in each county. AllCare compares its Membership's rate of treatment by age band and condition to the OHA profile to identify subpopulation needs. Another resource that AllCare uses to analyze cost and utilization of its BH benefit is the Oregon Behavioral Health System Metrics reporting. AllCare compares its Members' experience for 10 of the Mental Health Diagnoses of highest prevalence in the state. AllCare then incorporates an analysis of patient acuity using MedInsight (a population management analytical tool from Milliman) with its analysis of prevalence when developing funding for the next budget cycle.

5. **How will Applicant contract for Behavioral Health services in primary care service delivery locations, contract for physical health services in Behavioral Health care service delivery locations, reimburse for the complete Behavioral Health Benefit**

Package, and ensure Providers integrate Behavioral Health services and physical health services? There are four payment methods that AllCare uses to routinely reimburse for services provided for the complete BH Benefit Package. They are: Capitation, Enhanced Capitation, traditional Fee for Service (FFS), and Enhanced Fee for Service. AllCare's Traditional FFS payment model is based on Oregon's FFS payment schedule and applied to individually billed services. AllCare's standard capitation approach for mental health subcontractors is used for a significant portion of AllCare provider network. It is updated annually using prevalence of major BH conditions by age bands and acuity for the population. The integrated models of care are reimbursed primarily through Enhanced Capitation (tied to quality as defined in our response to Attachment 8 – Value Based Payment), or Enhanced FFS (tied to quality as defined in our Attachment 8 – Value Based Payment) payment models. Enhanced Capitation is often used for payment in integrated service locations where there is an expectation of frequent contact with BH personnel, or the continued presence of that personnel is needed to achieve the goals for integration at that site. For example, AllCare pays Enhanced Capitation to its BH contractor for the Jackson and Josephine-Douglas regions to fund embedded BH personnel at primary care offices and a large OB/GYN practice. AllCare also pays Enhanced Capitation to its BH contractor for Curry County to fund BH personnel embedded in the elementary and high schools in the service area. Enhanced FFS payment fits integration efforts where the contact is more episodic in nature, or in which the AllCare Member population at the site is not yet large enough to spread the risk of capitation. When Options for Southern Oregon opened its first primary care office within one of its BH clinics, Enhanced FFS was chosen for the primary care services that included intensive care protocols for the SPMI population as PCP assignments at that site grew.

Shown in the table below is a sampling of integrated physical and BH locations funded by AllCare throughout our service area. It also shows the payment model typically used to fund the integrated services at the site.

Site / Primary Services / Payment Model	Integrated Services Category	Integrated Services Detail
Site: Patient Centered Primary Care Home (PCPCH) **Primary Services:** Physical Health **Payment Model for Integrated Services:** Enhanced Capitation and/or Enhanced Fee For Service	✓ Mental Health ✓ SUD ✓ Oral Health	✓ BH screenings ✓ Case Consultations ✓ Health & Behavior services ✓ Interdisciplinary Team Meetings ✓ Psychoeducational Groups ✓ Short term therapeutic interventions ✓ Warm handoffs ✓ MAT services ✓ Peer Support Services
Site: Mental Health Clinics	✓ SUD ✓ Primary Care	✓ Co-occurring Treatment ✓ Expanded Care Coordination

Site / Primary Services / Payment Model	Integrated Services Category	Integrated Services Detail
Primary Services: Mental Health **Payment Model for Integrated Services:** Enhanced Capitation	✓ Oral Health	✓ Health Screenings ✓ Interdisciplinary Team Meetings ✓ MAT services ✓ Oral Health screenings and treatment services ✓ Smoking Cessation ✓ Telehealth ✓ Warm handoffs ✓ Primary Care
Site: School Based Health Centers/Schools **Primary Services:** Physical Health **Payment Model for Integrated Services:** Fee for Service	✓ Mental Health	✓ BH screenings ✓ Case Consultations ✓ Health & Behavior services ✓ Interdisciplinary Team Meetings ✓ Psychoeducational Groups ✓ Short term therapeutic interventions ✓ Warm handoffs
Site: Substance Use Disorder (SUD) Clinics **Primary Services:** SUD **Payment Model for Integrated Services:** Enhanced Fee For Service	✓ Mental Health ✓ Primary Care ✓ Oral Health	✓ Assessment & Service Planning ✓ BH screenings ✓ Case Consultations ✓ Health Screenings ✓ Interdisciplinary Team Meetings ✓ Oral Health screenings and treatment services ✓ Smoking Cessation ✓ Warm handoffs ✓ Short term therapeutic interventions
Site: Criminal Justice (Adult & Juvenile) **Primary Services:** Governmental Programs **Payment Model for Integrated Services:** Fee For Service	✓ Mental Health ✓ SUD	✓ Assessment & Service Planning ✓ Case Consultations ✓ Group Counseling ✓ Individual Counseling ✓ Interdisciplinary Team Meetings ✓ Peer Support Services ✓ Warm handoffs ✓ Short term therapeutic interventions ✓ Psychoeducational Groups ✓ BH screenings

Site / Primary Services / Payment Model	Integrated Services Category	Integrated Services Detail
Site: DHS **Primary Services:** Child Welfare **Payment Model for Integrated Services:** Fee for Service	✓ Mental Health	✓ BH screenings ✓ Case Consultations ✓ Health & Behavior services ✓ Psychoeducational Groups ✓ Short term therapeutic interventions ✓ Warm handoffs ✓ Assessment & Service Planning ✓ Interdisciplinary Team Meetings
Site: Other Access Points e.g. WIC, Head Start, Child Abuse Intervention Centers, Youth and Adult Peer Programs, Sobering Centers, Syringe Exchange Programs **Primary Services:** Governmental or Non-Profit Programs **Payment Model for Integrated Services:** Fee for Service plus AllCare Community Investment Grant support	✓ Mental Health ✓ SUD	✓ BH screenings ✓ Case Consultations ✓ Short term therapeutic interventions ✓ Warm handoffs ✓ Assessment & Service Planning

Examples of primary care and medical specialist locations in which AllCare funds embedded BH staff include:

- WIC offices in our service areas;
- Many of the elementary and high schools throughout our region;
- Two FQHCs in Medford, one in Josephine County and one under development in Curry County;
- Four independent primary care practices located in urban and rural Jackson and Josephine Counties;
- Public health offices in Josephine County;
- Collaborative clinic, Birch Grove in Medford.

AllCare's Alternative Payment Model for Behavioral Health offers incentives to BH contractors to provide integrated care by BH clinicians in Child Welfare offices, Correctional Facilities, Emergency Rooms, dental clinics, Women's Health clinics, primary care and specialty medical clinics, and schools.

6. **How will Applicant ensure the full Behavioral Health benefit is available to all Members in Applicant's Service Area?** As part of AllCare's health equity mission, we ensure that *"...all members in our communities have the opportunity to attain their full potential and highest level of health".* To that end, we have undertaken the following:

- Two of our full time staff have graduated to date from Oregon Health Authority's Developing Equity Leadership through Training and Action (DELTA) program. AllCare's Leadership was exposed to and trained in Multicultural Listening Sessions.
- Through the use of demographic and claims data, AllCare identified that a disparity exists for two populations in Emergency Room utilization. Members who identify as Native American and Members diagnosed with a Severe and Persistent Mental Illness (SPMI) have a significantly higher rate of ED utilization, compared to the rest of our CCO population. AllCare facilitated a series of Listening Sessions in 2018 to determine why these Members accessed the ED to a disproportionate degree. This informed our efforts to assist our Members in engaging or re-engaging with their primary care provider or more appropriate care settings that will better meet their cultural and linguistic needs.
- A planning team was developed that included representation from AllCare, Southern Oregon Health Equity Coalition (So Health-E), and local leaders.

Four (4) sessions held in 2018. These were the findings:
- Provider offices accessible before 9am and after 5pm is needed in the region
- Referrals and Authorizations cause barriers to members
- They will go to the ER to be seen if the Referral or Auth is denied
- Will also go to the ER if the provider refuses to submit an Authorization or Referral
- More interpreters are needed for Limited English Proficiency Speakers
- There are barriers to Alternative care in certain areas
  - Providers also are not referring for these services in an optimal way
- Appointments are too far out
- Members wants to go to Primary Care if they can get in
- Dental access is a huge priority to members
- More "On-Demand" ride availability from ReadyRide (NEMT) was desired

We are systematically developing and implementing action plans to address these issues, and we employ multiple strategies to increase our Members' access to care. For example, we negotiated the provision of regular walk-in hours in all three regions with our BH contractors. We continually monitor where Members are accessing services compared to where our Members live and where practices are closed or open to inform our provider recruiting efforts. We have increased access to extended hours (before 9:00 am and after 5:00 pm) in all three regions. Where the need for a specific type of service is identified, we have developed creative approaches to meet the need. Service expansion at Birch Grove Health Center, a community health center in Medford operated by La Clinica is an example of collaboration and creativity to problem solve. We partnered with Jackson County Mental Health, Jackson Care Connect, OnTrack (SUD), and the Addictions Recovery Center

(ARC) to embed behavioral health treatment staff at Birch Grove who screen patients and provide Warm Handoffs to behavioral health treatment services.

AllCare's provider integration strategy expands access to the BH benefit through the co-location and integration of behavioral and physical health providers in primary care clinics, mental health and SUD treatment locations, OB/GYN offices, schools, public health offices, and homeless program locations. Our provider contracting strategy increases access to BH benefits by APM incentives to improve performance on the following measures of access: average wait time from referral to first appointment; percentage of first appointments within 30 days of Assessment; percentage of at least three treatment episodes within 90 days of initial assessment; percentage of follow up within 7 or less days after mental health hospitalization; percentage of follow up within 30 or less days after mental health hospitalization or Rehab discharge; the number of level 1 or 2 (low acuity) ED visits per thousand Members of those receiving services from a behavioral health agency; the annual increase in the percentage of behavioral health visits by CCO Members, availability of Warm Handoffs from the behavioral health agency; the percentage of children who receive a mental health assessment within 60 days of entering DHS custody; and the percentage of Members, when surveyed, responded "Satisfied" with the services they received through the behavioral health agency. AllCare provides and supports a wide range of BH preventive services throughout its service area, such as community training for Mental Health First Aide, Suicide Prevention (ASIST, QPR, CALM, AMSR), and Crisis Intervention Training (CIT). AllCare supports the presence of mental health therapists and/or skills training in schools, therapists in Head Start classrooms, and therapists who are available through WIC in each county. AllCare also supports the provision of Older Adult Behavioral Health Specialists in each county who provide education, training, and resources to all providers about Senior Behavioral Health on a broad array of topics pertinent to seniors including medication considerations and increased suicide risk.

7. **How will Applicant ensure timely access to all Behavioral Health services for all Members?** We ensure timely access to behavioral health services by analyzing data from Internal Quality Concerns, complaints, grievances, and appeals on issues of network adequacy, and use the information to develop strategies to address access issues.

   As a result of these strategies, we have increased access to MH and SUD services through Warm Handoffs at the moment in which the Member is motivated to change. We have embedded BH personnel to make and receive Warm Handoffs in hospital EDs, primary care and specialist offices, schools, homeless programs, sobering centers, missions and Southern Oregon University Student clinic. To reach youth where they are, we have included support of an intensive care management program for homeless youth in Jackson and Josephine Counties through the Maslow Project.

   AllCare's Behavioral Health Alternative Payment Method incentivizes continual improvement on timeliness of initial and ongoing engagement. We pay incentives to our

BH contractors to continue to improve performance on the following measures of timely access to care:

   i.   Average wait time from referral to first appointment;

  ii.   Percentage of first appointments within 30 days of initial assessment;

 iii.   Percentage of at least three treatment episodes within 90 days of initial assessment;

 iv.   Percentage of follow up within 7 or less days of mental health hospitalization;

  v.   Percentage of follow up within 30 or less days of mental health hospitalization or Rehab discharge;

 vi.   The number of level 1 or 2 (low acuity) ER visits per thousand Members (of those receiving services from a behavioral health agency – this is a proxy for access to behavioral health evaluation and treatment);

 vii.   The annual increase in the percentage of behavioral health visits by CCO Members; availability of warm handoffs;

viii.   The percentage of children who receive mental health assessment within 60 days of entering DHS custody; and

 ix.   The percentage of Members who respond "Satisfied" with their experience with Behavioral Health care and appoint availability when desired.

8. How will Applicant ensure that Members can receive Behavioral Health services out of the Service Area, due to lack of access within the Service Area, and that Applicant will remain responsible for arranging and paying for such out-of-service-area care?
AllCare has policies and procedures in place to review and approve care from non-network providers in case issues of timeliness or access arise. We coordinate care, and reimburse non-network, out-of-area providers for covered services and transportation in instances in which covered services are medically necessary but not available within the service area on a timely basis. AllCare's Behavioral Health Care Coordination Team coordinates health related services (flex funds), medically appropriate health services, and services/supports outside the scope of AllCare's contract when doing so allows for preservation of the Member's placement or treatment plan.

Adult Members receiving needed residential SUD treatment outside AllCare's service area are considered to be in a temporary absence from their home county, and by our policy, this does not represent a change of residence or a change in enrollment when the Member will return to our service area at the end of their stay. By our policy, Children placed in Behavioral Rehabilitation Service (BRS) by Children and Family Services (CAF) are also considered to be in a temporary placement, and will remain enrolled with AllCare. Our Behavioral Health Care Coordinators coordinate for all health services needed which can include: medically appropriate health services, health related services (flex funds) and services/supports outside the scope of AllCare's contract when doing so allows for preservation of the Member's placement or treatment plan. AllCare works with the Oregon Health Authority and appropriate CMHP in managing admissions and discharges for children placed in Secure Children's In-patient (SCIP) and Secure Adolescent In-patient (SAIP), and these Members remain enrolled with AllCare, and assist with coordinating

care during the entire length of stay and discharge planning. Adults admitted to the Oregon State Hospital (OSH) are currently dis-enrolled from AllCare during their stay. However, AllCare's Behavioral Health Care Coordinators continue to follow these Members from admission and participate in discharge planning, and support seamless transfers back to the Member's home county and re-enrollment in AllCare. It is our policy and consistent practice for AllCare's BH Care Coordinators to follow all Members receiving out of area services and to ensure continuity of care and a smooth transition back into their home county.

9. **How will Applicant ensure Applicant's physical, oral and Behavioral Health Providers are completing comprehensive screening of physical and Behavioral Health care using evidence-based screening tools?** AllCare's Value Based Payment (VBP) for physical, behavioral, and oral health providers specifies use of OHA, National Quality Forum (NQF), Healthcare Effectiveness Data & Information Set (HEDIS), Children's Health Insurance Program Reauthorization Act (CHIPRA), or Patient Centered Primary Care Home (PCPCH) approved measures where they are available. These OHA, NQF, and PCPCI approved measures specify the evidence-based screening tools that are permissible for each measure. AllCare currently tracks, analyzes data on, and incentivizes improved performance in the following evidence-based screening measures and follow up care from oral/dental health providers: oral exam and provision of fluoride varnish for children, oral exam for DHS children in first 60 days, oral evaluations for diabetic Members, and oral exams for pregnant Members. AllCare tracks, analyzes data on, and incentivizes improved performance by its behavioral health contractors on the following evidence-based screening and follow up care: the SBIRT and DAST for inappropriate use of prescription drugs and non-prescription drugs or use of illicit drugs; SBIRT and Audit for alcohol use; the PHQ-2 and PHQ-9 for depression; tools used as part of the Intensive Outpatient Services and Supports (IOSS) for Children programs include the PHQ2 and PHQ 9, GAD 7, DLA 20, the ECSII; the CANS Oregon Mental Health Assessment tool is used in addition to the comprehensive mental health assessment for all children placed in DHS foster care and for children in the Wraparound program; the Child Behavior Check List (CBCL) is used routinely as part of the Parent-Child Interaction Therapy (PCIT) programs; and the ASAM assessment is used for Substance Use Disorders. Internal audits in the appropriate use of these evidence-based tools and follow up care are conducted by AllCare's behavioral health contractors (Options for Southern Oregon and Curry Community Health), and AllCare audits for the appropriate use of the tools and follow up care on its behavioral health contractors annually (or more often if concerns are identified). AllCare tracks and incentivizes improvements in the following measures of evidence-based screening and follow up care from physical health professionals: SBIRT (OHA measure using HSD-Approved Evidence-Based Screening Tools), depression screening (PHQ-2 or PHQ-9) and follow up (NQF 0418), tobacco use screening and prevalence reduction (OHA CCO Incentive Measure), colorectal cancer screening (HEDIS), preventive well child and adolescent visits (CHIPRA #12), BMI screening & follow up nutrition & activity counseling (NQF 0024), developmental screening for children 12-36 months of age using

one of the OHA approved screening tools, and childhood immunization status (HEDIS). AllCare tracks, analyzes data on, and incentivizes improvements in the following evidence-based screening and follow up care from physical health facilities (hospitals): clearly explained patient discharge instructions (based on CMS Value-Based Purchasing Model Patient Experience Survey), Reduce ED Visits within 7 days post discharge (CMS Shared Savings Program), Reduce Readmissions within 7 days post discharge (CMS Shared Savings Program), percentage of patients with PCP follow up within 14 days of hospital discharge, rate of catheter-associated urinary tract infections, and rate of central line-associated blood stream infections.

10. **How will Applicant ensure access to Mobile Crisis Services for all Members to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute Care Psychiatric Hospital, in accordance with OAR 309-019-0105, 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320?** AllCare contracts with our service area CMHPs and/or the Local Mental Health Authority for 24/7 crisis line services, hospital response and Mobile Crisis Services. The mobile crisis teams are comprised of trained Masters level clinicians and Qualified Mental Health Associates and/or Certified Peers who respond to crises at hospitals and in the community. If a community member is experiencing a mental health crisis, a Mobile Crisis Team will respond and assess the situation with the goal of engaging the member in behavioral health services to prevent arrest, incarceration, unnecessary emergency room use, or avoidable hospitalization. Response is often to police requests, doctor's offices, schools, homeless programs, jail, detox and sobering centers. The Mobile Crisis Teams provide a crisis assessment and stabilization, referral and Warm Handoff to on-going BH treatment. The Jackson County Mental Health (JCMH) crisis team provides warm hand-offs to AllCare's contracted Certified Community Behavioral Health Center (CCBHC) or other network providers in Jackson County. The CCBHC reports daily on efforts to engage these Members with community-based services to AllCare's BH CC Supervisor. In Josephine and Curry Counties, the Mobile Crisis Team Members provide the response and stabilization activities, and also the active outreach and engagement activities. The Mobile Crisis Teams work collaboratively with the jail diversion teams operated by the contracted mental health agencies to provide continuity of care for members who may be at risk of becoming part of, or who are already in the criminal justice system. Our Mobile Crisis Teams have access to two child and youth diversion residential respite homes in our service area. Crisis staff can admit into these programs 24/7. Planned respites are frequently used by clinical staff and in coordination with AllCare's Behavioral Health Care Coordinators to prevent crises and unnecessary emergency room use. A similar process is in place for the three adult crisis resolution centers, one in Jackson, Josephine and Coos (serving Curry), that divert people from hospitals and jails, and facilitate stabilization in a community setting. Members have discharge plans in place when they are discharged from crisis respite programs including Warm Handoffs to planned, individualized treatment.

11. **Describe how Applicant will utilize Peers in the Behavioral Health system.** The personal lived experience of a Certified Peer Support Specialist (PSS) helps to create a

genuine connection with AllCare Members and engages them in the right service at the right time and supports them on the road to recovery. We find that using Peer Support Specialists aids in the design of a more effective and culturally responsive system of services. Peer support specialists (adult, youth and parent) are fully integrated into our providers' treatment teams including: mobile crisis response, community based crisis stabilization programs, co-occurring inpatient treatment, jail diversion, residential treatment, supported housing for post-prison women in recovery from substance use disorders and their children, supported clean and sober housing programs for those with co-occurring disorders, Assertive Community Treatment, Wraparound services, EASA, Illness Management Recovery groups, SUD treatment, and supported housing.

Many psychotropic medications are highly correlated with metabolic syndrome which has a significant impact on health, quality of life and longevity. AllCare supports the development of Peer Wellness Coaches who assist Members with mental health issues who have or are at risk of developing co-morbid metabolic syndrome through Options' Certified Community Behavioral Health Clinics (CCBHC). Peer delivered Wellness Coaching helps our Members with severe mental illness address major health disparities such as shorter lifespans and impaired health-related quality of life compared to the general population. Anticipated outcomes include improvements in physical health, general and perceived health as well as, increased engagement in healthy lifestyle behaviors. AllCare provides financial support for the education and certification of all types of Peer Specialists. AllCare's support has promoted the evolution and spread of Peer services in our service area and provides another avenue of employment for individuals with this training as a critical component of our Traditional Health Worker workforce. AllCare also provides financial support to Peer-run programs including drop-in centers and club houses in our service area that connect our Members to needed services and supports.

12. **How will Applicant ensure access to a diversity of integrated community supports that mitigate SDOH-HE, increase individuals' integration into the community, and ensure all Members access to Peer services and networks?** As part of AllCare's health equity mission, we ensure that *"…all members in our communities have the opportunity to attain their full potential and highest level of health".* AllCare's internal Community Health Improvement Team (CHIP) funds programs and efforts to improve the quality of life of the members of our community and health outcomes for them. AllCare devotes significant resources to research and evaluation of its efforts to improve the impact of the Social Determinants of Health and Health Equity (SDOH-HE), including: education of the AllCare governance Board and Committees on SDOH-HE, SDOH-HE training for the members of the Community Advisory Councils (CACs), internal evaluation and reporting on health outcomes, healthcare costs, and improvements in SDOH-HE; and third-party, external review of Member engagement and satisfaction, partner satisfaction in shared programs, sustainability of programs, and economic impact to the community. AllCare's programs in Oral Health Integration have resulted in the following: hygienists in two residential SUD treatment program locations, and in a "Mom & Me" program providing

preventive dental care and sealants in Medford. In the area of Education and Family Strengthening, AllCare provides technical assistance and financial support to the following programs: promotion of the PAX Good Behavior Game; Trauma Informed school districts, support of CASA, Foster Parents, and DHS Child Welfare; Family Strengthening Programs; Cradle to Career initiatives; and a wide range of youth development programs including the Boys & Girls Club. To promote the availability of affordable, accessible housing, AllCare's investment model includes a diverse array of member-centric options such as Rogue Retreat and Hope Village which are second-chance housing programs that provide strong case management support. In the area of Behavioral Health, AllCare's participation and program support has led to more effective systems and improved community outcomes in the areas of adverse childhood experiences, school and community partnerships and Systems of Care. AllCare has staff dedicated to teaching and training its staff, and the staff of providers and community partners on heath equity, and incents participation in health equity training for its contracted providers. AllCare's contracted Supported Education programs are embedded in our local community college and university, and these programs assist Members in earning their GED, and in earning college credits, certifications and degrees. AllCare provides direct support to develop the workforce in a variety of traditional and non-traditional health workers, including Peer Support Specialists for behavioral health and Community Health Workers. AllCare's Intensive Care Coordinators and Community Health Workers integrate the efforts of physical, behavioral health, and oral providers to engage our Members in Behavioral Health treatment, facilitate their access to community resources such as housing, child care and Peer services, and provide culturally and linguistically appropriate guidance on health, nutrition, access to health care and social assistance. Our Behavioral Health contractors maintain a robust set of Peer programs, with Peers embedded in teams providing children, family and adult services, such as: early psychosis intervention, Assertive Community Treatment programs, Wraparound services, and parent mentoring programs to provide first-person perspectives on mental illness and addictions and enhance program engagement and success. Peers co-facilitate our evidence-based Illness Management and Recovery (IMR) programs in outpatient and residential settings to guide participants in the development of their own recovery plan and to succeed in living in their community. AllCare and its Behavioral Health contractors support and connect adult and youth Members to local Peer-lead organizations, including club houses and drop in centers that increase Member integration into our community through social connections and mentoring. Peers are also embedded in our supported housing programs for Members with SUD and mental health diagnoses, and provide regular on-site mentoring and community connections to these Members.

B. Billing System & Barriers to Integration (recommended page limit 2 pages)

Applicant must identify and address billing system and policy barriers to integration that prevent Behavioral Health Provider billing from a physical health setting. Applicant will develop payment methodologies to reimburse for Warm Handoffs, impromptu

consultations, integrated care management services and all services for evidence-based treatments (for example, Wraparound, ACT, PCIT, EASA, Peer Delivered Services). Applicant will examine equity in Behavioral Health and physical health reimbursement.

1. **Please describe Applicant's process to provide Warm Handoffs, any potential barriers to ensuring Warm Handoffs occur and are documented, and how Applicant plans to address them.** Warm Handoffs are occurring consistently at multiple locations throughout AllCare's region, focusing especially on care settings where physical and behavioral care are integrated. AllCare reimburses its behavioral health contractors for Warm Handoffs through Enhanced Capitation and Enhanced Fee-for-Service (FFS) payment arrangements. The "enhancement" of the capitation rate or fee schedule is calculated to compensate for licensed and non-licensed staff like Traditional Health Workers and Peer Specialists providing Warm Handoffs in a variety of circumstances and care settings. Many Warm Handoffs are occurring regularly in treatment settings that have embedded staff integrating behavioral and physical care. Examples of these integrated settings in which Warm Handoffs are a regular occurrence include: Rogue Community Health Center, a FQHC with fully integrated primary care in Medford where the Warm Handoffs flow seamlessly between mental health, SUD, and primary care providers and staff; from primary care provides to BH staff who are embedded in 4 primary care offices around Jackson County; and from SUD staff at Addictions Recovery Center in Medford to MH counseling staff. Examples of regularly occurring Warm Handoffs in the Josephine-Douglas region include two fully integrated primary care/MH/SUD locations in Grants Pass, and at The Women's Health Center from OB/GYN providers and staff to embedded mental health staff. Examples of regularly occurring Warm Handoffs abound in Curry Co. in three cities in which primary care is integrated into all of Curry Community Health's BH treatment locations, and Warm Handoffs are a regular occurrence to BH staff who are embedded in all of the elementary and high schools in the county. AllCare's enhanced capitation arrangement funds embedded BH staff in most of the elementary and high schools in Jackson and Josephine Counties as well, and Warm Handoffs occur in those settings with regularity. Other settings in which Warm Handoffs are occurring during transitions of care are at hospitals and Emergency Rooms. Warm Handoffs from emergency room and hospital Discharge Planning staff to Options for Southern Oregon's staff members occur in both Josephine and Jackson Counties. Recently, AllCare's funding and collaboration efforts led to the development of an Engagement Clinician who works with the emergency departments and hospitals in the Rogue Valley to link members to needed SUD treatment at the level and in the timeframe in which they are willing to engage. Other settings in which Warm Handoffs are occurring with regularity are WIC offices, Child Welfare offices, and through relationships with Juvenile Justice and Adult Corrections in all three regions. The only issue that AllCare has identified that could be called a barrier, is a lack of uniformity in how Warm Handoffs are documented throughout the healthcare and social service systems. AllCare and its contractors have agreed that Warm Handoffs will occur and will be documented in the member's clinical record by both the referring and receiving providers. The intent is to prescribe uniformity for the

documentation and billing of Warm Handoffs. AllCare's BH Team will evaluate the Warm Handoff procedures for all of our contracted BH providers during our annual review.

2. **How does Applicant plan to assess for need and utilization of in-home care services (Behavioral Health services delivered in the Member's home) for Members?** AllCare has implemented a process in order to screen all of our Members for a variety of needs including for available State Plan Home and Community Based Services (HCBS). AllCare Population Health employs certified Community Health Workers to conduct an initial Health Risk Survey (HRS) with each new Member. If the Member is referred for care coordination based on the HRS an additional assessments are conducted within 10 days or as quickly as the Member's health condition requires. AllCare's HRS includes questions with regard to a Member's ability to complete their activities of daily living (ADL's) and diagnoses that may contribute to impairments of their ADL's, including past or present behavioral health diagnoses. The HRS is designed not only to identify health risks and barriers to care but to also identify what resources in the community the Member might benefit from. This includes possible eligibility for State Plan HCBS (including in-home services) or other community support programs. Members whose responses to the HRS indicate they may need assistance with their ADL's, whether it may be in-home or community-based living, are referred to an AllCare Care Coordination team. The Care Coordination Team includes a RN Care Coordinator (CC), Intensive Case Manager (ICM), Certified Community Health Worker (CHW) and/or another certified traditional health worker who might specialize in specific health conditions. The Care Coordination Team will outreach to the Member, and with Member's permission, perform an in-home assessment to determine Member's specific needs regarding their ADL's and instrumental activities of daily living (IADLs) and determine which diagnosis is the primary driver for the needed assistance. Once the primary diagnosis driving the need is identified the Care Coordination Team will assist the Member in navigating the application and assessment process with the appropriate agency.

The primary diagnosis driving the need for assistance is a key component for determining which State Plan or Medicaid funded program, and through which agency, the Member should apply. Aging and People with Disabilities (APD) provides in-home services for people with physical diagnosis and condition that impair their ADLs. The State I/DD Services contracts with either the County or a designated Brokerage to provide in-home service programs to children and adults with intellectual or developmental delays that impair their ADLs. When the primary diagnosis driving the need for assistance is a behavioral health diagnosis the AllCare Care Coordination Department will connect Members directly to the most appropriate contracted behavioral health providers. If a Member's behavioral health needs are complex or there is question regarding driving diagnosis the Care Coordination Department has access to the Behavioral Health Care Coordinator (BHCC) for consultation and getting the Member connected to the appropriate services with the appropriate provider.

Each time a Member accesses one of AllCare's contracted behavioral health providers a biopsychosocial evaluation is completed which includes the assessment of Member's ability to complete their activities of daily living and other in-home service needs. A Member's need for in-home services are also identified at these agencies through ongoing case management and intensive care coordination services. When it is identified through an assessment or ongoing services that a Member requires assistance in the home the following types of services may be offered:

- Personal Care Attendant Services (PCa20);
- 1915(i) Home and Community Based Service (HCBS);
- Assertive Community Treatment (ACT);
- In-home respite services;
- Skills Training;
- Case Management; and
- Therapeutic Services.

3. **Please describe Applicant's process for discharge planning, noting that discharge planning begins at the beginning of an Episode of Care and must be included in the care plan. Discharge Planning involves the transition of a patient's care from one level of care to the next or Episode of Care. Treatment team and the patient and/or the patient's representative participate in discharge planning activities.** AllCare begins discharge planning as part of the initial care plan that is developed when a Member enters treatment with a Behavioral Health provider or facility. Our contracted BH providers are required to start discharge planning upon admission to treatment and to continuously reassess/review the Member's discharge plan with them and/or their identified supports. AllCare facilitates discharge planning beyond coordination with physical, behavioral, and oral health providers to include our community resource partners to promote successful transitions of care.

Shown below is our typical process for discharge planning specifically for members enrolled in our BH Care Coordination program.

Step 1 - Notification of:
- ED presentation or admission to Inpatient Hospital for BH diagnosis.
  - Notifications received by Collective Medical, Hospital notification/request for authorization or internal reports
- Out of Area admission to SUD detox/residential, child MH residential, Child Welfare placement in BRS or OSH. Notification by provider notification call/secure email or admission notifications forms.
- Other complex needs/high acuity Member in need of assistance transitioning from one episode of care to another. Notification from PCP, AllCare staff, BH providers, Member/family self-referral, internal reports. Examples: Member wanting to step out of Opioid Treatment Program to PCP prescribed MAT or a Member discharging from SNF for a resolved medical issue but needs coordination of BH needs.

Step 2 - Assignment to:

- Contracted BH agency to make initial contact and discharge planning.
- BH CC team for initial contact and discharge planning.
- Both BH Agency and BH CC team for Members who decline needed BH services or have complex needs.

Step 3 - Process:

- Immediate contact with ED/Hospital, treatment or BRS provider to discuss discharge plan and who else is on Member's treatment team.
- Coordinate team Member's involvement and provide accountability for team Members to follow through with assigned tasks.
- Ensure Member's team has all info about resources from AllCare, local providers and community resources to aid in successful discharge planning.
- Document goals and discharge plan in AllCare's Case Management system with interventions, tasks, barriers and timelines.

Step 4 - Follow up:

- Contact receiving providers to ensure d/c plan was executed and address if not.
- Follow up in 30, 60, 90 days with providers and/or Member to track follow up and engagement and assist with any additional barrier removal needed.
- Close BH Care Coordination case if Member is engaged with appropriate BH treatment providers and has no additional needs.
- May re-open case at any time if Member needs assistance or has another episode of care.

4. **Please describe Applicant's plan to coordinate Behavioral Health care for Fully Dual Eligible Members with Medicare providers and Medicare plans, including ensuring proper billing for Medicare covered services and addressing barriers to Fully Dual Eligibles accessing OHP Covered Services.** Seamless coordination of BH care is provided to AllCare Dual Eligible Members through AllCare's use of billing and claims systems, network provider education, and the efforts of AllCare's Enhanced Community-based and BH Care Coordinators. AllCare Dual Eligible Members have access to the Medicare provider network and the provider network. AllCare's billing and claims systems are programed to automatically execute a cross check between the AllCare BH provider network and the BH provider network for Dual Eligible Member's bills or encounters. The AllCare BH network is comprised of independent clinicians. The BH providers in this network are given training by AllCare Provider Network staff each year on any Medicare benefit changes, best practices in billing, and resources available to the Dual Eligible. The BH providers in the AllCare network are also given annual training by AllCare Provider Network staff on Medicare benefit changes, best practices in billing, and resources available to the Dual Eligible. AllCare's claims system is programmed to automatically cross check the Medicare benefit package and the OHP covered benefits to assure that Dual Eligible Members receive the maximum benefit coverage to which they are entitled. AllCare's claims system applies the Medicare benefits and payments first, before the OHP benefits.

There are no barriers to Dual Eligible Members accessing OHP Covered Services through AllCare. The care coordination and support that Dual Eligible Members receive from AllCare is exceptional. AllCare's Intensive Care Coordination Program's Care Coordinators at AllCare reach out to every AllCare Medicare Advantage Member to offer care coordination services by phone (if available) and mail after enrollment and every year thereafter at a minimum. They help Dual Eligible Members to select providers, schedule appointments, accompany the Member to their appointments, and participate in the appointment if the Member wishes. This team provides in-home safety and needs assessments, and over 80% of the interaction with the Member is face to face. They collaborates with staff in the BH Care Coordination Team and the population health team. Enhanced Care Coordinators from the BH Care Coordination Team are also available to attend BH appointments with the Dual Eligible Members, and coordinate care and support with the Enhanced Care Coordinators. At the start of each Dual Eligible Members enrollment with AllCare, the initial screening and needs assessment provides the basis to define who from the support staff will be the Member's regular contact for care coordination. In this way, we avoid duplication of services, and provide the best fit of personnel in partnership with the Member.

C. MOU with Community Mental Health Program (CHMP) (recommended page limit 6 pages)

Applicant will enter a MOU with Local mental health Authority that will be enforced and honored. Improved health outcomes and increased access to services through coordination of safety net services and Medicaid services.

1. **Describe how Applicant plans to develop a comprehensive Behavioral Health plan for Applicant's Service Area. Please include dates, milestones, and Community partners.** AllCare has contracts in place with all Local Mental Health Authorities (LMHAs) in our service area. We participated jointly with our Local Mental Health Authorities in a collaborative Community Health Assessment in early 2018, AllCare agreed to help fund and participate in a collaborative CHA in Jackson, Josephine and Curry counties. In Curry County, the collaborative CHA was developed in collaboration with the CAC and the other CCO located in Curry, Advanced Health. In Jackson and Josephine counties, the process utilized a convener of health care regional community leaders, Jefferson Regional Health Alliance (JRHA), hired a non-profit public health organization, Health Resources in Action (HRiA). HRiA was charged to provide strategic guidance and technical assistance for the CHA and to collect, analyze and report the data for the final CHA deliverables. It was believed that by joining efforts with our Local Mental Health Authorities, other CCOs (Jackson Care Connect and Primary Health), hospitals (Providence and Asante Health Systems), FQHCs (Siskiyou Community Health Center, Rogue Community Health and La Clinica), and Public Health Departments (Josephine and Jackson County) there would be a collective impact on health care transformational activities that involved the SDoH, addressing the economic, cultural and system barriers to health care access while reducing

the costs of health care services. In addition, relationships and resources could be leveraged through collaboration to implement best practices and ensure a sustainable health care system. Over 1,100 residents, stakeholders, health care consumers, focus groups and interviewees participated in the collaborative CHA process. Through the process of compiling, analyzing and synthesizing qualitative data, a list of fifteen themes emerged. This list was then prioritized by key stakeholders resulting in the following six priority themes: substance use, affordable housing, mental health and wellbeing, poverty and employment, parenting and life skills and education and workforce development. From those six priority themes, the list was narrowed to three areas that community stakeholders, consumers, and partners prioritized as being the most important in improving the health of the region: Behavioral Health (mental health and substance use), housing and parenting support and life skills.

The 2020 CHIP is to be completed by June 2019 and will be used as a 'guide' to reflect a consistent and formal community health improvement plan across all sectors in southwest Oregon. In Curry and Coos County, an effort has begun with AllCare and Advanced Health in the development of the collaborative CHA and CHIP for those counties utilizing the same process.

Through the CACs' input, listening sessions, compilation of county and state data and surveys the CHA will be used to prioritize the work. Though interventions may be collaborative, the different community partners will have the flexibility in the development of their CHIPs that reflect specific demographic, quality needs and desired outcomes. AllCare has determined that access to preventative and restorative oral health care, partnering with public safety officials and maintaining the ACEs and trauma informed programs is of paramount importance.

AllCare will coordinate with our Local Mental Health Authorities to develop AllCare's Comprehensive Behavioral Health Plan as required in Section 3 Care Coordination and Integration of Exhibit M-Behavioral Health in Appendix B of the RFA (the Sample Contract). Our Comprehensive Behavioral Health Plan will be developed in coordination with the LMHAs targeting the following milestones, and others as they are identified and prioritized, starting in 2020:

- We will use AllCare's internal cost and utilization analyses of the BH benefit, network adequacy reporting, and quality measure reporting to compare our results with data from the OHA's Behavioral Health Profile of the prevalence and treatment of Mental Health and SUD Conditions for Medicaid Members by county.
- Data from our regional Community Mental Health Programs and Local Mental Health Authorities, including their most recent Gap Analyses to develop recommendations for changes to AllCare BH programs and review utilization to inform our plan.
- We will develop recommendations for improvements in our processes to address Member needs from reports from our local health equity coalitions to inform us regarding health disparities.

- We will analyze Department of Education and school district data, (i.e. Student Wellness surveys, attendance and graduation rates) to determine if we need to enhance current BH support initiatives for school age Members.
- We will engage with and use the data from the Oregon Pediatric Improvement Partnership Project (OPIPP).
- We will use the Behavioral Health Collaborative recommendations and future findings to identify improvement needs for our BH programs.
- We will review the Department of Human Services (DHS) data on children in the custody of the State or at risk of being in the custody of the State and work with our BH contractors to develop a list of best practices relevant to serving these Members, and determine if changes are needed in our processes and BH programs.
- We will review Law Enforcement and specialty court data pertaining to populations with behavioral health needs and collaborate with our BH contractors to identify specific program enhancements that may be needed to best serve these Members' needs.
- We will solicit input from our community resource partners and provider network on our current physical, behavioral, and oral health integration approaches and outcomes, and incorporate this input into our Comprehensive Behavioral Health Plan.
- We will review national and OHA data and recommendations on Workforce Development approaches and outcomes and evaluate whether changes in best practices need to be incorporated in our Workforce approach for our Behavioral Health Plan.
- Our Comprehensive Behavioral Health Plan will be reviewed by the Community Advisory Council in each region for input and changes, and ultimately approved by AllCare's Board of Governors.

2. **Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the CHP. Please include dates and milestones.**
AllCare will collaborate with the LMHAs and Community Partners to achieve the goals set by the Health Systems Division of the OHA for CMHPs. AllCare has collaboratively worked with other CCOs and numerous community partners to complete a comprehensive collaborative Community Health Assessment in each county of our service area; key components of evaluating community needs for the CMHP. The collaborative Community Health Assessment identified several behavioral health related needs in each county which are being prioritized in all the collaborative Community Health Improvement Plans (CHIP). Our collaborative CHIPs will be completed by the end of June 2019. AllCare is participating and coordinating with the LMHAs and other community partners in the development of a Regional Collaborative Community Health Improvement Plan. The Plan participants have selected three priority areas: Behavioral Health, Housing, and Parenting Support & Life Skills. Five AllCare management staff members and three AllCare Community Advisory Council members are participating in the Community Health Improvement Plan development with LMHA representing each county in our service area. Dates and milestones that have been defined for accomplishment by the Steering Committee and the work groups include:

- 2/12/19 – Steering Committee began development of Vision Statement;
- 2/20/19 – Formed Work Groups and defined goals;
- 3/13/19 – Finalize Vision Statement;
- 3/15/19 – Develop list of CHIP document requirements for partner organizations;
- 4/9/19 – CHP document outline drafted;
- 4/12/19 – Select goals;
- 4/26/29 – Select population outcome measures;
- 5/19/19 – Select strategies;
- June, 2019 – Finalize and approve CHP document;
- July, 2019 – Create Action Plans;
- August, 2019 – Initiate Action Cycles.

The strategies and Action Plans will inform the development of the Community Mental Health Plan and AllCare will actively partner to develop the CMHP and work diligently to achieve its goals. We will be partnering with CMHP and community partners in Coos-Curry counties to replicate a similar collaborative CHIP process and timeline.

3. **Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the local plan. Please include dates and milestones.** AllCare has participated in the development of the Biennial Implementation Plans previously completed by each CMHP and we look forward to supporting the CHMPs in development of future Plans and goals. AllCare was given the opportunity to participate in the Josephine County Prevention Plan and we will hope to participate in the development of County Prevention plans throughout our service area in the future. AllCare participated in the Sequential Intercept Model (SIM) mapping training in Jackson and Josephine Counties in January 2017, and we will continue to collaborate in those processes and plans. We will also work to assist Curry County in bringing the SIM process to their communities. AllCare currently supports the CMHPs in our region with their provision of OHA contracted services for our Members, including Jail Diversion, Choice Model, Specialty Courts, and Personal Care Assistants to name only a few.

4. **Does Applicant expect any challenges or barriers to executing the written plan or MOU extension with the Local Mental Health Authority? If yes, please describe.** AllCare does not expect any barriers to executing the written plan.

D. **Provision of Covered Services**

Applicant must monitor its Provider Network to ensure mental health parity for Members.

1. **Please provide a report on the BH needs in Applicant's Service Area.** Please see report in *EXHIBIT 11.1a-BHAdequacy2019Qtr1JXCUJOCO; EXHIBIT 11.1b-SUD2019QTR1.*

2. **Please provide an analysis of the capacity of Applicant's workforce to provide needed services that will lead to better health, based on existing Behavioral Health needs of the population in Applicant's Service Area.** AllCare evaluates physical and behavioral network adequacy by applying time and distance standards which vary by provider type (primary care/PCPCH, maternity, behavioral health, hospitals, pharmacy, oral health, and specialists.) AllCare currently reviews distance with a 10-mile standard. This information is updated and assessed on a quarterly basis. AllCare compares its two specialist networks (physical health and behavioral health) to each other for purposes of network adequacy and the BH network compares favorably to the physical health specialist network and mental health parity goals.

3. **How does Applicant plan to work with Applicant's local communities and local and state educational resources to develop an action plan to ensure the workforce is prepared to provide Behavioral Health services to Applicant's Members?** AllCare's Provider Services Department will continue to work to increase contracted prescribers with Data Waiver (DEA-X) to increase capacity and access to Medication Assisted Treatment (MAT). AllCare's BH contractors are working actively to recruit providers to Southwest Oregon who are, or are willing to become MAT prescribers, and who desire to work in fully integrated physical and behavioral health practice locations. AllCare will also work with local community colleges and OHA approved trainers to Increase access to all Traditional Health Worker certification trainings. We currently work with local high schools, community colleges and universities regarding program development for career pathways in substance use disorders counseling, qualified mental health associate and qualified mental health professional certifications and peer support/wellness specialists, and we will continue this work. AllCare supports our contracted providers in their staff educational and workforce development endeavors, internships and tuition reimbursement programs. AllCare is participating in Oregon Health Sciences University's Extension for Community Healthcare Outcomes (ECHO) program to offer providers and their staff training in specialty areas for Continuing Education Units.

4. **What is Applicant's strategy to ensure workforce capacity meets the needs of Applicant's Members and Potential Members**? AllCare will look to OHA's Behavioral Health Collaborative Workforce work group's recommendations and the BH Workforce Assessment to be completed by the Farley Center in spring 2019 for the development of an additional recruitment and retention strategies. AllCare will support the planned coordination of the local SUD treatment provider's standardized educational, training and workforce development collaborative process. The intention of this process is to provide consistent training amongst staff of local SUD treatment providers throughout the continuum of certifications and to elevate the skill set of the BH workforce. AllCare encourages BH providers to focus on expanding the expertise, the importance of quality standards as well as creating a culture of growing staff, as current staff move forward.

5. **What strategies does Applicant plan to use to support the workforce pipeline in Applicant's area?** We will continue to support and collaborate with the programs that

already exist in our service delivery areas that are working to align education, training and job placement efforts in order to create interest and skill beginning with K-20. These programs include career fairs, career related learning partnerships, dual (post-secondary) credits for high school students and science, technology, engineering & Math (STEM) opportunities. AllCare is currently funding a youth pathways partnership, a local initiative that provides long term, innovatively structured, internships to local high school students with an emphasis on health care sector jobs. The ultimate goal of this project is not only to grow our health care workforce, but to also incentivize local talent to remain in our community upon completion of the training program. AllCare has contributed to the development of RCC's new Health Professions Center that has recently broken ground. Based on our BH health network adequacy reporting, AllCare will collaborate with Rogue Community College (RCC) on development and implementation of behavioral health training programs. AllCare has added medical interpreters in rural locations in the service area through its support of interpreter training. And, AllCare created a local pathway to facilitate an additional 34 newly certified medical interpreters into our service areas and partner agencies. AllCare support continuing education and training for Traditional Health Workers and Peer Certification programs. In addition, AllCare offers training to the community on SDOH-HE, ACES and trauma informed care. We also have paid for internships for Master's level BH clinicians to work in our service area. Lastly, AllCare offers assistance to its BH contractors with the burdensome analytical requirements for BH clinician loan repayment programs.

6. **How will Applicant utilize the data required to be collected and reported about Members with SPMI to improve the quality of services and outcomes for this population? What other data and processes will Applicant collect and utilize for this purpose?** AllCare Health will utilize data for the following:
   - Quality issues and trends;
   - Adequate capacity;
   - Root cause analysis;
   - Population health markers;
   - Prevention and opportunities to reduce health risk scores;
   - Gaps and weaknesses in the full spectrum of community continuum of care;
   - Impact of resources and Health Related Service expenditures to address SDOH-HE;
   - Sub-contractor compliance; and
   - Cost and utilization of BH services.

   Other data to be collected and utilized to improve quality and outcomes:
   - OHA provided data (i.e. OHA Quality Incentive Measures Dashboard);
   - Sub-contractor provider data;
   - Grievance and Appeals;
   - Interrater Reliability Results; and
   - Reports from contracted BH provider on-site audits.

7. **What Outreach and/or collaboration has Applicant conducted with Tribes and/or other Indian Health Care Providers in Applicant's Service Area to establish plans for coordination of care, coordination of access to services (including crisis services), and coordination of patient release?** Portions of AllCare's service area overlaps with the service areas of three tribes: the Cow Creek Band of Umpqua Indians, the Coquille Indian Tribe, and the Confederated tribes of Coos, Lower Umpqua and Siuslaw Indians. AllCare is directly contracted with United Indian Health Services in Curry County. AllCare's BH contractor for Jackson, Josephine, Jackson and Douglas Counties holds an MOU for coordination of care and access to services, warm handoffs, and patient release of information with the Cow Creek Band of Umpqua Indians who have AllCare Members primarily in the Douglas County area. The Coquille Indian Tribe, and the Confederated tribes of Coos, Lower Umpqua and Siuslaw Indians have been offered the options to negotiate formal MOUs with AllCare and/or its BH contractors, and have declined at this time. AllCare continues to look for opportunities to partner with local tribes. However, AllCare's BH contractors do provide a full array of BH services to all Members of these tribes on an individual Member basis. In Klamath County, the Klamath Tribes service area is contiguous to the eastern borders of AllCare's service area, and although the Klamath Tribes do not wish to have a written MOU, AllCare and its BH contractors provide full services, including care coordination, patient release, and crisis services to Klamath Tribe members on an individual Member basis.

E. **Covered Services Components (recommended page limit 36 pages)**

1. **Substance Use Disorder (recommended page limit 2 pages)**

    How will Applicant support efforts to address opioid use disorder and dependency? This includes:

    a. **How will Applicant provide, in a culturally responsive and linguistically appropriate manner, SUD services to Members, including outpatient, intensive outpatient, residential, detoxification and MAT services?** AllCare provides and requires cultural competence training and continuing education for all our employees. We incent our contracted providers and their staff to participate in ongoing training. The training AllCare provides covers topics including: Health Literacy I and II, SDoH-HE, Cultural Agility, Cultural Humility, Barriers to Care, Pronoun Training, and Implicit Bias. AllCare offers payment incentives to our BH partners who reach or exceed a minimum of 70% of their providers and staff who complete approved cultural competence training, or who have an *OHA Qualified* or *Certified* medical interpreter on staff at their location. AllCare has added a component in our audit process to review our BH provider partners' needs and strengths in this arena and are responding to Members in a culturally responsive and linguistically appropriate manner. We believe the full spectrum of SUD need to be a part of any successful treatment plan. It is the nature of the disease, that our members may require differing levels of care at any given

point in time. The BH Team at AllCare work closely with our Members in all settings to ensure successful transitions of care to each Member's highest possible level of health. AllCare offers bi-lingual staff in all of our contracted BH network. AllCare has also brought Medical Interpreter training to our contract partners, including our SUD providers, increasing certified interpreters 5 times the historic rate in our employees and provider network since program inception just a few years ago. AllCare also provides financial support for the Certification of Prevention Specialists in Alcohol, Drug Misuse, and Tobacco. AllCare has a full-time Certified Prevention Specialist on its staff.

b. **How will Applicant provide culturally responsive and linguistically appropriate alcohol, tobacco, and other drug abuse prevention and education services that reduce Substance Use Disorders risk to Members?** AllCare has a wide array of alcohol, tobacco and other drug abuse prevention and education services that reduce SUD risk to Members. AllCare also provides and requires cultural competence training and continuing education to its contractors and staff who provide prevention and education services to our Members. AllCare provides cultural competence training for its employees and all staff are required to attend. Wellness Coordinators like the Tobacco Cessation Coordinator support cessation planning and goal achievement in sensitive and appropriate language. AllCare supports SUD screening and prevention education with BH staff integrated into most of the elementary and high schools in our service area, and these providers and staff are encouraged or required (depending on their employment relationship) to complete cultural competence training. AllCare offers financial incentives to primary care, medical specialists, and BH contracted providers to increase screening, education, and counseling to Members for tobacco cessation, and for drug and alcohol use. These providers are also offered and required to have cultural competence education. AllCare has also worked to add tribal natives to our provider panel and Spanish speaking clinical staff to SUD residential facilities in our service area.

c. **How will Applicant inform Members, in a culturally responsive and linguistically appropriate manner, of SUD services, which will include outpatient, intensive outpatient, residential, detoxification and MAT services?** AllCare employs a 4-pronged strategy of informing Members of SUD services in a culturally and linguistically appropriate manner. They include culturally and linguistically appropriate information on SUD services available through the AllCare website, hard copy printed information, provider network education and training, and community partner education and training. The website and hard copy materials include culturally and linguistically appropriate guidance for Members on SUD services, where they are located, how to access them and how to get help to access them, and alternatives to opioids. Provider and community partner education and training includes cultural competency, and how specific SUD services can be accessed. Education on SUD services available through AllCare and cultural competency training has been offered

and accepted by a diverse set of community partners, including Ready Ride (a Non-Emergency Medical Transport service), So. OR Education Service District, Grants Pass School District, Futures without Violence, Hearts with a Mission, and Josephine County Public Health Dept., and The Women's Center (the largest OB/GYN practice in Josephine County). AllCare's Provider Network Dept. offers recurrent training on how to help Members to access SUD and Care Coordination services, and on cultural competency.

d. **In collaboration with local providers and CMHPs, ensure that adequate workforce, Provider capacity, and recovery support services exist in Applicant's Service Area for individuals and families in need of opioid use disorder treatment and recovery services. This includes: sufficient up to date training of contracted Providers on the PDMP, prescribing guidelines, buprenorphine waiver eligibility, overdose reversal, and accurate data reporting on utilization and capacity.** AllCare has been a collaborator with local providers and CMHPs in Southern Oregon, contributing technical expertise and support to the founding and continued operation of the Oregon Pain Guidance Group (OPG). The OPG is a multidisciplinary group of physicians, pharmacists, insurance providers, emergency room providers, pain medicine specialists, mental health counselors, SUD professionals, public health professionals, and others. The OPG promotes community education, provides an annual pain conference, a website devoted to best practices in pain and addiction management, and the production of the Pain Treatment Guidelines. In the introduction to the Guidelines, the majority of the drafting and revisions of the Guidelines is credited to the Medical Director and Health Officer of Jackson County Health and Human Services and a Medical Director employed by AllCare. AllCare has worked and will continue to work to build a greater capacity and encourage innovation and collaboration to ensure that adequate workforce, provider capacity, and evidenced-based recovery services exist in our service area. AllCare participates in the review of current guidelines, medication best practices, overdose reversal data for our area in the OPG and internally. We have supported a local growth of MAT providers and now are currently working to create a community capacity report. It is important that, as a community, we are constantly building on this foundational education and mentoring of existing and new staff with up to date training in evidence-based care in this area of care. AllCare staff are currently working with local providers of MAT service, LADPC (Local Alcohol and Drug Planning Committee), local CCOs, hospitals and other organizations to create local pathways into MAT services, SUD services including capacity reports, AllCare also provides on-going community education, provider peer supports well as Narcan access and use. AllCare staff regularly participates in community SUD awareness events.

e. **Coordinate with Providers to have as many eligible Providers as possible be DATA Waiver so that they can prescribe MAT drugs**. AllCare has supported and participated in local Physician-lead efforts to encourage and support more physicians

becoming DATA (DEA-X) waivered, often providing pharmacy consultation or additional resources as needed. AllCare funds ECHO educational opportunities and has provided grants for new local providers to add services that support evidence-based treatment of SUD. AllCare also promoted participation in a provider collaborative on Medication Assisted Treatment in primary care settings.

f. **Coordinate care with local Hospitals, Emergency Departments, law enforcement, EMS, DCOs, certified Peers, housing coordinators, and other local partners to facilitate continuum of care (prevention, treatment, recovery) for individuals and families struggling with opioid use disorder in their Community.** AllCare currently coordinates with community partners to facilitate prevention, treatment and recovery from opioid use disorder, including: Drug Court and other parts of the criminal justice system; Emergency Rooms (ex. we facilitate an ASAM assessment and provide motivational interviewing at the hospital and coordinate follow-up treatment options); DHS (ex. Coordination to find options to keep families intact while parents are in treatment for opioid use disorder), and elementary schools and high schools in which we support preventive education, identification and treatment of opioid use disorder. AllCare also supports and coordinates care with Grants Pass Sobering Center. AllCare also funds case management in Rogue Retreat, a provider of transitional housing.

g. **Additional efforts to address opioid use disorder and dependency shall also include**:
   - **Implementation of comprehensive treatment and prevention strategies**
   - **Care coordination and transitions between levels of care, especially from high levels of care such has hospitalization, withdrawal management and residential**
   - **Adherence to Treatment Plans**
   - **Increase rates of identification, initiation and engagement**
   - **Reduction in overdoses and overdose related deaths**

AllCare promotes prevention, identification, engagement, and treatment by incentivizing substance use screening, counseling, and BH treatment by its PCPs BH staff integrated into most elementary and high schools in our area. Our BH contractors routinely received notice of Member transitions from inpatient, withdrawal treatment and residential providers and collaborate with AllCare's BH Care Coordination Team to coordinate for smooth transitions. AllCare's BH Care Coordination Team audits the clinical documentation records of our BH contractors and providers for adequacy in treatment planning and patient adherence. As part of the audit process for adherence, AllCare's pharmacist staff review Member opioid use and monitors for opioid outliers in prescribing. AllCare supports reduction in overdose and deaths through local programs that provide needle exchange and test strips for fentanyl at DHS and public health dept. offices. We partner with several non-profit organizations to provide education on OD reversals, provider education on Narcan use and coverage for our

Members taking prescription drugs or illicit drugs, and community education on risk of OD for patients receiving initial opioid prescriptions. AllCare provides education on potential overdose for Members who are 'opiate naive', and education of prescribers to recognize that any may be vulnerable to over dose. AllCare provided financial support to our local Health Department to teach police officers to administer Narcan for overdose reversals. AllCare also provides financial support to syringe exchange programs in our region. And, AllCare participates in and provides Opioid Peer Navigators for our state's pilot project. AllCare's Performance Improvement Project for 2018 focused on improving opioid safety through the reduction of high morphine dosage through provider and community education. To reduce readmissions to hospitals, AllCare provides outreach from our Opioid Peer Navigators to Members who have been hospitalized due to opioid misuse.

2. **Fewer readmissions to the same or higher level of care (Prioritize Access for Pregnant Women & Children Ages Birth to 5 Years) (recommended page limit 6 pages)**

Applicant will prioritize access for pregnant women and children ages birth through five years to health services, developmental services, Early Intervention, targeted supportive services, and Behavioral Health treatment.

a. **How will Applicant ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting? What will take place if the screening reveals concerns?** AllCare is reviewing potential incentives opportunities that would facilitate periodic social-emotional screening for all children birth through five years are conducted in the primary care setting at the time of any well-child visit. AllCare, in coordination with the early learning hubs, would provide technical assistance to primary care providers in using the Ages and Stages Questionnaire-Social Emotional component (ASQ:SE). If the screening reveals any concerns the provider, as appropriate, utilize internal integrated BH services or make a referral to the appropriate contracted mental health provider and contact AllCare's Care Coordination team to follow up on screening concerns and referral. As required under the CCO 2.0 contract, AllCare will require social-emotional screening for children birth through five years in PCP setting. AllCare will add additional ACE-informed programs that promote resiliency and recovery in regions where they are needed for Member and parent referral when screening reveals concerns.

b. **What screening tool(s) to assess for adverse childhood experiences (ACEs) and trauma will be used? How will Applicant assess for resiliency? How will Applicant evaluate the use of these screenings and their application to developing service and support plans?** AllCare has contributed to universal education of Neurological, Epigenetic, ACES and Resiliency (NEAR) across the spectrum of providers to children and their families including, but not limited to:
   - Schools and other educational settings;
   - Primary care and specialty providers;

- Allied service providers, including APD, Child Welfare, Children and Families and I/DD Services;
- Providers who treat victims of domestic violence and sexual assault;
- All of AllCare's employees;
- The members of AllCare's Community Advisory Council; and
- Child care programs including the YMCA and Boy's and Girl's Clubs.

AllCare participates in the Self-Healing Communities Initiative. As part of the Self-Healing Communities Initiative, Southern Oregon Success and Southern Oregon University are charged with monitoring the results from the statewide student wellness surveys, Oregon Pregnancy Risk Assessment Monitoring System (PRAMS), Behavioral Risk Surveillance System (BRFFS) and other community wellness surveys on population health. AllCare employees and AllCare's contracted providers have been trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care, and AllCare provides regular technical assistance on these topics to providers.

c. **How will Applicant support Providers in screening all (universal screening) pregnant women for Behavioral Health needs, at least once during pregnancy and post-partum?** AllCare Maternal/Child Health Care Coordination provides a Maternal Health Risk Survey for all new members identified as being pregnant by claims data and eligibility files from OHA receive a Maternal Health Risk Survey; as part of this assessment we ask the member about mental health diagnoses as part of their health history. During our Delivery Transition of Care survey, completed once they have delivered, we ask the member about the following: uncontrollable crying with no cause or trigger, those close to you have concerns regarding the severity of your mood swings, have overwhelming fears in regard to caring for your baby that cause you to have difficulties getting through the day or sleeping at night. AllCare provided funding and technical assistance to the Women's Health Center (the largest OB/GYN practice in Josephine County) to develop their protocol for universal, evidence-based screening of all patients for depression, alcohol and substance use, threat of domestic violence, trauma, or homelessness during pregnancy and at post-partum visits. The AllCare Maternal/Child CC Team facilitates warm handoffs to BH and attends BH appointments with the Member at their request. Pregnant Members and post-partum Members receive vouchers which can be redeemed at the Babe Store in exchange for keeping regularly scheduled appointments with their PCP during and after pregnancy. This store offers diapers, blankets, clothing available for redemption. AllCare operates a Babe Store in Grants Pass, Cave Junction, Medford and plans are underway for the new Brookings office location. This program provides opportunities to identify potential post-partum issues by the Member's provider and by AllCare staff who work at the Babe Store.

d. **How will Applicant ensure that clinical staff providing post-partum care is prepared to refer patients to appropriate Behavioral Health resources when indicated and that systems are in place to ensure follow-up for diagnosis and treatment?** AllCare's Maternal/Child care coordination staff will make outreach to

the Member's provider if the member reports symptoms or we feel there is a need for further evaluation. The provider will refer (although a 'referral' is not needed) the member to Options, CCH or any contracted provider. AllCare staff also directly refer Members and provide Warm Handoffs to an Options contacted provider or CCH for support and coordination. AllCare funds embedded staff at the Women's Center to make Warm Handoffs to Options for BH treatment. AllCare has relationships with many of the WIC office personnel who see pregnant and postpartum Members in their offices, and sends BH Traditional Health Workers to the WIC office to accept Warm Handoffs of Members who need to connect with BH providers.

e. **How will evidence based Dyadic Treatment and treatment allowing children to remain living with their primary parent or guardian be defined and made available to families who need these treatments?** AllCare will define Dyadic Treatment as it is defined in Appendix A of the RFA: **"Dyadic Treatment"** means a developmentally appropriate, evidence supported therapeutic intervention which is designed to actively engage one caregiver and one child together during the intervention to reduce symptomology in one or both participants, and to improve the caregiver-child relationship." AllCare's contracted mental health providers, Options in Jackson & Josephine and CCH in Curry, will provide a comprehensive assessment to review if this is a clinically indicated need. The contracted mental health providers have specific programs that address children and families in the child welfare system such as Parent-Child Interaction Therapy Program, and the Family Care Collaborative (FCC), a Department of Human Services (DHS) program in which Options (one of our BH contractors) participates. FCC is designed to reduce the likelihood of children coming into foster care, to increase reunification of the child's family and to shorten the length of stay for children who are in foster care. The Family Care Collaborative provides support and services for the entire family which increases the rate of participation and success. The FCC team consists of a mental health clinician, parent peer support specialists, and a skills trainer. All members of the FCC team act as mentors to both the family and foster families. Family therapy targets specific issues that have been problematic within the family over time. The Peer Recovery Support Specialists are directly involved in teaching the use of "Behavioral Teaching" model to the foster parents and biological parents. They go into both the foster family and biological family's homes and actually model the use of the Behavioral Teaching approach with the children and observe the family interacting, providing specific coaching and training to the parents/guardians. Teaching is provided to the parent/guardian in the home around issues of daily living, understanding their children's strengths and limitations and targeted, developmentally appropriate use of the Behavioral Teaching model. The FCC model is very positive, clear and focused on the possibilities of what "can be" for the families, with a very structured, concrete, predictable and interpersonally supportive set of techniques for how to get there.

f. **How will Applicant ensure that Providers conduct in-home Assessments for adequacy of Family Supports, and offer supportive services (for example, housing**

adequacy, nutrition and food, diaper needs, transportation needs, safety needs and home visiting)? In each region, AllCare's Maternal-Child Health Team works to provide care coordination for expectant members and their children up to age 5. The Team contacts every member who has been identified through claims as being pregnant and does a thorough assessment to establish any health care and support or service needs. All members aged 0-5 identified as needing care coordination are also referred to the Maternal-Child Health Team. This Team does in-home assessments, and provides on-going care coordination through pregnancy and the postpartum period. The goal of the Team is to assess the all-around needs of our members and connect them to the appropriate following community resources: Project Baby Check and Healthy Start ~ Healthy Families of Southern Oregon; Family Nurturing Center both Jackson & Josephine Counties; Women, Infants and Children for all Counties in Service area; Regional Early Learning Hubs; and Head Start programs. All the providers above have components of home visiting in their programs. AllCare's Maternal-Child Health Team provides programs in the home such as lactation consults and baby massage trainings. The Team member will also accompany the mother to counseling sessions and attend counseling if desired by the Member. At each point of contact throughout the healthcare system, there are multiple opportunities to assess additional supports that may be needed to help families thrive and stay healthy.

g. **Describe how Applicant will meet the additional Complex Care Management and evidence-based Behavioral Health intervention needs of children 0-5, and their caregivers, with indications of ACEs and high complexity.** The Parent-Child Interaction Therapy Program is delivered to AllCare Members by Certified PCIT Therapists. PCIT is an evidenced-based treatment model for young children (2-7) and their parents/caregivers. This strength-based intervention is a criteria-based program, which uses live feedback and coaching to teach parents/caregivers specific skills designed to improve relationships and to reduce child negative behaviors by changing the parent/caregiver interaction patterns. PCIT has been found to be effective for young children with behavior problems due to a variety of reasons. AllCare also provides an Intensive Outpatient Services and Supports (IOSS) Program for Children. IOSS services may be delivered at a clinic, facility, home, school, other provider or allied agency location or other setting as identified by the child and family team. AllCare also provides Intensive Care Coordination (ICC) in a family and youth driven, strengths based, culturally and linguistically appropriate care coordination and navigation service to assist children 17 and younger, and their families, as they transition in and out of intensive community and facility service programs. The IOSS includes: an Intensive Care Coordinator or Wraparound Coordinator, Provider/Parent/Guardian participation, a proactive safety and crisis plan, service coordination planning, Family support and respite care, proactive safety and crisis planning that uses professional and natural supports, and behavior support planning. AllCare also provides System of Care & Wraparound Initiative services meeting the fidelity standards described in the OHA

System of Care Wraparound Initiative guidance document and follows guidelines in the Oregon Best Practice Guide (see https://www.pdx.edu/ccf/best-practice-guide).

h. **How will Applicant ensure children referred to the highest levels of care (day treatment, subacute or PRTS) are able to continue Dyadic Treatment with their parents or primary caregivers whenever possible?** AllCare BH Care Coordinators work closely with the child's mental health Intensive Treatment Coordinator and the Child/Family Team to provide health related services (including flex funding) to support treatment. AllCare is contracted to provide an array of Intensive Treatment Services (ITS) for Children, all of which actively coordinate with the PCIT provider, parent/caregiver, and child for continued treatment of the dyad. These coordinating services include: Psychiatric Day Treatment Services (PDTS) Psychiatric Residential Treatment Facilities (PRTF) and Services (PRTS), Children's Sub-Acute Psychiatric Care. Intensive Treatment Services are provided by programs that have received an Intensive Treatment Services (ITS) Certificate of approval from OHA Health Systems Division under OAR Chapter 309, Division 022 or a Child and Adolescent Integrated Psychiatric Residential Facility and Residential Substance Use Disorders Treatment Program License (also called an IPSR or "Integrated license"). ITS providers must meet the standards and conditions of OAR 309-022-0165 (Behavior Supports), OAR 309-022-0170 (Emergency Safety Interventions) and OAR 309-022-0175 (Restraint and Seclusion). ITS programs must all be licensed by the Department of Human Services as a child-caring agency as defined in OAR Chapter 413, Division 215. Families and children referred to the highest levels of care are encouraged and supported to maintain contact with their providers to continue treatment either in person or via telehealth services. AllCare funds ReadyRide (NEMT) transport to counseling, provides day care for children of parents in counseling, and encourages and supports parents to bring their child with them to counseling.

i. **Describe Applicant's annual training plan for Applicant's staff and Providers that addresses ACEs, trauma informed approaches and practices, tools and interventions that promote healing from trauma and the creation/support of resiliency for families.** AllCare in collaboration with another area CCO funded training for our staff and all Jackson and Josephine County providers following the Self-Healing Communities Model provided by Southern Oregon Success. AllCare supported internal staff in becoming certified to do trauma informed and resiliency training and is currently providing that training to providers and partners in Curry County. Southern Oregon Success continues to provide free ongoing trainings and events regarding Neuroscience, Epigenetics, Aces and Resilience (NEAR).

3. **Care Coordination (recommended page limit 12 pages)**

   Applicant is required to ensure a Care Coordinator is identified for individuals with severe and persistent mental illness (SPMI), children with serious emotional disorders (SED), individuals in medication assisted treatment for substance use disorder (SUD),

and Members of a Prioritized Populations. Applicant must develop standards for Care Coordination that reflect principles that are trauma informed, linguistically appropriate and Culturally Responsive. Applicant must ensure Care Coordination is provided for all children in Child Welfare and state custody and for other prioritized populations (e.g., intellectual/developmental disabilities). Applicant must establish outcome measure tools for Care Coordination.

a. **Describe Applicant's screening and stratification processes for Care Coordination, specifically:**

(1) **How will Applicant determine which enrollees receive Care Coordination services?** AllCare uses a variety of screening and stratification approaches to determine which Members will benefit from and receive Care Coordination services. Newly enrolled Members are asked to complete a Health Risk-Assessment Survey (HRS) to identify support needs, chronic conditions, and safety risks. The information is gathered by live phone interviews and the score falls into a stratification system that triggers Care Coordination outreach, either during the initial phone interview or as a follow up call. Part of continuing education for the entire contracted network of providers and community resource partners includes encouragement to refer Members to us for Care Coordination (a simple note or call suffices – no form needs to be completed), and each Member is evaluated by a Care Coordinator and is stratified from the survey or information available. AllCare also applies an identification and stratification to ED claims, and triggers follow up and evaluation by Care Coordinators. Members are encouraged to contact AllCare to request help with medical, behavioral health, oral health, and support needs through Member written materials, the AllCare website, and by Member Services and other AllCare staff. All Member requests are followed up and assessed by Care Coordinators. Additionally, AllCare has a 24/7 Nurse Help Line, and every call is reviewed by an AllCare Care Coordinator to ensure that all Member care coordination needs are identified and met.

(2) **How will Applicant ensure that enrollees who need Care Coordination are able to access these services?** AllCare's philosophy of "no wrong door" applies to Care Coordination services and we employ many strategies to help our Members access the services they need. This includes warm handoffs from community partners, providers, Emergency Department, and public health department staff. We have Community Health Workers, Peer Support Specialists, Home Health and BH staff who will meet Members at home or at their preferred location to facilitate entry to Care Coordination. AllCare BH Care Coordinators reach out to all Members and providers who are caring for our Members Out-of-Area, to help the Member, family/caregivers, and service area providers to experience a seamless transition of care and a quick reintegration of the Member with their home providers and community resources.

(3) How will Applicant identify enrollees who have had not utilization with in the first 6 months of Enrollment, and what strategies will Applicant use to contact and assess these enrollees? If required for the CCO contract effective 1/1/20, we will create a report that identifies those Members who received no services in the first 6 months compared to OHA eligibility files. Using this "Gap List" of Members, we will reach out to the Member and to determine if their PCP assignment meets their needs, and to facilitate scheduling a PCP visit. To further close this gap, we will launch an information campaign targeting our PCPs, to let them know that we will be sending them a "Gap List" of their assigned Members not seen in the first 6 months, with the expectation that the PCP follow up with these Members, either with an appointment reminder of the appointment we were successful in scheduling, or to reach out to the Member to attempt to schedule their first PCP appointment. We will also use this "Gap List" to flag these Members in our Collective Medical software (formerly PreManage), a real-time Emergency Room intake and tracking system, so that we can send a Traditional Health Worker to the ER to meet the Member and attempt to make a plan with them for redirection into primary care, or for a PCP visit as a follow up to the ER encounter.

b. **How does Applicant plan to complete initial screening and Assessment of Intensive Care Coordination (ICC) within the designated timeline? (May submit work flow chart if desirable).** Initial Screening & Assessment of BH populations (SPMI, SED, SUD, MAT) for Intensive Care needs occurs at multiple points, including:

- In AllCare through an Initial Health Risk Survey or enrollment into one of our Care Coordination programs;
- By contracted Mental Health providers through screening, comprehensive psychosocial assessment or other program intake assessments;
- By contracted SUD providers through screening, comprehensive psychosocial assessment, ASAM assessment or other program intake assessments; and
- By allied Agencies such as Hospitals, Child Welfare, APD, I/DD, Criminal Justice, OYA

Once an Intensive Care Coordination need is identified by AllCare's BH Care Coordination Team, they track the timeline from communication with the identifying agency to completion of ICC Assessment using the Essette Care Management documentation system. The Care Management allows us to track and report on due dates for the Assessments and outstanding tasks for completion within the timeline. Alerts are set for completion within the time line with the case is opened and the report alerts department management on due dates.

c. **Please describe Applicant's proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans.**

Development of an Intensive Care Coordination plan is triggered by any of the following:

- AllCare Members engaged in mental health services that have two or more placement disruptions due to emotional and/or behavioral precipitators in less than one year;
- AllCare Members placed in a correctional facility solely for the purpose of stabilizing a mental health condition;
- AllCare Members placed out of the CCO catchment area in Behavior Rehabilitation Services programs under the jurisdiction of child welfare;
- AllCare Members known to be receiving or to have received care in an Emergency Department, or admission to Acute Inpatient Psychiatric Care and/or Sub-Acute Care or upon discharge from such care; and/or
- All Dual Eligible Members are assigned an ICC and receive an individual plan of care coordination plan that is customized to their needs.

ICC services and care plans can be provided in the most appropriate setting to meet the Member's preferences and needs, and Member needs are communicated between agencies involved in the Member's care. AllCare's Mental Health contractors typically will provide the ICC services for SPMI and Children with SED through ACT, Wraparound, EASA, Intensive Community Treatment Services and Choice Model. AllCare's SUD providers typically take the lead for Care Coordination services for Members receiving MAT services, Members using IV Drugs, and those who are pregnant and/or parenting and have SUD. AllCare's BH Care Coordination team stays in regular contact with the care coordinators at our contracted providers, and our contracted or allied agencies to determine how we can support the care plan and identify if/when AllCare should take the lead on ICC. AllCare is continuously monitoring progress and ensuring updating of ICC care plans. Contracted providers and allied agencies are educated on ICC services that AllCare provides to prevent duplication of services and to maximize the value of each agency.

d. **How does Applicant plan to provide cost-effective integrated Care Coordination (including all health and social support systems)?** AllCare's capitated payments to its BH contractors are balanced with regular audits for timeliness, access and outcomes. AllCare's PCP capitation formula includes payment to support outreach to AllCare Care Coordinators for care coordination support, regardless of whether the Member need is based in social service support needs, physical, behavioral, or oral care. The integration of BH staff in physical health locations including primary care, women's health, ED, and health department offices throughout AllCare's service area, making for easy, Warm Handoffs and efficient referrals to Care Coordination before most needs escalate to crises. The integration of primary care into behavioral health locations in Curry, Josephine, and Jackson Counties contributes to more Members engaged in needed Care Coordination and crises averted; thereby avoiding care in higher intensity, and more costly settings. The education of our network of community partners, like

Ready Ride drivers (non-emergency medical transport), homeless shelters, and integration of BH staff in most of the elementary and high schools in our service area has developed into an effective early identification system for Care Coordination needed to avoid crises that result in unnecessary ED use, avoidable hospitalizations and readmissions resulting in lower rates for all three since AllCare's baseline year.

e. **What is Applicant's policy for ensuring Applicant is operating in a way guided by person-centered, Culturally Responsive, and trauma-informed principles?** AllCare requires that all its staff and incents contracted providers to receive ongoing training on culturally sensitive and responsive, linguistically appropriate care. Each year, AllCare offers payment incentives to our contracted and subcontracted providers and BH partners who reach or exceed a minimum of 70% of their providers and staff who complete approved cultural competence training. All of AllCare's Care Coordination Teams are educated in person-centered care planning that is culturally sensitive and trauma-informed. AllCare provides the same training in SDOH-HE to its BH Contractors and their staff as it does to its own employees, and AllCare audits our BH contractors' clinical documentation records to assure that culturally responsive, linguistically appropriate, trauma-informed care is being delivered to our Members. Please see *EXHIBIT 11.3-2017-18 Health Equity Training Schedule.pdf*; *EXHIBIT 11.4-2018-19 Health Equity Training Schedule.pdf*.

f. **Does Applicant plan to delegate Care Coordination outside of Applicant's organization? How does Applicant plan to enforce the Contract requirement if Care Coordination delegation is chosen?** AllCare will delegate a portion of Care Coordination to its BH contractors. AllCare monitors and oversees Care Coordination services throughout our service area; this includes oversight of Care Coordination support that is an integral part of Evidence Based programs such as the Patient Centered Primary Care Homes, WrapAround services, and ACT programs. AllCare will examine the changes from the current CCO contract and for the portions of Care Coordination services that it delegates, it will negotiate inclusion of the CCO 2.0 contract requirements with its BH contractors. AllCare will continue to audit the adequacy, timeliness and quality of the services provided by its BH contractors in order to enforce the CCO contract requirements, and to ensure that high quality, medically appropriate care is provided. At all levels of care, and for care delivered through BH Contractors and any contracted provider, AllCare has plans and processes to monitor and assure compliance with standards of care and contractual requirements woven throughout its Quality Assurance and Compliance programs. Every quality issue is investigated by our Quality Team, led by a Medical Director, with a well-defined process to elevate follow up in AllCare's Compliance Department, and/or Community Advisory Councils.

g. **For Fully Dual Eligibles, describe any specific Care Coordination partnerships with your Affiliated Medicare Advantage plan for Behavioral Health issues.**

AllCare operates its Medicare Advantage BH provider network in partnership with a set of independent BH clinicians. AllCare's Care Coordination oversight of this partnership is the Intensive Care Coordination Program's (ICCP) Care Coordinators who assess each newly enrolled Dual Eligible Member. The BH clinicians in this network tend to specialize in selected diagnoses or treatment modalities and the ICCP Care Coorinators regularly help Dual Eligible Members to assess the BH providers listed by specialty and location who will best fit their needs. The BH clinicians in this network are familiar with the ICC coordinators and they appreciate their support in scheduling, transportation, accompaniment to the appointment.

h. **What is Applicant's strategy for engaging specialized and ICC populations? What is Applicant's plan for addressing engagement barriers with ICC populations?** AllCare executes multiple strategies for engaging specialized and ICC populations. One approach is by increasing BH access points to make it easier for our Members to engage in BH services where they are already receiving other types of services. This allows a transfer of Member trust built in a familiar setting to the BH service provider, thereby allowing ICC needs to be more easily identified and met. A second engagement strategy we use is to support positions like Engagement and Outreach staff at most of our contracted BH settings. These Engagement and Outreach staff will meet with Members at emergency rooms and hospitals, and reach out to Members to reengage them when they miss appointments or stop services. Another example of AllCare's commitment to engage and address barriers for our most vulnerable Members is our Member Listening Sessions with follow up and action planning around our Members' stated barriers/needs. Through AllCare's Member Listening Sessions process, we are able to identify crucial disparity data, and reach out to populations experiencing barriers to hear directly from our Members themselves. This process has led to action planning directly with providers and their staff to work to improve access, engagement, and eliminate barriers for our Members.

i. **Please describe Applicant's process of notifying a Member if they are discharged from Care Coordination/ICC services. Please include additional processes in place for Members who are being discharged due to lack of engagement.** AllCare will notify each member of their discharge from care coordination/ICC services at least 10 days prior to the date of discharge (when feasible) and 30 days prior when discharge is due to lack of engagement or inability to reach the member. Members can be discharged from care coordination/ICC services for the following reasons:
- Factual confirmation of the death of a member;
- Clear written statement from member that they no longer wish to receive services;
- Member has been admitted to an institution where he or she is ineligible for covered services (excluding admission to Oregon State Hospital as members are followed by BH Care Coordination prior to admission, upon admission and periodically throughout admission and discharge as necessary.);
- Member's whereabouts are unknown and AllCare has received returned mail from the USPS with no forwarding address and the Authority and Department have no

other address (AllCare's care coordination team reaches out to current providers per claims, NEMT vendor and OHA/DHS or other allied agencies in order to update member contact information prior to discharge);

- Verification that another state, territory, or commonwealth has accepted the member for Medicaid services;
- Member's health has improved sufficiently to allow for them to self-manage their care or a provider/partner has been identified as a more appropriate care coordination lead and the member has agreed and is successfully engaged with that provider/partner; and
- Lack of engagement due to treatment or care coordination plan misalignment is not grounds for member's discharge from care coordination/ICC services. Care Coordination team will use motivational interviewing to encourage members to identify the barriers or areas of misalignment in order to re-engage member. When Members agree with their individual plan, they become re-invested and once again will work towards the goals. If a Member expresses the misalignment is with one or more staff from the current care coordination team, they will be offered care coordination services with another team.

AllCare Care Coordination letters provided to Members include:
- CC participation confirmation letter (not program specific & acts as a welcome letter)
- Member declined care coordination letter (offers member to follow up anytime for care coordination)
- Unable to reach you letter (attempting contact for care coordination)
- Unable to reach you recently letter (care coordination had started but member stopped all contact)
- Care Coordination Completion Letter (congratulations to member for completing plan, welcome to contact AllCare for reengagement in care coordination in the future)

AllCare requires our BH Contractors to follow policies and procedures set out by AllCare regarding discharge from care coordination/ICC services and AllCare's BH team performs an on-site compliance review, at least annually, to ensure providers are following appropriate process.

j. **Describe Applicant's plans to ensure continuity of care for Members while in different levels of care and/or episodes of care, including those outside of Applicant's Service Area. How will Applicant coordinate with Providers across levels of care?** AllCare's BH Care Coordination Team, ICCP Team, and Care Coordination Team for physical health collaborate with the Care Coordination teams from its BH contractors to provide continuity of care at transition points identified in multiple ways. AllCare receives daily notice of admissions to residential SUD treatment, and to acute medical and long term care facilities via reports and Prior

Authorization requests, and from EDs through Collective Platform (formerly PreManage). Notifications may also be from out of area providers in writing or by phone. Notification triggers entry of the information into the AllCare information systems by AllCare UM staff, and also triggers Care Coordination review. AllCare is alerted to changes in levels and/or episodes of care through its referral information system and from contracted providers and community partners who have been trained to refer our Members for Care Coordination. AllCare Care Coordination Teams meet with the Care Coordination teams from our BH contractors on a regular basis to coordinate on high acuity, high risk Members throughout the episode of care. It is AllCare's policy and practice to coordinate care with out of area facilities and professional care providers delivering MH and SUD services to our Members on as a matter of policy and regular routine. Our out of area process is: (1) notice is received about out of area care, (2) the Member is entered into UM review and enrolled into Care Coordination, (3) discharge planning in initiated, and (4) transitions of care to coordinate all the services the Member needs is pursued until it is confirmed that Member needs are met. An out of area care coordination example is when an AllCare BH Care Coordinator finds an oral provider or PCP to deliver needed care to a Member who is in a residential treatment facility that is out of area.

k. **How will Applicant manage discharge planning, knowing that good discharge planning begins from the moment a Member enters services?** AllCare's BH contractors start care planning for discharge from services with their initial assessment of each Member referred to them. Care Coordination teams from our BH providers collaborate with AllCare's BH, Dual Eligible, and physical health Care Coordination Teams, providing discharge planning for our Members at entry to services such as ICC, ITS, Behavioral Rehabilitative Services, Mental Health Residential Treatment Services, Long Term Psychiatric Care, Choice Model, Psychiatric Security Review Board, Acute Inpatient Psychiatric Care, Mental Health Crises, Intensive Outpatient SUD Treatment, Residential SUD Treatment, Detoxification, and MAT. At each point of care, our BH contractors and AllCare's internal Care Coordination Teams oversee the process to make sure it is seamless and meets the Member's needs.

l. **What steps will Applicant take to ensure Care Coordination involvement for ICC Members while they are in other systems (e.g. Hospital, subacute, criminal justice facility)?** Care Coordination Teams from AllCare and our BH contractors collaborate with other systems (including hospital, subacute, criminal justice facilities) as our ICC Members change level of care as a standard care coordination practice. AllCare has a very robust CC Team and have worked diligently to work collaboratively with these external systems. Our internal Members services division also tracks when our members are place in a system e.g. Justice system and may no longer appear to be covered by our plan, based on length of incarceration, to ensure we know where they are and anticipate their reenrollment pre-emptively preparing. The reason members services is the point of contact is that they are also the point of re-enrollment.

m. **Describe how Applicant will ensure that ICC Care Coordinators will maintain the 15:1 caseload requirement?** It is AllCare's policy that our subcontracted mental health providers maintain and monitor their caseload requirements for the evidence-based fidelity programs including: Wraparound, ACT, Supported Employment and EASA. AllCare tracks numbers in these programs on a regular basis.

n. **Which outcome measure tool for Care Coordination services will Applicant use? What other general ways will Applicant use to measure for Care Coordination?** AllCare is exploring the Care Coordination Measures Atlas from AHRQ and evaluating the domains and measures we may want to include to update our evaluation of Care Coordination services. Internally, we use our Care Management documentation system to measure time between triggering events and care plan development, and track actual achievement of outcomes in care coordination and care plan goals. We track and calculate trends in low acuity (Level 1 & 2) ED visits, admissions, and readmissions as indirect measures of Care Coordination success. Ways that we use to measure Care Coordination for Members receiving BH services include time from referral to Care Coordination and the creation of a care plan, the % of Members who receive 3 or more BH treatment episodes within 90 days of initial assessment, the % of Members ≥ age 6 who receive follow up BH services within 7 days of a mental health hospital discharge, the % of Members ≥ age 6 who receive two qualifying BH services within 30 days of a mental health hospital discharge, the % of follow up BH services within 30 days of a residential alcohol/drug rehab discharge, #/1,000 Members who have a low acuity (Level 1 or 2) ED visits of those receiving services from the BH agency. General ways we measure for Care Coordination effectiveness include: include time from referral to Care Coordination and the creation of a care plan, the number of Members who have had 5 or more ED visits in the previous 6 months, readmissions in the first 30 days after discharge, and percentage of Members who have had a PCP visit in the previous year.

o. **How will Applicant ensure that Member info is available to Primary Care Providers, specialists, BH providers, care managers, and other appropriate parties (family, caregivers) who need the information to ensure the Member is receiving needed services and Care Coordination?** AllCare uses secure email and confidential voice mail services for care coordinators. To communicate with Members, families, care givers, and providers to plan and coordinate services. AllCare promotes the convenient and secure exchange of information among providers and coordinators involved in Member care, and AllCare was a founding contributor to the original Jefferson HIE formerly known as Reliance. This HIE was started in SW Oregon for secure provider exchange of patient information by primary care, specialist, BH providers, and care coordinators, and AllCare continues to actively promote its use. Reliance has expanded statewide through Oregon's HIE program. We identify providers, caregivers, family members, collaborating partners like our BH contractors, and community resources who would be helpful in care planning and coordination as

part of the care coordination initial assessment. As long as the Member is willing for them to participate, we actively seek participation by those identified in the care planning and coordination process.

4. **Severe and Persistent Mental Illness (SPMI) (recommended page limit 6 pages)**

   a. **How will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?** We at AllCare believe that regular outreach and communication with local Choice Model providers, DHS, OHA, and other state funded programs and operating entities can only help our Members to receive the most from their OHP and other program benefits. Part of the reason that our partnerships with our two BH contractors, Options for Southern Oregon and Curry Community Health (CCH) have worked so well to integrate care is that these partners share our philosophy on continual care improvement through communication with all our partners. We are attuned to the special needs of our Members with SPMI and in 2013 and 2014, AllCare provided start-up support to Options for Southern Oregon to develop a PCPCH integrated into Option's BH treatment location in Grants Pass. Options vision for development of their integrated PCPCH was, and is, focused on best practices in delivering care for our mutual patients with a SPMI diagnosis. AllCare also provided technical support to Options during start-up to develop and implement an evidence-based protocol for SPMI Members at risk for metabolic syndrome. This provides the best practices in prevention and care for these SPMI Members at risk. Another illustration of the desire on our part, and on the part of our BH partners, to improve the care of the vulnerable SPMI population is our policy with Options and CCH to routinely coordinate care with staff at state funded programs designed to accommodate Member and care giver needs to allow Members to stay in their home or the least intensive setting that is safe and desired by the Member.

   b. **How will Applicant provide oversight, Care Coordination and transition planning to Members receiving BH services (e.g. Mental Health Rehab Services, Personal Care Services and Habilitation services in licensed and non-licensed settings) to ensure transitions to the most appropriate Community setting once the Member no longer need services at the higher level?** It is AllCare's policy for its BH Care Coordination team to follow and coordinate care for our Members receiving these services and part of this coordination is working with the various entities who oversee and provide these services to move Members to the least intensive, most integrated setting possible as their skills, abilities and needs change.

   c. **How will AllCare ensure Members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing Member's housing needs?** AllCare will identify members with SPMI via internal Health Risk-Assessment Survey (HRS), internal claims reports, and referrals from various sources. AllCare has

internal Care Coordination and BH Care Coordination teams who provide support and ICC for Members with SPMI across the lower levels of care. Members who require a higher level of mental health treatment, such as assertive community treatment, or members who are transitioning back into community-based care from residential or respite services, will be provided with a qualified mental health associate (QMHA) case manager from AllCare Health's contracted mental health provider. Community mental health provider staff at a QMHA level provide case management services including the following:

- Gaining access to and maintaining resources such as Social Security benefits, general assistance, food stamps, vocational rehabilitation, and housing;
- Arrangement of transportation to help them apply for benefits;
- Referral and coordination to help individuals gain access to services and supports identified in the service plan to include but may not be limited to individuals at risk of suicide;
- Care and services coordination and warm handoff processes; and
- Assist with a follow-up visit within seven days of discharge from an acute care psychiatric hospital.

AllCare's internal care coordination and BH care coordination teams are available to assist all our contracted provider's and community partners with additional assistance around housing resources in the community and technical assistance regarding requesting health related service funding to supplement other community housing resources. AllCare also works in collaboration with CMHP and community housing providers to develop, start-up, and support housing projects in our service area to increase the availability of housing options for our Members with SPMI.

d. **How will Applicant assist Members with SPMI to obtain housing, Supported Housing to the extent possible consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?** AllCare will identify SPMI Members with housing needs with our Health Risk-Assessment Survey (HRS), from internal claims systems, and by referrals from providers and a wide variety of other sources. AllCare's Care Coordination teams provide care coordination to meet the housing needs of SPMI Members who require support at lower levels of care. AllCare's internal care coordination and BH care coordination teams collaborate with our contracted provider's and community partners with additional assistance around housing resources and health related service funding to supplement housing resources. SPMI Members who require a higher intensity levels of mental health treatment, such as assertive community treatment, or members who are transitioning back into community-based care from residential or respite services, will be provided with a qualified mental health associate (QMHA) case manager through AllCare's contracts. Community mental health provider staff at a QMHA level provide case management services includes the following:

- Gaining access to and maintaining resources such as Social Security benefits, general assistance, food stamps, vocational rehabilitation, and housing;
- Arrangement of transportation to help them apply for benefits;
- Referral and coordination to help individuals gain access to services and supports identified in the service plan to include but may not be limited to individuals at risk of suicide;
- Care and services coordination and warm handoff processes; and
- Assist with a follow-up visit within seven days of discharge from an acute care psychiatric hospital.

AllCare works in collaboration with CMHP and community housing providers to develop, start-up and support housing projects in our service area to increase the availability of housing options for our Members who need support to succeed in the least restrictive setting possible that is safe and desired by the Member.

AllCare's MH subcontractors Options for Southern Oregon (Options) and Curry Community Health (CCH) have strong Supported Housing programs. Options and CCH supportive housing staff teach and assist clients with SPMI diagnoses in all areas of a person's life such as obtaining and maintaining housing, employment, education, social relationships and good physical, mental and emotional health. In addition to expertise in making successful placements for Members with SPMI diagnoses in Adult Foster Homes (AFH), Community-Based Structured Housing (CBSH) facilities, Options provides supported housing within their communities. Options has a long history of developing and managing safe, affordable housing for people with mental health and/or addiction recovery needs. Options low-density apartment buildings and shared homes are tailored to meet the specific needs of individuals in recovery, and are located throughout our community and accessible by public transit. Options has developed and operates 17 units of Transitional Supported Housing through three apartments designated for those with mental health issues, addictions, and chronic homelessness. AllCare will continue to develop opportunities to improve communication, resources sharing and development within our communities.

e. **How will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred and eligible for ACT services (as required in OARs 309-019-225 through 309-019-255)?** AllCare requires and receives quarterly internal audit reports from both of its BH contractors providing the ACT programs to AllCare Members. These reports summarize the SPMI Member referrals to the contractor's ACT program, whether the individual was assessed as eligible, whether or not those eligible were engaged in the ACT program, and if an individual was not engaged in the program, why not, and what steps are in place to best meet that individual's needs within the scope of their expressed desires and preferences. AllCare performs its own audit of our contractors' ACT programs on a quarterly basis. Actual and expected

utilization are reviewed at that time as well. This serves as an additional avenue for early identification of a need for expanded capacity from our BH contractors.

f. **How will Applicant determine (and report) whether ACT team denials are appropriate and responsible for inappropriate denials? If denial is appropriate for that particular team, but Member is still eligible for ACT, how will Applicant find or create another team to serve Member?** AllCare audits records on all Members who were denied to determine: what follow up plan was created by the MH subcontractors to meet the Member's needs within the scope of their expressed preferences, and whether the denial was appropriate or not. AllCare's agreement with its MH subcontractors includes a stipulation that each contractor will enroll any eligible Member (who was appropriately denied enrollment with an ACT team) with another team model, or the MH subcontractor will create a new team that will be appropriate for that Member. AllCare is currently reviewing appropriate models with our CMHPs based on diagnoses, needs, and best practice guidelines. Our CMHPs have collaborated with us to meet each individual Member's needs, often creating an individualized intensive, team-based plan to encompass the Member's full spectrum of issues and needs. AllCare audits Options and Curry Community Health quarterly for wait listing to assure that they implement expansion of their ACT teams in advance of 10 Members or more on their ACT wait list.

g. **How will Applicant engage all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation as required by the Contract?** AllCare and/or it's MH subcontractors will identify a provider or care coordinator from one of it's Assertive Community Treatment (ACT) teams to meet face to face with any and every Member who declines to participate in the ACT program, to discuss Member needs and benefits of services. The ACT team member will describe ACT services, how to access them, and explain the role of the ACT team. The ACT team member will discuss the Members self-identified needs with the Member and offer ideas on how the supports offered through the ACT can be individualized to meets those needs.

If the Member continues to decline to participate, the ACT team member may explore the Member's articulated needs and the benefits of the ACT program using Motivational Interviewing skills. If the Member continues to decline participation, AllCare and/or the ACT contractor may utilize a Peer Support Specialist, or a care coordinator with an existing relationship with the Member, to discuss ways that the ACT program may meet their self-identified needs, enhance their care, and support independent community living. Ultimately, a Member has a right to choose and the Care Coordinators will work with the Member to develop a plan that best meets Member's needs, highlighting that ACT may continue to be available and the best option. If the Member ultimately continues to decline participation in ACT, we will provide a multi-disciplinary team who will develop an individualized care plan that is

focused on that Member's needs, with services such as supported employment, supported housing, and/or care management and coordination, as appropriate.

h. **How will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include Care Coordination?** AllCare and/or its BH contractors will provide evidence-based intensive services for adults with SPMI diagnoses who continue to decline ACT participation. These services are similar to services for children and youth provided in our Intensive Care Coordination, Wraparound, or Intensive Treatment services and we follow best practices. OHA guidelines and/or Milliman's Care Guidelines as appropriate. We will track Members who decline ACT participation and reach out to them to attempt to engage them in evidence-based programs by monitoring claims, prior authorization requests and unnecessary emergency department visits. We will coordinate these Member's care with their PCP, specialty care, and their points of contact with community resources to provide the services and support they need and will accept.

i. **How will Applicant work with Secure Residential Treatment Facilities (SRTFs) to move a civilly committed Member with SPMI to move to the next level of care in the most integrated and appropriate Community setting?** AllCare and its MH subcontractors will provide intensive care coordination to expeditiously move civilly committed adult Members with SPMI, who no longer need placement in a SRTF, to a community placement in the most integrated setting appropriate for that person. Discharge planning and intensive care coordination will focus on the Member's care needs consistent with the transfer criteria established by an interdisciplinary team and documented in the discharge plan. AllCare and its MH subcontractors will partner with the Choice Model ENCC to actively seek housing for these Members, consistent with their individual treatment goals, their clinical needs, and the Member's informed choice. We will attempt to meet the Member's geographic preferences and housing preferences to the degree that they can be reasonably accommodated in light of cost and availability. We will connect or reconnect them with providers in their area, and work with the Member and providers to seamlessly transition the Member into the community and appropriate level of care.

j. **How will Applicant work with housing providers and housing authorities to assure sufficient supportive and Supported Housing and housing support services are available to Members with SPMI?** In response to the original legislation to 'improve the health of the community', AllCare hired dedicated staff to be liaisons between oral health (2013), education K-12 (2013), NEMT (2014), and housing (2016). Integrating health with entities not directly related to physical health care was a component of their job duties; this resulted in those key staff being the direct contact for the primary areas of focus as well as other Social Determinants of Health (SDoH). The goal is to support non-medical activities or projects in the communities served that

directly impact an individual's current health status or long-term health outcomes. AllCare's Board (utilizing the CHIP and CHA) adopted three major Board goals for the CCO Initiatives: Community Engagement, Housing and Education (K-12). One of the interventions in supporting the Board goals was to establish a team (AllCare Community Health Improvement Team) to develop a process to review requests for grants, donations and sponsorships from external stakeholders. The manager of this team works directly with external stakeholders and the consultants in the formulation of unique metrics that support the Triple Aim and support the sustainability of the varied programs. In 2016, OnTrack, an SUD treatment agency based in Medford, considered buying a 15-unit apartment complex and turning the building into transitional housing for the organization's clients and their families. AllCare CCO provided the necessary funding to make sure that they reached their goal and made their dream a reality. AllCare contributes to a diverse array of Member-supportive options such as Rogue Retreat and Hope Village, second-chance housing programs in Josephine County that provide strong case management support. In 2018, AllCare allocated grants for developing housing for the homeless in Curry County. AllCare is also a consistent contributor to CCH and Options' initiatives to provide supported housing in the community to provide safe, affordable housing for people with mental health and/or SUD recovery needs.

k. **Provide details on how Applicant will ensure appropriate coverage of services for SPMI Members in acute psychiatric care, and ER, and peer-directed services, in alignment with the Contract.** AllCare's Care Coordination Teams currently coordinate care for our adult Members with SPMI diagnoses with our BH contractors and other community providers like home health, Ready Ride (NEMT). We work with care coordination teams from state facilities, programs and agencies along with our various contractors to prepare for these vulnerable Members to be placed in the most integrated setting appropriate, with intensive care coordination to support achievement of each Member's treatment goals, and to arrange to meet their clinical needs, while respecting their preferences. Before we become financially responsible for the mental health residential benefit after Contract Year 2021, AllCare will establish a policy and procedure for the development and implementation of a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period. The management plan will address: Members discharged from Acute Care Psychiatric Hospitals to ensure Members are provided a Warm Handoff to a Case Manager (QMHA), Certified Peer, and/or other community providers prior to discharge, and that all such Warm Handoffs are documented; Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870; adult Members receive a follow-up visit with a community Behavioral Health provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital, or 3 days if Member is involved in

Intensive Care Coordination services; reduction of readmissions for adult Members with SPMI to Acute Care Psychiatric Hospitals; coordination with system community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated setting, consistent with the individual's treatment goals, clinical needs and the individual's informed choice; and working with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and shall work with Acute Care Psychiatric Hospitals in the development of each individual's housing assessment. The housing assessment will be documented in a plan for integrated housing that is part of the individual's discharge plan, and will be based on the individual's treatment goals, clinical needs, and the individual's informed choice. Contractor shall notify, or require the Acute Care Psychiatric Hospital to notify, the community provider to facilitate the implementation of the plan for housing. If required as stated in Exhibit M, Section 3.c. of the Sample Contract entitled Emergency Room Utilization, AllCare will establish a policy and procedure for the development and implementation of a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Emergency Department in a six-month period. The management plan will address the following key areas: (a) Reduce admissions to emergency departments. (b) Reduce readmissions to ED. (c) Reduce the length of time Members spend in emergency departments. (d) Ensure Members with SPMI have appropriate connection to community-based services after leaving an ED and will have a follow-up visit from Intensive Care Coordinator or other relevant provider within 3 (three) days. AllCare will work with hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED. Contractor shall develop remediation plans with EDs with significant numbers of ED stays longer than 23 hours. AllCare will also work with hospitals on strategies to reduce ED utilization by Members with Behavioral Health disorders. AllCare is and has been a leader in developing education and employment for Peer Delivered Services (PDS). We employ Peer Wellness Specialists, Community Health Workers, and Personal Health Navigators who serve and support our Members in coordination with our BH contractors, providers, and community resource partners. AllCare will encourage utilization of Peer Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs. We will provide our Members information that will must include a description of Peer Delivered Services and how to access it, a description of the types of PDS providers, an explanation of the role of the PDS provider, and ways that PDS can enhance a Member's care. We will provide access to Peer-Delivered Services for each Member seeking these services consistent with OAR 309-019-0105.

5. Emergency Department (recommended page limit 2 pages)

a. **How will AllCare establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has 2 or more readmissions to an ED in a six-month period? The management plan must show how AllCare plans to: reduce admissions to EDs; reduce readmissions to EDs; reduce the length of time Members spend in EDs; and ensure adults with SPMI have connection to Community-based services after leaving the ED; and Members with SPMI will have a follow-up visit within three days.** AllCare currently pursues a redirection strategy for inappropriate ED utilization, and has had some success in reducing inappropriate ED visits. AllCare tracks ED utilization via claims reporting and Collective Medical's web based program (formerly PreManage). This program provides AllCare with real-time notices when an AllCare Member presents at contracted hospital ED. AllCare also has an established workflow with its BH contractors who reach out to AllCare Members while they are still at the ED if possible. If our BH contractors cannot connect with the Member at the ED, they follow up with the Member afterwards. AllCare care coordinators work with the BH contractors to follow AllCare Members with BH diagnoses and employ established pathways to reduce visits and readmissions to EDs. AllCare's current protocol to reduce ED visits and readmissions is triggered by Members who have 5 or more ED visits in a three-month period. Under this protocol, care coordinators reach out to these Members and co-develop plans with their PCP or our BH contractor to divert the Member to more regularly scheduled care and away from the use of emergency services. Care plan options may include a new, specific goal for ongoing care, the implementation of an ED care guideline in the Collective Medical (formerly PreManage) system to specifically inform Emergency Department staff of the plan, and/or an Interdisciplinary Team meeting to discuss how best to assist the member in utilizing the most appropriate level of care for their BH and physical health needs. If required as stated in Exhibit M, Section 3.c. of the Sample Contract entitled Emergency Room Utilization, AllCare will establish a policy and procedure for the development and implementation of a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Emergency Department in a six-month period. The management plan will address the following key areas: (a) reduce admissions to emergency departments, (b) reduce readmissions to emergency departments, (c) reduce the length of time Members spend in emergency departments, and (d) ensure Members with SPMI have appropriate connection to community-based services after leaving an emergency department and will have a follow-up visit from Intensive Care Coordinator or other relevant provider within 3 (three) days. AllCare will work with hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons, and length of time in the ED. We will develop remediation plans with EDs with significant numbers of ED stays longer than 23 hours. We will also work with hospitals on strategies to reduce ED utilization by Members with Behavioral Health disorders. To pursue these requirements, AllCare's Behavioral Health Director will confer with

AllCare's Vice President of Population Health Management to create a policy and procedure for the development of the management plan for contacting each Member with 2 or more ED readmissions in 6 months. The policy will detail the roles or position titles needed for representation from AllCare and its BH contractors necessary to develop a management plan to achieve the goals listed above, and a minimum meeting frequency for regular meetings. From this policy and procedure, a Management Plan Workgroup will be established. The policy and procedure will also determine oversight within AllCare for the Management Plan Workgroup.

6. **Oregon State Hospital (recommended page limit 1 page)**

    a. **How will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI?** Because we monitor acute admissions and stay in regular contact with our MH subcontractors and Choice Model Coordinators, we are aware when a member transitions to OSH and start immediately participating in the Interdisciplinary Treatment Team Meetings (IDTs). AllCare works with our contracted CMHPs, the three Choice Model Coordinators in our region and the Oregon State Hospital social workers when an AllCare member is admitted to the Oregon State Hospital (OSH). Our BH Care Coordination (BHCC) team monitors all acute psychiatric hospitalizations along with Options for Southern Oregon (Options) and Curry Community Health (CCH) from admission to discharge. This allows us to assist with convening all the treatment and system partners involved in the members care to discuss alternatives to OSH in order to try to transition the Member to a lesser restrictive level of care as soon as possible. On a broader level, AllCare convenes and co-chairs the Southern Oregon Regional Acute Care Council (SORACC). OSH Junction City's Administrator and Social Worker Supervisor participate in SORACC along with our regional CCOs, hospitals, Community Mental Health Programs (CMHPs), Choice Contractors, Veterans Affairs, OHA, Intellectual/Developmental Disabilities (I/DD) and other behavioral health treatment providers. We meet on a quarterly basis to improve processes, discuss barriers, share data, share successes and build effective communication to better coordinate with one another.

    b. **How will Applicant coordinate care for Members receiving Behavioral Health treatment while admitted to the State Hospital during discharge planning for the return to Applicant's Service Area when the Member has been deemed ready to transition?** We coordinate care for these Members with our MH subcontractors (also the CMHP) for the Member's home County as the primary point of contact with OSH. We collaborate with our MH subcontractors /CMHP and Choice Model Coordinators to continuously monitor our Members in OSH and supplement the MH subcontractor's involvement in discharge planning through the OSH Interdisciplinary Team conferences to facilitate continuity of care. AllCare ensures that the CMHPs, Choice Model Coordinators, legal guardians, other supports and system partners are all

effectively communicating and collaborating to aide in the member's successful transition of care from OSH. If the Member's natural supports, CMHP and/or Choice representative cannot provide all the necessary resources for a timely discharge, AllCare's BH Care Coordination Team offers Health Related Services to help address the necessary resources to ensure a successful and expeditious discharge and reintegration into the Member's home county. If required as stated in Exhibit M, Section 3.b. of the Sample Contract entitled Oregon State Hospital, AllCare will continue, in accordance with OAR 309-091-0000 through 0050: (a) Coordinate with applicable subcontractors as needed regarding Oregon State Hospital discharges for all adult Members with SPMI; (b) Coordinate care for members receiving behavioral health treatment while admitted to the State hospital during discharge planning for the return to Home CCO or to the receiving CCO if the Member will be discharging into a different CCO when the Member has been deemed ready to transition; (c) Arrange for both physical and behavioral health care services coordination; (d) Provide case management, care coordination and discharge planning for timely follow up to ensure continuity of care; (e) Coordinate with OHA regarding members who are presumptively or will be retroactively enrolled upon discharge; (f) Arrange for all services to be provided post-discharge in a timely manner; and (g) Provide access to evidence-based intensive services for adult Members with SPMI discharged from Oregon State Hospital who refuse ACT services. AllCare will not facilitate discharges from OSH to a secure residential treatment facility unless clinically necessary. AllCare will comply with the directive that no one shall be discharged to a secure residential treatment facility without the express approval of the Director of OHA or his/her designee.

7. **Supported Employment Services (recommended page limit 1 page)**

   a. **How will Applicant ensure access to Supported Employment Services for all eligible adult members in accordance with OAR 309-019-0275 through 309-019-0295?** AllCare's contracted Supported Employment (SE) program providers are Options for Southern Oregon in Jackson and Josephine County and Curry Community Health in Curry County. Each agency has a Supported Employment Specialist who coordinates AllCare Member referrals and manages the Supported Employment program as follows: offer SE service and supports to any member who has a serious mental illness and expresses the desire to work; cooperates with the OHA Health Systems Division approved reviewer to meet and exceed the expectation of the Supported Employment Annual Fidelity Review; and submits quarterly reports using Division approved forms and procedures. AllCare's Behavioral Health Team provides oversight and monitoring of the Supported Employment programs by the following: monitoring of each programs annual fidelity review performed by the Divisions approved reviewer along with our own On-site compliance reviews which includes review of the Supported Employment program and Oregon Administrative Rules regarding SE; in the event a provider does not meet fidelity standards or an actionable

finding is identified through AllCare' s Behavioral Health Team on-site compliance review, AllCare will work with the contracted provider toward the goal of meeting and exceeding fidelity requirements; monitoring of all program denials to ensure they are based on established criteria and are recorded and compiled in a manner that allows denials to be accurately reported out; following the Notice of Adverse Benefit Determination process for all appeals of SE service denials; providing technical assistance from AllCare's Care Coordination and BH Care Coordination regarding Health Related Services (flex funds) and Non-emergent Medical Transportation (NEMT) to overcome individual member barriers.

8. **Children's System of Care (recommended page limit 2 pages)**

Applicant will fully implement System of Care (SOC) for the children's system. Child-serving systems and agencies collaborating in the SOC are working together for the benefit of children and families.

a. **What Community resources will Applicant be using or collaborating with to support a fully implemented System of Care?** AllCare collaborates with numerous system partners and community agencies to support our three regional Systems of Care. Our Rogue Valley SOC groups have aligned with a regional achievement collaborative called Southern Oregon Success (SORS) where system/agency participants represent a full continuum of infant, youth and adolescent services from cradle to career. The role of the SOC structure in that collaboration is to focus on our most vulnerable youth/families who are multi system involved. Our Rogue Valley SOCWI is also aligned with the Cross Systems Collaborative work that has been done primarily in Jackson County. AllCare also works very closely with our subcontracted Community Mental Health Programs across our region who deliver Wraparound services and support a large portion of the SOC work. The CMHPs hold the SOCWI history, skills, knowledge base and technical assistance. AllCare has engaged with OHA, PSU SOCWI and the other CCOs in our region over the past year. Our goal has been to bolster the work that the CMHPs have been doing for several years by providing additional support, resources and structure to achieve meaningful engagement and sustainable improvements in our child serving systems. Additionally, there is consistent participation and collaboration from Child Welfare, Juvenile Justice, Intellectual/Developmental Disabilities, School Districts/Special Education, Early Learning and Primary Care throughout our region. We require formal contracts be in place with each identified systems partner that include expectations for participation, accountability and agreed dedication of resources (staff time, ancillary and financial).

b. **Please provide detail on how AllCare will utilize the practice level work group, advisory council, and executive council**. The Practice Level Workgroups discuss and review Wraparound practice barriers and find solutions whenever possible. They also work on practice barriers that exist between system partners that impact our Wrap youth and their families to improve processes and communication amongst child serving agencies. Any unresolved barriers get reported to the SOC Advisory Committee for review. The Practice Level Group has representation at the Advisory Level so they can continually

communicate barriers and solutions to/from those two groups. Our Practice Level Workgroups consist of representatives from all our regional CCOs, our contracted Mental Health providers, Juvenile Justice, Child Welfare, I/DD, School District staff, Youth Peer Support specialists, Family partners, FQHC/SBHC Mental Health clinicians and Pediatricians.

The Advisory Committees review and address Wraparound and other practice barriers that are not resolved by the Practice Level workgroup. They report barriers, recommendations and solutions to the Executive Committee. They also advise on policy development and enactment of policies and procedures adopted by SOC. They review Wrap referral data and trends as well as fidelity reports and outcome data. This level of the SOC really provides the structure and oversight to the process as a whole to ensure all levels are following the strategic plan. The Advisory Committees consist of representatives from all our regional CCOs, our contracted Mental Health providers, other Children/Youth Mental Health providers, NAMI, Juvenile Justice, Child Welfare, CASA, I/DD, I/DD Brokerages, School District staff, PTA rep, Youth Peer Support specialists, Family partners, FQHC/SBHC Mental Health clinicians and Pediatricians. Barriers or new policy or procedures that cannot be resolved or approved at the Practice Level or Advisory Level go to the Executive Level. The Advisory committee has representation on the Executive Council for communication of recommendations, barriers and resolutions amongst all levels.

The Executive Council develops and approves policies/procedures, shared decision-making regarding funding and resource allocation and development. This committee also reviews outcomes, data and trends in info generated at Wrap Review through Advisory levels. Discussions and problems solving around unmet needs in the community to support the expansion of the service array also happen at this level. The Executive Council consists of representatives of the CCOs, its main contracted Mental Health providers. Child Welfare, Juvenile Justice and I/DD. Other local Executives from SORS are also a part of this committee. All required data and reporting will be submitted to the State System of Care Steering Committee.

c. **How does Applicant track submitted, resolved, and unresolved barriers to a SOC?**
   Each level will generate and maintain a spreadsheet with the info/data they are responsible for collecting. All reports (that do not contain PHI) will be directed to the Executive Council where CCO reps will coordinate report to OHA/State Steering committee and keep for our records. Individual level tracking will be sent securely to AllCare by the Wrap review committee chair quarterly. AllCare will be participating at each level to address any barriers for data gathering/reporting to ensure info is collected according to OHA's specification in the CCO contract.

d. **What strategies will Applicant employ to ensure that the above governance groups are comprised of youth, families, DHS (Child Welfare, I/DD), special education, juvenile justice, Oregon Youth Authority, Behavioral Health, and youth and Family voice representation at a level of at least 51 percent?** Youth and Family involvement has worked hard to get and stay at 51% or greater over the years our SOCWI have been in

place. Our region has consistent participation from our Wraparound Youth & Family Partners and multiple peers who are staff at local Youth Serving agencies but lacks non-paid youth and family peers throughout our SOC. Our SOC Advisory Councils have made targeted outreach efforts to our local School Districts and Parent Teacher Associations to elicit feedback about child/youth serving systems in our region. The Advisory group also challenged each agency to recruit a peer/family from their system to engage in the person's desired SOC level. Recent discussions about infusing SOC information and marketing materials at all community events that AllCare and our Contracted Mental Health agencies are attending to educate, promote and recruit interested youth/families that have the desire to make positive changes in our intensive services systems so that others avoid needing those services or are at least able to more easily access/participate/complete those services. AllCare has a deep-rooted culture of putting our Member's needs first and valuing their voices. We are committed to ensuring majority representation of youth and family voice at all levels of our SOC structures and will make investments in staff time, incentives or ongoing support in order to achieve this goal.

9. **Wraparound Services (recommended page limit 4 pages)**

   Applicant is required to ensure Wraparound Services are available to all children and young adults who meet criteria.

   a. **Provide details on how Applicant plans to ensure administration of the Wraparound Fidelity Index Short Form (WFI-EZ)?** AllCare's MH subcontractors (Options for Southern Oregon and Curry Community Health) perform the WFI-EZ by contractual arrangement with AllCare. AllCare audits a random sampling of the content of individual phone or face-to-face interviews. AllCare's contracted Wraparound providers use WrapTrack to easily perform the WFI-EZ and other Wraparound Fidelity Assessment System tools. AllCare reviews their policies and procedures for collecting Wraparound and Fidelity data annually. Because AllCare participates at each level of Wrap and SOC, we will be able to identify when there are barriers to administering WFI-EZ and will work with our contracted MH agency or enlist the assistance of our SOC to resolve.

   b. **How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?** AllCare's subcontracted MH agencies have demonstrated their ability to track and communicate Wraparound data as they are currently reporting to AllCare and OHA the E-Cans data. WFI-EZ scores and other required data will be collected by the MH agency using their current tracking process. AllCare will be present at Wrap Review and at other levels of SOC to ensure the data is communicated to each level. AllCare will work with our contracted MH agency or enlist the assistance of our SOC to resolve any barriers in data communications.

   c. **How does Applicant plan to receive a minimum of 35 percent response rate from youth?** AllCare is confident that having policies and procedures in place around the WFI-EZ will assist in obtaining at least a 35% response rate from youth. If there are continued

barriers to achieving this then solutions like providing a tablet for youth to take their survey or provide incentives might be considered. AllCare will work with our subcontracted MH agency or enlist the assistance of our SOC to discuss possible solutions for obtaining a higher youth survey response.

d. How will Applicant's Wraparound policy address:

(1) How Wraparound services are implemented and monitored by Providers? AllCare's policy will include the services and supports available and how to gain access and approval when needed. It will outline required elements of Wraparound such as eligible/target populations, numbers served, expectation of fidelity, inclusion of Wrap Principles and SOC Core Values and include qualified family/peer support as appropriate. It will also address requirement for Wraparound Fidelity Assessment Tools that include ongoing Team and Process evaluation and monitoring. AllCare will review the providers Wrap policies and procedures annually and will participate in Wrap Review and SOC to identify Wrap implementation issues.

(2) How Applicant will ensure Wraparound services are provided to Members in need, through Applicant's Providers? As our local SOCs are building and growing, so is the community's knowledge of Wraparound Services and Supports. Our core partner agencies participate in Wrap Review or are educated about the Wrap referral process to encourage all Members identified as being in need are brought to the review committee. AllCare has made significant efforts to educate schools and agencies not regularly participating in a SOC level on Wraparound and have committed to streamline referrals in Jackson County to one review committee when there are 2 CCOs and 3 different provider agencies. This single access point for referring helps to reduce barriers for agencies that have Members in need.

e. Describe Applicant's plan for serving all youth in Wraparound services so that no youth is placed on a waitlist. Describe Applicant's strategy to ensure there is no waitlist for youth who meet criteria. Ongoing community education and effective Wrap Review committees help to ensure appropriate referrals to Wrap and that there are not Members who do not qualify for Wraparound being approved for the services. Our Review Committees have strong cross system participation so a referral that does not meet Wrap criteria gets a comprehensive list of relevant resources that might help the Member. Those resources and contact info for involved agencies get communicated back to the referral source. The waitlist is also monitored at every Wrap Review meeting. AllCare will work with our subcontracted MH agencies if we see a waitlist to find additional resources or add a second Wrap team. AllCare would also enlist the assistance of our SOC to discuss possible strategies to address the need for Wraparound in our community.

As required in the language of the Sample Contract in number (7) of Exhibit M, Section 3. Entitled Care Coordination and Integration, subsection b. entitled Wraparound Services, AllCare will maintain sufficient funding and resources to implement Wraparound services

for all eligible youth and place no youth on a wait list. We will monitor the number of Members on wait list for Wraparound services and add a Wraparound team based on need.

f. **Describe Applicant's strategy to ensure that it has the ability to implement Wraparound services to fidelity. This includes ensuring access to Family and youth Peer support and that designated roles are held by separate professional as indicated (e.g. Wraparound coaches and Wraparound supervisors are filled by two difference individuals).** AllCare works very closely with our subcontracted MH providers and their Wrap teams. Our participation at all levels helps us to be proactive in working with our providers and partners to address areas of need. This includes Fidelity measures, Family/Peer support participation and that roles are clearly defined and maintained to the Fidelity standards.

- *EXHIBIT 10.2-Traditional Health Worker Integration Plan*;
- *EXHIBIT 10.3-2013-2019 Curry CHA*;
- *EXHIBIT 10.4-Josephine Jackson Curry CHIP 2014*;
- *EXHIBIT 10.5-Collaborative CHA Josephine-Jackson 2018*; and
- *EXHIBIT 10.6-Collaborative CHA Coos-Curry 2018*

B. Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership.

CCOs will be expected to invest in services and initiatives to address the Social Determinants of Health and Health Equity in line with Community priorities, through a transparent decision-making process that involves the CCO's CAC, and involving meaningful partnership with SDOH-HE Partners. For the first two years of SDOH-HE spending, OHA has designated a statewide priority for spending on Housing Related Services and Supports, including supported housing. OHA reserves the right to continue and/or establish a new statewide priority during the subsequent years of the Contract.

Beginning CY 2020, CCOs will be required to spend a portion of end-of-year surplus, derived from annual net income or excess reserves, on Health Disparities and the social determinants of health. This statutory requirement – ORS 414.625(1)(b)(C) – will be operationalized through Oregon Administrative Rule, as described in the rule concepts accompanying this RFA.

Further, OHA intends to establish a two-year incentive arrangement – the SDOH-HE Capacity-Building Bonus Fund ("SDOH-HE Bonus Fund") – to offer bonus payments above and beyond the capitation rate to CCOs that meet SDOH-HE-related performance milestones. Performance will be evaluated, and payments awarded to qualifying Contractors beginning CY 2021. The SDOH-HE Bonus Fund will be contingent on availability of funds under the Medicaid growth cap and any required CMS approval. CCOs will receive monetary bonus payments from the SDOH-HE Bonus Fund based on measured performance improvement according to key performance milestones throughout the calendar year. Total SDOH-HE Bonus Fund payments will be subject to a maximum percentage of the CCO's annual capitation rate. CCOs will be required to provide OHA with narrative and financial reporting of SDOH-HE Bonus Fund expenditures, including any funds distributed to SDOH-HE partners, in the manner and form required by the agency.

OHA intends to develop the program structure, including performance milestones, Payment distribution methodology, and reporting requirements, between January 2019 and November 2020, with a targeted implementation during CY 2021. OHA additionally intends to establish a public advisory group, the SDOH-HE Measurement Workgroup, to recommend SDOH-HE related performance milestones, and outcome measures as relevant to OHA, and the Health Plan Quality Metrics Committee and Metrics and Scoring Committee.

Metrics may include a combination of process and outcome metrics, where process metrics are designed to reward CCOs for successfully taking key steps to address SDOH-HE (for example, form necessary partnerships, build program infrastructure) and outcome metrics are designed to reward CCOs for performance in addressing SDOH-HE. Further, CCOs will be required to align spending of SDOH-HE bonus funds received with the CCO's SDOH-HE priorities, in order to continue growing and increasing impact in this critical area.

In the fall of 2020, OHA intends to issue to CCOs:

- **The list of performance milestones, benchmarks, and specifications for CY2021**
- **Full program documentation, including SDOH-HE Bonus Fund structure, methodology and disbursement timeline for the subsequent year, published on the OHA website.**
- **The estimated maximum Payment each CCO could qualify to receive in 2021 if it meets all performance milestones under the program.**
- **The estimated percentage of 2021 capitation rates CCOs could qualify to receive in 2022 under the SDOH-HE Bonus Fund (i.e. estimated percentage of 2022 Payments).**

The SDOH-HE Bonus Fund is intended to be part of a coordinated strategy to incentivize and support increased spending on SDOH-HE over the course of the five-year contract. Additional elements of this strategy include:

- **Performance-based reward: implement a variable profit margin to award CCOs according to efficiency and quality of care (evaluation beginning in 2020, incorporated into rates in 2022).**
- **Risk adjustment for social factors: risk adjust capitation rate based on social factors at the population and/or Member level (evaluation beginning in 2020, incorporated into rates in 2022). OHA intends to explore incentivizing collection of Member-level data through the SDOH-HE Bonus Fund starting in CY2020 to inform risk adjustment beginning in 2022.**
- **SDOH-HE Quality Pool metrics: Recommend SDOH-HE quality metrics to the Health Plan Quality Metrics and Metrics and Scoring Committees via the Health Equity Measurement and SDOH-HE Measurement Workgroups.**

1. **Informational Questions**

   a. **Does Applicant currently hold any agreements or MOUs with entities that meet the definition of SDOH-HE partners, including housing partners? If yes, please describe the agreement.** AllCare, through each of its three Community Advisory Councils (CACs), maintains MOUs with local partners whose missions impact the social determinants of health, in the areas of housing, nutrition, transportation, utilities, early childhood development, and the built environment. In addition, AllCare began its transition to a legal "Benefit Company" in 2016 and in 2017 became the only CCO to obtain Certified B Corp™ status in Oregon.

Certification was obtained through the nonprofit, B Lab. AllCare has invested more than $9.0 million to address SDoH in southwest Oregon since 2016 and has funded more than 175 SDoH projects across our three county service area in partnership with local community based programs, services, and agencies. Examples of our MOUs include the following partners:

Rogue Retreat: AllCare has worked with Rogue Retreat since 2015 to support housing for vulnerable community members in Jackson County. In July 2017, AllCare shifted to a Per-Member-Per Month contract that has helped to expand capacity and stabilize annual funding for this critical program for the homeless.

Oasis Shelter Home: AllCare supports the Oasis Shelter Home through community investment in outreach services as well as community engagement activities that help create stable housing through the Curry Housing Fund. Investments support staffing, community education, and provider integration.

Rebuilding Together Rogue Valley: Through Care Coordination, the AllCare staff and CACs, AllCare works with RTRV to conduct referral-based home assessments and repairs to help seniors and disabled adults age safely in place, prevent falls and slips, and prevent re-hospitalization or escalation.

Rogue Valley Council of Governments: AllCare contracts to referral services and has an embedded RVCOG staff member working in our building with our Care Coordination team to support this work. Additionally, we have a service contract to provide post-hospitalization home meal delivery to eligible members.

Our investments in the above programs (and many more) over the last four years have nurtured strong community partnerships and established a deep understanding of the communities we serve and the breadth and depth of the root causes of poor health. We draw upon this experience to develop our responses described within Attachment 10 as well as to strengthen our commitment to invest in programs and services over the course of the next CCO contract cycle.

b. **Does Applicant currently have performance milestones and/or metrics in place related to SDOH-HE? These milestones/metrics may be at the plan level or Provider level. If yes, please describe.** Yes; AllCare established SDoH-HE baseline measurements for target populations, including but not limited to Health Risk-Assessment Survey (HRS) with SDoH-HE component, access to care, referral completion, and individualized care plans related to SDoH-HE. For integrate programs such as Non-Emergent Medical Transportation, we monitor access, wait times, complaints, and member/provider satisfaction.

With oversight from the Board, each of our three CACs has the responsibility to set funding priorities based on the specific needs of their respective county, which are quite diverse given variation in urban/rural splits, different demographic configuration of the population served, and variation in the level of local resources to meet SDoH needs and health equity needs. As such, each CAC and our internal CHIP Team have a different criteria and performance milestones and/or metrics to guide investment decisions and oversight responsibilities.

All three CACs set their funding priorities based on the collaborative CHAs/CHIPs and the following directives for projects that: Leverage other

community funding and projects; Address health disparities and health equity; Build program infrastructure; positively affect AllCare members; Align with CCO priorities related to Quality Metrics, Transformation Plan Measures, Performance Improvement Measures, and Care Coordination; and support the Triple Aim, meets core planning principles: evidence-based, balance strategies across all age groups; support the needs identified in the Community Health Assessment (CHA); create positive, measurable changes in the health of individuals and/or communities; and strategies that can be built upon over time.

c. **Does Applicant have a current policy in place defining the role of the CAC in tracking, reviewing and determining how SDOH-HE spending occurs? If yes, please attach current policy. If no, please describe how Applicant intends to define the role of the CAC in directing, tracking, and reviewing SDOH-HE spending.** Yes; It is AllCare's policy that community programs submit an application request for funds to support programs that address the SDoH-HE initiatives. Programs that receive approval for funding by the CACs must submit regular progress reports using our standardized form throughout duration of the project. Please see *EXHIBIT 10.1b-CAC temporary funding procedure*; *EXHIBIT 10.10-AllCare CAC Funding Application 2019* and *EXHIBIT 10.11-AllCare CHIP Funding Application 2019*. Staff summarize the information and present the results to each of the CAC's for their approval of funding requests as well as their oversight of the implementation process for each project.

d. **Please describe how Applicant intends to award funding for SDOH-HE projects, including:**

   (1) **How Applicant will guard against potential conflicts of interest:**
   All applications forwarded to the CHIP team are reviewed and team members who declare conflicts of interest will abstain or recuse themselves. Applications are reviewed based on several factors including: their ability to serve member needs, collaborative CHIP/CHA priorities, connection to board goals, the triple aim, oral/mental/physical health integration, health equity, agency capacity, and sustainability.

   (2) **How Applicant will ensure a transparent and equitable process:**
   The CAC's ensure a transparent and equitable process for selecting projects for funding by applying the criteria outlined above in 1(b). In 2016, AllCare formed an internal team, Community Health Improvement Plan (CHIP) Team, to research, review, and recommend community-based SDoH-HE partners in alignment with the AllCare Board of Governor's priorities on the SDoH. These include: Housing, Education, and Community Engagement. AllCare was one of the first CCOs to recognize the importance of improving community health as a way of improving individual health.

   (3) **How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the**

Community: We report to the Board on a routine basis. We also regularly post testimonials on the AllCare website, sponsor radio and television ads, and our leadership team is represented on numerous local boards, chambers of commerce, and trade associations where information is shared with the broader community. AllCare staff offer technical assistance to funded projects to ensure successful outcomes.

Additionally, we post an annual Benefit Corporation report outlining our community investments, outcomes, strategies and plans for the future. We contract with CORE (the Centers for Outcomes Research and Education) for third-party scientific analysis of key community investments. We conduct internal reviews of our own data, using MedInsight, to analyze member data and determine risk scores related to SDoH-HE interventions.

e. **For the statewide housing priority only: please provide proposed metrics for assessing the impact of investments in this area.** A recent ECONorthwest survey estimated the dire need for affordable housing at 7,000+ units and wait-list times can be as long as four years. Throughout most of southern Oregon, there are no emergency or warming shelters. Specific results or measures for assessing the investment in housing include: increased surveys and screens, decreased hospital readmissions, decreased recurring infections, completion of hepatitis-C treatments, reduction in severity of Health Risk-Assessment Survey Scores, decrease in patient discharge-to-street (from hospital or inpatient care), increased graduation rates from housing programs, reduction in eviction rates, increased number of beds/units, increased access to transitional or supportive units for specific populations (e.g. unsheltered youth), ratio of affordable housing permits applied for versus issued from municipal planning departments and reduced time on waiting lists.

2. **Evaluation Questions**

   a. **Please describe the criteria Applicant will apply when selecting SDOH-HE partners.** Currently, SDoH-HE partners and projects are awarded based on:
   - Documented local community needs as defined in the Collaborative CHA and the CHIPs, with a focus on affordable and transitional housing;
   - Evidence-based programs and services;
   - Alignment with AllCare's mission and values;
   - Number of members impacted by the project/initiative;
   - Prior experience as an AllCare partner;
   - The level of funding requested and timelines;
   - Implementation capabilities and staff experience in other similar projects (i.e. data collection and reporting capabilities);
   - Member feedback;
   - Community partner feedback and community reputation; and
   - Sustainability and ability to leverage other projects.

   b. **Please describe how Applicant will broadly communicate the following information to the public and through its network of partners: its SDOH-**

HE spending priorities, the availability of funding for projects, how interested parties can apply for consideration, and the project selection process. Public communication of AllCare spending priorities, funding levels, application processes and selection processes occurs through:

- Individual CACs and their RFA processes;
- Local media;
- Easy access to the funding application on the AllCare's website; and
- AllCare staff networking and collaboration on local boards, associations, and public agencies involved in the SDoH-HE.

c. **Please describe how Applicant will track and report SDOH-HE expenses and outcomes, including technological capacity and process for sharing and collecting data, financial systems, and methods for data collection.**
AllCare tracks and reports project specific data by using MARA scores, member engagement, claims data, etc. This occurs through quarterly and annual reports submitted (using our report template) by the recipient to AllCare staff who review and evaluate the reports and present results to the appropriate CAC for oversight and feedback. In addition, AllCare's CFO tracks expenses and prepares regular financial reports on all funded projects.

d. **Applicant will submit a plan for selecting Community SDOH-HE spending priorities in line with existing CHP priorities and the statewide priority on Housing-Related Services and Supports via the RFA Community Engagement Plan, as referenced in section A.**
Please see *EXHIBIT 10.1-Community Engagement Plan Tables.*

C. Health-Related Services (HRS)

1. Informational Questions

a. **Please describe how HRS Community benefit investment decisions will be made, including the types of entities eligible for funding, how entities may apply, the process for how funding will be awarded, the role of the CAC (and Tribes/tribal advisory committee if applicable) in determining how investment decisions are made, and how HRS spending will align with CHP priorities.**
Since 2016, AllCare has funded more than 175 Community Health Related Services (HRS), including low-income housing programs, local school programs and clinics, programs for low-income seniors, ACES training, youth programs, maternal and infant health programs, food banks, community centers, behavioral health providers, public health agencies, and community service organizations such as United Way and Rotary among others. Please refer to item B.2.a for how investment decisions are made by each CAC which has responsibility to select projects for funding specific to their county. AllCare participates in a Collaborative CHA and works with each CAC to identify local needs to be addressed in their respective CHIP. Once those needs are identified, the CACs take those

recommendations into consideration when deliberating their funding decisions for the SDoH-HE programs.

D. Community Advisory Council membership and role

1. **Informational Questions**

   a. **Please identify the data source(s) Applicant proposes to use when defining the demographic composition of Medicaid Members in the Applicant's Service Area.** Data sources used to define the demographic composition of Medicaid members across our service area include state census data, member surveys, and eligibility data reflected on the 834 file. The CCO tries to establish CAC membership to match the demographic composition of those served in each county. However, that is often difficult due to member willingness to serve and often in competition with other membership needs such as needed expertise in health services, community services, and local government agencies. Currently, membership across our three CACs include:

   Table 1: Current Demographic of AllCare CACs

	Jackson Co. CAC	Josephine Co. CAC	Curry Co. CAC
Consumers	4	6	6
Public Agencies	4	3	5
Providers	8	9	11
Total	16	18	22

2. **Evaluation Questions**

   a. **Applicant will submit a plan via the RFA Community Engagement Plan, as referenced in Section A, for engaging CAC representatives that align with CHP priorities and membership demographics, how it will meaningfully engage OHP consumer(s) on the CCO board and describe how it will meaningfully engage Tribes and/or tribal advisory committee (if applicable). Applicant may refer to guidance document CAC Member Assessment Recruitment Matrix.** AllCare utilizes an application process for consumers who wish to become members of a CAC. The application is easily accessible through multiple entry points on AllCare's website. Other members of the CACs are identified by AllCare who has the responsibility to identify potential CAC members with a focus on maintaining a balanced representation across consumers, providers, community-based programs and public agency participants. In the past, AllCare has reached out to local Tribes to engage with our CACs, but heretofore, the Tribes have declined to participate. AllCare is beginning to engage with the Cow Creek Band of Indians and will have further updates during the Readiness Review.

E. Health Equity Assessment and Health Equity Plan

1. **Informational Questions**

   a. **Please briefly describe the Applicant's current organizational capacity to develop, administer, and monitor completion of training material to organizational staff and contractors, including whether the Applicant currently requires its Providers or Subcontractors to complete training topics on health and Health Equity.** As stated in *EXHIBIT 10.7-AllCare Health Equity Plan 2019*, health equity is defined as all people and communities having the opportunity to attain their full potential and highest level of health. Achieving health equity requires valuing everyone while focusing on eliminating inequities experienced by groups that have encountered obstacles to health. Some of these obstacles may be based on their racial or ethnic group, income, gender identity, sexual orientation, neighborhood, disability, language, religion, insurance status, political affiliation, or other characteristics historically linked to discrimination or exclusion. Achieving health equity requires looking for solutions inside and outside of the health care system. This includes addressing social, economic and environmental conditions such as housing, employment, public safety, education, bias and discrimination that create unjust differences in health status and opportunities. It must also address policies and systemic structures that create barriers to equitable outcomes for all.

   Our Health Equity and Inclusivity Action Team's (HEIAT) Steering Committee is responsible for advancing policies, systems, and environmental changes that promote equity and address the social determinants of health. The Committee prioritizes health disparities for underrepresented populations, including racially and ethnically diverse communities, people with disabilities, age, gender, protected classes, mental illness, LGBTQ+ communities, and low-income individuals. The Committee is responsible for maintaining the Health Equity Strategic Plan (HESR) and provides oversight of the implementation of our strategic initiatives to staff, First-Tier, Downstream, and Related Entities (FDR Entities).

   The HEIAT Steering Committee is comprised of 12 – 14 Stakeholders and strives to have at least 51% representation from persons of color, persons of non-dominant sexual orientation or gender identity, persons with disabilities, and persons from disadvantaged socio-economic backgrounds. The Committee includes one member from each CAC and a decision maker from each of the following AllCare departments: Member Services, Provider Services, Population Health, Human Resource, Claims, Finance, Marketing, eHealth Services, Creative Services, and the Executive Team. There are six sub-committee workgroups including:
   - Community Engagement: All workgroups are expected to work with the community impacted by the policies and procedures being developed.
   - Culturally Specific Material: There are three priorities for this workgroup: a) Collaborate with the community to design, implement, and evaluate policies, practices and services that ensure cultural and linguistic appropriateness; b)

Establish culturally and linguistically appropriate goals and accountability to be infused through AllCare's planning and operations; c) Collect and maintain accurate, reliable demographic data used to monitor and evaluate the impact of Culturally Specific Materials Workgroup on health equity and outcomes.

- <u>Health Equity Data</u>: Their three areas of focus include: a) Create and produce a quarterly HE Report to identify health disparities across our service area; b) Identify methods to incorporate regional census data into data dashboards; and c) Utilize data to inform policy decisions and to target populations and geographies for interventions.
- <u>Language Access:</u> This group focuses on a) Creation of an annual Language Access Assessment and Workplan for AllCare; b) Assess quality of AllCare's Language and Access Services, including interpreters, translations, interpreter training for FDR Entities, and internal staff training; and c) Create and maintain AllCare's Language Access Policy.
- <u>Training and Education:</u> This group is responsible for a) Develop training and education with community input; b) Train the trainers within AllCare's service area to broaden the reach of available trainings; and c) Develop and update criteria for approving external cultural competence continuing education opportunities;
- <u>Policy:</u> This group focuses on a) Create a policy evaluation process that aligns with the Culturally Appropriate Standards in Health and Healthcare; b) Engage FDR entities to advocate policies that support the SDoH-HE; and c) Review, refine, and implement equitable firing practice policies in coordination with Human Resources.

AllCare employs internal staff who are exclusively responsible for developing, administering, and monitoring training material and staff participation in health equity and cultural diversity training. The program has three main goals:

- Train all new personnel as part of their on-boarding process.
- Conduct equity surveys of healthcare offices who are participating in AllCare's VBP Models and who are serving AllCare members.
- Increase availability of Certified Medical Interpreters across SW Oregon.
- Trainees include AllCare staff, our contracted providers and their staff, and our community-based partners. Our HEIAT is responsible for developing policies and procedures that focus on cultural and health equity, workforce diversity, and improvement for underserved populations. To date, 100% of AllCare staff have been trained along with 4,000+ staff and volunteers from 81 external partners from community based social and health services, including Grants Pass School District, RVCOG, LaClinica de Valle, OnTrack Recovery, Rogue Community Health, and Mountain View Family Practice among others.

b. **Please describe Applicant's capacity to collect and analyze REAL+D data.** AllCare's Equity and Inclusivity Action Team regularly collects and analyzes REAL+D data that ensures AllCare is meeting its goals and benchmarks regarding

equity, diversity, and cultural sensitivity among our enrollees, our provider network, our community partners, and our own personnel.

2. **Evaluation Questions (Health Equity Assessment)**

   See Health Equity Assessment Guidance Document

   a. **Please provide a general description of the Applicant's organizational practices, related to the provision of culturally and linguistically appropriate services. Include description of data collection procedures and how data informs the provision of such services, if applicable.**
   Please refer to *EXHIBIT 10.1-Community Engagement Plan Tables* and *EXHIBIT 10.7-AllCare Health Equity Plan 2019*. Provider offices that participate in AllCare's Value Based Payment Models (VBPs) are surveyed annually to determine patient satisfaction with access to care and their provider. In an effort to make the program more equitable the following question was added to the survey: "Do you feel that you were treated differently from other patients because of any of the following? (Check all that apply) Insurance Type, Race, Gender, Age, LGBTQ+, Disabled, Language, Other".

   b. **Please describe the strategies used to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the Service Area.** Based on current AllCare's diversity hiring policy, AllCare's strategies used to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the Service Area include staff health equity and cultural diversity training, scholarships to local colleges to train clinical and technical personnel in health equity, internships within AllCare, interpreter training and testing site, our value based payment models that address health equity issues, and provision of equity training for the broader community.

   c. **Please describe how Applicant will ensure the provision of linguistically appropriate services to Members, including the use of bilingual personnel, qualified and certified interpreter services, translation of notices in languages other than English, including the use of alternate formats. Applicant should describe how services can be accessed by the Member, staff, and Provider, and how Applicant intends to measure and/or evaluate the quality of language services.** AllCare routinely monitors the State of Oregon's Health Care Interpreter Adequacy. By analyzing that data, there is a shortage of interpreters across the service area of 13.1 FTE; of which 10.5 are in Jackson County Covering 17 languages, 2.3 in Josephine County covering 10 languages, and 0.3 FTE in Curry County covering 3 languages.
       In response, AllCare is now a licensed training site for the "Bridging the Gap" program which is a 64 hour interpreter training that meets the state of Oregon's requirements to become a qualified Medical Interpreter. In addition, we have become Oregon's third CCHI Certified Medical Interpreter Testing Site and

the only location in Oregon other than Portland to offer both the written and oral exam.

AllCare has added a reimbursement policy for Interpretive Services in a medical setting. Primary care clinics, physician specialty clinics and behavioral health clinics are required to arrange and bill for interpreter services provided at their site. The medical or behavioral health clinic is responsible for scheduling the interpreter at the time of scheduling the appointment. Interpreter services provided to AllCare members must be rendered by a Qualified or Certified interpreter with State of Oregon per Oregon Administrative Rule (OAR) 333-002-0000. All providers contracted with AllCare are accountable for ensuring that employed or contracted interpreters meet these requirements.

Services provided by interpreters who do not meet the qualifications outlined in 333-002-000 are ineligible for payment. As an example, minor children and other family members should not be used as interpreters. Interpreters who are not properly qualified cannot bill AllCare or the subscriber. These services are able to bill directly to AllCare through the claims process.

d. **Please describe how Applicant will ensure Members with disabilities will have access to auxiliary aids and services at no cost as required in 42 CFR 438.10, 42 CFR part 92, and Section 1557 of the Affordable Care Act. Response should include a description of how Applicant plans to monitor access for Members with disabilities with all contracted providers.** OHP members with disabilities currently have access to auxiliary aids and services at no extra cost as required by 42 CFR 437.10, 42 CFR part 92, and Section 1557 of the Affordable Care Act. AllCare also monitors claims for individuals identified as deaf and then ensures those individuals are connected to interpretive services. AllCare monitors the provider network offices for ADA compatibility.

3. **Requested Documents**

Policies and procedures describing language access services, practices, evaluation, and monitoring for appropriateness and quality. Please see *EXHIBIT 10.9-AllCare Health Equity Plan 2017*; *EXHIBIT 10.8-AllCare Health Equity Plan 2018*; *EXHIBIT 10.7-AllCare Health Equity Plan 2019*.

Policies and procedures related to the provision of culturally and linguistically appropriate services. It is the policy of AllCare to provide timely meaningful access for Limited English Proficiency (LEP) persons to all AllCare programs and activities. All contracted FDR entities provide free language assistance services to LEP individuals whom they encounter or whenever an LEP person requests language assistance services. All personnel are required to inform members of the public that language assistance services are available free of charge to LEP persons and that AllCare will provide these services. Our policy is to provide timely meaningful LEP access for all AllCare programs and activities. Please see *EXHIBIT 10.12-AllCare Language Access Policy 2019*; *EXHIBIT 10.14-Translation Policy 2019*; *EXHIBIT 10.13-Reimbursement Interpreter Services 2019*.

F. **Traditional Health Workers (THW) Utilization and Integration**

1. **Informational Questions**

    a. **Does Applicant currently utilize THWs in any capacity? If yes, please describe how they are utilized, how performance is measured and evaluated, and identify the number of THWs (by THW type) in the Applicant's workforce.** Since the 1990s AllCare has utilized staff, who are now called Traditional Health Workers (THW), in the areas of home visits, mental health home visits, and home visits for high-risk inpatient discharges. Today, AllCare, through its population health management program, employs case managers who coordinate with both internal THW staff and our partners' THW staff for similar types of home visits as well as:
        - non-emergent medical transports to health appointments and to pharmacies to pick up needed prescriptions;
        - assistance with choosing a PCP and scheduling new patient visits;
        - outreach to newly paroled OHP members who need assistance scheduling PCP appointments, behavioral health appointments, and/or referral to community based social service supports;
        - specialized supports for our dually eligible and special needs members; and
        - home visits to eligible OHP members in need of intensive care coordination/case management.

        AllCare currently employs several certified THWs across our three-county service area to deliver personalized and individualized patient services.

    b. **If Applicant currently utilizes THWs, please describe the payment methodology used to reimburse for THW services, including any alternative payment structures.** Our THW staff are employees of AllCare and are paid a competitive hourly rate for their services. They have access to the same benefits as all company personnel, including paid time off, sick leave, and health benefits. At this time, our THWs do not participate in any alternative payment structures. AllCare has supported THWs through CACs and internal CHIP team. This support for our THWs has typically focused on education (CHWs) and behavioral health (Peer Support Specialists).

2. **Evaluation Questions**

    a. **Please submit a THW Integration and Utilization Plan which describes:**
        - **Applicant's proposed plan for integrating THWs into the delivery of services:** Please see *EXHIBIT 10.2-Traditional Health Worker Integration Plan*.
        - **How Applicant proposes to communicate to Members about the benefits and availability of THW services;** Please see *EXHIBIT 10.2-Traditional Health Worker Integration Plan*.

- **How Applicant intends to increase THW utilization;** Please see *EXHIBIT 10.2-Traditional Health Worker Integration Plan*.
- **How Applicant intends to implement THW Commission best practices;** Please see *EXHIBIT 10.2-Traditional Health Worker Integration Plan*.
- **How Applicant proposes to measure baseline utilization and performance over time;** Please see *EXHIBIT 10.2-Traditional Health Worker Integration Plan*.
- **How Applicant proposes to utilize the THW Liaison position to improve access to Members and increase recruitment and retention of THWs in its operations.** Please see *EXHIBIT 10.2-Traditional Health Worker Integration Plan*.

3. **Requested Documents**

   Completed THW Integration and Utilization Plan (page limit: 5 pages): Please see *EXHIBIT 10.2-Traditional Health Worker Integration Plan*.

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

   For the current CHA, please see *EXHIBIT 10.5-Collaborative CHA Josephine-Jackson 2018* and *EXHIBIT 10.3-Curry CHA 2013-2019*.
   For the current CHIP, please see *EXHIBIT 10.4-Josephine Jackson Curry CHIP 2014*.

1. **Evaluation Questions**

   a. **Applicant will submit a proposal via the RFA Community Engagement Plan, referenced in Section A, describing how it intends to engage key stakeholders, including OHP consumers, Providers, local public health authorities, including local health departments, Tribes, Community-based organizations that address disparities and the social determinants of health, and others, in its work. The Plan should detail the Applicant's strategies for engaging its Community Advisory Council, its process for developing and conducting a Community Health Assessment, and development of the resultant Community Health Improvement Plan priorities and strategies. The Plan should specify how the Applicant's strategy for health-related services links to the CHP. Applicants should include information on approaches to coordinate care across the spectrum of services, as well as to encourage prevention and health promotion to create healthier communities.**
   Please see *EXHIBIT 10.1a-AllCare Community Engagement Plan narrative*.

H. **Reference Documents**
   - RFA Community Engagement Plan Requirement Components
   - RFA Community Engagement Plan Required Tables
   - CAC Member Assessment Recruitment Matrix
   - Health Equity Assessment Guidance Document
   - SDOH-HE Glossary

Attachment 12 — Cost and Financial Questionnaire

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response.

Page limits for this Cost and Financial Questionnaire is 20 pages. Items that are excluded from the page limit will be noted in that requirement.

A.   **Evaluate CCO performance to inform CCO-specific profit margin beginning in CY 2022**

OHA will implement a provision of its current waiver that requires the state to vary the profit load in CCO capitation rates based on an evaluation of CCO performance. The goal of the policy is to encourage CCOs to provide financial incentives for CCOs to improve the delivery of benefits to CCO Members. This includes more efficient use of Medical Services, increased delivery of high-value services, and an increased use of Health-Related Services when appropriate. The ability to increase the profit load for high-performing CCOs is designed to alleviate concerns that CCO investments that reduce costs and use of Medical Services will lead to capitation rate reductions that threaten CCO ability to maintain access to Health-Related Services and other programs that improve value and efficiency.

1.   **Does Applicant have internal measures of clinical value and efficiency that will inform delivery of services to Members? If so, please describe.** AllCare's Utilization Management team reviews services for quality, clinical value and efficacy by making sure the service requested is the least invasive, received at the least costly place of service, and occurring at an appropriate facility such as a center of excellence to ensure successful delivery of services as well as beneficial outcomes both cost and health related. We utilize reports that allow identification of spikes, trends, and outliers to adjust internal policy and process that will improve access and delivery of services to members. An example of this would include use of outpatient hospitals verses stand-alone surgery centers/ambulatory surgical centers. In respect to cost and quality of service we redirect members to utilize ambulatory surgical centers when appropriate. The UM department examines benefit configuration and administration regularly to verify that quality, safe and appropriate services are provided to members within state and federal guidelines.

2.   **What tools does the Applicant plan to deploy to identify areas of opportunity to eliminate Waste and inefficiency, improve quality and outcomes, and lower costs?** Tools incorporated by the Utilization Management department that assist in identifying waste, inefficiencies, cost concerns and outcomes include multiple electronic health record systems, specialized reports, and community and internal collaboration. AllCare has access to multiple EHR systems including those at many

of our contracted hospitals, state wide emergency departments, local provider offices, and health information exchange sites. Access to these sites ensures timely notification of services and medical documentation to support and review for appropriate care. The UM department also has a dedicated data analyst that creates specialized reporting that allows both clinical and non-clinical staff to easily view utilization reports that for example specifically look at over and underutilization of services, high cost services, and volume of services. These tools assist AllCare to identify trends, potential waste, prior authorization needs, cost associations and of course support department leadership in identifying internal process inefficiencies, waste and quality. As mentioned earlier concurrent hospital review is completed with the use of these designated reports as well. In addition to systems and reports, AllCare encompasses internal and community gatherings to address quality, outcomes, waste and cost. Weekly meetings are held within the UM department to address complicated member cases with discharge barriers or social determinants affecting their health to assist in suitable uses of resources and services as well as ensuring safe and quality outcomes among transitions. These meetings include an interdisciplinary team that may incorporate community staff such as the member's PCP, hospitalist, discharge planner, state case worker, etc. We feel communication among those involved in the members care and case are of highest value in determining successful outcomes. We also actively monitor claims to ensure there is no waste or inefficiencies.

3. **Does the Applicant have a strategy to use Health-Related Services to reduce avoidable health care services utilization and cost? If so, please describe.** Members are screened using a Health Risk Survey (HRS). The HRS screen includes SDoH questions to identify any possible gaps in care, potential needs or other health care risks associated with the member. Through the completion of an HRS, members may be identified for the need of services outside of the medical benefit for which Health-Related Services may be applicable. In addition, members, family, caregivers, providers or other entities such as DHS, APD, community partners, etc., may call and request assistance with health related services. All requests are reviewed and assigned to a Care Coordination. Some examples of how utilizing health related services that can reduce costs and unnecessary utilization:

- Provided transportation for members to remain compliant with Community Correction obligations reducing recidivism rates
- Supplies hotel stays for homeless members for the duration of HEP C treatment supporting medication compliance
- Supplied hotel stays for homeless members in need of wound care upon reducing risk of infection
- Provided cellular devices for members removing coordination barriers between the member and medical care team or other community partners and entities necessary to navigate independent and SDoH.

4. **What is the Applicant's strategy for spending on Health-Related Services to create efficiency and improved quality in service delivery?** AllCare has a policy that is based on the Health-Related Services Oregon Administrative Rules. All

requests submitted are reviewed by the Care Coordinator. The Care Coordinator seeks family, community and agency resources for availability. If no availability is found through these resources and the request meets AllCare's policy and the OAR guidelines, funds are approved for the Health Related Service. For approved/denied requests the member and provider are notified of the request outcome. All purchases are reported to finance for tracking and documentation is retained as required. Every Health Related Service purchase has a measurable goal with a documented outcome. All the documentation is maintained within AllCare's case management EHR, Essette.

5.   **What process and analysis will the Applicant use to evaluate investments in Health-Related Services and initiatives to address the Social Determinants of Health & Health Equity (SDOHHE) in order to improve the health of Members?** There are multiple internal committees that provide oversight and monitoring of Health Related Services. All Health Related purchases have documented outcomes in the member's EHR, Essette. These committees also evaluate funding needs and gaps for members and the community specific to SDoH. With oversight from the Board, each of our three Community Advisory Councils has the responsibility to set funding priorities based on specific needs of their responsive counties. Each CAC and our internal Community Health Improvement Plan Team have different criteria and performance milestones and/or metrics to guide investment decisions and oversight responsibilities.

B.   Qualified Directed Payments to Providers

Beginning in 2020, OHA will develop a program of qualified directed payments (QDP) for the repayment of most provider taxes paid by Hospitals in Oregon. The specific parameters and methodology of the QDPs for fiscal year 2020 will be determined following completion of the 2019-21 Legislatively Adopted Budget and will rely on input from a variety of stakeholders. OHA will promulgate administrative rules to include a Quality and Access pool for Hospitals reimbursed by Medicare based on diagnostic-related groups (aka, DRG Hospitals).

1.   **Does Applicant currently measure, track, or evaluate quality or value of Hospital services provided to its enrollees? If so, please describe.** AllCare currently evaluates quality and value of hospital services by having a Registered Nurse review hospital admissions against national, evidenced based criteria for appropriateness and quality of care. Access to the tools mentioned above allows for timely review upon admit and concurrent review throughout the members stay. Specific items are monitored for such as: use of restraints, infection control, universal precautions, appropriate place of service, and length of stay. Quality of care is also looked at related to services provided such as wound care, therapy, nutrition, discharge planning, and social services. Any concern identified by the RN is escalated for review by a Medical Director and if warranted brought to the clinical review team. These cases may be referred to the quality and compliance departments as well.

C.   **Quality Pool Operation and Reporting**

OHA will adjust the funding mechanism of the quality incentive pool from a bonus to a withhold of a portion of CCO capitation rates. This allows CCO expenditures of Quality Pool funds to be considered in capitation rate development and be included in the Medical Loss Ratio (MLR) requirements that apply to the CCOs. This change is intended to motivate CCOs to make timely investments in their communities and the providers and partners that enable their achievement of metrics associated with the incentive program. Including CCO spending of incentive pool earnings in capitation rate development increases the transparency of the program while retaining significant flexibility for CCOs in how they utilize their Global Budget.

1.   **Does the Applicant plan to distribute Quality Pool earnings to any public health partners or non-clinical providers, such as SDOH-HE partners or other Health-Related Services Providers? If so, please specify the types of organizations and providers that will be considered**. Distribution of Quality Pool earnings is divided into three pools. Ten percent is withheld to cover administrative costs of managing the quality pool. The remaining 90% is divided equally between our value based payments to our providers and our community partners who offer programs impacting the Social Determinants of Health. Our Value-Based Payments providers include primary care, specialty care (including maternal health and pediatric), Behavioral Health, Oral Health, and Facilities such as hospitals and skill nursing. This covers a wide range of entities including alcohol and drug treatment programs, methadone treatment centers, surgery centers, dental care clinics, and non-emergent medical transport services. Our community partners in the social determinants of health who receive grant funding from our Quality Pool involve more than 175 entities over the last three years, including affordable housing programs such as Rogue Retreat and the Maslow Project, school based clinics in all of our local school districts, local YMCAs, local food banks, and other service organizations that serve the same population such Rotary Clubs.

2.   **How much of the Quality Pool earnings does the Applicant plan on distributing to clinical Providers, versus non-clinical providers? Please discuss the approach as it relates to SDOH-HE partners, public health partners, or other Health-Related Services Providers**. AllCare CCO currently pays 10% of its Quality Pool earnings to its affiliate company, AllCare Management Services to cover the cost of administering the program. The distribution of the remaining 90% is determined annually by the AllCare Board of Governors. In 2018, the funds that were received in July for the 2017 Quality Pool were distributed as follows: 45% was evenly distributed between our providers who participate in our Value Based Payment programs, including PCPCH, Maternal Health, Pediatrics, Behavioral Health providers, and Oral Health Providers. The remaining 45% was allocated to support our Social Determinants of Health programs that focus primarily on affordable housing programs for the homeless, school based clinics, and public

health. AllCare's three Community Advisory Councils are involved in the selection process of the SDoH programs for funding in each of the three counties we serve.

3. **How much of the Quality Pool earnings does the Applicant plan on investing outside its own organization? On what would Applicant make such investments.** AllCare allocates 90% of its Quality Pool earnings for investments outside of our organization. The Board of Governor's makes a decision annually on how these funds will be allocated. In the past, half of the allocation is used to fund our Value Based Payment programs and the other half is allocated to fund our investment in Health-Related Service Providers with an emphasis on housing and early child-hood education.

4. **How will the Applicant decide and govern its spending of the Quality Pool earnings?** AllCare has extensive VBP programs that determine the amounts that will be paid to the providers participating in the programs. For the Quality Pool earnings that fund AllCare's SDoH – HE investments AllCare requires submission of funding applications/requests to their respective CAC or directly to the AllCare internal staff team. These funding applications are then review for the proposed program or services to be funded and approved if it meets our criteria for allocation of funds. That criteria includes 1) viability of the project to materially impact the intended recipients of the services; 2) the request address known gaps in community health as identified in the Community Health Assessment; 3) the request aligns with Community Health Improvement Plan initiatives; 4) there is a history of positive prior experience with the requesting agency; and 5) there is demonstrated experience in program staff to effectively manage grant funds and their ability to achieve desired outcomes to improve community health. We also have policies and procedures for AllCare to invest in community needs as we see fit.

5. **When will Applicant invest its Quality Pool earnings, compared with when these earning are received?** AllCare funds its Value Based Payments within one month of receiving the cash proceeds of the Quality Pool. The funds allocated for SDoH are currently funded throughout the year based upon applications and need.

6. **Does the Applicant have sufficient cash resources to be able to manage a withhold of a portion of its Capitation Payments?** Yes.

D. **Transparency in Pharmacy Benefit Management Contracts**

OHA seeks to address increasing pharmacy costs by increasing the transparency of CCO relationships with Pharmacy Benefit Managers (PBMs) and requiring no-spread contracts between CCOs and PBMs. CCOs will be required to ensure they are receiving competitive pricing from their PBMs by obtaining 3rd party market checks audits.

1. **Please describe the PBM arrangements Applicant will use for its CCO Members.** AllCare contracts with MedImpact who serves as our Pharmacy Benefit

Manager. Under that contract there is no pay for performance and no spread. The contractor undergoes an audit annually performed by AllCare staff along with staff from the actuarial and consulting firm, Milliman, Inc. In addition, an annual market check is performed by Milliman. All rebates are managed on a pass-through basis to AllCare and we use those proceeds to offset pharmacy costs.

2. **Does Applicant currently have a "no-spread" arrangement with its PBM?** Yes

   If not, please describe the steps the Applicant will take to ensure its contracts are compliant with these requirements and the intended timing of these changes. If changes cannot be made by January 1, 2020, please explain why and what interim steps Applicant will take to increase PBM transparency in CY 2020. (In order for an extension in the timeline to be considered, Applicant must show it is contractually obligated to use non-compliant PBM and shall provide OHA a copy of PBM agreement as justification along with a plan to ensure compliance with transparency requirements at the earliest date possible) Not Applicable

3. **Does the Applicant obtain 3rd party market checks or audits of its PBM arrangement to ensure competitive pricing**? Yes

   If not, does the Applicant have a plan to receive this analysis? If so, how often are these analyses performed, what is done with this third party data and what terms inside of your PBM contract allow this analysis to have power for the CCO to ensure its pharmacy contract remains competitive? Not Applicable

4. **Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements?** We do not plan to use the Oregon Prescription Drug Program. We use the same PBM as the State's TPA and our analysis indicates that our costs are lower than what we would incur if we transitioned to the State. In addition, administering our pharmacy benefit through a TPA would create access barriers to our Providers and the Members they serve.

E. **Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria**

OHA seeks to address increasing pharmacy costs by increasing the alignment of CCO preferred drug lists (PDLs) with the PDL used by OHA for the fee-for-service program with a particular focus on high-cost drugs and on alignment strategies that reduce overall program costs and/or improve the pharmacy benefit for OHP Members. OHA will work in conjunction with Successful Applicants to establish initial PDL alignment criteria and will take additional steps to modify alignment criteria over time. As part of this requirement, CCOs will be expected to make public and accessible their PDLs as well as the coverage and Prior Authorization criteria for all pharmaceutical products.

1. **Does Applicant currently publish its PDL?** Yes

If not, please describe the steps the Applicant will take to ensure its PDL is publicly accessible concurrent or in advance of the Year 1 Effective Date for prescribers, patients, dispensing pharmacies, and OHA. Not Applicable

2. **Does Applicant currently publish its pharmacy coverage and Prior Authorization criteria concurrently with or in advance of changes made?** Yes, but AllCare is in the process of developing and/or updating our criteria.

   If not, please describe the steps the Applicant will take to ensure its pharmacy coverage and PA criteria are both publicly accessible for prescribers, patients, dispensing pharmacies, and OHA and updated in a timely manner. Not Applicable

3. **To what extent is Applicant's PDL aligned with OHA's fee-for-service PDL?** AllCare's PDL aligns with OHA's fee-for-service PDL if the medication meets our criteria that requires equal or better efficacy, equal or better safety, and equal or lower cost at point of sale.

   Please explain whether and how supplemental rebates or other financial incentives drive differences in the Applicant's PDL as compared to the fee-for-services PDL: AllCare does not always choose drugs based on cost. There are instances where higher cost drugs are favored over lower cost agents if they meet other criteria to improved efficacy or improved safety.

4. **Does the Applicant plan to fully align its PDL with the fee-for-service PDL? If not, please describe exceptions.** AllCare looks forward to working with other CCO Pharmacy Programs and Fee-for-Service Pharmacy Programs to align our collective PDLs.

F. **Financial Reporting Tools and Requirements**

OHA will enhance financial reporting and solvency evaluation tools by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk Based Capital (RBC) tool to evaluate carrier solvency, along with supplemental schedules as requested by OHA (identified in Exhibit L of the Contract). CCOs will file required NAIC reports using Statutory Accounting Principles (SAP). A financial hardship exemption will be available for Year 1 for CCOs with a demonstrated financial hardship related to converting to SAP and filing reports through NAIC. Additional reporting through the Exhibit L Financial Reporting Template will be required. OHA will promulgate administrative rules describing regulatory interventions based on RBC level.

1. **Does Applicant or any Affiliate of Applicant currently report on NAIC health insurance forms? If so, please describe the reporting company or companies**

and its relationship with Applicant. AllCare CCO, Inc. does not currently report on NAIC health insurance forms. Its affiliate company, AllCare Health Plan, Inc. holds a Certificate of Authority to transact health insurance within the State of Oregon and files NAIC health insurance forms. Both companies have the same parent company, AllCare Health, Inc. and are 100% wholly-owned.

2. **Does the Applicant currently participate and file financial statements with the NAIC?** No.

3. **Has Applicant prepared a financial statement which includes a RBC calculation? If so, please submit.** The only RBC calculations that AllCare has prepared is in relation to this RFA.

4. **Does the Applicant currently have experience reporting in SAP either directly or through any Affiliate of Applicant?** Yes, AllCare CCO has experience reporting in SAP through its affiliate company, AllCare Health Plan, Inc. In addition, the CFO has an extensive background and experience in SAP.

5. **Does the Applicant seek an exemption from SAP and NAIC reporting for 2020? If yes, please explain in detail (a) the financial hardship related to converting to SAP for the filing, and (b) Applicant's plan to be ready to use SAP in 2021.** Yes, AllCare CCO intends to request and exemption from SAP and NAIC reporting for 2020.

    (a) AllCare's management team has had numerous discussions with its external auditors regarding the change to SAP. AllCare will be required to go back to its inception in 2012 and perform GAAP and SAP adjustments for each year to arrive at the appropriate beginning balance for both RBC purposes and to meet auditing standards to comply with the audit requirements under this new method. This will require a large amount of time on both the tax accountants and AllCare staff as well as significant costs for this work to be performed.

    (b) Yes, with these requirements in place, AllCare CCO would be ready for SAP in 2021.

6. Please submit pro forma financial statements of Applicant's financial condition for three years starting in 2020, using Enrollment, rates and cost projections that presume Applicant is awarded a Contract under this RFA. If OHA expects there may be more than two CCOs in Applicant's Service Area, OHA may require Applicant to submit additional pro forma financials based on the expected number of CCOs. OHA will evaluate Applicant's pro forma financials to assure that they provide a realistic plan of solvency. See the RFA Pro Forma Reference Document and UCAA Supplemental Financial Analysis workbook template for a complete description of the requirements and deliverables. The pro forma workbook templates and required supporting documents are excluded from the page limit.

Please refer to the Exhibits attached to this Response to Attachment 12 which include the following documentation.

Required Documentation

- Redacted - Completed Pro Forma Workbook Templates (NAIC Form 13H)
- Redacted - Completed NAIC Biographical Affidavit (NAIC Form 11)
- Redacted - Completed UCAA Supplemental Financial Analysis Workbook Template
- Redacted - Three years of Audited Financial Reports

G.   Accountability to Oregon's Sustainable Growth Targets

OHA seeks to improve the connection between CCO Contracts and the sustainable growth targets established in Oregon's Medicaid waiver and the legislatively enacted budget.

1.   **What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year?** AllCare has established budgets, strategic goals and benchmarks annually. In 2017 AllCare established a Healthcare Task Force Committee which is comprised of executive and management staff from Population Health, Medical Affairs, Claims, IT, Finance, Provider Services, Contracting. The Committee also includes a number of internal data analysts and outside financial and actuarial consultants. The team has developed a dashboard report that is reviewed at each monthly meeting to identify trends and results that deviate from AllCare targets. When emerging experience and leading indicators suggest the potential for financial results to deviate from targets, the team works to develop strategies to bring these areas into alignment with the established budget and goals. These strategies include focused medical management and population health initiatives, changes in provider contracts, claims audits and communication with providers. Past history of these activities has resulted in renegotiation of provider contracts, revision in the capitation payment to primary care provider, and a third party audit of ER claims for proper coding and billing. These are some real-life examples of how the Healthcare Task Force identifies and addresses various issues of cost and performance. Favorable experience and trends are also reviewed and strategies put in place in order to ensure these results are maintained. AllCare has invested extensively in the SDoH to improve the health of the community as a whole. AllCare has seen reductions in medical costs because of these investments.

2.   **How will the CCO allocate and monitor expenditures across all categories of services?** Annually, AllCare establishes a budget by service category to allocate and monitor claims, administrative and SDoH expenditures. AllCare works with an outside actuarial firm, Healthcare Analytic Solutions, to obtain quarterly reports of actual cost and utilization experience by service category. The Healthcare Task Force noted above monitors actual experience compared to budgets by service category and the results of this comparison are presented to executive management

and the finance committee. In addition, these reports are presented to and reviewed with the Finance Committee on a monthly basis. Additionally, the financial results compared to budget targets are presented to the CCO board and the AllCare parent company board on a monthly basis.

3. **What strategies will the Applicant utilize related to Value-Based Payment arrangements to achieve a sustainable expenditure growth?** AllCare CCO is looking at the opportunity to tie value based payment to prescription medications. Examples of conversations are tying Hepatitis C payments to patient outcomes or 'flat payments' for total Hepatitis C treatments. Other areas are continuing to steer members to lower cost settings in both outpatient hospital and radiology services. AllCare continually seeks innovative opportunities for VBPs that will drive to a sustainable growth margin. AllCare also does VBPs for preventative medical treatments and interactions.

4. **What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members?** AllCare enlists a variety of strategies to ensure that our members receive medically appropriate care while containing the cost of that care. 1) AllCare CCO utilizes nationally recognized care guidelines (MCG) in reviewing requested services in addition to reviewing against the OHA benefit package; 2) AllCare works with Primary Care and Specialty providers to promote the use of health related services (HRS) which can greatly impact the health outcomes of an individual; 3) In July 2018 AllCare restructured Primary Care capitation models by adding an additional tier level to reduce payment on those members that had not been seen by their PCP in a 12 month rolling timeframe; 4) AllCare executive staff reviews contractually required 'under and over-utilization' data on a scheduled basis. For example, it was identified that our members at high risk for HIV infection reflected an under-utilization for PReP (Pre-exposure prophylaxis). The use of PReP can greatly impact people at very high risk for HIV. This led to outreach initiatives with our members, providers and local coalitions.

5. **Has the Applicant achieved per-Member expenditure growth target of 3.4% per year in the past? Please specify time periods.** AllCare's rate of growth from 2017 to 2018 was approximately 4%. It should be noted that the rate of growth from 2017 to 2018 was adversely impacted by the redetermination process which took place in 2017. According to the CCO 2.0 procurement rate methodology document, the statewide impact of redetermination on 2017 was 1.68%. This means that the 2017 cost would have been 1.68% higher had 2017 data been fully reflective of the members remaining after redetermination. Adjusting AllCare's 2017 cost for redetermination results in an adjusted rate of growth from 2017 to 2018 under the 3.4% budget. In addition, the 2017 to 2018 AllCare's retail pharmacy cost and utilization trends for was held to .9%.

H. **Potential Establishment of Program-wide Reinsurance Program in Future Years**

OHA seeks to establish a statewide reinsurance program to better control costs related to high-cost medical conditions, treatments, and patients.

1. **What type of reinsurance policy does the Applicant plan on holding for 2020? Please include the specifics. (e.g. attachment points, coinsurance, etc.)** AllCare has an Excess of Loss Reinsurance agreement and intends to continue the policy into the year 2020. The policy is for combined hospital and professional services with a $250,000 deductible with 10% coinsurance. Once a Member's aggregate hospital and professional costs are in excess of $250,000, the reinsurance company takes on 90% of those allowed costs per the agreement.

2. **What is the Applicant's reasoning for selecting the reinsurance policy described above?** AllCare has carried an Excess of Loss Reinsurance policy since prior to the inception of the CCOs. This type of policy provides AllCare the ability to pass the risk of large losses to the reinsurance company and provides protection in the event of these situations.

3. **What aspects of its reinsurance policy are the most important to the Applicant?** The simplicity of the excess of loss reinsurance which allows reporting based upon the aggregate claims incurred within the reinsurance contract period and claims paid within the filing period. AllCare reports monthly to the reinsurer based upon paid claims information and receives payment in a timely manner.

4. **Does existing or previous reinsurance contract allow specific conditions or patients to be excluded, exempted, or lasered out from being covered?** The current and existing reinsurance contracts allow for specific conditions and/or patient's attachment points to be lasered in the contract. The current contract does not have any specific conditions or patients excluded, exempted or lasered out from coverage.

5. **Is Applicant able to leave or modify existing reinsurance arrangements at any time or is Applicant committed to existing arrangements for a set period of time? If so, for how long is Applicant committed to existing arrangements? Are there early cancelation penalties?** AllCare's current policy runs from November, 2018 to November, 2019. There is a minimum premium associated with the contract that would be required in the event of termination.

I. **CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk**

OHA seeks to ensure continued financial viability of the CCO program as a whole so as to ensure OHP Members are protected from potential access barriers that could come with a CCO insolvency event. In addition, OHA may implement new solvency

regulation tools that are similar to those utilized by DCBS in its regulation of commercial carriers that would allow OHA to prevent or meliorate insolvency events.

1. **Please describe Applicant's past sources of capital**. AllCare CCO's past sources of capital have been sourced internally with its parent company, AllCare Health, Inc.

2. **Please describe Applicant's possible future sources of capital**. AllCare's future sources of capital would be sourced internally with its parent company, AllCare Health, Inc. and its affiliated companies. In addition, AllCare has a very positive banking relationship with a major world-wide bank.

3. **What strategies will the Applicant use to ensure solvency thresholds are maintained?** AllCare has successfully established and maintain the required solvency thresholds for the OHP plan prior to the establishment of the CCOs as well as since the inception of the CCO model. AllCare Board of Governors' and Finance Committee meet throughout the year to monitor the thresholds are maintained at appropriate levels. AllCare's Board has established internal solvency threshold goals of 10:1 and has maintained this goal in all quarters since December 31, 2014 with one exception of March 31, 2017.

4. **Does Applicant have a parent company, Affiliate, or capital partner from which Applicant may expect additional capital in the event Applicant becomes undercapitalized? If so, please describe**. Yes, AllCare CCO has a parent company, AllCare Health, Inc., and additional affiliated companies to rely upon in the event AllCare CCO becomes undercapitalized.

J.   Encounter Data Validation Study

1. **Please describe Applicant's capacity to perform regular Provider audits and claims review to ensure the timeliness, correctness, and accuracy of Encounter Data**. All of AllCare's claims department staff, including analysts, supervisor, and director are certified Professional Coders. In addition, the claims department employs two Certified Professional Medical Auditors. Daily operations incorporate multiple monitoring reports that are assigned to claim's department staff who review claims that fall within the specific criteria, such as unbundling, claim timeliness, plan and the OHA guidelines. Groupings, clusters and irregular billing practices require additional review which can consist of chart review, clinical review, and conversations with Providers and staff.

2. **Does Applicant currently perform any activities to validate Claims data at the chart level that the claims data accurately reflects the services provided? If yes, please describe those activities**. AllCare contracts with an independent auditing firm to perform large claims samplings for chart audits. Data is supplied to this contracted vendor which can be random or specific as trends are identified.

A final report is compiled and presented to AllCare for review and discussion of any actionable items. AllCare is currently working to complete a facility audit with our network hospital systems.

K. **Cost and Finance Reference Documents**

- Exhibit L Financial Reporting
- Exhibit L Financial Reporting Supplemental SE
- 2020 Minimum Medical Loss Ratio Rebate Calculation Report Instructions
- 2020 Minimum Medical Loss Ratio Template

L. **Exhibits to this Attachment 12**

- Oregon CY20 Procurement Rate Methodology
- CCO 2.0 Procurement Rate Methodology Appendix I
- RFA Pro Forma Reference Document
- UCAA Supplemental Financial Analysis
- CCO RFA Enrollment Forecast

Attachment 13 — Attestations

Applicant Name: AllCare CCO, Inc.

Authorizing Signature: _____

Printed Name: Douglas L. Flow, PhD, CEO

Instructions: For each attestation, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all attestations. If an attestation has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These attestations must be signed by a representative of Applicant.

Unless a particular item is expressly effective at the time of Application, each attestation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract. Each section of attestations refers to a questionnaire in an Attachment, which may furnish background and related questions.

A. General Questions Attestations (Attachment 6)

1. Contract

a. Is Applicant willing to enter into a Contract for 2020 in the form of Appendix B?

[X] Yes [ ] No

If "no" please provide explanation:_____

b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?

[X] Yes [ ] No

If "no" please provide explanation:_____

2. Subcontracts

a. Is Applicant willing to hold written agreements with Subcontractors that clearly describe the scope of work?

[X] Yes [ ] No

If "no" please provide explanation:_____

b. Is Applicant willing to provide to OHA an inventory of all work described in this Contract that is delegated or subcontracted and identify the entity performing the work?

[X] Yes [ ] No

If "no" please provide explanation:_____

  c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?

    [X] Yes   [ ] No

    If "no" please provide explanation: _____

3. Third Party Liability and Personal Injury Lien

  a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member's Third Party Liability?

    [X] Yes   [ ] No

    If "no" please provide explanation: _____

  b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?

    [X] Yes   [ ] No

    If "no" please provide explanation: _____

  c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?

    [X] Yes   [ ] No

    If "no" please provide explanation: _____

  d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?

    [X] Yes   [ ] No

    If "no" please provide explanation: _____

4. Oversight and Governance

  a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or Control stake?

    [X] Yes   [ ] No

    If "no" please provide explanation: _____

B. Provider Participation and Operations Attestations (Attachment 7)

1. General Questions

  a. Will Applicant have an individual accountable for each of the operational functions described below?

    • Contract administration

    • Outcomes and evaluation

    • Performance measurement

- Health management and Care Coordination activities
- System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO
- Behavioral Health (mental health and addictions) coordination and system management
- Communications management to Providers and Members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer
- Quality Performance Improvement
- Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
- Traditional Health Workers Liaison

[X] Yes [ ] No

If "no" please provide explanation: _____

b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?

[X] Yes [ ] No

If "no" please provide explanation: _____

c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities?

[X] Yes [ ] No

If "no" please provide explanation: _____

d. Will Applicant (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or Referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse Providers for dispensing a 72-hour supply of a drug that requires Prior Authorization?

[X] Yes [ ] No

If "no" please provide explanation: _____

e. Will Applicant comply with all applicable Provider requirements of Medicaid law under 42 CFR Part 438, including Provider certification requirements, anti-discrimination requirements, Provider participation and

consultation requirements, the prohibition on interference with Provider advice, limits on Provider indemnification, rules governing payments to Providers, and limits on physician incentive plans?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation:_____

i. Will Applicant's contracts for administrative and management services contain the OHA required Contract provisions?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation:_____

j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health services, as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO? Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation:_____

k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

l.   Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

    [X] Yes   [ ] No

    If "no" please provide explanation: _____

m.   Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?

    [X] Yes   [ ] No

    If "no" please provide explanation: _____

n.   Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority's comprehensive local plan for the delivery of mental health services (ORS 430.630)?

    [X] Yes   [ ] No

    If "no" please provide explanation: _____

o.   Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO's Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?

- Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;

- The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;

- Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;

- Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and

- Addressing diverse patient populations in a linguistically diverse and culturally competent manner.

    [X] Yes   [ ] No

    If "no" please provide explanation: _____

p.   Will Applicant establish policies, procedures, and standards that:

- Ensure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;

- Ensure access to medically necessary care and the development of medically necessary individualized care plans for Members;

- Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;

- Communicate and enforce compliance by Providers with medical necessity determinations; and

- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

q.   Will Applicant have verified that contracted Providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified Providers in the future?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

r.   Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

s.   Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

t. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration? Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities).

[X] Yes [ ] No

If "no" please provide explanation: _____

u. Is it true that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation, subsidiaries, or entities with an ownership stake, if applicable) or its Subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services?

[X] Yes [ ] No

If "no" please provide explanation: _____

2. Network Adequacy

a. Is Applicant willing to monitor and evaluate the adequacy of its Provider Network?

[X] Yes [ ] No

If "no" please provide explanation: _____

b. Is Applicant willing to remedy any deficiencies in its Provider Network within a specified timeframe when deficiencies are identified?

[X] Yes [ ] No

If "no" please provide explanation: _____

c. Is Applicant willing to report on its Provider Network in a format and frequency specified by OHA?

[X] Yes [ ] No

If "no" please provide explanation: _____

d. Is Applicant willing to collect data to validate that its Members are able to access care within time and distance requirements?

[X] Yes [ ] No

If "no" please provide explanation: _____

      e.   Is Applicant willing to collect data to validate that its Members are able to make appointments within the required timeframes?

            ☒ Yes   ☐ No

            If "no" please provide explanation: _____

      f.   Is Applicant willing to collect data to validate that its Members are able to access care within the required timeframes?

            ☒ Yes   ☐ No

      g.   Is Applicant willing to arrange for Covered Services to be provided by Non-Participating Providers if the services are not timely available within Applicant's Provider Network?

            ☒ Yes   ☐ No

3.   Fraud, Waste and Abuse Compliance

      a.   Is Applicant willing to designate a Compliance Officer to oversee activities related to the prevention and detection of Fraud, Waste and Abuse?

            ☒ Yes   ☐ No

            If "no" please provide explanation: _____

      b.   Is Applicant willing to send two representatives, including the Applicant's designated Compliance Officer and another member of the senior executive team to attend a mandatory Compliance Conference on May 30, 2019?

            ☒ Yes   ☐ No

            If "no" please provide explanation: _____

C.   Value-Based Payment (VBP) Attestations (Attachment 8)

      1.   Have you reviewed the VBP Policy Requirements set forth in the VBP Questionnaire?

            ☒ Yes   ☐ No

            If "no" please provide explanation: _____

      2.   Have you reviewed the VBP reference documents linked to the VBP Questionnaire?

            ☒ Yes   ☐ No

            If "no" please provide explanation: _____

      3.   Can you implement and report on VBP as defined by VBP Questionnaire and the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/) and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

            ☒ Yes   ☐ No

            If "no" please provide explanation: _____

4. Will you begin CCO 2.0 – January 2020 – with at least 20% of your projected annual payments to your Providers under contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

[X] Yes [ ] No

If "no" please provide explanation: _____

5. Do you permit OHA to publish your VBP data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to your care delivery areas, Patient-Centered Primary Care Home (PCPCH) payments, and other information about VBPs required by this RFA? (OHA does not intend to publish specific payments amounts from an Applicant to a specific provider.)

[X] Yes [ ] No

If "no" please provide explanation: _____

6. Do you agree to develop mitigation plans for adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and Members with complex health care needs, as well as populations at the intersections of these groups) and to report on these plans to OHA annually?

[X] Yes [ ] No

If "no" please provide explanation: _____

7. Do you agree to the requirements for VBP targets, care delivery areas and PCPCH clinics for years 2020 through 2024, as set forth in the VBP Questionnaire?

[X] Yes [ ] No

If "no" please provide explanation: _____

8. Do you agree to the requirements for VBP data reporting for years 2020 through 2024, as set forth in the VBP Questionnaire?

[X] Yes [ ] No

If "no" please provide explanation: _____

9. Should OHA contract with one or more other CCOs serving Members in the same geographical area, will you participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO's VBP Provider contracts for common Provider types and specialties?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

10. If, after the discussion described in the previous question, OHA informs you of the Provider types and specialties for which the performance measures apply, will you incorporate all selected measures into applicable Provider contracts?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

D. Health Information Technology (HIT) Attestations (Attachment 9)

1. HIT Roadmap

a. Does Applicant agree to participate in an interview/demonstration and deliver an HIT Roadmap with any refinements/adjustments agreed to with OHA during Readiness Review, for OHA approval?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

b. Does Applicant agree to provide an annual HIT Roadmap update for OHA approval to include status/progress on CCO-identified milestones, and any adjustments to the HIT Roadmap; as well as participate in an annual interview with OHA?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

2. HIT Partnership

a. Does Applicant agree to participate in the HIT Commons beginning 2020, including agreeing to do all of the following:

• Maintaining an active, signed HIT Commons MOU and adhering to its terms,

• Paying annual HIT Commons assessments, and

• Serving, if elected, on the HIT Commons Governance Board or one of its committees?

$\boxed{\text{X}}$ Yes ☐ No

If "no" please provide explanation: _____

b.   Does Applicant agree to participate in OHA's HIT Advisory Group, (HITAG), at least once annually?

     ☒ Yes   ☐ No

     If "no" please provide explanation: _____

3.   Support for EHR Adoption

a.   Will Applicant support EHR adoption for its contracted physical health Providers?

     ☒ Yes   ☐ No

     If "no" please provide explanation: _____

b.   Will Applicant support EHR adoption for its contracted Behavioral Health Providers?

     ☒ Yes   ☐ No

     If "no" please provide explanation: _____

c.   Will Applicant support EHR adoption for its contracted oral health Providers?

     ☒ Yes   ☐ No

     If "no" please provide explanation: _____

d.   During Year 1, will Applicant report on the baseline of EHR adoption among its contracted physical health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

     ☒ Yes   ☐ No

     If "no" please provide explanation: _____

e.   During Year 1, will Applicant report on the baseline of EHR adoption among its contracted Behavioral Health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

     ☒ Yes   ☐ No

     If "no" please provide explanation: _____

f.   During Year 1, will Applicant report on the baseline of EHR adoption among its contracted oral health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

     ☒ Yes   ☐ No

     If "no" please provide explanation: _____

g.   Will Applicant report to the state annually on which EHR(s) each of its contracted physical health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See

https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

[X] Yes [ ] No

If "no" please provide explanation: _____

h.   Will Applicant report to the state annually on which EHR(s) each of its contracted Behavioral Health Providers are using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology?   See   https://chpl.healthit.gov/   and https://www.healthit.gov/topic/certification-ehrs/2015-edition   for   more information about Certified EHR Technology.

[X] Yes [ ] No

If "no" please provide explanation: _____

i.   Will Applicant report to the state annually on which EHR(s) each of its contracted oral health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

[X] Yes [ ] No

If "no" please provide explanation: _____

4.   Support for HIE

a.   Will Applicant ensure access to timely Hospital event notifications for its contracted physical health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

[X] Yes [ ] No

If "no" please provide explanation: _____

b.   Will Applicant ensure access to timely Hospital event notifications for its contracted Behavioral Health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs?

[X] Yes [ ] No

If "no" please provide explanation: _____

c. Will Applicant ensure access to timely Hospital event notifications for its contracted oral health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs.

☒ Yes   ☐ No

If "no" please provide explanation: _____

d. Will Applicant use Hospital event notifications within the CCO, for example to support Care Coordination and/or population health efforts?

☒ Yes   ☐ No

If "no" please provide explanation: _____

e. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted physical health Providers?

☒ Yes   ☐ No

If "no" please provide explanation:_____

f. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted Behavioral Health Providers?

☒ Yes   ☐ No

If "no" please provide explanation:_____

g. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted oral health Providers?

☒ Yes   ☐ No

If "no" please provide explanation:_____

h. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted physical health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes   ☐ No

If "no" please provide explanation:_____

i. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted Behavioral Health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes   ☐ No

If "no" please provide explanation:_____

j.   During Year 1, will Applicant report on the baseline of HIE access and use among its contracted oral health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

[X] Yes   [ ] No

If "no" please provide explanation: _____

k.   Will Applicant report to the state annually on which HIE tool(s) each of its contracted physical health Providers is using, using definitions and data sources agreed upon during Readiness Review?

[X] Yes   [ ] No

If "no" please provide explanation: _____

l.   Will Applicant report to the state annually on which HIE tool(s) each of its contracted Behavioral Health Providers is using, using definitions and data sources agreed upon during Readiness Review?

[X] Yes   [ ] No

If "no" please provide explanation: _____

m.   Will Applicant report to the state annually on which HIE tool(s) each of its contracted oral health Providers is using, using definitions and data sources agreed upon during Readiness Review?

[X] Yes   [ ] No

If "no" please provide explanation: _____

5.   Health IT for VBP and Population Management.

a.   For the initial VBP arrangements, will Applicant have by the start of Year 1 the HIT needed to administer the arrangements (as described in its supporting detail)?

[X] Yes   [ ] No

If "no" please provide explanation: _____

b.   For the planned VBP arrangements for Years 2 through 5, does Applicant have a roadmap to obtain the HIT needed to administer the arrangements (as described in its supporting detail)?

[X] Yes   [ ] No

If "no" please provide explanation: _____

c.   By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers?

[X] Yes   [ ] No

If "no" please provide explanation: _____

d. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with accurate and consistent information on patient attribution?

☒ Yes ☐ No

If "no" please provide explanation:_____

e. By the start of Year 1, will the Applicant identify for contracted Providers with VBP arrangements specific patients who need intervention through the year, so they can take action before the year end?

☒ Yes ☐ No

If "no" please provide explanation:_____

f. By the start of Year 1, will the Applicant have the capability to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services that can inform the targeting of interventions to improve outcomes?

☒ Yes ☐ No

If "no" please provide explanation:_____

g. By the start of each subsequent year for Years 2 through 5, will the Applicant CCO provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in the arrangement(s) in place for each year?

☒ Yes ☐ No

If "no" please provide explanation:_____

E. **Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)**

1. **Social Determinants of Health and Health Equity Spending, Priorities, and Partnership**

a. Is Applicant willing to direct a portion of its annual net income or reserves, as required by Oregon State Statute and defined by OHA in rule, to addressing health disparities and SDOH-HE?

☒ Yes ☐ No

If "no" please provide explanation:_____

b. Is Applicant willing to enter into written agreements with SDOH-HE partners that describe the following: any relationship or financial interest that may exist between the SDOH-HE partner and the CCO, how funds will be distributed, the scope of work including the domain of SDOH-HE

addressed and the targeted population, whether CCO will refer Members to the SDOH-HE partner, the geographic area to be covered, how outcomes will be evaluated and measured, and how the CCO will collect and report data related to outcomes?

[X] Yes   [ ] No

If "no" please provide explanation: _____

c. When identifying priorities for required SDOH-HE spending, is Applicant willing to designate, define and document a role for the CAC in directing, tracking and reviewing spending?

[X] Yes   [ ] No

If "no" please provide explanation: _____

d. Is Applicant willing to align its SDOH-HE spending priorities with the priorities identified in the Community Health Improvement Plan and its Transformation and Quality Strategy, and to include at least one statewide priority (e.g. housing-related services and supports, including Supported Housing) in addition to its Community priorities?

[X] Yes   [ ] No

If "no" please provide explanation: _____

2. **Health-related Services**

a. Is Applicant willing to align HRS Community benefit initiatives with Community priorities from the CCO's Community Health Improvement Plan?

[X] Yes   [ ] No

If "no" please provide explanation: _____

b. Is Applicant willing to align HRS Community benefit initiatives with a designated statewide priority should OHA require it?

[X] Yes   [ ] No

If "no" please provide explanation: _____

c. Is Applicant willing to designate, define and document a role for the CAC when determining how Health-Related Services Community benefit initiatives decisions are made?

[X] Yes   [ ] No

If "no" please provide explanation: _____

3. **Community Advisory Council membership and role**

a. Is the Applicant willing to provide to OHA an organizational chart that includes the Community Advisory Council, and notes relationships between entities, including the CAC and the Board, how information flows between the

bodies, the CAC and Board connection to various committees, and CAC representation on the board?

☒ Yes ☐ No

If "no" please provide explanation: _____

4.   Health Equity Assessment and Health Equity Plan

a.   Is Applicant willing to develop and implement a Health Equity Plan according to OHA guidance, which includes a plan to provide cultural responsiveness and implicit bias education and training across the Applicant's organization and Provider Network? See Sample Contract and Cultural Responsiveness Training Plan Guidance Document.

☒ Yes ☐ No

If "no" please provide explanation: _____

b.   Is Applicant willing to include in its Health Equity Plan at least one initiative using HIT to support patient engagement?

☒ Yes ☐ No

If "no" please provide explanation: _____

c.   Is Applicant willing to adopt potential health equity plan changes, including requirements, focus areas and components, based on OHA plan review feedback and, when applicable, based on guidance provided by the Oregon Health Policy Board's Health Equity Committee?

☒ Yes ☐ No

If "no" please provide explanation: _____

d.   Is Applicant willing to designate a single point of accountability within the organization, who has budgetary decision-making authority and health equity expertise, for the development and implementation of the Health Equity Plan?

☒ Yes ☐ No

If "no" please provide explanation: _____

e.   Is Applicant willing to faithfully execute the finalized Health Equity Plan?

☒ Yes ☐ No

If "no" please provide explanation: _____

f.   Is Applicant willing to a) ask vendors for cultural and linguistic accessibility when discussing bringing on new HIT tools for patient engagement and b) when possible, seek out HIT tools for patient engagement that are culturally and linguistically accessible?

☒ Yes ☐ No

If "no" please provide explanation: _____

5.   **Traditional Health Workers (THW) Utilization and Integration**

a.   Is Applicant willing to develop and fully implement a Traditional Health Workers Integration and Utilization Plan?

[X] Yes   [ ] No

If "no" please provide explanation: _____

b.   Is Applicant willing to work in collaboration with the THW Commission to implement the Commission's best practices for THW integration and utilization?

[X] Yes   [ ] No

If "no" please provide explanation: _____

c.   Is Applicant willing to fully implement the best practices developed in collaboration with the THW Commission?

[X] Yes   [ ] No

If "no" please provide explanation: _____

d.   Is Applicant willing to develop and implement a payment strategy for THWs that is informed by the recommendations from the Payment Model Committee of the THW Commission?

[X] Yes   [ ] No

If "no" please provide explanation: _____

e.   Is Applicant willing to designate an individual within the organization as a THW Liaison as of the Effective Date of the Contract?

[X] Yes   [ ] No

If "no" please provide explanation: _____

f.   Is Applicant willing to engage THWs during the development of the CHA and CHP?

[X] Yes   [ ] No

If "no" please provide explanation: _____

g.   For services that are not captured on encounter claims, is Applicant willing to track and document Member interactions with THWs?

[X] Yes   [ ] No

If "no" please provide explanation: _____

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

   a. Is Applicant willing to partner with local public health authorities, non-profit Hospitals, any CCO that shares a portion of its Service Area, and any Tribes that are developing a CHA/CHP to develop shared CHA and CHP priorities?

   $\boxed{\text{X}}$ Yes ☐No

   If "no" please provide explanation: _____

   b. Is Applicant willing to align CHP priorities with at least two State Health Improvement Plan (SHIP) priorities and implement statewide SHIP strategies based on local need?

   $\boxed{\text{X}}$ Yes ☐No

   If "no" please provide explanation: _____

   c. Is Applicant willing to submit its Community Health Assessment and Community Health Improvement Plan to OHA?

   $\boxed{\text{X}}$ Yes ☐No

   If "no" please provide explanation: _____

   d. Is Applicant willing to develop and fully implement a community engagement plan?

   $\boxed{\text{X}}$ Yes ☐No

   If "no" please provide explanation: _____

F. **Behavioral Health Attestations (Attachment 11)**

   1. **Behavioral Health Benefit**

      a. Will Applicant report performance measures and implement Evidence-Based outcome measures, as developed by the OHA Metrics and Scoring Committee, and as specified in the Contract?

      $\boxed{\text{X}}$ Yes ☐No

      If "no" please provide explanation: _____

      b. Will Applicant work collaboratively with OHA and its partners to implement all of the requirements in Exhibit M of the Contract?

      $\boxed{\text{X}}$ Yes ☐No

      If "no" please provide explanation: _____

      c. Will Applicant be fully responsible for the Behavioral Health benefit for Members beginning in CY 2020?

      $\boxed{\text{X}}$ Yes ☐No

      If "no" please provide explanation: _____

      d. Will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner? Fully integrated manner means that Applicant

will not sub-capitate any Provider or entity for Behavioral Health services separately from physical health services nor will Applicant enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services.

[X] Yes [ ] No

If "no" please provide explanation: _____

e. Will Applicant report on the information and data specified in the Performance Expectations section as specified in the Contract and submit an annual report to OHA for review and approval?

[X] Yes [ ] No

If "no" please provide explanation: _____

f. Will Applicant have sufficient resources, including technological, financial, Provider and workforce, to integrate the Behavioral Health benefit with oral and physical health care benefits?

[X] Yes [ ] No

If "no" please provide explanation: _____

g. Will Applicant ensure the provision of cost-effective, comprehensive, person-centered, Culturally Responsive, and integrated Community-based Behavioral Health services for Members?

[X] Yes [ ] No

If "no" please provide explanation: _____

h. Will Applicant provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally Responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care?

[X] Yes [ ] No

If "no" please provide explanation: _____

i. Will Applicant follow Intensive Care Coordination standards as identified in OAR 410141-3160/70?

[X] Yes [ ] No

If "no" please provide explanation: _____

j. Will Applicant ensure Members have access to Referral and screening at multiple health system or health care entry points?

[X] Yes [ ] No

If "no" please provide explanation: _____

k. Will Applicant use a standardized Assessment tool, to adapt the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member?

$\boxed{X}$ Yes ☐No

If "no" please provide explanation: _____

l. Will Applicant work collaboratively to improve services for adult Members with SPMI as a priority population? Will Applicant make significant commitments and undertake significant efforts to continue to improve treatment and services so that adults with SPMI can live and prosper in integrated Community settings?

$\boxed{X}$ Yes ☐No

If "no" please provide explanation: _____

m. Will Applicant ensure Members have timely access to all services under the Behavioral Health benefit in accordance with access to service standards as developed in Appendix C, the Administrative Rules Concept Document, under OHPB #17?

$\boxed{X}$ Yes ☐No

If "no" please provide explanation: _____

n. Will Applicant have an adequate Provider Network to ensure Members have timely access to Behavioral Health services and effective treatment in accordance with the Delivery System and Provider Capacity section of the Contract?

$\boxed{X}$ Yes ☐No

If "no" please provide explanation: _____

o. Will Applicant establish written policies and procedures for Prior Authorizations, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and be responsible for any inquiries or concerns and not delegate responsibility to Providers?

$\boxed{X}$ Yes ☐No

If "no" please provide explanation: _____

p. Will Applicant establish written policies and procedures for the Behavioral Health benefit and provide the written policies and procedures to OHA by the beginning of CY 2020?

$\boxed{X}$ Yes ☐No

If "no" please provide explanation: _____

q. Will Applicant require mental health and substance use disorder programs be licensed or certified by OHA to enter the Provider Network?

    ☒ Yes   ☐ No

    If "no" please provide explanation: _____

r. Will Applicant require Providers to screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)?

    ☒ Yes   ☐ No

    If "no" please provide explanation: _____

s. Will Applicant ensure Applicant's staff and Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/)?

    ☒ Yes   ☐ No

    If "no" please provide explanation: _____

t. Will Applicant ensure Providers are trained in Trauma Informed approaches and provide regular periodic oversight and technical assistance to Providers?

    ☒ Yes   ☐ No

    If "no" please provide explanation: _____

u. Will Applicant require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACEs) and trauma in a Culturally Responsive and Trauma Informed framework and approach?

    ☒ Yes   ☐ No

    If "no" please provide explanation: _____

v. Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?

    ☒ Yes   ☐ No

    If "no" please provide explanation: _____

w. Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?

    ☒ Yes   ☐ No

    If "no" please provide explanation: _____

x.   Will Applicant include OHA approved Behavioral Health homes (BHHs) in Applicant's network as the BHHs qualify in Applicant's Region?

[X] Yes   [ ] No

If "no" please provide explanation: _____

y.   Will Applicant assist Behavioral Health organizations within the delivery system to establish BHHs?

[X] Yes   [ ] No

If "no" please provide explanation: _____

z.   Will Applicant utilize BHHs in their network for Members to the greatest extent possible?

[X] Yes   [ ] No

If "no" please provide explanation: _____

aa.   Will Applicant provide a full psychological evaluation and child psychiatric consultation for children being referred to the highest levels of care (day treatment, subacute or PRTS)?

[X] Yes   [ ] No

If "no" please provide explanation: _____

2.   MOU with Community Mental Health Program (CMHP)

a.   Will Applicant enter into a written memorandum of understanding (MOU) with the local Community Mental Health Program (CMHP) in Applicant's Region by beginning of CY 2020, in accordance with ORS 414.153?

[X] Yes   [ ] No

If "no" please provide explanation: _____

b.   Will Applicant develop a comprehensive Behavioral Health plan for Applicant's Region in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, Peers, families, housing authorities, housing Providers, courts)?

[X] Yes   [ ] No

If "no" please provide explanation: _____

c.   Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the local Community Mental Health Program (CMHP) for the delivery of mental health services under ORS 430.630

[X] Yes   [ ] No

If "no" please provide explanation: _____

3.   **Provisions of Covered Services – Behavioral Health**

a.   Will Applicant provide services as necessary to achieve compliance with the mental health parity requirements of 42 CFR§ 438, subpart K and ensure that any quantitative treatment limitations (QTLs), or non-quantitative treatment limitations (NQTLs) placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i)?

$\boxed{\text{X}}$ Yes   ☐ No

If "no" please provide explanation: _____

b.   Will Applicant assume accountability for Members that are civilly committed and are referred to and enter Oregon State Hospital; be financially responsible for the services for Members on waitlist for Oregon State Hospital after the second year of the Contract, with timeline to be determined by OHA; and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the Contract, with timeline to be determined by OHA?

$\boxed{\text{X}}$ Yes   ☐ No

If "no" please provide explanation: _____

c.   Will Applicant reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health Provider, and reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical Provider?

$\boxed{\text{X}}$ Yes   ☐ No

If "no" please provide explanation: _____

d.   Will Applicant ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards? Will Applicant remain responsible for coordinating Behavioral Health services with Non Participating Providers and reimbursing for services?

$\boxed{\text{X}}$ Yes   ☐ No

If "no" please provide explanation: _____

e.   Will Applicant ensure continuity of care throughout episodes of care and provide Intensive Care Coordination and general Care Coordination as specified in the Contract?

$\boxed{\text{X}}$ Yes   ☐ No

If "no" please provide explanation: _____

4.   **Covered Services Component – Behavioral Health**

a.   Will Applicant establish written policies and procedures for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114? Will the emergency response system provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions?

[X] Yes   ☐ No

If "no" please provide explanation: _____

b.   Will Applicant ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, and 309-019-0300 to 309019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute psychiatric care facility?

[X] Yes   ☐ No

If "no" please provide explanation _____

c.   Will Applicant establish written policies and procedures for a Quality Improvement plan for the emergency response system?

[X] Yes   ☐ No

If "no" please provide explanation: _____

d.   Will Applicant collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in Community integrated settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons?

[X] Yes   ☐ No

If "no" please provide explanation: _____

e.   Will Applicant work with Hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED? Will Applicant develop remediation plans with EDs with significant numbers of ED stays longer than 23 hour?

[X] Yes   ☐ No

If "no" please provide explanation: _____

f.   Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an ED in a six-month period?

[X] Yes   ☐ No

If "no" please provide explanation: _____

g. Will Applicant make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment?

[X] Yes [ ] No

If "no" please provide explanation: _____

h. Will Applicant establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold?

[X] Yes [ ] No

If "no" please provide explanation: _____

i. Will Applicant assure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute, and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

[X] Yes [ ] No

If "no" please provide explanation: _____

j. If Applicant identifies a Member, over age 18 with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder, is appropriate for Long Term Psychiatric Care (State Facility level of care), will Applicant request a LTPC determination from the OHA LTPC reviewer?

[X] Yes [ ] No

If "no" please provide explanation: _____

k. If Applicant identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site?

[X] Yes [ ] No

If "no" please provide explanation: _____

l.   If Applicant identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site?

[X] Yes   [ ] No

If "no" please provide explanation: _____

m.   For the Member age 18 and over, will Applicant work with the Member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated Community-based setting possible consistent with Member choice?

[X] Yes   [ ] No

If "no" please provide explanation: _____

n.   Will Applicant authorize and reimburse Care Coordination services, in particular for Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed Community treatment programs? Will Applicant authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160-70?

[X] Yes   [ ] No

If "no" please provide explanation: _____

o.   Will Applicant ensure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

[X] Yes   [ ] No

If "no" please provide explanation: _____

p.   Will Applicant provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC?

[X] Yes   [ ] No

If "no" please provide explanation: _____

q. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer bridger, or other Community provider prior to discharge, and that all such Warm Handoffs are documented?

[X] Yes ☐ No

If "no" please provide explanation: _____

r. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870?

[X] Yes ☐ No

If "no" please provide explanation: _____

s. Will Applicant ensure all adult Members receive a follow-up visit with a Community Behavioral Health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital?

[X] Yes ☐ No

If "no" please provide explanation: _____

t. Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?

[X] Yes ☐ No

If "no" please provide explanation: _____

u. Will Applicant coordinate with system Community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs and the individual's informed choice?

[X] Yes ☐ No

If "no" please provide explanation: _____

v. Will Applicant ensure coordination and appropriate Referral to Intensive Care Coordination to ensure that Member's rights are met and there is post-discharge support? If Member is connected to ICC coordinator, will Applicant ensure coordination with this person as directed in OAR 410-141-3160-3170?

[X] Yes ☐ No

If "no" please provide explanation: _____

w. Will Applicant work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and work with Acute Care Psychiatric Hospitals in the development of each individual's housing assessment?

[X] Yes [ ] No

If "no" please provide explanation:_____

x. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period?

[X] Yes [ ] No

If "no" please provide explanation:_____

y. Will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

[X] Yes [ ] No

If "no" please provide explanation:_____

z. Will Applicant coordinate services for each adult Member with SPMI who needs assistance with Covered or Non-covered Services?

[X] Yes [ ] No

If "no" please provide explanation:_____

aa. Will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

[X] Yes [ ] No

If "no" please provide explanation:_____

bb. Will Applicant provide Utilization Review and utilization management, for Members receiving Behavioral Health Services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals

who no longer need placement in such setting transition to the most integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

$\boxed{X}$ Yes $\quad \square$ No

If "no" please provide explanation: _____

cc. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

$\boxed{X}$ Yes $\quad \square$ No

If "no" please provide explanation: _____

dd. Will Applicant ensure that Members with SPMI receive Intensive Care Coordination (ICC) support in finding appropriate housing and receive coordination in addressing Member's housing needs?

$\boxed{X}$ Yes $\quad \square$ No

If "no" please provide explanation: _____

ee. Will Applicant ensure Members with SPMI are assessed to determine eligibility for ACT?

$\boxed{X}$ Yes $\quad \square$ No

If "no" please provide explanation: _____

ff. Will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

$\boxed{X}$ Yes $\quad \square$ No

If "no" please provide explanation: _____

gg. Will Applicant ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed?

$\boxed{X}$ Yes $\quad \square$ No

If "no" please provide explanation: _____

hh.   Will Applicant, when ten (10) or more of Applicant's adult Members with SPMI in Applicant's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Applicant solutions, create additional capacity by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams?

☒ Yes   ☐ No

If "no" please provide explanation: _____

If Applicant lacks qualified Providers to provide ACT services, will Applicant consult with OHA and develop a plan to develop additional qualified Providers? Will lack of capacity not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist? Will no individual on a waitlist for ACT services be without such services for more than 30 days?

☒ Yes   ☐ No

If "no" please provide explanation: _____

ii.   Will Applicant ensure all denials of ACT services for all adult Members with SPMI are: based on established, evidence-based medical necessity criteria; reviewed, recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate; and follow the Notice of Adverse Benefit Determination process for all denials as described in the Contract?

☒ Yes   ☐ No

If "no" please provide explanation: _____

jj.   Will Applicant be responsible for finding or creating a team to serve Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards?

☒ Yes   ☐ No

If "no" please provide explanation: _____

kk.   Will Applicant be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation?

☒ Yes   ☐ No

If "no" please provide explanation: _____

ll.   Will Applicant require that a Provider or care coordinator meets with the Member to discuss ACT services and provide information to support the Member in making an informed decision regarding participation? Will this include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member's self-identified needs, and ways that

ACT can enhance a Member's care and support independent Community living?

☒ Yes ☐ No

If "no" please provide explanation:_____

mm. Will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC?

☒ Yes ☐ No

If "no" please provide explanation:_____

nn. Will Applicant report the number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month?

☒ Yes ☐ No

If "no" please provide explanation:_____

oo. Will Applicant ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative?

☒ Yes ☐ No

If "no" please provide explanation:_____

pp. Will Applicant document efforts to provide ACT to individuals who initially refuse ACT services, and document all efforts to accommodate their concerns?

☒ Yes ☐ No

If "no" please provide explanation:_____

qq. Will Applicant offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services?

☒ Yes ☐ No

If "no" please provide explanation:_____

rr. Will Applicant ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs?

☒ Yes ☐ No

If "no" please provide explanation:_____

ss.   Will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI in accordance with OAR 309-0910000 through 0050?

[X] Yes   [ ] No

If "no" please provide explanation: _____

tt.   Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-0190295? ("Supported Employment Services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR 309-019-0225.)

[X] Yes   [ ] No

If "no" please provide explanation: _____

uu.   Will Applicant work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism?

[X] Yes   [ ] No

If "no" please provide explanation: _____

vv.   Will Applicant work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

[X] Yes   [ ] No

If "no" please provide explanation: _____

ww.   Will Applicant provide Substance Use Disorder (SUD) services to Members, which include outpatient, intensive outpatient, medication assisted treatment including Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, and OAR Chapter 415 Divisions 20, and 50?

[X] Yes   [ ] No

If "no" please provide explanation: _____

xx.   Will Applicant comply with Substance Use Disorder (SUD) waiver program designed to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, upon approval by Centers for Medicare and Medicaid Services (CMS)?

[X] Yes   [ ] No

If "no" please provide explanation: _____

yy. Will Applicant inform all Members using Culturally Responsive and linguistically appropriate means that Substance Use Disorder outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are Covered Services consistent with OAR 410-141-3300?

$\boxed{\text{X}}$ Yes   ☐ No

If "no" please provide explanation: _____

zz. Will Applicant participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access?

$\boxed{\text{X}}$ Yes   ☐ No

If "no" please provide explanation: _____

5. Children and Youth

a. Will Applicant develop and implement cost-effective comprehensive, person-centered, individualized, and integrated Community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles?

$\boxed{\text{X}}$ Yes   ☐ No

If "no" please provide explanation: _____

b. Will Applicant utilize evidence-based Behavioral Health interventions for the needs of children 0-5, and their caregivers, with indications of Adverse Childhood Experiences (ACEs) and high complexity?

$\boxed{\text{X}}$ Yes   ☐ No

If "no" please provide explanation: _____

c. Will Applicant provide Intensive Care Coordination (ICC) that is Family and youth driven, strengths based and Culturally Responsive and linguistically appropriate and abide by ICC standards as set forth in Appendix C, Administrative Rules Concept under OHPB #24 and in accordance with the ICC section in the Contract? Will Applicant abide by ICC standards as forth in Appendix C, Administrative Rules Concept, under OHPB #24, and in accordance with the ICC section in the Contract?

$\boxed{\text{X}}$ Yes   ☐ No

If "no" please provide explanation: _____

d. Will Applicant provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and Family? Will Services alleviate crisis while allowing for the

development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder?

☒ Yes ☐ No

If "no" please provide explanation: _____

e. Will Applicant adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS) and/or Intensive Outpatient Services and Supports?

☒ Yes ☐ No

If "no" please provide explanation: _____

f. Will Applicant ensure the availability of service, supports or alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting?

☒ Yes ☐ No

If "no" please provide explanation: _____

g. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒ Yes ☐ No

If "no" please provide explanation: _____

h. If Applicant identifies a Member is appropriate for LTPC Referral, will Applicant request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and under, available on the Contract Reports Web Site?

☒ Yes ☐ No

If "no" please provide explanation: _____

i. Will Applicant arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition?

☒ Yes ☐ No

If "no" please provide explanation: _____

j. Will Applicant coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA? For a Member 17 and under, placed by DHS Child

Welfare through a Voluntary Placement Agreement (CF 0499), will Applicant also coordinate with such Member's parent or legal guardian?

[X] Yes ☐No

If "no" please provide explanation: _____

k. Will Applicant ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the eligibility and timeline criteria in the Contract?

[X] Yes ☐No

If "no" please provide explanation: _____

l. Will Applicant have funding and resources to implement, to fidelity, Wraparound Services?

[X] Yes ☐No

If "no" please provide explanation: _____

m. Will Applicant enroll all eligible youth in Wraparound and place no youth on a waitlist?

[X] Yes ☐No

If "no" please provide explanation: _____

n. Will Applicant screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at the link below and in Wraparound Service OARs? http://www.oregon.gov/oha/hsd/amh/pages/index.aspx.

[X] Yes ☐No

If "no" please provide explanation: _____

o. Will Applicant establish and maintain a functional System of Care in its Service Area in accordance with the Best Practice Guide located at https://www.pdx.edu/ccf/bestpractice-guide including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and Family voice representation to be 51 percent?

[X] Yes ☐No

If "no" please provide explanation: _____

p. Will Applicant have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council?

[X] Yes ☐No

If "no" please provide explanation: _____

q. By end of CY 2020, will Applicant have written Charters and new Member handbooks for Practice Level Work group, Advisory Council and Executive Council?

[X] Yes [ ] No

If "no" please provide explanation: _____

G. Cost and Financial Attestations (Attachment 12)

1. Rates

a. Does Applicant accept the CY 2020 Rate Methodology appended to Attachment 12?

[X] Yes [ ] No

If "no" please provide explanation: _____

2. Evaluate CCO performance to inform CCO-specific profit margin

a. Does Applicant agree to performance and efficiency evaluation being used to set profit margins in CCO capitation rates?

[X] Yes [ ] No

If "no" please provide explanation: _____

b. Does Applicant agree to accept the CCO 2.0 capitation rate methodology as described in the Oregon CY20 Procurement Rate Methodology document and also accept the performance evaluation methodology and its use in setting CCO-specific profit margins?

[X] Yes [ ] No

If "no" please provide explanation: _____

c. Does Applicant agree to report additional data as needed to inform the performance evaluation process, including data on utilization of Health-Related Services?

[X] Yes [ ] No

If "no" please provide explanation: _____

d. Is Applicant willing to have OHA use efficiency analysis to support managed care efficiency adjustments that may result in adjustments to the base data used in capitation rate development to further incentivize reductions in Waste in the system?

[X] Yes [ ] No

If "no" please provide explanation: _____

3. **Qualified Directed Payments to Providers**

    a. Is Applicant willing to make OHA-directed payments to certain Hospitals within five Business Days after receipt of a monthly report prepared and distributed by OHA?

        $\boxed{\text{X}}$ Yes   ☐No

        If "no" please provide explanation: _____

    b. Is Applicant willing to report to OHA promptly if it determines payments to Hospitals will be significantly delayed?

        $\boxed{\text{X}}$ Yes   ☐No

        If "no" please provide explanation: _____

    c. Is Applicant willing to exclude the portion of OHA-directed payments for provider tax repayment when negotiating alternative or Value-Based Payment reimbursement arrangements?

        $\boxed{\text{X}}$ Yes   ☐No

        If "no" please provide explanation: _____

    d. Is Applicant willing to provide input and feedback to OHA on the selection of measures of quality and value for OHA-directed payments to Providers?

        $\boxed{\text{X}}$ Yes   ☐No

        If "no" please provide explanation: _____

4. **Quality Pool Operations and Reporting**

    a. Does Applicant agree to having a portion of capitation withheld from monthly Capitation Payment and awarded to the Applicant based on performance on metrics based on the Quality Incentive Pool program?

        $\boxed{\text{X}}$ Yes   ☐No

        If "no" please provide explanation: _____

    b. Does Applicant agree to report to OHA separately on expenditures incurred based on Quality Pool revenue earned?

        $\boxed{\text{X}}$ Yes   ☐No

        If "no" please provide explanation: _____

    c. Does Applicant agree to report on the methodology it uses to distribute Quality Pool earnings to Providers, including SDOH-HE partners and public health partners?

        $\boxed{\text{X}}$ Yes   ☐No

        If "no" please provide explanation: _____

d. Does Applicant have a plan to evaluate contributions made by SDOH-HE and public health partners toward the achievement of Quality Pool metrics?

[X] Yes [ ] No

If "no" please provide explanation:_____

5. Transparency in Pharmacy Benefit Management Contracts

a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 5. If not, please answer parts b-f of this question.

[ ] Yes [X] No

If "no" please provide explanation:_____

In 2019, AllCare used an independent third party actuarial and consulting firm, Milliman, Inc. to compare the potential savings using the rates from OPDP and compared to the potential savings using our current contract with MedImpact. This is what they found:

- Oregon Prescription Drug Program (OPDP) – This pricing option grants CCO access to the Northwest Prescription Drug Consortium's negotiated rates. Estimated savings compared to total estimated cost, over a three-year contract term: 1.5% or $1.9 million

  o MedImpact PBM Services (Incumbent) –Estimated savings compared to total estimated cost, over a three-year contract term: 4.1% or $5.1 million

Given this information and our need to be good stewards of the States money, it is clear that we need to stay with our current contract. This is an important area that allows us to control costs without compromising services.

b. Will Applicant use a pharmacy benefit manager that will provide pharmacy cost pass through at 100% and pass back 100% of rebates received to Applicant?

[X] Yes [ ] No

If "no" please provide explanation:_____

c. Will Applicant separately report to OHA any and all administrative fees paid to its PBM?

[X] Yes [ ] No

If "no" please provide explanation:_____

d. Will Applicant require reporting from PBM that provides paid amounts for pharmacy costs at a claim level?

[X] Yes [ ] No

If "no" please provide explanation:_____

e.   Will Applicant obtain market check and audits of their PBMs by a third party on an annual basis, and share the results of the market check with the OHA?

[X] Yes   [ ] No

If "no" please provide explanation: _____

f.   Will Applicant require its PBM to remain competitive with enforceable contract terms and conditions driven by the findings of the annual market check and report auditing?

[X] Yes   [ ] No

If "no" please provide explanation: _____

6.   **Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria**

a.   Will Applicant partner with OHA on the goal of increasing the alignment of CCO preferred drug lists (PDL) with the Fee-For-Service PDL set every year by OHA?

[X] Yes   [ ] No

If "no" please provide explanation: _____

b.   Will Applicant align its PDL in any and all categories of drugs as recommended by the P&T committee and as required by OHA?

[X] Yes   [ ] No

If "no" please provide explanation: _____

c.   Will Applicant post online in a publicly accessible manner the Applicant's specific PDL with coverage and Prior Authorization criteria in a format designated by OHA and update the posting concurrently or before any changes to the PDL or coverage/PA criteria become effective?

[X] Yes   [ ] No

If "no" please provide explanation: _____

7.   **Financial Reporting Tools and Requirements**

a.   Is Applicant willing to partake of all financial, legal and technological requirements of the National Association of Insurance Commissioners (NAIC) in whatever capacity necessary to file its financial information with OHA under NAIC standards?

[X] Yes   [ ] No

If "no" please provide explanation: _____

b. Will Applicant report its required financial information to OHA on the NAIC's Health Quarterly and Annual Statement blank ("Orange Blank") through the NAIC website as described in this RFA, under NAIC standards and instructions?

$\boxed{X}$ Yes ☐ No

If "no" please provide explanation: _____

c. Will Applicant report its financial information to OHA using Statutory Accounting Principles (SAP), subject to possible exemption from SAP for 2020 as described in this RFA?

$\boxed{X}$ Yes ☐ No

If "no" please provide explanation: _____

d. Will Applicant file the financial reports described in this RFA, including Contract Exhibit L and supplemental schedules with the instructions referenced in this RFA?

$\boxed{X}$ Yes ☐ No

If "no" please provide explanation: _____

e. Is Applicant willing to resubmit its pro forma financial statements for three years starting in 2020, modified to reflect the Enrollment expected assuming other CCOs that may operate in Applicant's Service Area?

$\boxed{X}$ Yes ☐ No

If "no" please provide explanation: _____

f. Does Applicant commit to preparing and filing a Risk Based Capital (RBC) report each year based on NAIC requirements and instructions?

$\boxed{X}$ Yes ☐ No

If "no" please provide explanation: _____

g. Is Applicant willing to submit quarterly financial reports including a quarterly estimation of RBC levels to ensure financial protections are in place during the year?

$\boxed{X}$ Yes ☐ No

If "no" please provide explanation: _____

h. Is Applicant willing to have its RBC threshold evaluated quarterly using a proxy calculation?

$\boxed{X}$ Yes ☐ No

If "no" please provide explanation: _____

i. If Applicant's estimated RBC falls below the minimum required percentage based on the quarterly estimation, is Applicant willing to submit a year-to-date financial filing and full RBC evaluation?

[X] Yes ☐ No

If "no" please provide explanation: _____

8. Accountability to Oregon's Sustainable Growth Targets

a. Does Applicant commit to achieving a sustainable growth in expenditures each calendar year (normalized by membership) that matches or is below the Oregon 1115 Medicaid demonstration project waiver growth target of 3.4%?

[X] Yes ☐ No

If "no" please provide explanation: _____

b. Does Applicant similarly commit to making a good faith effort towards achievement of future modifications to the growth target in the waiver?

[X] Yes ☐ No

If "no" please provide explanation: _____

c. Does Applicant agree that OHA may publicly report on CCO performance relative to the sustainable growth rate targets (normalized for differences in membership)?

[X] Yes ☐ No

If "no" please provide explanation: _____

d. Does Applicant agree that OHA may institute a Corrective Action Plan that may include financial penalties, if a CCO does not achieve the expenditure growth targets based on the current 1115 Medicaid waiver?

[X] Yes ☐ No

If "no" please provide explanation: _____

9. Potential Establishment of Program-wide Reinsurance Program in Future Years

a. Will Applicant participate in any program-wide reinsurance program that is established in years after 2020 consistent with statutory and regulatory provisions that are enacted?

[X] Yes ☐ No

If "no" please provide explanation: _____

b. Will Applicant use private reinsurance contracts on only an annual basis so as to ensure ability to participate in state-run program if one is launched at the start of a calendar year?

[X] Yes ☐ No

If "no" please provide explanation: _____

    c.   Does Applicant agree that implementation of program-wide reinsurance program will reduce capitation rates in years implemented as a result of claims being paid through reinsurance instead of with capitation funds?

                ☒ Yes   ☐ No

                If "no" please provide explanation:

10. **CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk**

    a.   Is Applicant willing to have its financial solvency risk measured by Risk Based Capital (RBC) starting in 2021?

                ☒ Yes   ☐ No

                If "no" please provide explanation:

    b.   Is Applicant willing to achieve a calculated RBC threshold of 200% by end of Q3 of 2021 and thereafter to maintain a minimum RBC threshold of 200%?

                ☒ Yes   ☐ No

                If "no" please provide explanation:

    c.   Is Applicant willing to report to OHA promptly if it determines that its calculated RBC value is or is expected to be below 200%?

                ☒ Yes   ☐ No

                If "no" please provide explanation:

    d.   Is Applicant willing to report to OHA promptly if it determines that its actual financial performance departs materially from the pro forma financial statements submitted with this Application?

                ☒ Yes   ☐ No

                If "no" please provide explanation:

    e.   Will Applicant maintain the required restricted reserve account per Contract?

                ☒ Yes   ☐ No

                If "no" please provide explanation:

11. **Encounter Data Validation Study**

    a.   Is Applicant willing to perform regular chart reviews and audits of its encounter claims to ensure the Encounter Data accurately reflects the services provided?

                ☒ Yes   ☐ No

                If "no" please provide explanation:

      b.   Is Applicant willing to engage in activities to improve the quality and accuracy of Encounter Data submissions?

           ☒ Yes   ☐ No

           If "no" please provide explanation: _____

H.   **Member Transition Plan** (Attachment 16)

    1.   Is Applicant willing to faithfully execute its Member Transition Plan as described in Attachment 16?

           ☒ Yes   ☐ No

           If "no" please provide explanation: _____

Attachment 14 — Assurances

Applicant Name: <u>AllCare CCO, Inc.</u>

Authorizing Signature: _____

Printed Name: <u>Douglas L. Flow, PhD, CEO</u>

Instructions: Assurances focus on the Applicant's compliance with federal Medicaid law and related Oregon rules. For each assurance, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all assurances. If an assurance has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These assurances must be signed by a representative of Applicant.

Each assurance is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. **Emergency and Urgent Care Services.** Will Applicant have written policies and procedures, and oversight and monitoring systems to ensure that emergency and urgent services are available for all Members on a 24-hour, 7-days-a-week basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? (See 42 CFR 438.114 and OAR 410-141-3140]

   [X] Yes   [ ] No

   If "no" please provide explanation:_____

2. **Continuity of Care.** Will Applicant implement written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorizations to other Providers? Will Applicant follow Intensive Care Coordination (ICC)/ENCC standards and Care Coordination standards, including transition meetings, as directed in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208 and OAR 410-141-3160]

   [X] Yes   [ ] No

   If "no" please provide explanation:_____

3. Will Applicant implement written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant's Primary Care and Referral Providers? Will Applicants communicate these policies and procedures to

Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance? Will Applicants document all monitoring and Corrective Action activities? Will such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law? [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]

☒ Yes ☐ No

If "no" please provide explanation:

4. Will Applicant have an ongoing quality performance improvement program for the services it furnishes to its Members? Will the program include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction? The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance. [See OAR 410-141-0200]

☒ Yes ☐ No

If "no" please provide explanation:

5. Will Applicant make Coordinated Care Services accessible to enrolled Members? Will Applicant not discriminate between Members and non-Members as it relates to benefits to which they are both entitled including reassessment or additional screening as needed to identify exceptional needs in accordance with OAR 410-141-3160 through 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance.? [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220]

☒ Yes ☐ No

If "no" please provide explanation:

6. Will Applicant have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix B "Sample Contract"? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.228, 438.400 – 438.424]

☒ Yes ☐ No

If "no" please provide explanation:

7.   Will Applicant develop and distribute OHA-approved informational materials to Potential Members that meet the language and alternative format requirements of Potential Members? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; OAR 410-141-3280]

[X] Yes   [ ] No

If "no" please provide explanation:_____

8.   Will Applicant have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant provided in the Member handbook or via health education, about the availability of intensive Care Coordination for Members who are aged, blind and/or disabled, or are part of a prioritized population, and appropriate use of emergency facilities and urgent care? Will Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; and OAR 410-141-3300]

[X] Yes   [ ] No

If "no" please provide explanation:_____

9.   Will Applicant have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Appendix B, Core Contract? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]

[X] Yes   [ ] No

If "no" please provide explanation: _____

10.   Will Applicant provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled; Members with high health needs or multiple chronic conditions; Members receiving Medicaid-funded long-term care or long-term services and supports or receiving Home and Community-Based Services (HCBS) under the state's 1915(i), 1915(j), or 1915(k) State Plan Amendments or the 1915(c) HCBS waivers, or Behavioral Health priority populations in accordance with OAR 410-141-3170? Will Applicant ensure that Prioritized Populations, who sometimes have difficulty with engagement, are fully informed of the benefits of Care Coordination? Will Applicant ensure that their organization will be Trauma Informed by January 1, 2020? Will Applicant utilize evidence-based outcome measures? Will Applicant ensure that Members who meet criteria for ENCC receive contact and service delivery as required in OAR 410141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor

Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208]

X Yes ☐ No

If "no" please provide explanation: _____

11. Will Applicant maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant and its Providers or Subcontractors will not hold Members responsible for debt incurred by the Applicant or by Providers if the entity becomes insolvent? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 447.46]

X Yes ☐ No

If "no" please provide explanation: _____

12. Will Applicant participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards? Has Applicant executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]

X Yes ☐ No

If "no" please provide explanation: _____

13. Will Applicant maintain an efficient and accurate system for capturing Encounter Data, timely reporting the Encounter Data to OHA, and regularly validating the accuracy, truthfulness and completeness of that Encounter Data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242; and the Contract]

X Yes ☐ No

If "no" please provide explanation: _____

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

[X] Yes   [ ] No

If "no" please provide explanation: _____

15. **Assurances of Compliance with Medicaid Regulations**

Item 15 of this Attachment 14 has ten assurances of Compliance with Medicaid Regulations. These Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to be eligible to contract as a CCO. For purposes of this section and the federal Medicaid regulations in 42 CFR Part 438, a CCO falls within the definition of a "managed care organization" in 42 CFR 438.2. This section asks the Applicant to provide a brief narrative of how the Applicant meets each applicable Assurance. The Applicant must provide supporting materials available to the OHA upon request.

Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15:

a. **Medicaid Assurance #1 – 42 CFR § 438.206 Availability of services.**

As a managed care organization, AllCare ensures the availability of services in the following ways: First, it contracts with 97% of all providers available that deliver physical, behavioral, and oral health services in our three county service area. Secondly, all enrollees have an assigned primary care provider who is contractually obligated to deliver medically necessary health services and to coordinate with an enrollee's care coordination team to ensure timely access to the full continuum of care needs through development of individualized care/treatment plans that support the triple aim of better individual health, better community health, at reduces costs. To promote the triple aim, AllCare includes access and quality measures in its seven Value Based Payment Models that incent providers to 1) use lower cost care settings when quality outcomes are equal or better; 2) offer expanded hours into the evening and/or on weekends to accommodate enrollee work or school schedules; 3) emphasize health equity and cultural diversity by rewarding providers who participate in AllCare's health equity/diversity training courses and utilize our expanded interpreter program which now includes more than 91 interpreters covering 11 languages (up from 1 interpreter in 2016) and 4) emphasize prevention and wellness services to improve the overall health of the communities we serve. For subspecialty health care services not available in our rural communities and sometimes not available within our service area, AllCare arranges to transport Members to the closest contracted provider

in Medford or an out-of-contract provider to ensure the Member receives the care they need in a timely manner and at no cost to them.

b. **Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.**

As a CCO since 2012, AllCare has provided annual reports to the OHA that lists all contracted providers in our network and to verify our capacity as measured by the number of provider FTEs per 1000 enrollees by specialty. We also provide annual reports that include geo-access data to demonstrate network adequacy as measured in driving time and distance metrics among our OHP enrollees by zip code. This information is updated on a regular basis to ensure that network capacity standards by type of service are being met. In addition, it is important to note that AllCare is not the only CCO serving southwest Oregon's counties. We collaboratively compete with a different CCO in each of the three counties we serve. This ensures choice for all OHP Members and also ensures that enrollees can change CCOs if they experience barriers to care due to lack of capacity or insufficient services in one CCO over another. This incentivizes all CCOs in SW Oregon, including AllCare, to maintain and nurture their network of contracted providers to ensure enrollee satisfaction and continuity of care.

c. **Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.**

AllCare maintains a robust Care Coordination program that is centralized through our headquarters in Grants Pass, OR, Josephine County to ensure continuity of care. Our care coordination team is comprised of registered nurses, social workers, respiratory therapists, behavioral health specialists, traditional health workers, and disease management educators/coordinators. This team collaborates with our Utilization Management/Prior Authorization team to ensure Members receive the care they need in a timely manner. The team also collaborates with up-stream primary care providers, specialists and inpatient facilities to coordinate care and support transitions of care across care settings, ensure continuity of care, develop comprehensive and individualized care plans, and monitor Member progress toward personal goals. Upon enrollment, members with special needs as identified by the state are contacted to ensure they select a primary care provider within 30 days and schedule an initial exam and initial screening within 90 days. Data sharing occurs through our health information exchange operated by Reliance which ensures privacy and confidentiality as required in 45 CFR Parts 160 and 164.

d. **Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.**

AllCare maintains an automated service authorization system on our Provider Portal where most contracted provider service requests and referrals are managed and approved real time. There are 102 services that require prior authorization by our team of Utilization Management nurses and physicians that must be addressed within 14

days of initial request. Expedited reviews are managed within a 72 hour window for physical health and 24 hour window for medications. In all instances, both on-line and direct review, AllCare ensures that authorized services are sufficient in amount, duration, or scope to achieve the purpose for which the services are intended and that services are deemed medically necessary to meet the health needs of each individual Member as recommended by his/her health care provider and care team. Delivery of services is in compliance with our internal standards as well as state policy regarding health equity which do not allow any restrictions on amount, duration or scope of treatment from one person to the next. Our internal policies ensure that coverage and authorization of services are focused on a) prevention, diagnosis, and treatment of each individual's disease, condition, or disorder that results in health impairment and/or disability; b) age-appropriate growth and development; c) attain, maintain, or regain functional capacity; and d) ensure optimal access to community living and patient centered goals that reflect each individual's functional and behavioral optimal capacity. We braid utilization management with the SDoH (such as housing, food and transportation) to improve health outcomes. To achieve these goals, our on-line system and direct review processes ensure consistent application of review criteria for authorization decisions. We use nationally recognized evidence-based care developed by Milliman. In the event of an adverse benefit determination, AllCare staff notify the requesting provider and provide written notification to the Member. If provider and/or Member disagree, AllCare has in place a grievance and appeals process that is fully compliant with state and federal guidelines.

e. **Medicaid Assurance #5 – 42 CFR § 438.214 Provider selection.**

AllCare maintains written policies and procedures that are embedded within our downstream provider contracts to ensure compliance with all state and federal laws governing the delivery of physical health, behavioral health, and oral health across the continuum of care as well as public health, social services, and community based providers. Our credentialing and recredentialing program is compliant with state rules and regulations and overseen by the Quality Committee appointed by Board of Governors. The Committee meets every other month to address credentialing issues across our provider network on an individual provider basis.

f. **Medicaid Assurance #6 – 42 CFR § 438.224 Confidentiality.**

AllCare's internal health information system is HIPAA compliant. For more detail, please refer to Attachment 9 for a full description of our Health Information System.

g. **Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.**

AllCare follows defined appeal and grievance processes which are in accordance with the Oregon Administrative Rules, OHA contract, and federal guidelines. Dedicated staff review notice of adverse benefit decisions (NOABD) for NEMT, oral health, behavioral health and medical services. If a member or authorized representative believes they are entitled to receive, including delay in providing,

arranging for, or approving the health care services (such that a delay would adversely affect the health of the member) they may appeal or grieve the adverse decision. AllCare members have appeal rights for the following circumstances: adverse determinations based on the type or level of service, medical necessity, level of care setting; effectiveness of a covered benefit; reduction, suspension; termination of a requested service; a previously authorized service; or the denial of payment for a service. Also a member may appeal a denial if AllCare fails to provide the services in a timely manner or fails to act within timeframes. AllCare has sufficient grievance procedures to acknowledge the receipt, disposition and documentation of each grievance from an AllCare member regarding the delivery of NEMT, behavioral health, dental or medical care services. The established procedures promote a timely, confidential and organized system for resolving a member's grievance as outlined in the Oregon Administrative Rules, OHA contract and federal guidelines. AllCare ensures that grievances are reviewed by appropriate clinical personnel with expertise in treating the member's condition or disease if the review involves decisions regarding the quality of care.

h. **Medicaid Assurance #8 – 42 CFR § 438.230 Sub contractual relationships and Delegation.**

AllCare's contracts now in place across our entire provider network comply with both state and federal Medicaid rules and regulations. The contracts specify the exact scope of services to be delegated, activities, and obligations that are delegated to the subcontracted entity, including reporting responsibilities as specified in our Medicaid contract with the state. Our subcontractors also agree to allow state, federal, and CCO audit of their books, records, contracts, computer or other electrical systems that pertain to any aspect of services and activities performed or determination of amounts payable under our contract with the State of Oregon.

i. **Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.**

AllCare ensures through its provider contracts that all providers across the continuum of care, including physical health, behavioral health, and oral health, adopt practice guidelines that are based on valid and reliable clinical evidence and consider the needs of our enrollees. Guidelines are reviewed by our Quality Committee periodically to ensure they are consistent with utilization management policies and procedures, meet enrollee needs, are consistent with coverage of services, and are applied uniformly across the continuum of care.

j. **Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.**

AllCare complies with Oregon's requirements imposed by CMS regarding maintenance of a health information system that collects, analyzes, integrates, and reports data on utilization, claims, grievances and appeals, dis-enrollments, etc. This includes a) mechanized claims processing and retrieval systems; b) automated data collection on provider and enrollee characteristics as defined by the State; and c)

verification of data accuracy and timeliness of reported data from capitated providers as well as screening for data completeness, logic, and consistency.

Attachment 15 — Representations

Applicant Name: <u>AllCare CCO, Inc.</u>

Authorizing Signature: _____

Printed Name: <u>Douglas L. Flow, PhD, CEO</u>

Instructions: For each representation, Applicant will check "yes," or "no". On representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all representations.

These representations must be signed by a representative of Applicant.

Each representation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. **Will Applicant have an administrative or management contract with a contractor to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program?**

   [X] Yes   [ ] No

   Explanation: AllCare CCO will contract with AllCare Management Services, LLC. Please see Attachment 6, *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for the contract.

2. **Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the systems or information technology to operate the CCO program for Applicant?**

   [X] Yes [ ] No

   Explanation: AllCare CCO will contract with AllCare Management Services, LLC. Please see Attachment 6, *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for the contract.

3. **Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the claims administration, processing and/or adjudication functions?**

   [X] Yes [ ] No

   Explanation: AllCare CCO will contract with AllCare Management Services, LLC. Please see Attachment 6, *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for the contract.

4. **Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Enrollment, Disenrollment and membership functions?**

   [X] Yes [ ] No

   Explanation: AllCare CCO will contract with AllCare Management Services, LLC. Please see Attachment 6, *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for the contract.

5. **Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the credentialing functions?**

   ☒ X Yes ☐ No

   Explanation: AllCare CCO will contract with AllCare Management Services, LLC. Please see Attachment 6, *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for the contract.

6. **Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the utilization operations management?**

   ☒ X Yes ☐ No

   Explanation: AllCare CCO will contract with AllCare Management Services, LLC. Please see Attachment 6, *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for the contract.

7. **Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Quality Improvement operations?**

   ☒ X Yes ☐ No

   Explanation: AllCare CCO will contract with AllCare Management Services, LLC. Please see Attachment 6, *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for the contract.

8. **Will Applicant have an administrative or management contract with a contractor to perform all or a portion of its call center operations?**

   ☒ X Yes ☐ No

   Explanation: AllCare CCO will contract with AllCare Management Services, LLC. Please see Attachment 6, *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for the contract.

9. **Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the financial services?**

   ☒ X Yes ☐ No

   Explanation: AllCare CCO will contract with AllCare Management Services, LLC. Please see Attachment 6, *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for the contract.

10. **Will Applicant have an administrative or management contract with a contractor to delegate all or a portion of other services that are not listed?**

    ☒ X Yes ☐ No

    Explanation: AllCare CCO will contract with AllCare Management Services, LLC. Please see Attachment 6, *EXHIBIT 6.5-Example Subcontract between AllCare CCO and AllCare Management Services* for the contract.

11. **Will Applicant have contracts with related entities, contractors and Subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract, other than as disclosed in response to representation 1-10 above?**

   ☒ Yes ☐ No

   Explanation: Behavioral Health and Oral Health contractors

12. **Other than VBP arrangements with Providers, will Applicant sub-capitate any portion of its Capitation Payments to a risk-accepting entity (RAE) or to another health plan of any kind?**

   ☒ Yes ☐ No

   Explanation: Behavioral Health, Oral Health, and non-emergent medical transportation contractors.

13. **Does Applicant have a 2019 CCO contract? Is Applicant a risk-accepting entity or Affiliate of a 2019 CCO? Does Applicant have a management services agreement with a 2019 CCO? Is Applicant under common management with a 2019 CCO?**

   ☒ Yes ☐ No

   Explanation: AllCare CCO, Inc. currently has a 2019 CCO contract.

Attachment 16 — Member Transition Plan

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response.

Page limits for this Member Transition Plan is 10 pages. Items that are excluded from the page limit will be noted in that requirement.

1.   **Background and Supporting Sources**

As described in Section 5.8 Member Enrollment, OHA will hold an Open Enrollment period for Members in Choice Areas of the state. Members in these areas may move from their current plan to another plan during the Open Enrollment period. For purposes of its Application, Applicant should assume that all of its service areas will be Choice Areas.

The Member Transition Plan should describe the process for the safe and orderly transfer of Members to another CCO and receiving Members from another CCO during the Open Enrollment period and how the plan will maximize and maintain continuity of care for Members. This includes, but is not limited to, continuity of care with primary and specialty care Providers, primary care and Behavioral Health homes, and plans of care, Prior Authorizations, prescription medications, medical Case Management Services, and Transportation.

The Member Transition Plan should include specific processes for Members who may suffer serious detriment to their physical and mental health or who are at-risk of hospitalization or institutionalization, if any breakdown in service provisions or access to care were to occur, including services provided by Practitioners that may not be contracted with the new CCO. OHA considers these populations to include, but not limited to:

• **Prioritized Populations;**

• **Medically fragile children;**

• **Breast and Cervical Cancer Treatment program Members;**

• **Members receiving CareAssist assistance due to HIV/AIDS;**

• **Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services;**

• **Members discharged from the Oregon State Hospital or Medicaid funded residential Behavioral Health programs in the last 12 calendar months; and**

• **Members participating in Oregon's CMS approved 1915 (k) and 1915 (c) programs for individuals who have met institutional level of care requirements in order to access Home and Community-Based Services (HCBS) under these federal authorities. These individuals are at risk of institutionalization or would require**

Addictions Recovery Center

EDUCATION · TREATMENT · COUNSELING

www.AddictionsRecovery.org

April 5, 2019

Review Committee – RFA-OHA-46690-19
Oregon Health Authority
500 Summer Street NE
Salem, OR 97301

Dear Review Committee:

Please accept this letter as evidence of Addictions Recovery Center's unqualified support of AllCare Health CCO for a new five-year contract with the Oregon Health Authority. AllCare Health CCO consistently demonstrates its commitment to the health and well-being of Jackson and Josephine County residents through innovative strategies and community engagement. The CCO integrates medical, behavioral and dental health services in our community, while incorporating innovative and thoughtful strategies to address social determinants of health and health equity.

Please consider the following while making your determination:

- The team at AllCare Health is in tune with the complex behavioral health needs of the community and is dedicated to building and supporting a comprehensive network of providers to support clients with Substance Use and Mental Health Disorders.
- AllCare Health CCO is consistently responsive to the needs of its members and providers and provides leadership and innovative solutions.
- AllCare Health CCO is a willing resource when its members require wrap-around services.
- AllCare Health CCO is supportive with site reviews and post payment audits.
- AllCare Health provides a multitude of training opportunities for providers to enhance provider skills and quality of care for our clients.
- AllCare Health CCO solicits and is responsive to provider input.
- AllCare Health CCO has demonstrated a willingness to invest in social determinants of health.

AllCare Health CCO has developed deep relationships with community and clinical leaders, convened inspired conversations across our communities about how to improve health and well-being, participate in local collaboratives to prevent or address mental illness, addictions or chronic disease, and helped fill gaps or enhance delivery of services across the continuum. Lastly, AllCare Health CCO has been an integral part of Addictions Recovery Center's substantial growth for the last five years, and we look forward to continuing to our partnership for the next five years to improve the health of our shared populations and our communities.

Respectfully,

Lori Paris
President and Chief Executive Officer
Addictions Recovery Center, Inc.

541.779.1282

Business Office and Mailing Address
1003 East Main Street, Suite 104
Medford, OR 97504

Walk-In Clinic and Outpatient Services
1025 East Main Street
Medford, OR

Fresh Start Detox and Sobering
338 North Front Street
Medford, OR

Inpatient Services
16 South Peach Street
Medford, OR

Tuesday, April 16, 2019

Oregon Health Authority
500 Summer Street NE
Salem, Oregon 97301

RE: AllCare Health CCO Letter of Reference

To whom it may concern:

Until I recently retired, it was my unique privilege and honor to be a Family Practice Nurse Practitioner in Southern Oregon helping thousands of individuals and families live healthier lives. I had a less traditional practice where I took a more hands-on approach with my patients. I would personally bring them into the examination rooms and spend more time with them as needed. In our office, we kept a rack of free clothing for women in case they needed a new outfit for important events such as a job interview. I believe this extra time and non-medical support helped me build trust with my patients and, as a result, they had better health outcomes.
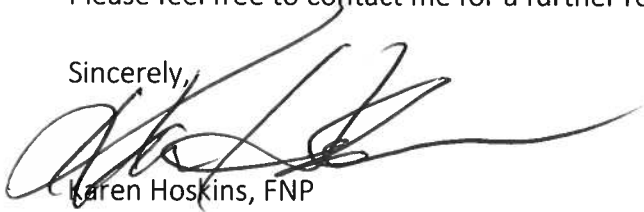
I became a contracted provider with AllCare CCO in 2012 when they became a CCO. AllCare was one of the key reasons I was able help my patients in this more holistic manner. AllCare was an early adopter of changing the way primary care providers were reimbursed. They focused on paying more for quality outcomes for patients and constantly worked with our small office to ensure we could be successful with these new funding systems. This focus on paying for quality allowed me to spend more time with my patients and do the non-medical health services that truly improved the overall health of my patients.

AllCare's commitment to the community often went way beyond patients. A few years ago our community was rocked with the sudden passing of a local primary care provider, Ray Millette. Our community was extremely saddened by his loss, but patients still needed to receive medical care. I stepped up to help by seeing many of Ray's patients and making sure that they were able to get necessary medical attention. AllCare also stepped-up by wrapping support around me to insure the tragedy of Ray's death didn't lead to more tragedies in our community as these transitions took place.

AllCare is a one-of-a-kind organization that has helped countless providers help tens of thousands of southern Oregonians live healthier lives. AllCare is an organization that Oregon should be proud to call their own.

Please feel free to contact me for a further reference at 541-218-7369.

Sincerely,

Karen Hoskins, FNP
(Retired)

Oasis Shelter Home
Serving survivors of domestic and sexual violence

Thursday, April 11, 2019

Oregon Health Authority
500 Summer Street NE
Salem, Oregon 97301

RE: AllCare Health Letter of Reference

To whom it may concern:

Oasis Shelter Home, inc. is an emergency shelter for adult and child victims of domestic violence and sexual assault. Oasis was founded as a result of a grass roots effort dedicated to establishing a haven for victims of family violence in Curry County, Oregon, population 22,000.

The shelter, which has been housing victims since 1995, has 15 beds, 2 full bathrooms, 2 laundry rooms and a playroom complete with toys and games and is the only emergency shelter between Coos Bay, Oregon and Crescent City, California, a 150 mile stretch. Oasis operates a toll free 'hot line' which is listed on the National Directory of Domestic Violence Shelters and receives crisis calls from across the U.S. Oasis also provides Outreach Services to victims and survivors.

Over the past five years Oasis has been able to successfully partner with AllCare CCOs to help maintain or expand our infrastructure to support families or individual experiencing domestic or sexual abuse. AllCare has helped us by partnering with the County Government and their Curry County Community Advisory Council to give funding to help Oasis expand much needed access to local housing. AllCare has also directly contracted with us to provide juvenile forensic interviewing services for their members.

We very much appreciate the partnership with AllCare Health and their assistance in helping us to fulfill our mission of "Through shelter, advocacy, and education, we empower victims of domestic violence, sexual assault, and resulting homelessness, to achieve a life free from abuse."

If you would like to discuss this further please feel free to contact me directly by email at lea.s@oasisshelterhome.org or 541-425-5238.

Sincerely,

Lea Sevey, MHS
Executive Director
Oasis Shelter Home, Inc.

Monday, April 15, 2019

Oregon Health Authority
500 Summer Street NE
Salem, Oregon 97301

RE: AllCare Health Letter of Reference for CCO

To Whom It May Concern:

I was a solo board certified Family Practice physician for over 37 years in Grants
Pass, Oregon. For over two decades I had the honor and privilege of working with
AllCare Health and its founding organization, Mid Rogue Independent Physicians
Association (MRIPA).

MRIPA was founded on a vision of community, with patients and providers sharing
common bonds that transcended shorter-term barriers and challenges. That vision
of community and mutual wellbeing has continued as a foundational value of
AllCare Health as the organization has grown in complexity and scope. It has been a
guiding principle in the evolution of the organizations response to the rapid and
profound changes that have occurred in health care in general.

As a provider I can truthfully state if not for the existence of AllCare Health I would
have retired a decade sooner. Their support in all aspects of patient care as
experienced by a provider 'in the trenches' was both superb and critical. From
enabling me to transition (almost) painlessly to EMR, to seeking 'outside of the box'
care for patient needs, I could always count on AllCare to be responsive and
appropriate. They provided support from the truly innovative to the mundane but
critical daily challenges. They are an open, transparent, compassionate and 'yes'
seeking organization.

As health care delivery has evolved they have proved to be superbly collaborative,
partnering as champions of integration and tirelessly seeking productive, smart
ways to deliver health care to our community. Over the years the patient
satisfaction surveys have been consistently positive in the face of cost effective
stewardship of the communities health care dollar resources.

In short, I strongly believe AllCare Health to be a shining star in the field of health
care organizations and they have my full endorsement.

Please feel free to contact me anytime at bobgentry47@gmail.com.

Sincerely,

Dr. Robert Gentry, MD
(Retired)

References

Addictions Recovery Center
Karen Hoskins, FNP
Oasis Shelter Home
Robert Gentry, MD

services in an institution within 30 days. Institution is defined as Hospital, Nursing Facility or intermediate care facility for individuals with intellectual disabilities.

A successful Member Transition Plan will result in a seamless transition experience for Members changing CCOs during the Open Enrollment period, with minimal and ideally no disruptions of care.

OHA will inform Applicants, in connection with RFA awards, which of its service areas are likely to be Choice Areas. In light of that information, Applicants are expected to submit a complete Member Transition Plan (not subject to the page limits of this RFA), gain OHA approval of its Plan, and update the Plan as part of negotiation activities, contracting, and Open Enrollment period processes.

2.   **Plan Contents**

a.   **Coordination between Transferring and Receiving CCOs**

OHA expects the Transferring and Receiving CCOs to work together and cooperate to achieve a successful transition for Members who change CCO during the Open Enrollment period.

This section should describe the Applicant's plan to coordinate with other CCOs as the Transferring and/or Receiving CCO. This includes but is not limited to establishing working relationships and agreements between CCOs to facilitate data sharing and validation, Member Prior Authorization history, Provider matching and Assignment, continuity of care and customer support.

The following response is predicated on the OHA providing timely and accurate TOC information to all CCOs on the assumption that the OHA commitments as defined in OARs 410-141-3061 and 3258 are met, including timely communication regarding Member termination dates for transferring CCOs and timely communication of eligibility dates for receiving CCOs; delineation of operational requirements for both the transferring and receiving CCOs; data reporting requirements; and defined timelines for submission of members' health data as needed to ensure seamless transitions.

It is AllCare's goal that transition of care services be provided to any newly enrolled Member, including Members transitioning from FFS Medicaid to AllCare or any Member that chooses to switch from an existing CCO to AllCare during an open enrollment period. It is also AllCare's goal that any AllCare member that chooses to transition from AllCare to another CCO receive continuity of care services in collaboration with the receiving CCO.

AllCare currently collaborates with a different CCO in each of the three counties we serve, including Jackson Care Connect in Jackson County, Primary Health of Josephine County in Josephine County, and Advanced Health in Curry County.

Beginning January 1, 2020 it is possible that four CCOs will serve Jackson County, with the potential addition of a CCO administered by Providence Health Plan in Medford and expansion of Primary Health of Josephine County to all of Jackson County. These changes will significantly increase the choices OHP members will face in their Medicaid CCO selection process. To facilitate member choice, AllCare is committed to collaborate and coordinate with all CCOs in each of the counties we serve to ensure continuity of care for all members.

To ensure continuity of care for all current and potential CCO members, AllCare will maximize efficiencies by leveraging the organization's HIT systems, business approaches and infrastructure; we will coordinate and manage data transfers among providers and CCOs through integrated policies and procedures across CCOs as established within inter-CCO Transition of Care agreements to be negotiated upon OHA decisions to award CCO 2.0 contracts.

b. **Transferring CCOs with Outgoing Members**

This section of the Member Transition Plan is required if Applicant (1) has a 2019 CCO contract, (2) is a risk-accepting entity or Affiliate of a 2019 CCO, or (3) has a management services agreement with or is under common management with a 2019 CCO.

(1) **Data Sharing**

This section should describe the plan to compile and share electronic health information regarding the Member, their treatment and services. Include data elements to be shared, formatting and transmittal methods, and staffing/resource plans to facilitate data transfers to the Receiving CCO(s).

AllCare's Transition of Care (ToC) program will be activated when a member chooses another CCO. AllCare will provide the following information for the receiving CCO once we are notified by OHA which CCO is involved and for which Member. Post notification, our ToC policies will, within the OAR timeframe, compile and transmit the following data, including but not limited to the following:
- Current prior authorizations and pre-existing orders;
- Prior authorizations for any services rendered in the preceding 24 months;
- Current behavioral health services provided;
- List of all active prescriptions; and
- Current ICD-10 diagnoses

AllCare hopes to operationalize ToC in the most sustainable and automated way possible. This will require establishing EDI/API mapping standards and guidance in the form of companion guides and partner CCOs to peer

data requests through the ToC predecessor/receiving CCO relationship. Without centralized standards or exchanges this effort will have to be multiplied times the number of CCOs awarded.

(2)   Provider Matching

This section should describe the methods for identifying Members' primary care and Behavioral Health home Providers and any specialty Providers, and transmitting that information to the Receiving CCO(s).

AllCare currently contracts with approximately 95% of the Medicaid enrolled primary care providers across our service area, 100% of Medicaid enrolled behavioral health providers and four Dental Care Organizations (DCOs). If one of our CCO members elects to switch CCOs while maintaining their relationship with their assigned primary care provider and/or behavioral health provider, AllCare can easily share the Member's personal health information via our web-based Provider Portal and the provider's electronic health record (EHR). Approximately 95% of our primary care providers have an existing EHR. The same capability is available to our contracted behavioral health providers.

(3)   Continuity of Care

This section should describe plans to support Member continuity of care, including but not limited to Prior Authorizations, prescription medications, medical Case Management Services, and Transportation. This section should include all Members regardless of health status with specific details to address those Members at risk as described in Section (1).

AllCare's continuity of care plan addresses two types of transitions: 1) transitions that will occur due to the open enrollment period in the Fall of 2019 for the 2020 contract year which could involve a substantial number of members all at once; and 2) ongoing transitions that occur throughout the contract year which are considerably less throughout the year. For transitions during open enrollment, AllCare will stratify receiving members based on the information delineated in item b (1) above. For those members who present with any conditions that are expressly delineated as needing intensive care coordination, AllCare will prioritize conducting Health Risk-Assessment Surveys (HRS) for transmitting members and refer the member for care coordination and care transition needs in collaboration with the transferring CCO. For members transitioning from AllCare to another CCO who require in intensive care coordination, we will coordinate with the receiving CCO to ensure continuity of care and/or agree to delay transition until the member has completed their current care plan.

For members transitioning to AllCare through the open enrollment process who do not indicate the need for immediate intervention, AllCare will ensure they have an assigned PCP and will assist in scheduling a PCP appointment within 90 days if the Member has not had a PCP visit within the last year. This includes new Member activities including initial health risk assessments and transmission of new Member Handbooks.

For all members who switch CCOs, AllCare will continue to assist with those transitions, either as a receiving CCO or a transitioning CCO as described above.

c.   Member/Provider Outreach for Transition Activities

This section should describe plans to work directly with outgoing Members and their Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping Members and Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Receiving CCO to ensure a seamless transition of care for the Member.

For outgoing members who are identified through our Member Services Department and/or through our Care Coordination team a need for additional support during transition, AllCare will help members by explaining the process and advocating on their behalf with their new CCO. The Care Coordinators will reach out to the receiving CCO case management team to facilitate a Warm Hand-off and explain any special needs that need to be addressed for each Member.

d.   Receiving CCOs with Incoming Members

(1)   Data Sharing

This section should describe the data reception plan for incoming Members, including but not limited to receiving and storing data files, front-end validation, system entry, output validation, and distribution.

This section is predicated on the assumption and belief that the OHA is in a unique position to provide the predecessor CCO in the 834 eligibility file or other EDI capacity so that AllCare can identify which CCO is the predecessor to seek incoming data files from. AllCare will need to coordinate with the other CCOs to establish agreements regarding a data reception plan for incoming members for both receiving and transitioning CCOs. It is our plan to initiate those discussions upon award of the CCO 2.0 contract at which point we will know which organizations need to participate. In the case of AllCare peering with more technologically

advanced CCOs, AllCare is eager to establish this data transfer with EDI and APIs for the most automatable, complete, and scalable solutions.

(2)   Provider Matching

This section should describe the methods for identifying Members' primary care and Behavioral Health home Providers and any specialty Providers, and enrolling Members with their assigned Providers. This includes contingency plans for assigning Members to appropriate Providers if they cannot be enrolled with the Provider from the Transferring CCO.

Provider matching will occur by utilizing data from the predecessor CCO; through member outreach by our Member Services Department; through our Care Coordination and outreach team; through our Utilization Management service requests, and through claims submissions.

(3)   Continuity of Care

This section should describe plans to support Member continuity of care, including but not limited to honoring Prior Authorizations, prescription medications, and Treatment Plans from the Transferring CCO, medical Case Management Services, and Transportation. This section should address the approach for all Members regardless of health status with specific details to address those persons described in Section (1). As the receiving CCO, the plan should address how the Receiving CCO will ensure access to all medically necessary services for Members at risk of serious detriment to their physical and mental health, hospitalization, or institutionalization.

- All Medicaid covered services will be allowed without prior authorization for new Members who meet Transitions of Care criteria, including:
  o Time limits for services that require Transitions of Care within 30 days for physical and oral care, within 60 days behavioral health care, and 90 days for the dual eligible.
- The Claims Department will pay for covered services regardless of plan requirements for non-contracted providers and non-contracted place of service. The Transitions of Care plan starts with the first date of eligibility on the plan and ends at 30, 60 or 90 days after the first date of eligibility depending on the type of service required as defined above.
- Excluded services include any current health-related services (flex services) that are not included within the Transitions of Care Plan.
- It is AllCare's plan to request information from the transitioning CCO including but not limited to the following:
  o Current prior authorizations and pre-existing conditions;

- o Prior authorizations for any services rendered in the preceding 24 months;
- o Current behavioral health services provided;
- o List of all active prescriptions; and
- o Current ICD-10 diagnoses
- Within the first 30 days of enrollment with AllCare, the Population Health department staff will monitor services received by the new Member that require prior authorization and will reach out to the Member and their Provider to facilitate the PA process as defined by AllCare.
- The ability for AllCare to operationalize this process will be dependent upon OHA's identification of the transitioning CCO's members.

(4)   Member/Provider Outreach for Transition Activities

This section should describe plans to work directly with incoming Members and their Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping Members and Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Transferring CCO to ensure a seamless transition of care for the Member.

For incoming members, our care coordinators will engage all Transitions of Care members for an initial health risk assessment to assess current needs.

Our Care Coordination and Member Services staff will help coordinate care for the Member, assisting with transition to in-network providers, accessing needed DME, and utilizing our formulary for prescription drugs. Requests for Health Related Services will be reviewed. And finally, we will ensure that providers have access to their patients' care plans for routine follow-up.

3.   Reference Documents:

- 2019 Contract Extension, Contract Termination and Closeout Requirements
- OAR 410-141-3061 Transition of Care Requirements
- OAR 410-141-3258 Contract Termination and Closeout Requirements
- Oregon's K Plan web page
- Oregon's Application for a 1915(c) HCBS Waiver